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Eastbrook House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 27 and 28 September 2016 and was unannounced. Eastbrook House provides accommodation and personal care for a maximum of 37 older people, some of whom are living with dementia. At the time of the inspection there were 37 people using the service.

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

At our last inspection in June 2015 we found that some aspects of medicines management were not safe. The provider had not submitted any applications, where relevant, for a Deprivation of Liberty Safeguard (DoLS) authorisation and accurate records had not been kept in relation to people's care and treatment. These resulted in breaches of Regulation 12, 13 and 17 of the Health and Social Care Act 2008.

Due to the serious nature of the breach of Regulation 12, relating to unsafe medicine management, we had taken enforcement action against the provider. We issued a warning notice to the provider detailing the issues we found and requiring them to become compliant within a specified timescale. An unannounced focused inspection took place in August 2015 to check that this significant breach of legal requirements had been addressed. During the inspection it was found that all legal requirements for medicines had been met.

During this inspection we again found there to be some aspects of medicines management that were not safe. Care staff were not signing the Medicine Administration Record (MAR), once a medicine had been administered to confirm that the person had received their medicines. We also found two examples of where people had not been given a particular medicine for a number of days due to poor communication and poor management of medicines.

Risks associated with people's care and support needs had been identified and these had been assessed, giving staff instructions and directions on how to safely manage those risks. However, where records were needed to be kept in relation to monitoring food and fluid intake and turning charts to monitor people's skin integrity, these had not been completed to ensure that these areas were safely monitored and that people were protected from those identified risks.

We found the home to be clean and tidy. However, on the second day of the inspection we noted a significant odour originating from the main lounge on the ground floor. We highlighted this to the registered manager who told us that they would address the issue.

Systems were in place which monitored the quality of service provision with a view to making improvements. It was positive to note that the provider had identified some of the same issues as identified as part of this inspection. However, the provider had not recorded what actions had been taken as a result

of identifying the issues and had not put in place improvement plans to minimise re-occurrence.

People told us that they felt safe and were happy with the care that they received at Eastbrook House. Care staff were aware of what constituted abuse and the actions they would take if abuse was suspected.

The provider ensured that safe recruitment practices were observed which included obtaining criminal record checks from the disclosure and barring service, previous employment history and references from previous employment confirming past conduct especially when working with vulnerable adults.

Food looked appetising and the chef was aware of any special diets people required either as a result of a clinical need or a cultural preference. People and relatives spoke positively about the food at the home. However, we found that people, especially those living with dementia were not offered any meal choices.

Care plans were specific to each person and their needs. These were detailed and person centred. People's likes and dislikes and care preferences had been noted.

Senior managers, head of care and care staff demonstrated a good level of understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The registered manager had submitted applications to the local safeguarding authority for each person who required an authorisation to ensure that people were legally being deprived of their liberty which was in their best interest.

Care staff enjoyed working at the home and were positive about their experiences and the support that they received from the registered manager and their colleagues. Staff confirmed that they received regular training which enabled them to care for people with effectively. Care staff received regular supervision and had also gone through their annual appraisal with the registered manager.

We spoke with a number of professionals during the inspection and also obtained feedback from local commissioners and health professionals. Feedback received was positive and no concerns were noted in relation to the care and support people received.

At this inspection we found breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches were in relation to people receiving safe care and treatment and the safe management of medicines. You can see what action we told the provider to take at the back of the full version of the report.

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. Medicines were not managed properly which may have put people at risk. Issues identified included incomplete recording of medicines which had been given. Some people did not have particular medicines administered to them for a number of days.

Risks to people were identified and assessed so that people were safe. However, food and fluid charts and turning charts were not completed properly, in line with recommendations noted on the care plan in order to protect people from those identified risks.

People who lived at the home told us that they felt safe and were happy with the care and support that they received. Care staff knew about safeguarding adults and the actions they would take to report any signs of abuse.

Safe recruitment practises were followed and the required checks were undertaken prior to staff starting work.

Is the service effective?

Good

The service was effective. All care staff confirmed that they received regular training. Care staff also confirmed that they were well supported by senior managers and received regular supervision. Appraisals had been completed with all staff.

The service was following the principles of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS). All staff demonstrated a good understanding of the MCA and DoLS.

