Eastfield Lodge Care Home LLP

Eastfield Lodge Care Home

Inspection report

7 Stanley Road
Leicester
Leicestershire
LE2 1RF

Tel: 01162703861
Website: www.eastfieldcare.com

Date of inspection visit:
08 March 2016
09 March 2016

Date of publication:
28 April 2016

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

This inspection took place on the 8 and 9 March 2016 and was unannounced.

Eastfield Lodge Care Home provides residential and nursing care for up to 17 older people, who are living with dementia and may have a physical disability. At the time of our inspection there were 13 people in residence. Accommodation is provided over two floors with access via a stairwell with a stair lift. Communal living areas are located on the ground floor. The service provides single rooms. There is a walled garden which is in the main laid to lawn.

Eastfield Lodge Care Home did not have a registered manager in post at the time of our inspection. 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.

Visitors we spoke with told us they believed their relatives to be safe at the service. We found the approach to people's safety was not consistent. Whilst people could be confident that staff were knowledgeable about their role and responsibilities in reporting and acting upon potential abuse or avoidable harm their approach to maintaining people's safety as a result of identifying risks was not always managed consistently.

In some instances we found that the emphasis on ensuring people's safety meant people's independence was compromised. Where risks had been identified and reviewed, potential risks were not supported by a care plan which detailed how risks were to be managed by staff to promote people's welfare and safety.

There were sufficient staff to keep people safe, however we found staff knowledge and skills were not fully reflective of the needs of people who used the service. This meant staff were not always able to support people well.

People's medicines were managed safely by nursing staff who reviewed people's records to ensure their medicine had been administered as prescribed and were safely stored. We found that there were shortfalls in medicine administration guidance as people's care plans did not sufficiently provide guidance as to how people who on occasions declined their medicine were to be supported.

The approach to staff induction, training and on-going supervision and appraisal was not consistent. There was no plan in place to structure staff development. Staff's competency was not assessed and their opportunity to develop their skills and training was limited. This impacted on the ability of the service to determine and further develop the quality of the service it provides through staff development.

People enjoyed the meals provided and we found meals to be of a good quality, with people being offered

choice. We found the dining experience for people could be improved to provide a more enjoyable time for people to socialise.

Staff were caring in their approach to people but the quality of care had the potential not to be consistent as the information contained within people's care plans and other records was difficult to determine. We found there was a lack of cross referencing and consistency of information between different documents, which made it difficult to get an overview as to people's needs.

People's care plans contained information as to their nursing and personal care needs, but contained very little if any information about them as a person. We found this meant staff delivered care based on the completion of tasks, with little consideration as to how they could support the person in a way that met their individual needs.

People's lifestyle and preferences were not factored into their daily lives as people's opportunity to engage in and develop their care plans was limited. Information about people's hobbies and interests had not been explored by staff, and therefore the opportunity for people to continue with their interests had not been planned for. People's opportunity to take part in activities was further reduced as the activity organiser was limited as to the time they had to provide activities as they were required to providing personal care and support to people.

Concerns and complaints were recorded and we found examples of where these had been investigated and had brought about improvements to the service. However we found there was no clear audit trail identifying whether those raising the concerns had been made aware of the outcome and any action taken.

The leadership and management of the service and its governance systems were not robust, which impacted on the quality and consistency of care being provided and restricted the development of the service. The provider did not have a system to ensure themselves that the service they were providing was governed well and that they were meeting their obligations.

We found four 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 consistently safe.

Staff were aware of their role and responsibilities in safeguarding people and to protecting them from avoidable harm.

Risks to people were assessed, however these were not sufficiently documented to ensure people's safety was consistently maintained by staff.

There was sufficient staff to keep people safe and meet their personal care needs.

Medicine was administered by staff that were trained and records showed people's medicine was administered safely, however people's care plans did not provide sufficiently detailed information for people with specific administration needs.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff induction and on-going training, supervision and appraisal was not managed effectively.

