Community Integrated Care

Eachstep Blackley

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 24 and 25 April 2018 and was unannounced. We last inspected Eachstep Blackley in April 2017 and rated the service as Good overall with an outstanding rating for the well led domain. This is the first inspection the service has been rated as requires improvement.

Eachstep Blackley is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Eachstep Blackley accommodates up to 60 people. There are five households across three floors. Two households provide nursing care and three provide residential care for people living with dementia. At the time of our inspection there were 54 people living at the home.

There was a registered manager who had managed the service since it opened in 2012. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At this inspection we found breaches in the regulations for person-centred care, safe care and treatment and good governance.

Care plans and risk assessments for people living in the residential households did not contain sufficient information and guidance for the staff to follow to meet people's identified needs. Where risks had been identified there were no associated care plans on how these risks would be managed. Care plans and risk assessments for people living in the two nursing units did contain the required information and guidance.

A care plan champion had been appointed whose role was to support the senior carers on the residential units to review and update the care plans.

A quality assurance system was in place which reviewed a range of areas in the home. Accidents and incidents were reviewed by the registered manager to identify any patterns. Audits were completed for health and safety, care plans and medication. The provider's area manager visited the home regularly and completed their own observations and checks. However this had not identified the issues we found with the care plans on the residential units.

You can see what action we told the provider to take at the back of the full version of the report.

Call bells and requests for support were answered promptly; however we noted the lounge / kitchen areas were left unattended at times and we saw people enter other people's rooms uninvited. We have made a

recommendation for current staffing deployments to be reviewed, including the use of domestic staff, to ensure communal areas are not left unattended for long periods during the busy morning period.

People received their medicines as prescribed; however the recording of any medicines carried over from one month to the next was not always clear. We have made a recommendation that national guidelines are followed to record how people will communicate, verbally or non-verbally, that they require an 'as required' medicine to be administered.

People's confidential care files were stored in lockable cupboards in a quiet area of each household. We have made a recommendation that these cupboards are kept locked when not being accessed by the care staff.

People and their relatives said they felt safe living at Eachstep Blackley and that staff were kind, caring and treated them with dignity and respect. People said they were supported to maintain their independence by completing the tasks they were able to do themselves.

A robust recruitment system was in place. Staff received the training and support to undertake their roles through supervision meetings and staff meetings. New staff completed their initial training and shadowed experienced staff so they were able to get to know the people they would be supporting and their needs.

Staff told us that the management team were approachable and supportive.

There was a calm atmosphere at the home throughout our inspection. People were able to get up whenever they wanted, with staff members providing breakfast for people throughout the morning. The home was clean throughout. Equipment was checked and serviced according to national guidelines and the manufacturer's instructions.

People were supported to maintain their health and nutrition. Culturally appropriate food was prepared for those people who wanted it. Visiting health professionals were positive about the service, said staff had the information they asked for and followed any guidance they were given. Referrals to health professionals, such as GPs and district nurses were appropriately made.

The service was working within the principles of the Mental Capacity Act (2005). Capacity assessments and best interest meetings were completed where required and applications made for a Deprivation of Liberty Safeguards (DoLS) where a person was found to lack the capacity to make a decision.

People and their families were encouraged to be involved in their care through residents meetings and surveys. A families forum had been established which provided an opportunity for family members to meet to discuss any issues or concerns they may have about the home.

Information about people's life history, likes and dislikes was recorded, although this varied in detail depending how much information was provided by people's families if they were not able to provide it themselves.

A programme of activities was in place which people could choose to be involved in. Many of these took place in the ground floor. The service also had a café, which was also open to members of the public. However we saw people had little stimulation on the individual households.

The home had made many links with their local community, including the local primary school and cubs.

Eachstep facilitated a dementia café. The home was actively involved in research projects. A new project in conjunction with Lancaster University aimed to assess if involving people in everyday tasks, such as cleaning their room or setting the tables, could delay the progression of the person's dementia.

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.

Risk assessments on the residential households did not contain sufficient guidance for staff to reduce the identified risks.

People received their medicines as prescribed. Protocols for 'as required' medication did not contain details of how people would communicate if they needed the medicine.

Requests for support were responded to promptly. However there were times when the communal areas were left unattended as staff were supporting people in their rooms.

Is the service effective?

Good

The service was effective.

Staff received the induction training and support to carry out their roles.

The service followed the principles of the Mental Capacity Act (2005)

People's health and nutritional needs were met.

