Brookdale Healthcare Limited

Eynesbury House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Eynesbury House is registered to provide accommodation and care, without nursing, for up to nine people. On its website, the provider describes Eynesbury House as "a residential service designed to support adults with Asperger syndrome or High Functioning Autism."

The service is situated in a residential area of Eaton Socon, within walking distance of local facilities and the town centre of St Neots. The main house has six single bedrooms. The Mews, situated next to the main house, is a separate annex for three people who are able to live more independently. It has its own entrance and accommodation includes three single bedrooms and a kitchen/lounge/dining room.

The inspection visits to the service took place on 15, 22 and 25 August 2017. On 15 and 22 August 2017 the visits were unannounced. On 25 August 2017 we met with the provider's representatives to discuss our findings then returned to the service to complete the inspection. There were eight people living at the service when we visited.

At our previous inspection we rated the service as good in all five of the questions we ask. Since then, Brookdale Healthcare had become part of Tracscare. This meant that there were new directors of the organisation and some new systems, policies and procedures were being introduced.

Prior to this inspection a number of concerns had been raised with the Care Quality Commission (CQC). These had come from a range of sources and related mainly to staffing; staff turnover; the use of agency staff; and the ways in which some people were being supported. During the inspection we found that some of the concerns were substantiated. The service had been through a difficult patch. This was partly due to one person who had been admitted to the service who had felt they were not being supported appropriately. This person's behaviour had led to a number of staff leaving. Additional agency staff had been employed to ensure that everyone was safe. At the same time, a second person had been admitted who was very dissatisfied with the service because they did not want to be there. There had been a lack of strong leadership and the staff no longer worked as a team.

At the time of the inspection the first person had left. The second person demonstrated that they were still dissatisfied and expressed this very vocally. Following the inspection they were given notice to leave. We therefore found that there were very mixed views about the service, from people who lived at the service, their relatives and members of staff. However, a new manager had been appointed and staff were hopeful that the changes in the atmosphere they had begun to feel would develop into improvements in the service.

Although we saw some kindness and caring, we also saw that staff did not interact with people or engage them in conversation. Staff did not always treat people with respect, ensure people's privacy and dignity were maintained or support people to be independent.

There were not always sufficient staff on duty to make sure that people's needs were met in a timely

manner. Staff had received an induction and had undertaken training in topics relevant to their role although this was not always up to date. Staff had been recruited in a way that made sure that only staff suitable to work in this care service were employed.

This service requires a registered manager as a condition of its registration. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At the time of this inspection there was a registered manager in post. However, they had been on maternity leave and on their return had been promoted to area manager. A team leader had been the acting manager in their absence. A new manager had been appointed but was not present during the inspection visits.

Most people and their relatives were content with the service provided at Eynesbury House. Staff enjoyed working at the service and wanted to do the best they could for people living there. Some staff had felt they had not been supported well enough.

Staff had undergone training and knew how to recognise and report any incidents of harm or abuse. A range of potential risks to people had been assessed and guidance provided for staff so that the risks were minimised. Not all risks had been assessed, which meant that people were not always as safe as they could have been. Medicines were managed so that people received their prescribed medicines safely.

The CQC monitors the operation of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS), which apply to care services. People's capacity to make decisions for themselves had been assessed. Staff understood the principles of the MCA and DoLS and supported people to make decisions about their lives.

People's healthcare needs were monitored and staff supported people to attend appointments with a range of healthcare professionals. People were not always encouraged to eat regular meals.

Pre-admission assessments had not always been robust enough to ensure that the service provided was able to meet each person's needs. People had been as involved as they wanted to be in planning their care and support. People's support plans gave staff information about the ways in which each person wanted their care and support delivered but the information was not always up to date.

Complaints were listened to and addressed. People were encouraged to maintain relationships with their families and visitors were welcomed. The activities that were planned did not always take place and people were not offered enough to do to keep them occupied.

People, relatives and staff were given opportunities to share their views about the service and put forward ideas for improvements. Audits of a number of aspects of the service provided were carried out, although these were not always effective in driving improvement. Records were maintained as required. People's personal information was kept securely.

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.

Staff knew how to recognise and report any incidents of harm. Potential risks to people had not always been assessed.

