Care Quality Commission

Eagle View Care Home Limited

Eagle View Care Home

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Good
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Good

Overall summary

This inspection took place on 4 September 2015 and was unannounced. We last inspected this service on 4 August 2014 when the service was meeting the regulations.

Eagle View Care Home offers accommodation and personal care for up to 40 older people or people living with dementia. No nursing care is offered at this service. There were 39 people resident at the service on the day we inspected.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run. We received positive feedback about the registered manager throughout the inspection.

Staff understood what it meant to keep people safe and we saw that they had been trained in safeguarding adults. Staff had been recruited safely.

Medicines were managed safely by staff who had received appropriate training.

Summary of findings

The service had the beginnings of a dementia friendly environment in order to support people living with dementia to be able to be as independent as possible but further work was necessary. There were plans in place for those improvements to be made. We have recommended that the registered provider look at guidance around caring for people living with dementia and in particular dementia friendly environments.

Staff knew the people they cared for and were well trained in areas that related to the people they cared for. Staff worked within the principles of the Mental Capacity Act 2005.

The service was caring. From our observations during the day we saw that staff knew people well and saw that staff approached and spoke with people kindly and with respect. Staff were at times task orientated but the majority of interactions we witnessed were friendly and supportive.

The support for people who used the service at mealtimes was varied with some examples of poor practice around supporting people to eat and drink. We have recommended that the registered provider look at guidance in this area.

Although some people were offered and enjoyed activities throughout the day others were not stimulated by any activity which meant that there was a risk of social isolation for some people. We have recommended that the provider look at guidance around activities.

There was a quality assurance system in place which used audits in each area of the service so that there was a consistent approach to improvement. Areas of concern had been noted for action.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

This service was safe.

Staff understood what it meant to keep people safe and we saw that they had been trained in safeguarding adults. Staff had been recruited safely.

Medicines were managed safely. The registered manager ensured that servicing and safety checks were carried out ensured that people who used the service had access to safe premises and equipment.

Is the service effective?

Requires improvement

This service was not always effective. The service was beginning to make the appropriate changes needed to the environment in order to support people living with dementia to be able to be as independent as possible but further work was necessary.

Staff knew the people they cared for and were well trained in areas that related to the people they cared for. However, staff did not always support people appropriately when assisting them to eat and drink.

Staff worked within the principles of the Mental Capacity Act 2005. They had received training and were aware of how to apply for an authorisation for a person to be deprived of their liberty lawfully.

Is the service caring?

Good

The service was caring. From our observations during the day we saw that staff knew people well and saw that staff approached and spoke with people kindly and with respect. Staff were at times task orientated but the majority of interactions we witnessed were friendly and supportive.

We saw an example of a member of staff who showed care and compassion when dealing with a person who used the service.

Staff knocked on people's doors before entering.

Is the service responsive?

Requires improvement

The service was caring. From our observations during the day we saw that staff knew people well and saw that staff approached and spoke with people kindly and with respect. Staff were at times task orientated but the majority of interactions we witnessed were friendly and supportive.

We saw an example of a member of staff who showed care and compassion when dealing with a person who used the service.

Staff knocked on people's doors before entering.

Summary of findings

Is the service well-led?

Good

The service was well led. There was a manager in post who was registered with CQC.

The management team had identified any areas needing improvement and had developed an action plan for refurbishment.

There was a quality assurance system in place which used audits in each area of the service so that there was a consistent approach to improvement.

Eagle View Care 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 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 4 September 2015 and was unannounced. The inspection team was made up of an inspector and a specialist advisor who had experience of general and mental health nursing.

Prior to the inspection we looked at all notifications we had received from or about the service. We spoke with the local authority contracting and quality assurance officer for this service who told us that they had no concerns.

During the inspection we looked at five care and support plans, inspected six staff recruitment files and training records, a random selection of medication administration records, observed practice throughout the day and we 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 observed how medicine was managed and observed a lunchtime period in two dining rooms: one on the top floor and one on the ground floor. We analysed staff rotas, audits that had been completed, accident and incident reports and other documents which related to the running of this service.