People had access to health and social care professionals to make sure that they received appropriate care and treatment.

Is the service caring?

Good

The service was caring. We saw people were treated with kindness and compassion. The atmosphere in the home was warm, calm and relaxed.

People were treated with dignity and respect. We observed care

staff respecting people's privacy and dignity during the inspection.

Care plans detailed people's likes and dislikes as well as their choice and preferences on how they received their care and support.

Is the service responsive?

Good

The service was responsive. Care plans were person centred, detailed and specific to each person and their needs. People and relatives confirmed that they were consulted and their preferences were responded to.

The home had a complaints procedure. People and relatives confirmed that they knew whom to approach if they had any concerns or queries and these were responded to promptly and appropriately.

There was a weekly activities schedule on display. We observed a number of activities over the two days of the inspection. People had opportunities to take part in the activities that they chose to.

Is the service well-led?

Good

The service was well-led. Relatives and professionals informed us that the registered manager was approachable and that the service was managed well.

The quality of service was monitored. Regular audits had been carried out by the registered manager and a senior manager especially in relation to medicines management, health and safety. However, where issues were identified, there was no record of what actions were taken to resolve the issues so that improvements could be made.

Care staff felt well supported by the registered manager and other senior managers who were always available and visible around the home. Regular handover and staff meetings were taking place which were recorded.

Eastbrook 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, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We undertook an unannounced inspection of Eastbrook House on 27 and 28 September. The inspection was carried out by two inspectors 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.

Before we visited the home we checked the information that we held about the service and the providers including notifications and significant incidents affecting the safety and well-being of people who used the service and safeguarding information received by us. We reviewed the Provider Information Return (PIR) which the provider had sent to us. A PIR is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. We also looked at action plans that the provider had send to us following the previous inspection in June 2015.

We contacted the local commissioning team, the local health watch and a number of health and social care professions in order to obtain their feedback about the home and the service that it provides to people.

During the inspection we observed how staff interacted and supported people who used the service. We spoke with 18 people, five relatives, two health care professionals, five care staff, one activity co-ordinator, one head of care, the registered manager and two other assisting managers. After the inspection, we spoke with a further three relatives. We reviewed six care plans, six staff files, training records and records relating to the management of the service such as audits, resident, relative and staff meeting minutes and a number of policies and procedures.

Requires Improvement

Is the service safe?

Our findings

People and relatives told us that they felt safe at the home and that they were happy with the care and support that they received. One person, when asked if they felt secure responded, "Oh yes! We have easy access to all the staff and they really listen to you." Another person told us, "I feel safe, when I have my bell with me I know I can press it." A relative stated, "I believe her to be safe here" and another relative told us, "I have a good feeling of security now that she is here." However, despite this positive feedback there were some aspects of the service that were not safe.

At the last inspection in July 2015, the service was not meeting legal requirements for managing medicines safely. Due to the seriousness of the breach enforcement action was taken against the provider. A focused inspection took place in August 2015 to see if the provider had met the legal requirements. During the inspection we found that at that time the provider had addressed all identified issues and was seen to be meeting the legal requirements set by the Health and Social Care Act 2008.

During this inspection we found that the provider was again not managing medicines safely. We looked at the Medicine Administration Records for 37 people and found that there were incomplete records where people had been given their medicines but senior care staff had not signed the record confirming that the medicine had been given. We saw approximately ten different gaps on the MAR throughout the month of September 2016 for nine different people. This meant that although the medicine, for which the gap had been identified, had been removed from the blister pack, we could not confirm that the person had been given the relevant medicine, as there was no senior care staff signature confirming that this person had received their medicine.

We noted that for one person they had not been given a particular medicine as part of their regular medicines administration for seven days and for a second person the same had taken place for a period of 10 days. For one person, who had been prescribed a laxative, they had not received this medicine for ten days. Stock of this medicine was available within the home. A MAR had been completed up until 14 September 2016 from when a new MAR had commenced. However, no further doses had been given between 15 September 2016 and 25 September 2016. The medicine was then administered again on 26 September 2016. We asked the head of care about this, who was unable to give a clear explanation about why this medicine had not been administered during the noted period.