Recruitment practice ensured that new staff were suitable to work at the service. There were not always enough staff to make sure people's needs were fully met and people were kept safe.

Medicines were not always managed safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received a thorough induction and further training although this was not always up to date. Staff were not fully supported.

Staff supported and encouraged people to make choices and decisions about their lives.

People were not always enabled to have regular meals or encouraged to drink a sufficient amount of fluid. Staff supported people to maintain their health by attending appointments with relevant healthcare professionals.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff showed they cared and that they wanted to do their job well.

People were not always treated with kindness and compassion.

People's privacy, dignity and independence were not always promoted and upheld.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Pre-admission assessments had not always identified that people's needs could not be met by the service.

Support plans were detailed and personalised but did not always contain up to date information. People were encouraged to plan their week but staff did not always support them to engage with the plan.

The service had been very responsive to some people's needs so that those people had been enabled to progress to more independent living.

Complaints were listened to and addressed.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There had not been strong enough leadership in place to provide a cohesive staff team to support each person in the way they wanted to be supported. Some links with the local community were maintained.

People were given opportunities to share their views about the service.

A quality assurance system was in place, which included a range of checks and audits to monitor the quality of the service being provided, although this was not always effective.

Eynesbury House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, looked at the overall quality of the service, and provided a rating for the service under the Care Act 2014.

This inspection included two unannounced visits to the service, on 15 and 22 August 2017. On 15 August 2017 the visit was carried out by the lead inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience for this inspection had experience of caring for someone with complex needs. On 22 August 2017 the inspection was carried out by the lead inspector and an inspection manager. On 25 August 2017 the lead inspector and inspection manager met with the provider's representatives to discuss the findings of the inspection. The lead inspector followed the meeting with a third visit to the service to finish checking how medicines were managed and spoke with three members of staff, including the acting manager and area manager.

Prior to the inspection we looked at information we held about the service and used this information as part of our inspection planning. The information included notifications. Notifications are information on important events that happen in the service that the provider is required by law to notify us about. The information also included the provider's responses to concerns that had been raised.

In May 2017 the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information to assist with planning the inspection.

During our visits we observed how the staff interacted with people who lived at Eynesbury House. Over the three days we spoke with four people who lived there and twelve members of staff: eight support workers (including senior support workers); the acting manager; and two of the provider's representatives. One of the provider's representatives was the registered manager who had returned from an extended period of leave and had been promoted to area manager. The other was the nominated individual. We looked at four people's care records as well as other records relating to the management of the service. These included

records relating to the management of medicines, meeting minutes and audits that had been carried out to check the quality of the service being provided.

Requires Improvement

Is the service safe?

Our findings

People who lived at the service did not really express an opinion about whether or not they felt safe. A healthcare professional who had regular contact with the service, told us, "People are generally safe and feel they can talk to [staff] when they don't feel safe." Three people's relatives were sure that their family members were safe. One relative told us, "Yes, I do feel [name] is safe." Another relative said, "Yes, yes [name] is safe." A fourth person's relative related a very recent incident, which made them feel their family member was not always safe. The person had been taken to an appointment at a local hospital by staff who had then left the person there alone. The person had felt frightened and contacted their relative. Following the inspection the provider told us that staff had waited with the person until they had been admitted, which had been previously planned with the person. Staff had returned to the hospital as soon as they became aware that the person was not being kept in overnight and was ready to return home. The local safeguarding team were satisfied that no abuse had taken place. Nevertheless the person was frightened and did not feel that the staff had kept them safe.

There was a system in place to assess potential risks to each person's safety. The format of the assessment document was generic, covering 12 potential risks. When the risk to an individual was rated as high, guidelines were put in place for staff so that the risks were minimised. However, not all risks to individuals had been assessed, including risks related to specific activities and to being in the community. This meant that people were not always kept as safe as they could have been, as was demonstrated by the person being left alone at the hospital.

Staff had been trained to keep people safe from avoidable harm and abuse. Staff told us they knew how to recognise different forms of abuse and how to report any concerns, both to their managers and to external agencies responsible for safeguarding. One member of staff told us that they had reported incidents of bullying between two people who lived at the service, to managers, the local authority safeguarding team and to CQC. The acting manager said that a poster, giving everyone who came to the service details of how to report abuse, had been on display but had been taken down by one of the people who lived there. This had not been replaced.