Is the service caring?

Good

The service was caring.

People and relatives told us staff treated them with kindness, dignity and respect.

People's confidential care files were stored in lockable cupboards in a quiet part of each household. We have made a recommendation that these are locked when not being accessed by staff.

People's preferences and life histories were recorded.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care plans on the residential households did not contain sufficient information and guidance for the staff team.

An activities programme was in place, most of which took place on the ground floor. Stimulation on the individuals households was limited.

People's end of life care wishes were not recorded; however a visiting health professional was positive about the end of life care provided.

Is the service well-led?

Requires Improvement

The service was not always well-led.

A quality assurance system was in place; however this had not been sufficiently robust to identify the shortfalls found during our inspection.

A range of community links had been established, including with research institutes.

People and relatives were able to comment on the service through surveys, residents meetings and a family forum.

Eachstep Blackley

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 checked 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 prompted in part by an increase in the notifications of incidents at the home and the receipt of 'Share Your Experience' forms from relatives of people living at the home. Share your experience forms allow people to provide feedback about a service directly to the Care Quality Commission.

The information shared with CQC indicated potential concerns about the management of risk of falls and behaviour that may challenge the service. This inspection examined those risks.

This inspection took place on 24 and 25 April 2018. The first day of the inspection was unannounced. The inspection team consisted of three inspectors and an expert by experience on the first day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert had experience of services for older people. Two inspectors returned for the second day of the inspection.

We did not ask the provider to complete a provider information return (PIR). The PIR 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.

Prior to our inspection visit we reviewed the information we held about the service. We looked at the statutory notifications the home had sent us. A statutory notification is information about important events, which the provider is required to send to us by law. We contacted the local authority safeguarding and commissioning teams. They did not raise any concerns about Eachstep Blackley. We also contacted Trafford Healthwatch who said they did not have any information about the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

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 also observed people's mealtime experience and interaction between people using the service and staff throughout the inspection.

During the inspection, we spoke with eight people who used the service, eight people's relatives, three nurses, 12 members of care staff, two visiting health professionals, the activities co-ordinator, the registered manger, deputy manager and the provider's area manager.

We looked at records relating to the management of the service such as the staffing rota, policies, incident and accident records, three staff recruitment files and training records, seven care plans, meeting minutes and auditing systems.

Following our inspection we contacted a member of the Speech and Language Team (SALT) and the MacMillan nurse service. Their feedback can be seen within the body of the report.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe living at Eachstep Blackley. One person said, "Safe very much so" and another, "I feel safe here. The girl's (care staff) will help if someone is shouting." Relatives we spoke with told us that that they were happy with the care and support provided and had no concerns with regard to the safety of their relatives. One said, "Very safe here" and another, "I trust these people with my mum."

We found a marked difference in the identification, assessment and management of the risks people may face between the two nursing households and the three residential households.

On the nursing households we saw people's care records identified risks to their health and wellbeing, including the risk of falls, moving and handling, pressure ulcers and mal-nutrition using the Malnutrition Universal Screening Tool (MUST). Guidance was provided for staff as to how the identified risks were to be managed and mitigated.

However on the residential households we saw that whilst some risks had been identified there were no associated care plans to guide staff in how to support the person to reduce these known risks. For example, two people who were known to be at risk of falls did not have a falls risk assessment or falls care plan in place. Five people we reviewed were known to display behaviours that challenged the service and we saw behaviour monitoring charts had been completed by staff. Three people did not have a risk assessment, care plan or guidance around supporting the person when they displayed behaviours that challenged. Two people did have care plans in place for managing behaviour. This gave guidance to staff on how to try to reduce the person's agitation and how to use the MAPA (Management of Actual or Potential Aggression) techniques if required. MAPA is a recognised management and intervention technique for coping with escalating behaviour in a professional and safe manner.

We saw incident forms had been completed following each fall which were reviewed by the registered manager. We were shown a falls intervention file which logged each fall and noted where the fall happened, what time it occurred, what action was taken to further reduce the risk for example if a sensor was in place or a referral to the falls team had been made and if there were any trends or patterns to the falls across the home. The form prompted for the risk assessments to be reviewed; however, as noted above, the risk assessments did not provide guidance for staff in how to reduce the risks people faced. Any actions taken to reduce the risks were not easily seen in people's care files as the intervention file was held centrally. We noted that there was not a high rate of falls at the home.