We spoke with the registered manager, six care workers, and the administrator. We also spoke with a group of four people who used the service and observed eight other people as they were unable to talk to us. Two relatives, a district nurse and a GP spoke with us during the course of the day.

Good

Is the service safe?

Our findings

On our arrival at the service the fire alarm sounded. We waited in the entrance area following instruction from the fire marshall. Staff arrived quickly at the designated area and were told to care for people in the adjacent lounge, whilst other staff were allocated to check the source of the alarms and check the fire doors as directed in the fire risk assessment and plan. The source of the alarm was quickly identified, and the alarm was cancelled. Observation of the process indicated that it was carried out in a competent and safe manner and that staff were aware of their roles.

Staff understood what it meant to keep people safe and we saw that they had been trained in safeguarding adults. The care workers that we spoke to on the day of inspection demonstrated a good awareness of how to safeguard people and whistleblowing. A whistleblower is a worker who reports certain types of wrongdoing. They were able to articulate key issues that they would consider in relation to potential abuse by either staff or family members and were able to tell us who and how they would alert anyone if they witnessed abuse. There had been two concerns raised with CQC since the last inspection, one of which was referred to the local authority as a safeguarding alert by the registered manager. A safeguarding alert is the raising of a concern, suspicion or allegation of potential abuse or harm. The second concern was investigated by the service as a complaint. People could be confident that the registered manager was clear about their responsibilities in relation to safeguarding people when there had been incidents of abuse and would respond to incidents appropriately.

Staff employed by the service had been recruited safely. We looked at six staff recruitment files and saw Disclosure and Barring Service (DBS) checks and two references for each person. DBS, which was formerly known as the criminal records bureau, carries out checks which are used by employers to make sure that the people they employ are suitable to work with people who used the service.

On the day of the inspection there were two senior care workers, six care workers, two chefs, one cleaner, a laundry assistant, an administrator and the registered manager on duty caring for 39 people. We were told that there were five staff working at night and there was always a senior care worker on duty. The staff worked over three floors. We saw that there were sufficient staff on duty to meet people's needs.

When asked people who used the service told us they felt safe and we observed that people were safe. One person said, "Oh yes I'm safe here." A relative said, "I can go home and not worry about (relative)." They went on to tell us that if staff had any concerns they telephoned them.

We looked at staff rotas and spoke with staff and visitors about staffing levels. One care worker told us that staffing levels were, "Ok most of the time, but there are occasional pressures if folk are off sick and on holiday." During the inspection we saw that staff responded quickly to people's needs and a relative of a person who used the service said, "The staff are always around if we need them."

We saw that the communal areas were supervised throughout the day and at mealtimes staff were in sufficient numbers to assist people with eating and drinking. Based on the current level of occupancy, and the observed levels of dependency of people living at the home, the level of staff available appeared to be sufficient.

We looked at the systems in place for managing medicines and found that this was done safely. We observed a medicine round being carried out safely and competently. Medicines for people were stored in the 'nurse's room' on the first floor. This room was also used for District nurses records and equipment. There was adequate space for the three medicine trolleys, and had adequate cupboard storage space. Refrigerators for storing medicines were checked daily and were within the prescribed range but the room temperatures had been recorded as too warm during the hottest months of June, July and August. On some occasions they had exceeded the temperature recommended by the Pharmaceutical Society of 25 degrees centigrade. The rooms would benefit from a cooling system being installed to prevent this happening.

Pharmacy services were provided locally with a standard monitored dose system (MDS) used over a four week cycle. Medicine administration records (MAR) sheets were reviewed for a sample of 6 people, and were noted to be completed accurately. Any refused medicines were disposed of correctly in line with service policy and returned to the pharmacy.

Senior care workers administered medicines and there was a record of sample signatures. We were told by the senior care worker that they undertook an annual competency review. This was confirmed by the training records we

Good

Is the service safe?

looked at and we also saw that staff had received training in medicines administration. This meant that medicines were administered by people who were properly trained ensuring that people received their medicines safely.

People were prescribed medicines to be taken only 'when required'. These medicines needed to be given with regard to the individual needs and preferences of the person. There were clear descriptions of the circumstances in which these medicines could be administered and the amount enabling staff to support people to take these medicines correctly and consistently.