For a second person, who had been prescribed a medicine to treat congestive heart failure, the medicine had not arrived with the monthly medicines. This had not been picked up when monthly medicine receipts were checked. This meant that the person did not receive this medicine until another staff member highlighted the omission a number of days later. The person did not receive this medicine for a period of seven days.

We spoke with the registered manager about these omissions who confirmed that they were aware of one of the examples and agreed that this had been an oversight on the home's part. We also asked if medical guidance had been sought for both people to find out if there had been any significant impact on the person

as a result of not taking these particular medicines. For one person the GP had been informed, but only because they had to request a prescription to obtain the medicine. No medical advice or guidance had been sought for the second person, although no significant changes had been noted in the person's health.

This was breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other issues identified with the safe management of medicines at the last inspection in June 2015 had been addressed and improvements had been sustained. All medicines were stored safely and securely in the medicines cupboard on the ground floor. There was a daily record of the temperatures of the areas where medicines were stored as well as records of the medicines fridge within the medicines room. This ensured that medicines were stored at the required temperatures.

Controlled drugs were noted to be managed safely and stored in accordance with the regulations. Each time a controlled drug was administered, this was signed by two senior care staff and records were audited and stock checked on a weekly basis. Controlled drugs are medicines that the law requires are stored, administered and disposed of by following the Misuse of Drugs Act 1971.

A number of people received medicines which were disguised in food or crushed. Where medicines were administered covertly to a person, a Mental Capacity Assessment, alongside records of a best interest decision that had been made on the person's behalf, were recorded and had been signed by the GP and the family. However, we noted that the pharmacist had not signed any of the documentation also confirming their involvement. We brought this to the attention of the registered manager who confirmed they would speak with the pharmacist to address this.

The provider had completed monthly audits of the quality and accuracy of medicines management within the home. It was positive to note that the provider had picked up similar issues around the gaps on MAR which have been identified as part of this inspection. The registered manager informed us that issues identified with medicines administration were addressed with senior care staff responsible for administering medicines through staff meetings and verbal feedback. However, there was no record of the actions that had been taken and there was no evidence that an improvement plan had been put in place.

Care plans detailed all risks associated with people's health and support needs. Environmental as well as individualised risks were assessed and guidance and direction was provided to reduce or mitigate risks to ensure people were kept safe from harm. Risk assessments were completed for areas including choking, pressure sores, bleeding due to blood thinning medicines, falls and memory loss. However, where people were assessed as high risk of pressure sores and turning charts were in place or where the person's food and fluid intake needed to be monitored, recording was inconsistent. Fluid charts did not give detail on how much a person should be drinking per day and charts were not totalled at the end of each day which meant that people's fluid intake could not be monitored as there would be no record of how much fluid a person had consumed. If a person had a low intake over consecutive days, there was a risk that the records might not indicate that action might be needed to avoid the risks associated with poor fluid intake such as re-current urinary tract infections, poor skin integrity or weight loss.

Where people were noted to be at risk of pressure sores, turning charts were in place with guidance by district nurses, on how often a person should be re-positioned to prevent a pressure sore from occurring or to aide with the healing of a current pressure sore. For one person we saw that it was recommended that they be turned and re-positioned every two hours. However, records did not evidence this was happening. Records were inconsistent and during the evening period, the records suggested that person was not turned

or re-positioned for between four to six hours. The person was potentially being placed at risk of sustaining a pressure sore due to not being re-positioned appropriately as per guidance from the district nurses.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care staff that we spoke with were able to describe the different types of abuse and the actions they would take if abuse was suspected. One care staff told us, "I would take it straight to the managers." Another care staff explained, "I would report it. I would also listen to the person, I wouldn't make a judgement and I would try to understand the person who was making the allegation." Care staff told us, and records confirmed, that they had received training in how to safeguard vulnerable adults from abuse.

Care staff knew what 'whistleblowing' was and were able to tell us about the external agencies they could approach if they had concerns about people within the home. One staff member told us, "It's about reporting to the Care Quality Commission (CQC), local authority or the police when it is a manager or other staff member involved."

Each person living at the home had a personal emergency evacuation plan (PEEP) which detailed how the person was to be supported in case of an emergency which included details of how the person should be evacuated and what equipment maybe required. A copy of these were kept in a central file held within the office which was easily accessible in case of an emergency.