We reviewed three people's Waterlow risk assessments which showed they were at risk of developing pressure sores. There was no information to show how the known risk was being managed.

We discussed the lack of risk assessments with the registered manager. We were told all the guidance for supporting people should be within the 'routines' for the start and end of the day section in their care plans. These were not effective, were very brief and did not provide sufficient guidance for staff on how to mitigate any of the identified risks.

The lack of risk assessments and management plans was a breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regard to 2 (a) (b).

During our inspection we were told a nurse had been nominated as a 'care plan champion'. They had completed an audit for the nursing units and were due to support the senior care workers from across the residential households to improve the risk assessments.

We did see one residential care file for a person who had lived at Eachstep for 18 months who did have risk assessments and associated care plans in place to manage the identified risks.

Staff we spoke with were aware of the safeguarding procedures at the home. They understood how to report any safeguarding concerns and confirmed they had received safeguarding training. They told us they would report any concerns to the management team and were confident they would deal with any issues promptly and appropriately. They were also aware they could report concerns to other relevant agencies, for example the local authority or Care Quality Commission.

We asked people, relatives and staff about the number of staff on duty and received a mixed response. One relative said, "I do feel there's not a lot of staff, I've never seen staff on 1:1 with anyone, they're always busy" whilst another told us, "There's adequate (staff) numbers, but I don't know how many staff should be on duty."

At night there were five staff on duty, which included the senior staff member who administered medication, across all three residential households between 10pm and 8am. During the day there were five care staff and two senior staff across the three residential households. Two of the day staff worked an extended shift until 10pm to assist people going to bed. Some staff said there were sufficient staff, however others felt there were too few as the senior staff had to administer medicines and complete other tasks (such as reviewing care plans) which could leave one staff working on their own on a household.

From our observations we saw that call bells and requests for support were responded to promptly. However we also observed in the morning where there were no staff available in the lounge / kitchen area of the household for up to 20 minutes at a time as they were supporting people in their rooms. This could put people at risk as the people in the lounge area during this time were known to sometimes display behaviours that challenged and two of the people were at risk of falls.

We also saw people walking into other people's rooms. In one instance this caused the person to become vocal in telling the person to leave their room. On Thornlea household we observed one person repeatedly going in other people's rooms but staff were unaware of this. This included going into one person's room three times when they were in bed.

We saw domestic staff members talked with and supported people to mobilise if required when they were on the households. The domestic staff had completed all the relevant care training.

One staff member said, "There is not enough staff. Support workers are left a lot because seniors have other things to do. I'm concerned they (the people living on the household) are at risk."

On the nursing households there were four care staff and one nurse across both households at night. During the day there was one nurse and three care staff for each household. In addition there was one care staff working between 9am and 3pm and four care staff supporting people on a 1:1 basis. Staff on the nursing households felt there were enough staff to meet people's needs.

We discussed this with the registered manager who told us the home used the Isaac and Neville Intervals of need dependency tool to assess the number of staff required. However they also had flexibility to increase the staffing if required, for example if a person was unwell and needed extra support. Additional staff had also been deployed in the evening as it had been noticed that people became more anxious at this time of the day. They also explained that the domestic staff could also support people if required.

We recommend that the staffing deployment, including the use of domestic staff, is reviewed to ensure the lounge / kitchen areas are not left unattended for long periods during the busy morning period.

The home had a robust recruitment procedure in place. Staff files included an application form. Any gaps in employment were noted and explored at interview. References were obtained and appropriate checks had been made with the disclosure and barring service (DBS). The DBS checks to ensure that the person is suitable to work with vulnerable people. This meant the people who used the service were protected from the risks of unsuitable staff being recruited.

Each person's medicines were stored in a locked cabinet in their own room. A senior support worker told us this worked well as it ensured people received personalised support in the privacy of their own room.

We found there were no gaps within the medicine administration records (MARs); however, sometimes it was difficult to establish if staff had signed to confirm the medicine had been administered or if they had used a specific code to confirm the medicine was not administered, for example refused or not required. The registered manager reviewed two of the MARs and acknowledged these were not clear and agreed to discuss this with the staff team who were responsible for administering medicines. We also noted that the amount of tablets carried forward from one month to the next was not always recorded.

We carried out stock checks of medicines that were dispensed from containers. These were correct apart from three medicines. From the MARs we were assured that people received their medication as prescribed; however the issues noted with the recording of carried over medication and signatures meant the stock balances did not always tally.