Prior to the inspection visit, concerns had been reported anonymously to CQC that there were not enough staff to keep people safe and meet their needs. Staff told us there had been a period when staffing had been very difficult, with a number of staff leaving and higher use of agency staff. Whenever possible, the service used agency staff who had worked at the service previously, but this had not always been possible. Not all agency staff had worked in a way that supported people appropriately. Staff told us that in the two weeks before the inspection, staffing had started to improve. On the days we visited there were a sufficient number of staff on duty to keep people safe and meet their needs. The provider had used a range of creative ways of attracting staff to the service, but it had proved difficult to recruit suitable new staff.

The provider had a thorough recruitment process in place. Staff told us this included carrying out pre-employment checks such as references and a criminal records check, which had to be satisfactory before the member of staff was allowed to start work. This helped to ensure that only staff suitable to work at this

care service were employed.

The service took fire safety seriously and carried out all the required checks of the fire safety system. A fire officer had carried out a recent inspection. They had been satisfied that all was in order, other than the fire risk assessment needed to be reviewed. Although everyone who lived at the service was mobile, they also requested that a personal emergency evacuation plan be put in place for each person. In this way, staff and the emergency services would know how to support each person in the event of an emergency, such as a fire. One member of staff showed us that they were working through a training booklet with each person. This meant that people received training about what to do in the event of a fire, in the same way that staff had received training.

We looked at the way people's medicines were managed. An assessment had been carried out for each person who wanted to look after their own medicines, to decide whether they were safe to do so. People were at different stages. Some people kept their own medicines in a locked cabinet in their room and were fully responsible for taking them as prescribed. Other people were prompted or came to the office where their medicines were stored to request them. Records relating to medicines were kept as required. Staff had signed the medicines administration record (MAR) charts to show when a person had been given their medicines and quantities of all medicines received and disposed of were recorded. We checked whether the number of tablets remaining in the boxes tallied with the amounts recorded on the MAR charts: there were no discrepancies.

However, there had been a number of errors relating to administration of medicines. For example, the evening before our third visit a member of staff had not signed the MAR charts to show that a person had been given their medicines. People told us they often had to wait for their medicines because there had to be two staff trained to give medicines to sign that the person had taken them. They said that sometimes a member of staff from the service next door (another of the provider's locations) had to come and assist. Staff confirmed this was the case and also said that not all staff who had received training to give medicines were up to date with their refresher training. This meant that we could not be completely confident that people were receiving their medicines safely and as they had been prescribed.

Requires Improvement

Is the service effective?

Our findings

We looked at whether staff had the knowledge and skills to do their job properly. Staff told us they had undergone an induction period when they started working at Eynesbury House. The induction included spending several days at the provider's local training centre. This training was in different formats, including e-learning (on a computer), face-to-face with a trainer and practical training such as restraint. New staff then worked alongside experienced members of staff at the service. One member of staff told us, "I was happy with the training I was given: it prepared me [for my job]."

Following induction, staff had undertaken training in a range of topics related to their work. Staff had been provided with training relating to autism and training specific to individuals, such as diabetes training. This had been provided when a person with diabetes had moved into the service. One relative told us, "The staff appear to be trained." Another relative said, "[Name] is doing very well. Very expert staff." A healthcare professional said, "I have found that staff know more than they think they do." Some staff told us they were not fully up to date with all the refresher training they were required to do.