The registered manager explained that they did not complete a formal dependency level assessment for each person living at the home. Dependency level assessments look at the person's level of need which would determine the level of support that they required which would give the provider an indication of the required staffing levels within the home. Staffing levels were determined through observation of each person's needs and occupancy levels. Care staff were also consulted about the needs of people and where adjustments to staffing levels were required these were implemented straight away. For example, where a person required one to one attention this was reflected onto the staff rota. We spoke with care staff about staffing levels and all confirmed that there was enough staff available within the home. Our observations on the day of our inspection found that there was enough staff to meet the needs of the people living at the home. We also observed that staff did not appear to be rushed and had time to interact and talk with people living at the home.

We looked at the home's recruitment process to see if the required checks had been carried out before staff started working at the home. We found that there was safe processes in place whereby enhanced criminal record checks had been undertaken, written references and proof of identity had been obtained for each staff member employed.

We found the home to be clean and tidy. However, on the second day of the inspection we noted a significant odour originating from the main lounge on the ground floor. We highlighted this to the registered manager who told us that the smell may be originating from the carpets within the lounge area. The registered manager confirmed that this would be addressed.

At the last inspection in June 2015 it was noted that some cleaning substances were stored in a cupboard which was not locked. During this inspection we found that all cleaning cupboards which held all cleaning substances were locked.

All relevant equipment checks, checks of gas and electrical installations were documented and current

including quarterly fire alarm checks.

Good

Is the service effective?

Our findings

People and relatives told us that they believed that the care staff that supported them were appropriately trained and skilled. People and relatives were happy with the care and support that they received. One person told us, "This is a happy place, been here nearly four years, we all get on and they look after us well." Another person said, "The carers are on the whole very good." One relative when asked if they believed staff were adequately trained replied, "I think so, she [person] has no worries about her care." Feedback from a health care professional included, "The staff are knowledgeable about their residents, knowing their families, friends, likes and dislikes and often advise me on how to approach or communicate to get the most out of the resident I am reviewing."

Training records that we looked at confirmed that care staff had completed training in a variety of areas that helped them when supporting people living at the home. Topics included medicines management, safeguarding, fire safety, moving and handling and the Mental Capacity Act (2005). Training records were available that documented each staff member, the training course that they had attended and the date they completed the training. Records also noted the date the training was due to expire so that refresher training could be scheduled.

The registered manager explained that they were encouraging staff to attend best practise training on nutrition and hydration and falls. We were shown evidence of certain care staff who had been booked on this training over the forthcoming weeks. Care staff told us that they were always encouraged to attend a variety of training sessions. One care staff told us, "[name of senior manager] is always going around talking about training and there is a training notice in the staff room." Another care staff said, "I have managed to finish my NVQ 2 with the home. [Name of senior manager] comes around and talks about training which helps you to keep up to date."

The provider had also begun to deliver the care certificate to all new care staff employed by the service. The care certificate is a training course that covers the minimum expected standards that care staff should hold in relation to the delivery of care and support.

Care staff told us that they felt well supported by the registered manager and the senior management team in carrying out their roles effectively. One care staff told us, "The management is fair and I feel supported." Another staff member told us, "I can go to the [registered manager] and [senior manager] at any time and they are helpful." Care staff told us that they received regular supervision and records confirmed this. One staff member stated, "I have a supervision every six weeks. [Senior manager] fits it in around me." Another care staff told us, "I have supervisions and 1-2-1's. I discuss problems and we find a solution. They are very good." The registered manager had a document available which gave an overview of when supervisions had taken place so that this could be monitored.

Our inspection in June 2015 found that staff had not received an annual appraisal enabling them to review their personal development and progress. During this inspection, we found that the registered manager had implemented schedules to ensure that each staff member received an appraisal. Care staff we spoke with

and records confirmed that staff had received an appraisal over the last year.

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 homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

During the last inspection the service was found to be in breach of Regulation 13 of the Health and Social Care Act 2008 as we found that the service had not completed the relevant applications for people living at the service who were potentially being deprived of their liberty.