The senior support worker told us they ensured when handwritten MARs were required they duplicated the instruction from the original packaging to the MAR. We saw this practice was followed when we reviewed one person's handwritten entries.

Protocols for the use of 'as required' (PRN) medicines were in place which detailed the medicine, the dosage and what it was to be used for. However the protocols did not indicate how each person would communicate, either verbally or non-verbally, that the PRN was required. The staff we spoke with were aware of the signs to look for if a person required a PRN medicine to be administered, but this was not recorded. The MARs showed that PRN medicines were administered appropriately. We recommend national best practice guidelines are followed to ensure that sufficient information is included in the PRN protocols to guide staff as to when people may require a PRN medicine to be administered.

Covert medication is the administration of any medical treatment in disguised form. This usually involves disguising medication by administering it in food or drink. As a result, the person is unknowingly taking medication. We looked at records for two residents who were administered covert medication and saw the GP and family had been consulted with regard to administering covert medication in the person's best interest. Pharmacy instructions were in place as required.

Controlled drugs were appropriately stored and recorded. Controlled drugs are certain medicines that due

to their risks of misuse or abuse are subject to more stringent legal requirements in relation to their storage, administration and destruction.

We observed the home to be clean and free from malodours throughout our inspection, apart from one bedroom. The registered manager was aware there was an issue with the carpet in two rooms at the home. Attempts to thoroughly clean these carpets had not been successful and so new carpets were being ordered. Staff wore appropriate personal protective equipment (PPE), for example gloves and aprons, when supporting people with their personal care. We saw checks on the staff's hand washing techniques had been completed in April 2018. This should help ensure staff thoroughly cleaned their hands to reduce the chance of any cross infection when supporting people. All sluice rooms and storage rooms were securely locked, meaning people did not have access to potentially harmful chemicals.

We saw evidence that equipment was maintained and serviced in line with national guidelines and the manufacturer's instructions. Weekly checks were made on the fire alarm, emergency lighting system, call bells, wheelchairs and hoists. Legionella water checks were completed each month. At the time of our inspection an external contractor was completing some of these checks. The home was in the process of recruiting their own handyman. However, we noted that the portable appliance testing (PAT) had been completed in February 2017. Good practice guidelines state PAT testing for items that are moved frequently should be completed annually. We discussed this with the registered manager who liaised with the provider's facilities department to arrange for the PAT testing to be completed. Staff undertook weekly visual inspections of electrical equipment.

Personal emergency evacuation plans were in place for each person. These detailed the support a person would need in the event of having to leave the building in an emergency. Contact information and guidance was seen for staff to deal with any emergency situations such as a gas or water leak.

Good

Is the service effective?

Our findings

Staff told us they felt well supported by the management team at Eachstep. They said they received appropriate training which was updated at regular intervals. This was confirmed by the computer based training records, which highlighted when staff were due to have refresher training, allowing time for this to be arranged. Staff had completed training in areas such as moving and handling, the Management of Actual or Potential Aggression (MAPA), first aid, health and safety, fire safety, food hygiene, infection prevention and control and basic training for people who have a dementia. One staff member told us, "They're very good with training, I have regular refresher courses."

Staff completed one week of training when they joined the service and then shadowed experienced staff before being part of the rota. This meant staff were able to get to know the people they would be supporting and their needs. The induction training met the requirements of the care certificate, which is a nationally recognised set of principles that all care staff should follow in their working lives. When staff had completed their induction period they were enrolled onto a nationally recognised diploma in health and social care.

The registered manager told us 40 staff had signed up to complete a six week workbook based dementia training course and 20 staff were enrolled for an end of live six week workbook course.

Staff said they regularly met with their supervisor to discuss their role and had an opportunity to share their views. Records showed supervision meetings had taken place as planned every three months. Each staff member had a 'you can' booklet for the year. This detailed objectives set for the year and notes from each supervision meeting. We saw that staff were able to raise any concerns and ideas that they had in the supervision meetings.

This meant staff had the training and support to effectively support people at the service.

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).

The service was meeting the principles of the MCA. Capacity assessments and best interest decision meetings were seen in people's care files. Applications for DoLS had been made where people lacked capacity. A tracker was used to monitor applications made, DoLS authorised and when they expired so a re-application could be made.

Where relatives held Lasting Power of Attorney (LPA) this was recorded. An approved LPA is legally entitled to make decisions on behalf of a named person in the event they are no longer able to make the decision themselves.