We had mixed views from staff about the support they had received since the registered manager had gone on maternity leave. This period had included the admission to the service of a person with very challenging needs. This person had been uncooperative with the management of their health condition, which had led to mood changes including violent outbursts against the staff. The person had had numerous hospital admissions. Some staff told us they had received very good support, from colleagues, from the acting manager and/or from the provider's representative. Other staff had felt less well supported and some staff had left the service. Senior staff were responsible for supervising support workers and had, for the most part, been able to carry out the sessions they were meant to do. However, we could not be confident that staff had the knowledge, skills and support they needed to be able to do their job as well as possible.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care services and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

The mental capacity of each person who lived at the service to make certain decisions had been assessed and recorded. Some people had been assessed as lacking capacity, for example in relation to managing their finances. Staff told us that one person had been subject to a DoLS authorisation that restricted them from going out alone. Staff had worked with the person over a long period of time to ensure they were safe to go out and the DoLS authorisation had been cancelled. Staff had undertaken training relating to the MCA

and DoLS and were able to demonstrate that they understood the principles. One member of staff said, "We are here to respect people's decisions, even if sometimes these decisions are unwise." We saw that people were encouraged to make choices and decisions and staff respected those decisions. This meant that people were not unlawfully restricted.

People were encouraged and supported to be as independent as possible with regards to their eating and drinking. Some people did their own shopping or staff supported people who needed support to go shopping. Each person had cupboard and fridge space in the kitchen for their food. Staff were very proud of one person who had progressed to cooking their own meals on four evenings a week. Staff cooked for people who were not able to cook for themselves. There were no set mealtimes so people ate when they wanted to. One person told us that staff "encourage us to have healthy meals." We noted that although it was a very warm day, staff did not prompt people to make drinks, or offer to make drinks for people when making drinks for themselves or the inspectors. Not everyone was supported to have lunch. Daily records for one person showed that they were not coming out of their room for breakfast until late afternoon and were eating dinner during the night. Although staff told us this was their choice, this meant we could not be fully confident that people's needs relating to eating and drinking were being met.

Staff supported people, as far as each person wanted to be supported, to maintain their health. People told us that if they were not well they would have to go to the GP surgery. The staff confirmed that healthcare professionals such as GPs and nurses rarely visited the service. People were encouraged and supported to access whichever health service they required, including dentist, optician, chiropodist, and GP, in the community. Two people were supported to keep appointments with their GP on one of the inspection visit days.

One senior support worker told us that part of their role as shift leader was to ensure, as far as they were able to, that people attended medical appointments, with support if they needed it. Staff told us that recently they had supported one person to attend a medication review as the person had been very sleepy a lot of the time. The GP had reduced the dose of one of their medicines. However, this had not suited them, so a further appointment had been made. This demonstrated that people were supported to maintain their health.

Requires Improvement

Is the service caring?

Our findings

The service was not as caring as it should have been and staff did not always treat people with compassion, kindness and respect.

We found that people's needs in respect of their disability were not always understood by staff and were not always met in a caring way. We witnessed one member of staff being quite confrontational, both in their speech and in their body language, when one person was trying to draw them into an argument. To remove the member of staff from the situation, which they were not handling well, the shift leader asked them to go and support someone in another part of the service. However, although the member of staff turned to leave, they then turned back to prolong the confrontation. This was not caring, empathetic or respectful and showed that the member of staff lacked the professionalism to deal with the situation in the best way possible.

Staff did not always respect the building as people's home. In some ways this was difficult for them due to the layout of the main house. The small office, in constant use by the staff, could only be accessed through the lounge. This meant that people who wanted to watch the television were constantly interrupted by staff crossing in front of them. In the three-bedroomed annex there was a lounge/dining/kitchen for the people who occupied the bedrooms. Staff had become accustomed to using the back door and then the lounge as a through-route to access the bedrooms and the office on the top floor, when they could have used the front door and avoided the lounge. On the first day of our inspection we saw that a builder, refurbishing one of the bedrooms, was using people's lounge to make a telephone call. Staff had not recognised this as an infringement of people's private space. This meant that staff were not doing all they could to respect the building as people's home.

Some aspects of the service did not promote people's independence nor respect their dignity. People told us that some of the equipment in the service, such as the tumble drier in the annex and the oven in the main house had been out of action for some time. The house was not homely and was in need of redecoration. There were only a few photographs/ pictures on display. These were of people taking part in an activity and were pinned to a notice board without any care or attention so that the edges were curled and the photographs looked messy. On all three inspection visits, the communal areas of the service became very hot when the sun was out, but staff only opened windows or switched on the air conditioning when the inspectors asked them to. One person had been assessed as competent to look after their own medicines. However, their room was too warm so the medicines had been moved back to the office and the person had to ask each time they wanted them.