During this inspection we found that the service was meeting the requirements of the MCA and the Deprivation of Liberty Safeguards. Where any person living at the home lacked capacity and was being deprived of their liberty, we saw evidence that a mental capacity assessment had been completed and a Deprivation of Liberty Safeguard authorisation request had been submitted to the local authority. Where authorisations had been granted, this was documented within the care plan including details of any conditions that had been set. The registered manager held an overview of each person who had been granted an authorisation and the date it was due to expire so that re-authorisation could be requested.

Where a person lacked capacity, a multi-disciplinary approach had been taken in order to reach a decision which was in the person's best interests. Where a decision to administer covert medicines or a 'do not attempt cardiopulmonary resuscitation' had been made we saw evidence that the family and GP had been involved in the decision making process. This had been appropriately recorded within the persons care plan. We also saw evidence of best interest decisions that had been made in relation to a person requiring bed rails.

Staff and the registered manager demonstrated a good level of understanding of the MCA and DoLS and how this impacted on the way in which they supported people with their care needs. One care staff member told us, "The MCA is the Act to protect vulnerable adults who cannot make decisions on their own. For example, people who have had a stroke or who have dementia or a mental health illness." Another care staff explained, "Where a person can't make decisions and need an assessment to make this decision."

Care staff told us that they always sought consent from people when supporting them with their needs and requirements. One care staff told us, "People have choice with what they want to do, or wear, or eat. I always ask them." Care plans showed that where people were able to, they had signed their own care plan, consenting to the care that they received. Where people were unable to sign, relatives had been involved in the care planning process and had signed the care plan on the person's behalf and in their best interests.

People and relatives spoke positively about the food that was provided in the home. One person said, "Food is all fresh cooked and we can ask for something else if we don't like it." Another person told us. "Although the food is a bit boring we are able to make special requests and get something we fancy. I only have toast and cereal for breakfast but I could have an egg if I wanted to." Relatives feedback included, "She [relative] gives a thumbs up to the food" and "She [relative] is eating well and always has water or a drink next to her."

The home had a weekly set menu on display so that people were able to see what was on the menu for the day. The registered manager told us that the menu was set in consultation with people living at the home and was designed keeping in mind people's likes, dislikes and special requests. Alternatives were available if people did not want to eat the main dish of the day and the chef was aware of people's special dietary requirements in response to medical conditions or religious and cultural beliefs. However, on the day of the inspection and at the time of the meal, we observed that people were not given a choice of what they would like to eat especially for those people living with dementia who may not have known what was on the menu and may not have been able to request an alternative. We spoke to the registered manager about this observation who agreed it was something he would look into in order to improve.

During the inspection we observed people having lunch. The atmosphere was calm and relaxed. Food looked appetising and was well presented. People could choose if they wished to have their meal in the main dining room or in the lounge area. People appeared to be enjoying their meal. We observed staff were respectful and assisted each person who needed help with their meals. People were assisted in a dignified way but it was noted that two care staff were observed not to be communicating with people whilst they were eating and it seemed to be a task driven exercise opposed to support being offered in a person centred way.

The kitchen was located centrally within the home and it was positive to note that some people living at the home, who had capacity and were independent were able to access the kitchen whenever they so wished to make a drink or get a snack. At the last inspection in June 2015 it was noted that opened foods had not been labelled with the opening date to ensure that food was suitable for consumption. During this inspection we found that all opened food items in the fridge had still not been labelled. We spoke with the chef about this who commented that, "They normally do label food." We spoke to the registered manager about this who confirmed that all open foods should be labelled and would ensure this would be carried out going forward.

People's weights were recorded monthly or more frequently if people were at risk. This enabled the service to monitor people's health and nutritional intake. Where people had a low food or fluid intake or were at risk of weight loss, charts were in place to monitor food and fluid intake to ensure that people were eating and drinking sufficiently. Care records showed that people's health and well-being were monitored and people had access to a variety of health care professionals where and when required. When we asked people about whether they were supported with their health and medical needs people told us, "We can go to the dentist and optician (I've got some new glasses) and we don't have to wait. A chiropodist also visits" and "If I don't feel too good they will respond right away and get the GP in if necessary or whatever is needed. We can go to the optician or the dentist these days it's hard for them to bring equipment here so one of the boys (they are like family) [senior manager] will give us a lift with a care assistant very quickly."