The staff we spoke with had completed MCA training and were aware of the requirements of the Act. We observed staff asking people's consent before they provided support.

A pre-admission assessment was completed for all new referrals. This assessed the person's needs and involved the person, their relatives where appropriate and other medical or social care professionals involved in their current care and support. Initial care plans were written from this information.

We observed the morning handover on the nursing households. Each person's needs were discussed in detail. The nurses on duty for the day then provided the handover information to the day care staff. Staff said they were informed about the needs of new people moving to the home via the nurses or senior care staff as part of the handover. A staff member on the residential households said, "The seniors tell us in handover if there are any changes in people's needs; we get enough information to support people."

We observed lunch on all the households of the home. The dining experience was seen to be calm and unhurried. People received the support they required to eat their food; staff were seen to be patient and encouraging. People told us they enjoyed the food and they had a choice of meals. We observed that people were able to get up and have breakfast when they wanted to in the morning. People said, "We're well fed here" and "The food's good; there's no pressure to get up for breakfast."

The food served at Eachstep was provided by an external catering company, who supplied frozen options from a wide menu to meet people's nutritional needs. This included options to meet people's nutritional needs, for example pureed or soft meals. Additional meals were kept on the households in case people wanted a hot meal at different times. For example one person liked to sleep during the day and so was able to have a hot meal at night. This also meant if people's needs changed, or a new person moved to the home, their nutritional needs could be met.

The cook had a list of people's nutritional needs in the kitchen area and so was able to order the required meals form the catering company. Each household had a supply of breakfast cereals, bread, snacks and fruit available. If people were identified as needing 'finger food', for example if they were living with dementia and did not want to sit down to eat a meal, this could also be ordered by the chef.

Staff we spoke with were knowledgeable about people's nutritional needs. A list of who required fluids thickening to reduce the risk of choking was kept in each kitchen as a reference guide for staff.

People were weighed either weekly or monthly and we saw referrals had been made to the speech and language team (SALT) and dieticians when people were seen to be at risk of malnutrition or were having difficulty swallowing.

Following the inspection we contacted a member of the Speech and Language Team (SALT). They were very positive about the support provided by the home for people who had swallowing difficulties. Referrals were appropriate, made in a timely manner, any guidelines provided by the SALT were followed and staff had the knowledge and skills to support people with swallowing disorders.

This meant people's nutritional needs were being met by the service.

Each person was registered with a GP. We saw referrals had been made to district nurses, the dementia crisis team and other medical professionals when required. We spoke with two health professionals who were both positive about Eachstep Blackley. One said, "Staff know the residents really well and pick up any changes quickly" and "There is a very low instance of pressure damage (sores) here." Another told us, "'The home works well with the CPNs (community psychiatric nurses) – they are quite astute, they try hard to get things right."

This meant people's health needs were being met by the service.

People were able to personalise their rooms with their own pictures and photographs. Each door had space for a photograph of the person whose room it was. Some floors had memory boxes by each room. These could be used to keep items or pictures in that would assist a person living with dementia orientate themselves within the home and find their own room independently. However we saw that few of these were used at the time of our inspection. All bedrooms were en-suite with their own shower and shower seat, if required. An adaptable bathroom was available on each floor if people preferred having a bath. The first and second floors had access to a balcony area where people could sit in nice weather. There was an accessible garden area, growing flowers and vegetables and a chicken coup. One of the people who lived at the home assisted in tending the gardens.

On the nursing households there were familiar tactile items people were able to touch. A sensory room and cinema room had also been developed.

Good

Is the service caring?

Our findings

All the people and relatives we spoke with said that the staff were kind and caring. One person said, "They (the staff) are very attentive, very pleasant" and another told us, "Staff know you by your first name and have a joke now and then." Relatives were also complimentary about the care and support provided at the home. We were told, "Staff will always do more. Never found anything lacking here, there is always somebody here."

Two health professionals also told us they would be happy for one of their relatives to live at Eachstep Blackley.

We observed and heard positive interactions between members of staff and the people they were supporting throughout our inspection. Staff spoke calmly with the people they were supporting to explain what they were doing and to provide people with re-assurance. For example we observed staff supporting one person to transfer to a chair using a hoist. The staff members explained what they were going to do and spoke calmly with the person throughout the transfer to re-assure them.

Staff talked to people about their relatives and friends, and it was evident from these observations staff knew people well. We also saw staff offering people day to day choices, for example asking if people if they wanted a drink or snack.