People's consent to care and treatment was sought in line with legislation and guidance; however in some instances people's choices were restricted as staff were focused on reducing the likelihood of identified risks.

People were served food and drinks and had their nutritional needs met.

People were supported to access health care services; however people's care plans made it difficult to determine the support and care being provided.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff were caring in their approach to people; however they were

often focused on the completion of tasks, which restricted the delivery of person centred care and considering the individual needs of people.

The opportunity for people and their relatives to be involved in the development and reviewing of their care was limited.

People's privacy and dignity was not consistently considered as the service did not consider how its approach to care and support impacted on people.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Peoples care plans did not reflect people's lifestyle choices, and preferences which restricted the ability of staff to provide personalise care.

People's concerns and complaints were recorded and evidence showed that action was taken. However records were not always clear as to whether people had received a response to the issues they had raised.

Is the service well-led?

Requires Improvement

The service was not well-led.

People and their relatives had the opportunity to share their views, by the completion of surveys which were reviewed by the manager.

The service did not have a registered manager in place.

The leadership and management of the service were not proactive and there was little evidence to show that the provider supported and made available resources to develop and improve the service.

Governance and quality assurance systems were not robust and were not effective in determining the quality of the service provided and developing plans to bring about improvement.

Eastfield Lodge 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 on 8 and 9 March 2016 and was unannounced.

The inspection was carried out by one inspector and specialist professional advisor. The specialist professional advisor who supported us on this inspection was a qualified nurse with experience of palliative and end of life care within care homes. And has worked as an education facilitator in end of life care with regards care planning.

We contacted commissioners for social care, responsible for funding some of the people as well as health and social care professionals who support people using the service and sought their views about the service people receive.

We also reviewed the information that the provider had sent to us which included notifications of significant events that affect the health and safety of people who used the service.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with three people who used the service and spent time with people and staff in the communal areas of the service. We spoke with six visitors who were visiting their relatives and friends.

We spoke with the manager, the deputy managers, four members of staff and the chef. We looked at the records of five people, which included their care plans, risk assessments, medicine records, daily records and supporting documentation.

We also looked at the recruitment files of four members of staff, a range of policies and procedures,

maintenance records of equipment and the building and minutes of meetings.

We asked the manager to forward to us audits carried out and actions planned as a result of these and the matrix detailing staff training. These were provided as requested.

Requires Improvement

Is the service safe?

Our findings

Visitors told us that in their view their relatives were safe. One relative said, "I am confident [person's name] is looked after well and that they are safe." Staff were aware of their role and responsibilities in safeguarding people and reducing the risk of avoidable harm. Staff knew what to do if they had concerns about the welfare of any of the people who used the service, which included informing external agencies, which included the Care Quality Commission (CQC).

The CQC received information of concern prior to the inspection about the welfare of people at the service; we made referrals to the local authority that has responsibility for safeguarding. The local authority has investigated concerns, of which some have been substantiated, and continues to work with the manager and the staff to bring about identified improvements.

There were systems in place to monitor that the building and the equipment was safe. We looked at safety test certificates and records which confirmed this. Risk assessments had been carried out by independent companies, with regards to the fire system and an asbestos survey. The internal quality monitoring tool recorded the date when systems within the service were checked for their safety and compliance with relevant legislation, which included electrical and gas supplies to the service.

People's care records included risk assessments. These were regularly reviewed and covered areas of activities related to people's health, safety, care and welfare. Risk assessments identified the potential risk, however the action staff were to take to minimise risk was not comprehensively recorded or transferred to people's care plans. This had the potential to impact on the consistency of care and the safety of people. People in some instances displayed behaviour which challenged staff. Risk assessments had been put into place; however the guidance for staff was limited and advised staff to provide reassurance, but did not detail the form the reassurance should take, or refer staff to the use of distraction techniques.

We observed a person using a zimmer frame who was at risk of falling; they were being supported by a carer using one arm to support the person, whilst pulling along a dining room chair with their other arm. This was an unsafe practice for both the person and the member of staff.