Each care plan contained a GP and health professional visit sheet which recorded details of each visit that took place by the GP, chiropodist or optician. People were supported to maintain good health and had access to a variety of health care services. Care plans were updated accordingly following visits or appointments that people had attended. Healthcare professionals that we spoke with confirmed that the home were observant to people's changing health needs and promptly made the appropriate referrals where required. Records showed that referrals, in the form of emails, were sent to healthcare professionals.

Good

Is the service caring?

Our findings

Throughout the two days of the inspection we observed positive interactions between people, senior managers and all staff members employed at the home. The atmosphere within the home was warm and relaxed. Care staff were seen to be singing, talking and dancing with people throughout the two days. Feedback from people and relatives was very positive. One person told us, "They [care staff] are very nice. They come in and ask how I am." Another person said, "When I get to the carers that come regularly, we have a laugh." A third person told us, "It's a gentle place with so many different people. It can be a bit noisy (some shouting). I enjoyed the outing to Kew Gardens we all did it was so lovely. The best part about being here is that we are never alone."

Relatives feedback included, "I think the care is excellent," "We are just so happy with the care, they are caring" and "The care seems very good to me, perfectly alright."

We spoke with people and relatives about whether they felt involved with their own care provisions or the care provision of their relative. One person told us, "She [care staff] always asks how I am and follows up on things." Relatives told us that they always felt involved and that the home always contacted them to gain their opinion and consent where changes to the care and support of their relative was required. One relative commented, "They always check with me and have always consulted me about the care." Another relative told us, "They give me a call to let me know how my relative is." A third relative stated, "I am consulted and I do get asked questions."

Feedback from health care professionals about the care and support people received included, "I have witnessed some lovely compassionate interactions between staff and residents and I am impressed by the carers ability to recognise clinical changes or mental health concerns and seek help from GP and other health professionals and manage people right up to the end of life." A visiting health care professional told us, "They [care staff] are sweet. They have a laugh and a joke with them [people]."

Care plans that we looked at also contained information about people's wishes and choices regarding their end of life and how they wished to be supported. Care plans included advanced care planning documents which had been written in partnership with the person and their relatives and included information on how the person wished to be cared for when approaching end of life and whether they wished to be admitted to hospital or wanted to be cared for in the home. One healthcare professional told us, "There have been a few expected deaths recently which staff dealt with really well. Staff work well with me, identifying residents who would benefit from my input. When someone from Eastbrook contacts me they have already begun discussing with residents and families about their wishes for the future and I get a real sense of what the individual and/or family want prior to my input which is really helpful when thinking about do not resuscitate and advance care planning."

Care staff had a good understanding of how they were to maintain people's privacy and dignity. Observations of care staff practices also confirmed that people were treated with dignity and respect at all times. During our observations we saw one person who was supported by two care staff to be sat

appropriately on a pressure relieving cushion. Throughout the process both care workers spoke with the person, explaining what they were doing and checking if the person was comfortable.

Care staff explained and gave examples of how they maintained people's privacy and dignity. One care staff told us, "We give people a choice. When we are supporting people to the toilet we ask them whether they want us to stay with them or go. Some people do feel embarrassed and so we show them that respect."

As part of the training programme, the provider had organised for training to be delivered on equality and diversity. Staff had a good understanding about the importance of people's culture and diversity. Care plans were reflective of people's diversity in terms of their culture, religion and gender to ensure that these needs were respected. We spoke with one care staff about supporting a person who may identify themselves as being lesbian, gay, bisexual or transgender. They explained, "It's about treating people the same regardless of their beliefs or sexual orientation."

Good

Is the service responsive?

Our findings

People and relatives told us they received good care and support which was responsive to their needs and requirements. One person told us, "Oh yeah, they do listen to us." Another person stated, "I needed a bit of protection and I have it here, they are very kind and I'd be content to end my days here, lovely people, I'd call them mindful." Relatives comments included, "She [relative] is great. She is happy. She likes the staff. There is a good atmosphere" and "They [the home] have made her [relative] and us always feel welcome."

During the inspection in June 2015 we found that some care plans did not accurately record the care and treatment people required. For example, details of when a specific hoist was said to be required had not been specified in the care plan and risks associated with people's care and medical needs had not been correctly recorded. We also found discrepancies within the care plan where for example, one person was noted to be incontinent but further in the care plan it was recorded that the person was able to use the toilet independently.