Throughout our inspection the home had a calm and peaceful atmosphere. People were seen to get up throughout the morning when they wanted to. Breakfast was provided whenever they got up. This meant people were not restricted to only being able to have breakfast by a certain time and could have a lie in if they wanted to.

People had documents called 'my life so far' in their care files. We saw the amount of information varied in each one. For example, one person's record provided information about their family, career, hobbies and where they enjoyed going on holiday. This provided staff with information which helped them get to know the person and generate discussion. However, others had much less detail. We discussed this with the registered manager who said they tried to get as much background information as possible from people and their families, but this was sometimes very difficult as some families did not provide details about their relatives past lives.

People we spoke with said the staff treated them with dignity and respect. We saw training had been provided for staff for dignity in care. Everyone we saw was well dressed. Care staff we spoke with were able to describe how they maintained people's dignity when providing support. One said, "I try to protect people's dignity and privacy by making sure the door is closed when I assist with personal care and covering them with a towel where needed."

We also observed staff supporting people to maintain their independence where possible. For example staff encouraged people to mobilise around the home themselves, patiently offering re-assurance where

required.

This meant staff maintained people's dignity and privacy, supported them with respect and prompted them to maintain their independence where possible.

People's care plans did not include details of their cultural and religious needs. We were told staff had tried to communicate with one person who did not speak English by using a translation app on their phones. They had also spoken to the person's family to learn some key words in the person's language they could use. The catering company were able to provide culturally appropriate dishes where required. For example one person had been offered West Indian menu options; however they now chose alternative options. One relative said, "Catering staff have run taster days on different cultural diets and would cook meals if the residents liked it".

We were told two ministers visited the home to talk and pray with people if they wanted to. This meant that whilst people's cultural needs were not always recorded the staff supported people to meet these needs where people wished to do so.

We saw that where people did not have relatives who could be involved in decisions about their care and support referrals were made for an independent mental capacity advocate (IMCA) were made. This meant that an independent person would be involved in any best interest decisions about the person's care, to ensure their rights were protected.

People's confidential care files were stored in lockable cupboards in a quiet area on each household. However we noted that these cupboards were not kept locked when not being accessed by staff. We did not see any people living at the home or their relatives go near the cupboards where the files were stored; however the files were not securely stored to maintain people's confidentiality. We recommend the provider ensures the cupboards are locked when not being accessed by staff.

Requires Improvement

Is the service responsive?

Our findings

We looked at seven care plans in detail, two from the nursing households and five from the residential households. We found a marked difference between the care plans on the nursing households and those from the residential households.

The nursing care plans documented what people's needs were and how these needed to be met, for example personal care, communication and night time needs.

In four of the five residential care plans there was insufficient information about people's care needs. The registered manager told us the care plan had a section which detailed people's routines and all the information about people's support needs should be included in this section. However we saw that these sections were either very brief and did not contain all the relevant information about people's needs or had not been completed at all.

There was an 'areas of support' document that contained a one sentence overview of the support a person needed in a range of areas. The document had space to signpost to the relevant care plan for each identified need; however no care plans were noted on this document.

The care files contained a 'decision making profile.' However this did not identify how the person would make choices and decisions about the different aspects of their care and support. For example, in relation to eating drinking it was recorded 'I eat and drink normal food and fluids.' There was no information about how the person would make choices of the food or fluids they wanted.

One residential care plan, for a person who had lived at Eachstep for 18 months, did contain separate care plans for each area of identified need, for example for personal care, mobility and managing challenging behaviour.

There was a medicines care plan in each file. However these were generic and contained the same guidance on general policies and procedures to be followed. They were not person centred to include specific information for that person. For example one medicines care plan made no reference to the person storing medication in their mouth, even though we saw a member of staff had to sit with the person for 15 minutes until they had swallowed their medicines. For another person it was noted they may refuse their medication; however there was no information about what the staff should do if this happened.

The staff we spoke with were able to explain people's needs and the support they required.

People did not have any information recorded about their preferences for their end of life care, such as any religious needs, whether they wanted to stay at Eachstep or go into hospital and whether they wanted to be buried or cremated. The registered manager said they had engaged in an end of life care planning programme called the Six Steps, which is a nationally recognised programme of identifying people's wishes and needs at the end of their lives. Following the inspection we contacted the MacMillan nurse team. They

said they had recently visited the home with a view to start working with them again around people's end of life care. We were told a meeting with MacMillan and people's families had been arranged in May to start the process of discussing people's end of life wishes.