We checked the storage and recording and carried out a random check of the controlled drugs stock. These were correct and up to date. Controlled drugs are subject to the Misuse of Drugs Act 1971 which is intended to prevent their non-medical use.

We saw policies and procedures for managing medicines safely and saw that audits had been completed.

There were records available to show that regular maintenance and servicing of equipment had taken place.

The environmental health officer had visited to check food handling practices and the service had been awarded a rating of 5 which meant that they were exceeding the expected standards. The fire safety officer had visited in January 2015 and found the service to be meeting fire safety standards. This meant that the registered manager was doing all they could to maintain peoples safety by making sure that the equipment and the environment was fit for purpose.

During the inspection we were told that there was money kept on the premises for people who used the service. Each person had a separate wallet which was kept in the services safe. They could access their money at any time.The accounts for this money were computerised and every transaction had a receipt and was recorded by the administrator. We randomly checked one person's money which was correct. Because these processes were followed creating an audit trail there was less chance of financial abuse at this service.

Requires improvement

Is the service effective?

Our findings

When we asked people if the staff looked after them well one said, "They are looking after me" and another said, "They look after us really well." A visitor told us, "I am very happy with the service." And another told us, "The staff are good."

We saw that staff were trained in areas that related to the people they cared for. Staff received an induction and during the probationary period they completed all the training that they would need to carry out their role was completed. They worked alongside other staff that provided supervision to new members of staff. The company used an online training system which staff could access to complete their training as well as face to face trainers for practical skills such as moving and handling. They completed training in subjects such as safeguarding adults, dementia, mental capacity act and deprivation of liberty, manual handling and food safety. This meant that people were supported by staff who knew what they were doing which reduced the risk of poor care.

One member of staff told us, "I have had my induction. I had a one to one with the manager and worked with other carers and the seniors. There is always someone to lend a hand and everyone here works together." Another member of staff said, "I feel as if we get enough training. It is good." By investing in the training of staff the company were developing a workforce with knowledge and skills appropriate to their roles.

Staff had received training around the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty safeguards (DoLS) and were aware of their responsibilities in respect of this legislation. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). There were seven people being legally deprived of their liberty with authorisations in place. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met and we found there were no specific conditions in place.

People who used the service told us that they liked the food that was provided. We observed a meal being served at lunchtime in the top floor and ground floor dining rooms and we observed some people being supported with eating and drinking. Tables had been set with cutlery and condiments were available on the table. There were pictures of foods on the walls which showed people that this was a dining room. People were given support but there were some inconsistencies with care workers practice.

In the top floor dining room staff were sat at two of the tables with people who needed some assistance to eat, but they were not always focussed on people. One care worker left a person that they were assisting to eat three times to help clear other people's tables. This was distracting for the person. One person could not eat because they could not use their knife. Nothing was done immediately although a care worker eventually assisted the person. In the ground floor dining room however there was cheerful banter between people who used the service and the care worker. People did not need assistance to eat but the care worker supervised the dining room and gave people drinks or food when they were requested. When one person came to the dining room in pyjamas they were encouraged to join a table and eat their lunch. This meant that the support that people received at mealtimes was varied which could impact on people's wellbeing.

Staff told us, "Residents can ask if they want something and residents can have a hot or cold drink any time." In one lounge we saw a member of staff giving people drinks. They made sure that people had the appropriate drinking vessel and that they had a table beside them on which to rest their drink. In one case we observed them offer to change a drink for someone as it had gone cold. They made sure that everyone in the lounge got regular drinks. Some people's records indicated that they were not receiving sufficient fluids, but we had seen that people were given regular

Requires improvement

Is the service effective?

fluids so therefore were not at risk of dehydration but records needed to be improved. We highlighted this to the registered manager who agreed to look into this immediately.

Care workers used the Malnutrition universal screening tool (MUST) to identify if people were at risk of malnutrition. Use of this tool enabled staff to identify the most appropriate action to take.

Where there is a risk to a person's health because of weight loss identified a referral is requested through the GP for the dietician or speech and language therapist.

