Ross Healthcare Limited

Eastfield House Care Home

Inspection report

Eastfield Lane
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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?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Good**

Summary of findings

Overall summary

We carried out our inspection on 18 January 2016. This was an unannounced inspection.

Eastfield House is a care home providing personal care for mainly older people, including people living with dementia. The home supports up to 27 people. At the time of our inspection there were 23 people living in the home.

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.

There was a cheerful, calm atmosphere throughout the inspection. Staff were compassionate and clearly knew people well. People enjoyed living at the home and benefited from caring relationships. People had access to a range of activities, both within the home and in the community.

Everyone we spoke with was complimentary about the registered manager and felt confident to raise issues. The registered manager was knowledgeable about people's needs and was supportive of relatives.

People were supported to access health professionals when needed and this was done in a timely manner. Recommendations from health professionals were followed.

People were not always supported in line with the principles of the Mental Capacity Act 2005 (MCA) and records did not always accurately reflect people's capacity to make specific decisions.

Risks to people were not always identified and plans were not always in place when they were identified.

There were quality assurance systems in place to identify areas of improvement. Where issues were found, action plans were developed to address issues and improve the quality of care.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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.

Risks were not always identified. Where risks were identified care plans did not always include how risks would be managed.

There were sufficient staff to meet people's needs.

Medicines were managed safely. People received their medicines as prescribed.

Is the service effective?

Requires Improvement

The service was not always effective.
People were not always supported in line with the principles of the Mental Capacity Act 2005 (MCA).

Staff received regular supervisions and had access to development opportunities.

People received sufficient food and drink to meet their needs.

Is the service caring?

Good

The service was caring.

People were treated with dignity and respect.

People benefitted from staff who were kind and considerate.

People were involved in decisions about their care.

Is the service responsive?

Good

The service was responsive

People had access to activities that interested them and had regular contact with the local community.

People's care plans were personalised and identified what was important to them.

There was a complaint policy and procedure in place. People were confident to make complaints and were certain complaints would be dealt with promptly.

Is the service well-led?

Good

The service was well led.

There was a person-centred culture that put people first.

People and staff felt listened to.

There were effective quality assurance processes in place.

Eastfield House Care Home

Detailed findings

Background to this inspection

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

This inspection took place on18 January 2016 and was unannounced.

One inspector and an expert-by-experience carried out the inspection. 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 on this inspection had expertise in dementia care.

Prior to the inspection we looked at notifications received from the provider. A notification is information about important events which the provider is required to tell us
about by law.

Before the inspection, we asked the provider to complete 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 spoke with nine people who used the service, five visitors and one visiting health professional. We looked at four people's care records, four staff files and other records showing how the home was managed.

We spoke with the registered manager, the area operations manager, the deputy manager, a care coordinator, four care staff, the chef and the administrator.

Requires Improvement

Is the service safe?

Our findings

People's care records did not always contain risk assessments. Where assessments had been completed and a risk identified, there were not always plans in place to identify how the risks would be managed. For example, one person's care plan contained no assessments to identify if there were any risks to the person in relation to their care needs. Another person's care record had a completed risk assessment which identified they were at risk of pressure damage to skin. However there was no plan in place to support how the risk would be managed.

Care plans did not always contain up to date information relating to people's care needs which meant people were at risk of receiving care that was unsafe. For example, one person's care plan relating to the support a person needed to mitigate risks associated with a diagnosed condition had not been updated. The information was not consistent with information on the person's medicine administration record. We spoke to a member of the care team who told us the information in the care plan was not correct.

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

People told us the service was safe. Comments included: "Oh yes I feel safe, the staff are so helpful and nice to me"; "Oh I feel safe in here and have settled well"; "Oh yes I feel very safe I like it here" and "I have been here nearly three years and I feel very safe the staff are so good to me".

Staff were knowledgeable about their responsibilities to identify and report any issues relating to safeguarding vulnerable people. Staff told so they would report any concerns to their manager and knew where to report outside of the organisation if they felt concerns and not been taken seriously. This included contacting the Care Quality Commission (CQC) and the local authority safeguarding team.

The provider had a safeguarding policy and procedure in place. Records showed that procedures had been followed and safeguarding concerns raised to the local authority safeguarding team and notified appropriately to CQC.