A health professional we spoke with said the end of life care provided at Eachstep was good. They said, "I was recently very touched when a patient at end of life was taken out into the garden in their bed to spend time with their family in the fresh air."

We saw several compliments received by the service from people's families referring to the care and support provided at the end of people's lives. For example one compliment was, "We would like to thank all of you for the care, love and attention to my Dad in his last months, weeks and days."

This meant the care and support people received at the end of their lives was caring and met their needs ; however if people's wishes are not recorded the support may not meet their end of life wishes and preferences.

We found the lack of information in the care files about people's care and support needs to be a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regard to 3 (a).

Relatives told us they were informed of any changes in their relative's health or needs. One said, "Yes I am kept well informed if there are any changes" and another told us, "Staff will contact us for any issues." However there was no evidence that people or their families were involved in reviewing people's care needs and plans. A senior support worker told us staff knew people well so based the care plans on their knowledge of people's needs. One relative told us, "Staff will encourage feedback" but another said, "I've seen a folder in the bedroom, is that the care plan?"

On the second day of our inspection we were told a nurse had been nominated as a 'care plan champion'. They said the role entailed reviewing people's care plans and training and supporting the senior care workers in how to write robust care plans. They acknowledged that specific care plans were used on nursing households but these were not in the residential care files they had looked at. The nurse had previously completed an audit on the care plans in the nursing household the week before our inspection, with an action plan being in place for any shortfalls identified. They were now to work across all households and were due to meet with the senior care workers from the residential households later in the week of our inspection. We were told they would then be supernumerary to the rota for two weeks to be able to work on improving the care plans.

This meant the care plans should be reviewed and updated to contain additional information for staff to follow. We will look at this at our next inspection.

We saw that sensor mats were used to alert staff that people had got up or stood up from their chair when it had been assessed as being required to reduce the risk of falls.

We saw there was a timetable of activities arranged for people to join in with if they wanted to. A lot of these took place on the ground floor and people were supported to attend from the households. Activities included arm chair exercises, arts crafts and karaoke, and dances. Children from a local primary school visited each week during term time to read to people. A weekly cinema club was also held. The service also ran a café on the ground floor. This was open to members of the public and could be used by people and their visitors if they wanted to. A dementia café was organised each month in the café.

Staff said care staff were also encouraged to provide activities on the households and they sometimes had opportunity to do this after lunch but not always. On the day of the inspection we saw one person enjoyed colouring a book; this was identified as an activity they enjoyed in the care records. However, we also saw others sat for long periods with very little stimulation. We were told a new 6pm – 10pm shift had recently commenced. This was to assist people to get ready for bed and also to enable more activities, such as games to be arranged o each household.

The service had arranged with the catering company to produce a picture 'food album' so people would be able to choose their meals from looking at pictures as well as verbally or reading a menu. This should help people to make their own choices of the food they would like to have.

We saw there was a formal complaints policy in place. All complaints received had been acted upon appropriately and in a timely manner. Notes of any investigations were kept as well as the response given to the complainant. People and relatives also told us they would speak directly to the staff or manager if they had an issue, rather than using the formal complaints procedure. One person said, "I complained about cold tea and was happy that staff listened and now my tea is hot." A relative told us, "We raised a concern mum could not eat as her dentures were painful, staff fixed a dental appointment." This meant the staff team had responded to the verbal concern of the relative, thus avoiding the concern escalating any further.

We also saw the home had received numerous cards from relatives thanking them for the care and support given to their relative. One card said, "I have always felt at home when visiting my Dad and when I wasn't there staff kept me informed if there were any changes or problems with Dad." The Care Quality Commission (CQC) had also received two 'share your experience' forms which complimented the service stating they were very happy with the service and would recommend the home to other people.

Requires Improvement

Is the service well-led?

Our findings

The service had a registered manager in place as required under the conditions of their registration with the Care Quality Commission (CQC).

The home had a quality assurance system in place. Monthly checks were made of medication, care plans, infection control and health and safety. Incidents and accidents were reviewed and any patterns identified. A monthly quality assurance cycle sheet was also used. This had categories including for care plans, medication, the staff team, the environment, incidents, which were further broken down to specific questions. The registered and deputy managers added comments throughout the month on the checks they had made against the different categories and sub headings. The monthly form was checked by the area manager who also made their own comments.