Although staff knew some people very well, we found that for one person staff did not know about the person's skills in a certain area, which would have had a huge impact on the person's life.

We saw that there was very little interaction between people and staff when staff passed through the lounge, or even when staff were sitting in the lounge with people. The majority of the time staff completely ignored people, even when a person spoke directly to one of the staff. One person's relative told us there had been a

period recently when their family member had told them staff were "sharp" and were "ignoring" the person. This relative told us a member of staff had confirmed that what the person said was true. Another relative said staff had been rude to both them and their family member. They described this as "sneaky bullying".

People and their relatives had mixed views about the staff and whether or not staff provided them with the care and support they wanted and required. We spoke with three people's relatives who made very positive comments about the care their family members had received. Their comments included, "I am delighted with the care that has been given to [name]"; "Staff are great… they're always trying to help in every way they can"; and, "I have been extremely happy and [name] has received good care". One relative and their family member made very critical comments about the service. Neither were happy that the person had been placed at Eynesbury House and both felt the person was not being supported appropriately.

A healthcare professional who wrote to us said that on the occasional visits they had made to the service to see one person, staff "were very helpful." They added the person had been "very challenging to deal with" and said, "[staff] managed it very well indeed, with great professionalism."

Our discussions with staff showed that the staff wanted to do their job well. They cared about the people they were supporting. Most of the staff were clearly distressed that they had been unable, in recent months, to do the job in the way they wanted to do it and knew it should be done. Staff's comments included, "We're all very passionate and want to do a good job"; "The staff here are brilliant. A lot of morale has been lost in past months but they do their best"; and, "In general staff seem keen and they do want to do as much as they can." One member of staff was unclear (and so were the inspectors) why some staff, especially senior staff spent so much time in the office. This staff member said, "That's not care. I came into this job to make a difference and I can't do it here." All these comments demonstrated that there was huge potential within the staff team to turn the service around and make improvements for the people who lived at Eynesbury House.

People were empowered to make decisions about the way they led their lives and had choices in many aspects of daily living. This included the times they got up and went to bed, what they did during the day, whether or not they undertook planned activities and how and when they arranged their meals. Each person met weekly if they wanted to with their keyworker. During this meeting they were able to plan for the following week, including what activities they wanted to do. Unfortunately, some people had drifted into leading lives that were not fully conducive to maintaining their well-being. For example, one person was getting up later and later in the afternoon and having their dinner in the early hours of the morning. Staff were involving other healthcare professionals to try to assist the person to reverse this pattern. We saw that there were missed opportunities for people to be independent. One person asked staff about choosing paint colours for their room. The staff member said they would bring the person a paint colour chart but they could have offered to take the person to the shop to choose the paint themselves.

The intention of the service was to enable people to move on to more independent living. Support was designed to enable people to be as independent as they wanted to be. For example, plans included supporting people to access public transport, do their shopping, prepare their own meals, clean their rooms and do their laundry. This meant that people would be able to use public transport and feed and care for themselves when they moved on to more independent living. Some people had progressed well. One person had progressed to doing their own shopping and cooking their own dinner on four evenings a week. This person's relative told us, "They're [staff are] trying to encourage [name] to develop independence." However, staff told us that in recent months they had not acted consistently enough as a staff team to ensure that everyone was offered these opportunities in a way that encouraged them to participate.

Visitors were welcomed at the service, although staff said people rarely had visitors. People preferred to see

their relatives at their relatives' home.

The provider employed an advocacy service so that people had an independent person to talk to and to act on their behalf if they wanted them to. An advocate had visited the service every two weeks but we saw that the visits had ceased about three months before our inspection, due to the advocate's illness. The advocacy service had said they would try and provide support if anyone asked to speak to an advocate. The provider was meeting with the advocacy service to try to reinstate the visits, although the acting manager told us no-one had asked.

Requires Improvement

Is the service responsive?

Our findings

Pre-admission assessments were carried out, which were intended to ensure that only people whose needs could be met would be admitted to the service. However, this process had not been robust enough. Two people had been admitted whose needs could not be met by the service and they were given notice to leave. This meant these two people were subjected to yet another move. Also, as well as the needs of these two people not being met, there had been a detrimental impact on other people living in the service. One person had been bullied by these two people ganging up on them.