Medicines were managed safely and people received their medicines as prescribed. Where people required clinical observations before the administration of medicines these were completed and recorded. Medicine administration records (MAR) were accurately completed and codes entered to identify reasons when medicines were not administered. Where people were prescribed 'as required' medicines (PRN), protocols were in place to identify when PRN medicines should be given. Medicines were stored safely. Temperatures were measured and recorded daily for the medicine refrigerators and the rooms where medicines were stored. Records showed temperatures were within recommended limits. The medicine trolley was secured in a locked room when not in use and the nurse responsible for the medicine administration held the keys.

There were sufficient staff to meet people's needs. People and their relatives told us there were enough staff and that requests for support were answered quickly. One relative said, "There is always a member of staff

about".

Staff told us staffing levels were sufficient. One care worker said, "There is usually a senior member of staff and three care workers during the day. That is enough". Staff told us the manager was always visible in the home and would support staff when needed.

The atmosphere throughout the day was calm and call bells were answered promptly. Where people requested support this was responded to in a timely manner.
The registered manager used an assessment tool to identify the needs of the people using the service and to ensure enough staff were available to meet people's needs. Rotas showed that assessed staffing levels were achieved. The registered manager told us that agency staff were rarely used as permanent staff were happy to "pick up" additional shifts when people were on holiday or off sick.

Records relating to recruitment of new staff contained all the relevant checks. These checks had been completed before staff worked unsupervised in the home to ensure they were of good character. These included employment references and disclosure and barring checks (DBS). DBS checks enable employers to make safer recruitment decisions and prevent unsuitable people from working with vulnerable people.

Requires Improvement

Is the service effective?

Our findings

People were not always supported in line with the principles of The Mental Capacity Act 2005 (MCA). 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. Staff were not always clear about how they would support someone in line with the principles of the MCA. Not all staff we spoke with had received training in the MCA.

Care plans did not always contain mental capacity assessments where information indicated people may lack capacity to consent to their care. For example, one person's care plan identified the person was living with dementia and 'struggled to get words out' and 'difficulty speaking about what I want or need'. However, mental capacity assessment documents relating to their personal care, life enrichment, night care and maintaining a safe environment had not been completed.

Where mental capacity assessments had been completed they had not always been completed accurately. For example, one person's capacity assessment stated they did not have an impairment of the mind or brain. As result of this information the rest of the capacity assessment had not been completed. However, the person had a diagnosis of dementia and information in the persons care plan indicated the person had difficulty making some decisions.

The lack of understanding of the principles of MCA and the lack of accurate recording of people's capacity to make certain decisions meant we could not be sure people were able to consent to their care and if unable to consent whether care provided was in their best interest.

This issue was breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People benefitted from staff who were well supported and had the skills and knowledge to meet their needs. People and their relatives were positive about the support received. One relative said, "All [persons] needs are met and if they weren't he would soon tell me".

Staff were positive about the support they received. Comments included; "I have monthly supervisions and feel confident to make suggestions" and "[Registered manager] encourages training and makes sure it happens". Staff had regular supervisions and annual appraisals which identified development needs.

Staff had access to training to improve their skills and knowledge. One member of the care team had completed a course to improve their skills and knowledge in how to support people living with dementia. The member of staff was positive about the impact completing the course had on the way they supported people living in the home. We saw the member of staff using reminiscence techniques to engage a person in conversation.

Staff had access to national qualifications in social and health care. The deputy manager was completing their level three diploma in social and health care and told us their development plan identified they would be working towards their level five diploma.

Staff completed an induction before working alone. One care worker who had recently completed their induction told us, "My induction was really good, really thorough. I was bowled over that there was no expectation for me to do anything I was not comfortable with". Induction training included: safeguarding; health and safety; infection control; whistleblowing and dignity and respect.

People were complimentary about the food and drink offered. Comments included: "Mealtimes are lovely. I was putting on too much weight so I have cut out having a cooked breakfast every day"; "There is plenty to eat and drink, you chose your food in the morning if you don't like anything they will make you something else" and "We have a roast on Sunday and a lovely glass of wine".