However this quality assurance system had not been sufficiently robust to identify the shortfalls we found, for example the lack of information in the residential households' risk assessments and care plans. We saw the quality assurance cycle sheet specifically asked if protocols were in place for 'as required' (PRN) medication; however we found these had insufficient details on how people would communicate their need for a PRN medicine to be administered. The sheet also asked if confidential information was securely stored; however we found the cupboards where people's care files were kept were not locked during our inspection.

A quality assurance audit had been completed in November 2017 and an action plan had been developed. This had highlighted the need for specific care plans to be written for people, for example for dementia support. These had not been completed. Other actions, for example supervisions to be completed and the introduction of cream charts had been completed. The new Quality Partner told us a new quality assurance visit format was being trialled. This would involve a themed visit every three months focusing for example on medicines, infection control or care plans.

The lack of robust quality assurance systems was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the second day of our inspection we were told that a nurse had been tasked with supporting the senior care staff to complete risk assessments and care plans on the residential households. They had been given time as supernumerary to the rota to provide this support.

The provider had also engaged an external organisation to complete 'mock inspections' across all of their homes. Eachstep Blackley had not had a mock inspection at the time of our inspection. It was planned that the provider would then be able to identify any short falls in meeting the regulations and put actions in place to meet them.

We were told the registered and deputy managers were approachable and visible within the home. Relatives said they were able to discuss any concerns they had with the registered manager. One said, "They (registered and deputy managers) are very approachable" and another told us, "They will listen and will

change things." We observed that the registered manager knew people by name and was knowledgeable about them and their support needs. Staff also told us they enjoyed working at the home and felt well supported by the management team. One staff member said, "We have a good staff team here who do care."

The home was involved with local community groups and worked in partnership with other organisations. The local cubs visited three or four times a year as part of their community award badge, pupils from the local primary school visited each week during term time. Intergenerational activities have been shown to promote wellbeing in older people and also to give confidence to the young people involved. The home facilitated a dementia café that was held in the ground floor café. This was open to members of the public as well as people living at the home and their families. This meant the service was actively involved in their local community.

The service had also supported the creation of a 'family forum.' This is run by two family members of people living at Eachstep Blackley and aims to provide an opportunity for family members to meet to discuss any issues or concerns they may have about the home. The organisers then pass any information raised to the registered manager. One organiser told us, "It has been good for supporting new families who's loved one has gone into care and they have feelings of having abandoned them or guilt. We raised concerns that activities had 'dropped off'. Activities are now put on a whiteboard downstairs so we know what is arranged and an extra member of staff working 6-10pm was made available to help with activities in the evening." This showed the service constructively engaged with people's families and responded to any issues raised with them.

The service was due to start a research programme with Lancaster University to look at whether a using a programme called 'Namaste care' improved the quality of life for people living with advanced dementia. The programme was looking to introduce a range of physical, sensory and emotional approaches of care and support for people living with advanced dementia. It was hoped that this research would have a lasting effect on the home as the staff teams would gain skills which would then continue to be applied after the research study had concluded. The home was investing staff time into the research and said the initial staff response was very positive to the programme. This meant the service engaged in ways to seek innovation to provide improvements for the people living at the service.

We were shown the results of a recent survey for people living at the service and their relatives. 17% of the surveys had been returned and the responses were mainly positive. All the people who responded said they felt safe and the staff knew them well. We were also told the provider was also due to conduct a staff survey.

Residents meetings were held with staff talking with people in small groups rather than trying to get everyone together at once. This meant people had more opportunity to say what they thought about the service. Relatives meetings were also held every 3 months.

Staff meetings were held. Minutes showed these were used to inform staff about issues at the home and also for staff to raise concerns or ideas to the management team. Separate nurse and senior support worker meetings were also held.

Two staff members represented Eachstep Blackley at the providers staff forum. The chief executive officer (CEO) chaired this forum and this was a way for information about the organisation to be provided directly to the staff team and for staff to raise any issues directly with the CEO. This meant the service sought the views of people who lived at the home, their relatives and staff.

Services providing regulated activities have a statutory duty to report certain incidents and accident to the

Care Quality Commission (CQC). We checked the records at the service and found that all incidents had been recorded, investigated and reported appropriately.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care There was a lack of risk assessments and associated management plans Regulation 12 (1) with regard to 2 (a) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There was a lack of information and guidance in people's care files about their care and support needs. Regulation 9 (1) with regard to 3 (a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The quality assurance systems were not sufficiently robust and had not identified the issues found at our inspection. Regulation 17 (1)