During this inspection we found that care plans accurately recorded the care and support needs people living at the home. We reviewed six care plans and found that care plans were person centred and reflective of the needs and requirements of each person living at the home. Each care plan detailed the needs of the person, their likes and dislikes, their choices of how they wished for their care to be delivered and included risk assessments and guidance for staff on how to manage people's individual identified risks. For example, for one person who had been prescribed a blood thinning medicine, clear guidance was available to care staff on the actions to take if the person had a fall or had sustained a cut or injury. Information was consistent throughout the care plan and was ordered in a manner that allowed the care plan to be easily read and understood.

For one person who had been identified as having swallowing difficulties, there was clear information available within the care plan on when the person had been assessed by the Speech and Language Therapist (SALT) and their recommendations on how the person was to be supported with their food and fluid intake. There was clear guidance on thickening agents that were to be used with fluids which included the amounts that needed to be administered depending on the amount of fluid being given. When asked, care staff were also aware of this guidance and the directions that needed to be followed.

People's care plans were person centred and included details of people's background and life histories. Care plans included a life history booklet which provided information about the person, where they were born, where they lived and their occupation. Care staff told us that by reading the care plan they were able to get to know the person that they were supporting. One care staff told us, "The care is about them [person]. We get as much information as we can from family and friends and include it in the care plan."

Daily handover meetings were held at the start of every care shift. All care staff were required to attend. Handover meetings were recorded and gave care staff, at the beginning of their shift, information about people, any events or incidents, details of GP or healthcare professional visits and any other relevant information about people that care staff needed to be aware of so that people were supported

appropriately at that time.

In addition to this the registered manager, held staff handover meetings at the start of the week following the weekend and at the end of the week before the weekend began as a minimum, and in addition when any key issues or changes were noted for a person and their care. These were also recorded and care staff where required to read the minutes and confirm that they had read the minutes by signing the record ensuring that they had read understood any significant changes.

People, relatives and health care professionals told us that the home was responsive to their needs and where health care concerns were noted, the home ensured that appropriate referrals were made so that these concerns were addressed and that the person received the appropriate care and treatment. One relative told us, "They always give me a call to let me know about [relative] health." One visiting professional told us, "They [home] make referrals through the telephone if they have any concerns. Pressure care is managed very well. Once they notice anything they follow it up."

Relatives confirmed that they were always involved in the care planning process and that they were always consulted with all aspects of the persons care and health needs. One relative told us, "I am so happy we chose this place our relative looks so much better now that she is getting properly fed. Another thing is we [relatives] have total access to the home, so no secrets." A second relative said, "I have a good feeling of security now that she [relative] is here. I'm in regular contact with the management and I'm very satisfied with her [relative] care. The carers are always present and feel like old friends. They tell me that she [relative] has come on by leaps and bounds."

Each person living at the home had an allocated key worker. The key worker role involved paying specific attention to a person's personal care needs, ensuring they had sufficient personal clothing and toiletries, communicating with the family on day to day matters, arranging monthly reviews and updating their care plan. People knew who their allocated key worker was. One person told us, "My keyworker is very good. She is somebody personal to you but endless paperwork. Every month we have a review and she gives her own time and comes in an hour early. She always asks how I am and follows up on things."

Care plans were reviewed on a monthly basis or as and when required if there was any significant change. People and relatives confirmed that they were involved in the review process. The registered manager, head of care as well as care staff and key workers had made entries within the care plan as part of the review process or where changes within the required care and support had been noted.

An activities timetable was visible on the notice boards around the home and the home had a dedicated activities co-ordinator. A variety of activities were scheduled on each day of the week including bingo, keep fit, a visiting hairdresser and music therapy. On the day of the inspection we observed the activity co-ordinator interacting with people, playing a game of indoor skittles and playing a memory game. Records were kept for each person, making note of the activities that they had participated in.

A complaints policy and procedure was available to people and their relatives which gave information about the process to follow if they had any complaints or concerns. People and relatives knew who to complain to if they were dissatisfied with any aspects of their care or that of their relatives. We observed that the registered manager operated an 'open door' policy where people and relatives were able to approach them at any time. We looked at the home's complaints records and saw that complaints had been recorded and included the details of the investigation, the outcome and actions taken.