Each person had a support plan in place. Support plans were designed to give staff detailed information about the person and guidance on the way that person preferred their needs to be met. There were some good, very personalised areas of information in the care plans. For example, for one person a care plan had been drawn up to describe appropriate behaviour that the person was expected to show towards others. The plan clearly stated what the person had to do/not do, what staff should do and what the behaviour would achieve. This had been signed by the person to show that they agreed with the plan.

Staff explained that some of the plans had not been reviewed and were not fully up to date. We saw this to be the case. For example, one person's plan stated that there was a DoLS authorisation in place relating to the person accessing the community alone. The authorisation had been withdrawn as the person no longer needed to have their liberty restricted. Staff told us that one person's assessment and subsequent support plan had not included any information that the person could be physically violent. A member of staff had been injured. A one-page profile was being introduced to each person's support plan to give a quick overview of the person's needs. For one person we noted that there were a number of different documents in their records, including a one-page profile. These each gave differing information, for example about the person's age, their likes/dislikes and what was important to them. This showed that support plans did not give accurate, up-to-date information and guidance for staff.

Support plans relating to medicines that had been prescribed for people to take when required were in place. However, these were basic and used language that was open to interpretation. For example, one person had been prescribed a medicine to reduce their anxiety. The protocol for when this medicine should be offered did not include any guidance for staff on ways in which they might be able to reduce the person's anxiety without medicine. The protocol included that staff were to 'monitor' the person after the medicine had been given. There was no guidance on what they were monitoring nor when they were to take further action.

People were involved as much as they wanted to be in planning their care and support. Each person was offered the opportunity each week to meet with their keyworker and plan the following week's activities. Plans were written down and staff carried out any organisation that was needed, such as transport arrangements for an outing. Although a plan was in place for them, some people had opted to not engage in the process.

People told us there were not always enough staff to fully meet their needs. They described sometimes

having to wait a considerable time for their medicines because there were not enough staff with the required training to give them their medicines. Staff told us that planned activities and outings had not always taken place.

However, we also learnt that for some people the service provided by the staff had been very responsive to their needs and those people had made great progress. One person's relative told us, "[The service is] brilliant. [Name's] come on leaps and bounds since he's been there…. We've noticed a big difference. He was bored and restless [at his previous service] but this place has got him back on track." Another person's relative explained that their family member had "struggled" at their previous service but was doing very well at Eynesbury House. The person had progressed to only being shadowed (observed rather than accompanied) in the community, was doing their own food shopping and cooking their own meals. One person had progressed sufficiently to be moving in the very near future into supported living accommodation.

Some people were engaged in activities during our inspection visits. One person went to the cinema and staff told us they were accompanying another person to spend an evening in Bedford, doing whatever the person wanted to do when they got there. Another person was travelling to Peterborough to meet their music tutor. However, we saw little stimulation and engagement between staff and people who lived at the service. Several people spent much of the day milling about between the lounge and the garden. We did not see staff initiating any activities in the house, such as board games or ball games in the garden. This showed us that people were not offered enough to do to keep them occupied.

People were encouraged and enabled to keep in contact with their relatives. Staff provided transport to enable people to go to their relatives' home and accompanied people on home visits when required. One person's relatives had moved away from the area. These relatives were extremely grateful that staff brought their family member to meet them half way so that their journey was not impossibly long.

The provider had a complaints process in place. People knew they could talk to staff or the managers but one person we discussed this with did not know there was a form they could complete. This person and their relative were both very dissatisfied with the way the service responded to any issues they raised. However, other people and their relatives told us that the management and senior staff had dealt with any concerns. One person had been supported to complain to the provider. We saw that this had been responded to and everyone at the service had been reminded about the provider's policy relating to bullying. One relative said they would complain to the acting manager or their family member's keyworker. They told us, "[We've raised] a couple of things and they've sorted it. They've done what they said they'd do." Another relative described how their family member had felt they were not being given enough attention. The relative had written to the managers and told us, "They've been extremely supportive and I'm happy with what they've put in place." The acting manager showed us records which confirmed that issues brought to their attention had been responded to.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post for the service. However, they had been on maternity leave for several months and on their return had been promoted to the role of area manager for the provider. This meant that there had been an acting manager in charge of the service.