We saw in care files that people had access to health professionals when they needed medical support such as district nurses, optician, dietician and speech and language therapist. During the inspection we were able to speak with a district nurse and a GP. The GP said, "I have no concerns about this service. They call me appropriately and I can rely on the staff to call when a patient is ill. They call in a timely manner and staff are reliable." The district nurse said, "Staff follow instructions straight away. I sometimes don't need to ask them. They stay with us when we visit, take notes and do anything that needs doing." Staff were proactive in identifying when people required medical support.

We noticed as we looked around the service that it was fresh and clean with no malodours. However, the carpets in some areas were very worn. Some furniture in the dining room was mismatched and the chairs were stained. The registered manager told us that there were plans in place to upgrade the environment and furniture.

The service had gone some way to making this a dementia friendly environment but further work was necessary. We saw tactile wall hangings, pictures and there was music playing softly in some areas. However, there were areas in need of further improvement as we saw signage was basic and there were no orientation adjustments. For example, different coloured doors, identifying words or pictures on doors, contrasting colours for toilet seats. These adjustments could assist people living with dementia to be as independent as possible within their own environment. As all the people living at this service were living with dementia, there appeared to be a need for a clearly identified Dementia Lead or Champion who could develop a strategy and improve consistently throughout the service.

We recommend that the service considers best practice guidance around caring for people living with dementia; in particular supporting people to eat and drink and dementia friendly environments.

Good

Is the service caring?

Our findings

People who used the service told us, “The staff I know are okay” and “They look after us well” Visitors were complimentary about staff saying, “I am very happy with this service.”

A district nurse we spoke with told us that there were, “Friendly and helpful staff” at the service and a GP we spoke with said, “Staff are reliable.” People were well dressed and looked cared for.

From our observations during the inspection we saw that staff knew people well and saw that staff approached and spoke with people in a kindly fashion and with respect. One member of staff spoke to a person who used the service quietly and respectfully when asking if they needed any assistance to go to the bathroom. They got down to the persons level as they were seated and used touch on the persons arm to reassure them. This added warmth to the interaction and meant that others were not aware of what was said and maintained the person’s dignity.

Staff respected people’s privacy by knocking on doors before entering rooms and closing toilet and bathroom doors when people who used the service used them. Explanations were given by staff when they attended to people’s personal care needs and interventions that we witnessed were unhurried. In contrast the experience of one person at lunch time was not dignified with staff standing to feed them which was not a person centred approach. This showed that some staff responses were inconsistent and not person centred. However our overall impression during the day of the inspection was that staff were caring.

In several cases the conversation of residents between themselves and with staff was peppered with humorous remarks. We sat with three people who used the service in the entrance hall and they were laughing and having some banter between themselves. This helped to give a relaxed feel to the service. One relative told us that when their relatives telephone was broken staff loaned them theirs so that they could speak to their family. This was important to this person and staff had recognised the need to maintain that contact. The relative of this person told us, “(Relative) is happy here and the carers are great.”

Relatives told us they were free to visit at any time. When we spoke to one relative they told us that staff shared information with them and said, “They ring me if there are any problems” and another said, “If I want to discuss anything I can just knock on the managers door.”

Requires improvement

Is the service responsive?

Our findings

People's care and support needs had been assessed before they moved into this service. This meant the service ensured they could meet people's needs before they moved in. We saw records confirmed people's preferences, interests, likes and dislikes and these had been recorded in their care plan.

People and their families had been involved in discussions about their care and any associated risks and told us they liked to be involved. One relative told us, "I come in an afternoon and staff tell me about anything that I need to know."

Care plans were personalised and contained information about people's needs. There were comprehensive assessments, care plans and risk assessments for each person which included areas such as mobility, nutrition and skin care. These had been reviewed although there were some inconsistencies in recording.

Some of the records were not routinely available for care workers and it was not possible to cross reference care required and planned and the care that was actually delivered. Discussion with care workers revealed that they do not routinely have access to the assessments and care plans as they are locked in the nurse's room and their knowledge of what care was required was generated from the shift handover. In addition there were some inconsistencies in recording in daily notes and charts. This meant that there was potential for a lack of clarity about peoples care needs and how that care should be delivered. However, relatives told us and we observed that people were well cared for. The care workers would benefit from a revised system which gave them access to care plans and risk assessments which could be reviewed daily

We recommend that the service considers best practice around record keeping .