Good

Is the service well-led?

Our findings

People, relatives and health care professionals told us that they knew who the registered manager was and found the registered manager and the team of two other senior managers' approachable and available at all times. One person told us, "The management have a good heart." A relative explained, "All three brothers [registered manager and senior managers] are all very good to talk to. They will explain things if I don't understand." Another relative said, "[Name of registered manager and senior manager] I know I can go to them." The registered manager and other senior managers were observed to be visible around the home and knew all the people living at the home really well. Healthcare professionals told us, "I know the manager and I am able to report any concerns to them" and "I deal with the manager mainly but I have met all three brothers and they are all approachable and staff seem happy and morale seems high. I think the care home is very well managed."

Care staff were also positive about working at the home alongside the managers and fellow colleagues. One care staff told us, "It is a nice home. Senior managers are always available." Another care staff said, "I enjoy working here. I enjoy working with the clients and the management are fair. I feel supported." Care staff told us that the registered manager and senior managers were approachable and that they could discuss problems and care issues with them with the expectation that their concerns and problems would be positively listened to and addressed.

Care staff told us and records confirmed that regular monthly staff meetings were taking place. Agenda items included staffing levels in the evenings, break times, medication and discussions around people's care and support needs. The registered manager told us that by having regular staff meetings ensured that care staff were kept well informed of any changes and developments taking place within the home especially those relating to people's care and support needs.

The registered manager held bi-monthly meetings with people living at the home. During these meetings the registered manager discussed the menu choices with people and also got feedback from people about the quality of the food and whether they enjoyed the food. The meeting also discussed outings as well as care and support provided during the night and whether people could suggest any improvements that could be made.

The registered manager had recently organised a family meeting which he planned to hold every six months going forward. During this meeting, which had been organised as a social activity as well, discussions took place around summer outings, activities, befriending services and obtaining overall feedback around the care and support people received.

Positive links had been established by the registered manager and the home with local schools and places of worship. In partnership with members from one place of worship, the registered manager had agreed for them to visit the home on a weekly basis offering a befriending service to people living at the home. These regular visits meant that people had regular interactive and engaging visits which resulted in people's positive well-being.

People and relatives were given the opportunity to complete annual quality surveys as another way in which the provider could obtain feedback about the care and support people received. Based on the feedback, the provider could therefore learn and make improvements to the care and support people received. The most recent feedback forms had been handed out to people and relatives in April 2016. The provider told us that they were still in the process of collating the results with a view to producing a summary report with an action plan detailing any learning taken from the feedback and improvements that they plan to implement.

In addition to the quality surveys, the registered manager was able to show us a number of systems that he had in place to enable him to monitor and improve the quality of the service. We saw documented evidence to confirm that the registered manager and senior managers carried out checks which covered various aspects such as health and safety, medicines managements and care plans. It was positive to note that as part of their auditing systems, the registered manager and other senior managers had also identified similar issues identified as part of this inspection. However, the registered manager did not compile any action plans confirming what action had been taken once an issue had been identified. The registered manager told us that a lot of the actions taken involved verbal feedback to the care staff team which were not recorded. The registered manager assured us that this would be something he would implement as part of all future audit processes completed.

The home monitored all accidents and incidents including witnessed and un-witnessed falls so that people could be kept safe at all times as well as implement any learning from the incidents. Every accident and incident was logged on an accident form which included information about the incident, details of the incident, what action was taken and any learning that took place. The registered manager then sent monthly logs to the local Care Home Assessment Team (CHAT) so that if there were any emerging patterns for a particular person living at the home, these could be managed appropriately with the input of the district nurses and the GP. The CHAT is a service available to care and nursing homes in the local community which provide clinical and health care support to prevent hospital admissions where possible. We saw that the home had sent a recent referral to the CHAT for one person who had fallen regularly over the last month so that with the involvement of clinical professionals reasons as to why the person was falling could be identified and the person supported safely and appropriately.

The provider had a business continuity plan in place which addressed provisions that were place for a foreseeable emergency. Risks associated with the premises including the kitchen had been assessed.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider was not protecting service users from the risks associated with the unsafe management of medicines. The provider was not protecting service users and was not doing all that is reasonably practicable to mitigate identified risks associated with people's care and support needs.