A new manager had been appointed and had started work the week before our first inspection visit. The new manager had held a meeting to introduce themselves and staff in particular were feeling very positive about the appointment. The new manager was not able to be present on any of the three days of our inspection visit. The acting manager appeared tired and overwhelmed by the inspection process. They spent most of the three days shut away in an upstairs office.

People, their relatives and the staff had mixed views about the way the service had been managed. Some staff acknowledged that the acting manager had taken over at a very difficult time and told us the acting manager had "done their best". The provider had not filled the acting manager's team leader role, which meant the acting manager had been trying to fulfil both roles. We found that the service had been lacking strong leadership for several months before our inspection visits. This had been compounded by the admission of first one and then a second person to the service, both of whom had needs that staff had struggled to meet. Staff told us that one of the provider's senior staff had apologised to the staff team for the way they, including the acting manager, had been left feeling unsupported. A healthcare professional, in regular contact with the service, told us, "[There's been] a lack of strong direction and staff have felt quite stretched, which filters down to people [living here]." However, this professional felt hopeful about the future. They were complimentary about the staff team and said, "[The service] just needs a bit of pulling together."

Some of the people who lived at Eynesbury House told us they had not been offered opportunities to put forward their views about the service being provided, or if they did, their views were not listened to. The acting manager and staff told us that people were given this opportunity at the meeting held with their keyworker each week. They said that these had replaced the 'residents' meetings' that had been held previously, which had become dominated by the views of one or two people. Keyworker meetings gave everyone the opportunity to be listened to. The acting manager said the people who lived at the service were "pretty articulate" and they all knew they could chat with staff or "pop into the office" at any time. Most relatives made very positive comments about the responses they had had when they had raised issues. One relative told us, "We're in good communication so if anything occurs we talk it through."

We had mixed views from the staff, both about how they worked with each other and the support they received from their managers and the organisation. One member of staff said, "We work together well as a team. I feel appreciated for what I do, by people and other staff." This member of staff said they received supervision every two months and felt supported because they knew they could approach their supervisor at any time. Another member of staff told us, "I do love my job…I feel supported both professionally and personally." One member of staff had felt particularly unsupported following an incident in which they had been injured. They said they had not been contacted by any of their managers for several days and had not

had "a de-brief" when they returned to work. Another member of staff told us, "The main thing to improve here is teamwork and consistency. Team-wise we are not getting any better."

Some people told us they were happy living at Eynesbury House and all except one person's relatives were very satisfied with the service their family members were receiving. One relative said, "Honestly, we couldn't ask for more." Another relative told us, "[Name's] very happy there and they do a good job."

There were some links with the local community as people used local services such as the GP surgeries. People also visited local shops, cafes, restaurants and other leisure facilities such as the cinema. People told us that healthcare professionals, other than those employed by the provider, did not regularly visit the service. There were few visitors to the service as people preferred to visit their relatives at their relatives' homes or go out with them.

The provider had a system in place to monitor the quality of the service being provided to people living at Eynesbury House. Senior staff told us they had a number of daily and weekly checks that they were responsible for carrying out. These included checks of the fire safety system, water temperatures, the house vehicle and various aspects of the environment. Internal audits, such as audits of the medicines were carried out and the provider had a quality control team who visited all the provider's locations to carry out checks and audits. We noted that the four-weekly Infection Control and Health and Safety Report was just a list of dates when records such as cleaning schedules had not been signed by staff as completed. There were no actions set out nor any indication of who was responsible for carrying out any actions so that improvements would be achieved. The managers told us that a Key Performance Audit was used and the services had to score over 70%. Eynesbury House had recently scored 67% so additional support was being provided by the area manager. Following the inspection the provider told us, "The organisation also has an electronic quality monitoring system called RADAR. This system develops an action for every non-compliance and this is monitored at manager supervision."

Records required by regulation were maintained and were kept securely. The managers and senior staff were aware of their responsibility to send notifications to the CQC as required by the regulations.