Where people had specific dietary needs these were identified in people's care plans and staff were knowledgeable about people's dietary requirements. For example one person required restricted fluid intake due to their medical condition. Staff were aware of the amount of fluid the person required and all fluid intake was recorded and totalled to ensure the person's needs were met.

The chef was knowledgeable about people's dietary requirements. During the mealtime the chef spoke to people to ensure they were enjoying the food and offering additional servings. One person was feeling unwell; the chef spoke to the person who stated they did not feel like eating. The person was offered a glass of milk. The person's care plan detailed the person liked milk and to offer this if the person was not eating well. This meant people were receiving food and drink to meet their needs and preferences.

People had access to a range of health professionals. Records showed people had been referred to health and social care professionals which included: opticians, dentist, G.P's and diabetic specialist nurse. One health professional we spoke with told us the service was responsive to people's changing needs and referred people appropriately to their service.

Good

Is the service caring?

Our findings

People were positive about the caring nature of the staff. Comments included: "The staff are kind and extremely helpful. They will do anything for you"; "The staff are so lovely. I am respected and treated with dignity"; "The staff are very kind and caring and very helpful" and "The staff are caring, patient and kind. They treat me well".

Relatives were equally complimentary about the staff. One relative told us, "The staff are very caring and [person] is very much respected. I cannot fault them".

Staff had a caring approach to their work and clearly enjoyed supporting people. Staff spoke with kindness and compassion when speaking with people. During our inspection we saw many gentle and considerate interactions. For example, when staff were addressing people they knelt down to people's level and made eye contact. Where appropriate, staff used gentle touch to engage with people.

There was a cheerful atmosphere throughout the home and we saw many social interactions where people and staff were laughing together and enjoying each other's company.

Staff had a clear understanding of how to treat people with dignity and respect. Staff knocked on doors before entering and were discreet when discussing personal care needs in communal areas. People were addressed by their chosen names.

People were involved in decisions about their care. One person said, "I have a care plan. The files are downstairs, we go through it sometimes. I am definitely treated with dignity and respect. The staff always knock on the door and they always ask my consent, they are so polite".

Relatives told us they were involved in decisions about people's care and were informed of any changes. One relative told said, "My brother and I are very involved in [person] care". Relatives were contacted if there were any concerns about people's conditions.

Staff explained what they were going to do before supporting people. Staff made sure people understood what was going to happen and that people were happy for the support to be given. For example one care worker was supporting a person at lunchtime. The care worker offered the person an apron and said "May I put this on to protect your clothes".

People had been encouraged to complete end of life are plans. One person told us, "I made an advanced care plan some time ago; I don't want to be resuscitated". Care plans contained people's wishes in relation to their end of life care.

Good

Is the service responsive?

Our findings

People were positive about living at Eastfield House. One person told us, "The staff always ask my consent and I have never had to complain about anything, what is there to complain about, I love it here". Relatives were complimentary about the home. A relative said, "We are very happy with this home. I am welcome anytime day or night".

People had access to a variety of activities that interested them. The service employed an activity coordinator who was passionate about their role. The activity coordinator organised a range of activities in the home and regular outings in the homes mini bus. Activities included: a weekly art class, poetry reading, arts and crafts and beauty therapy which included manicures and pedicures. Two trips a week were organised for people to go out in the minibus. One person told us, "There are plenty of things for me to do here. We had a picnic on the minibus the other day; we went to Henley on Thames for the day and looked around a garden centre. I enjoyed that".
People who preferred to spend time in their rooms were supported to do so. One person told us, "I am happy with my own company. I love to read the paper and my magazines. The home makes sure I get them to read".

The activity coordinator had developed links with the local community and people were supported to attend monthly coffee mornings at a local group. Visitors from the local community were invited to events organised in the home. For example the home held annual fetes which were open to the local community.

Care plans contained detailed information about people's histories, likes, dislikes and what was important to term. For example, one person had a passion for dancing when they were younger. Although the person was no longer able to dance, they still enjoyed music. Staff we spoke with knew this about the person and described how they encouraged the person to sing along to music.