Although some people were offered and enjoyed activities throughout the day others were not stimulated by any activity which meant that there was a risk of social isolation for some people. The registered manager told us people living in the home were offered a range of social activities and that an activities co-ordinator was employed to support people with activities. We saw the activities co-ordinator was working on the day of our inspection but they were out with one person in the morning. The activities that were on offer were on the activities board and there was a newsletter produced which included dates for your diary to advertise events. The service was getting ready for its summer fair the following week.

However, it was difficult to decide what should be happening on the day of inspection from the activities board because it was disorganised. In addition there did not appear to be any personalised meaningful activities being organised that day. Much of the staff time was being channelled into tasks such as bathing, toileting and serving of drinks and meals which although important did not encourage much social stimulation and interaction. One care worker told us, "We would like to do more with people here but we don't get time" and, "People are not stimulated enough. It's a bit of a let down really." This was echoed by a relative who told us, "They need more activities."

Some people were sitting in the lounge area on the ground floor for long periods with little interaction (morning and afternoon), other than occasional staff contact when staff spoke to them in passing. However, in the main lounge on the first floor we sat and observed for a period during the morning. There were 10 people sat in the lounge who were all living with dementia. We saw that there was a member of staff in the lounge all the time and that they were interacting with people. They went to each person that was awake and chatted. As they did this people became more alert and started to join in which demonstrated that everyone would benefit from these types of interaction. In addition a more dementia friendly environment would encourage independent social interactions and stimulation.

There was a proposed programme of activities but people were not always aware of what was on offer which meant that not everyone was benefiting from activities which could result in social isolation for some people.

We recommend that the registered provider looks at best practice guidance around activities for people living with dementia.

We saw that there was information available for people to be able to make a complaint. There had been five complaints about the service since our last inspection. Two of these were on going but the others had been dealt with

Requires improvement

Is the service responsive?

in line with the service policy. There was a record of complaints kept and actions taken. This meant that the service took peoples comments seriously and acted upon them.

Good

Is the service well-led?

Our findings

We received positive comments about the registered manager of this service. A relative told us, “They are always bright, bubbly and cheerful.” Relatives were confident that they would sort out any issues that they raised. Staff told us they felt supported by the registered manager.

We saw that the registered manager attended management meetings and had also arranged staff meetings at the service for both day and night staff. We saw that these were minuted and saw that discussions had taken place about the planned changes within the company. This demonstrated that the registered manager kept themselves and staff informed about important events within the service.

The registered manager had also arranged resident and family meetings but at the last planned meeting in July 2015 no one had attended which could suggest that more convenient times for meetings or an alternative way of seeking feedback from people and there relatives may be of benefit.

The registered manager was efficient and well-motivated, and keen to develop the service. They told us that a new management company had recently taken over as the provider of this service. They highlighted areas where improvements were still needed and how an upgrade of the environment and furniture was planned by them to make the service a more dementia friendly environment. The registered manager was able to show us some documentation which confirmed the proposed improvements.

The registered manager was open and transparent during the inspection and was realistic about the improvements still needed in their discussions about the service with the inspector. They shared a clear vision for the future of this service and were able to tell us what plans were in place.

There was an effective quality assurance system in place which included audits for each area of the service. We looked at the audits and saw that any matters that were identified for improvement had been added to an action plan. For example, the catering audit had identified three areas for improvement one of which was linked to the planned improvements.

We saw that audits had been completed for medication in July 2015 and there was also medication weekly audit of medicines to ensure that any issues were captured at an early stage and improvements made. Audits were also in place for infection control, nutrition and health and safety and were completed monthly.

Up to date policies and procedures were in place and staff had signed to say they had read them. We saw that there were new policies and procedures in place ready to be introduced but the staff continued to use the existing policies and procedures until the new system had been fully rolled out. The policies and procedures which were up to date provided the support staff required to be able to carry out activities using up to date guidance.

The registered manager had made statutory notifications to CQC when they were required. These give us information about any events at the service that the registered manager was required by law to tell us about.