People's care plans were not always fully completed. For example, one person's plan contained blank care plans related to: Cognition, communication, behaviour and continence. This person's care plan also contained blank care documents for areas of care not relevant to the person. However, staff we spoke with were knowledgeable about the person's needs. We spoke to the registered manager and the operations manager about the concerns relating to the completion of care plans. They told us that new care plan paperwork had been introduced and that concerns relating to the quality of the care plans had been identified through a monthly visit report.

Following the visit report we saw that an action plan had been developed to address the issue. The action plans included the registered manager attending care plan training, this had been done, and she was now disseminating this learning to the staff and supporting them to complete care plans.

The service had a complaints policy and procedures which were displayed in the home. People and their relatives were aware of the complaints policy; however no one we spoke with had needed to make a formal complaint. People were confident that any complaints would be taken seriously and dealt with in a timely

manner. Comments included: "I have nothing to complain about in this home. If I needed to complain I would tell [registered manager]. This home communicates well"; "I have never had to complain, I would tell the manager, she pops in sometimes": "I have never complained. If I needed to I would tell [registered manager] and she would deal with it" and "We have never had to complain, there is nothing to complain about, we would just tell [registered manager] and she would deal with it".

Good

Is the service well-led?

Our findings

People were positive about the management of the service. Comments included: "This home is well managed. I have been here for years. [Registered manager] knows us all and we can talk to her about anything"; "[Registered manager] is very approachable. I can tell her anything she runs this home well; I would recommend this home to anyone"; "I think [registered manager] runs this home well, I can't think of anything they could do better. I would recommend this home to others" and "The manager is very good. I would recommend this home to friends, it is well managed".

Relatives were equally complimentary about the registered manager. One relative told us, "[Registered manager] is very nice and approachable. I would recommend this care home to anyone, the manager actually listens, the staff are well managed and she knows what is going on at all times. She actually works weekends. She is not one of these managers that stays in her office all the time".

Staff felt listened to and were confident that any issues would be dealt with promptly by the registered manager. Staff told us the registered manager was approachable. One member of staff said, "[Registered manager] is really good, really friendly. She takes time to ask and remembers details of what you tell her. She is very good at dealing with issues". Staff had regular meetings and there was a suggestion box for staff who did not feel confident to speak out at meetings.

Staff were aware of the whistleblowing policy and were confident to use it.

There was a culture in the home that put people at the centre of everything. The atmosphere was cheerful and relaxed. The registered manager was present in the home and spent time speaking with people, their relatives and staff. It was clear the registered manager was knowledgeable about all that happened in the home and modelled a person-centred approach to supporting people.

The registered manager had organised meetings for people and relatives. People we spoke with were aware of the meetings and attended if that was their choice. One person told us, "I never go to the meetings, my daughter does when it is possible for her to get there". The registered manager varied the times of the meetings to make it convenient for more relatives to attend. One relative told us, "We get the minutes of any meetings".

Prior to our inspection the service had notified us that a deputy manager was being appointed to support the registered manager and to enhance the knowledge of staff in relation to supporting people living with dementia. At our inspection the deputy manager was in post. The deputy manager was very positive about the support they had received from the registered manager since taking up the post.

There were quality assurance systems in place. The area manager carried out monthly audits based on the key lines of enquiry used in CQC inspections. The audits identified areas of improvement. We saw that the areas of concerns we found during our inspection had been identified. As a result of the audit, action plans were being developed to ensure the issues were rectified. There were audits carried out by the home which

included medicines and infection control.

Accidents and incidents were recorded and any actions identified. There was a system in place to enable the provider to have an overview of all accidents and identify any trends. This included monitoring falls and identifying actions relating to individuals and across the service.

Quality assurance questionnaires were sent out annually by the organisation. There was a low response to the most recent survey. The registered manager and operations manager felt this was due to the availability of the manager which enabled issues to be resolved in a timely manner as they occurred. The responses that were received were positive.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not ensure care and treatment was only provided with the consent of the relevant person. Staff were not always knowledgeable about the principles of the Mental Capacity Act 2005. Records did not always accurately reflect people's capacity to make decisions. Regulation 11 (1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure care and treatment was provided in a safe way for service users. Risks to the health and safety of service users was not assessed. The provider did not take all reasonable steps to mitigate risks. Regulation 12 (1) (2) (a) (b).