People who had been identified at risk of falling out of bed were provided a bed side guard, to prevent their falling. In addition some people had mats on the floor to provide support should they fall. We found during our inspection that mats on the floor prevented a bed table being left close to people who were cared for in bed, which meant they could not access drinks or their personnel possessions independently. There appeared to be no rationale for using both beds sides to prevent people from falling out of bed and mats on the floor to cushion their fall should they fall out of bed, which impacted on people's independence and demonstrated a lack of clarify for reducing identified risk.

Staff were focused on promoting people's safety and our observations showed staff did not always consider how this approach impacted on people's choice and independence. For example we saw a person on several occasions attempt to stand up, using their frame, on each occasion staff approached the person and

asked them to sit down as they were at risk of falling. Staff did not ask the person or appear to consider why the person was standing up. On one occasion we brought this to the attention of the nurse, who spoke with the person and the nurse asked staff to support the person in going to the toilet.

We found there were sufficient staff on duty to keep people safe. A member of staff was based in the lounge/dining area at all times, and positioned themselves so that they could observe people who were also seated in the entrance foyer. This promoted people's safety as staff were able to respond to people. A nurse was on duty throughout the day and night, who were supported by three to four carers in the morning and, three carers in the afternoon, and two during the night.

People's safety was supported by the provider's recruitment practices. We looked at recruitment records for staff. We found that all employees were checked as to their suitability to work with people.

People's medicine was administered by the nurse who was aware of the medicine policy and procedure. We looked at the medicine records for four people whose records we had viewed and found that medicine administration records had been completed appropriately. We saw the nurse on duty take medicine to each person individually and stayed with them until they had taken it. The nurse advised us that at the end of each day they went through the medicine records to check that they were in good order. We also saw records which showed that medicine stocks were checked at the beginning and end of each shift, during handover which both nurses signed as accurate; this showed the service had a system to manage medicines safely.

People in some instances had their medicine administered covertly (without their knowledge) as on occasions they declined to take their medicine. A best interest decision had been made involving the person's doctor, which had determined the person did not always have the capacity to make an informed decision about the implications of declining to take their medicine as they were living with dementia. One person's care plan stated that they may decline but in some instances would take medicine if administered by specific members of staff; we saw this working well during our inspection. This showed people's preferences, rights and choices were supported.

Although care plans stated that people's medicine could be given covertly, there was a lack of direction as to how it should be given, for example if with food, which food and how nursing staff were to ensure that all the medicine had been taken by the person.

We spoke with the nurse on duty about providing additional information within people's care plans to ensure people received their medicine consistently, which would promote the safety and consistency of care, especially when agency nurses administered medicine that were not familiar with the people using the service.

The service did not have a homely remedy policy and therefore people who were not prescribed paracetamol could not receive pain relieving medicine until it had been prescribed. We discussed this with the nurse and manager who told us they would consider the issue and develop a solution.

Requires Improvement

Is the service effective?

Our findings

Systems to ensure people were supported by staff that had the appropriate knowledge and skills to provide their care were not effective, which meant the care people receive may not be reflective of best practice, which has a potential to put people at risk. Staff upon starting work at the service did not receive a consistent and structured induction into their role. Records in staff files were haphazard and staff in some instances had no written record of their induction. The manager told us they, or experienced staff had inducted staff. A member of care staff told us that they had shown new members of staff around the service, pointing out the fire procedure, and advising them to read people's care plans. They said newly recruited staff 'shadowed' (worked alongside) experienced staff for two to three weeks. They went onto say that in their view there was insufficient time to complete staff induction.

We found the provider and manager did not have a consistent approach to the supervision of staff and that staff competency to undertake their role was not assessed. Staff did not have the opportunity to regularly reflect upon their working practices with the manager to identify future development and training to enable them to deliver effective care to people. Staff we spoke with told us that where supervisions did take place these were not planned in advance which meant staff were unable to prepare and consider points they wished to raise. The manager confirmed they did not have a schedule of planned staff supervisions in place. This meant the provider and manager were unable to assure themselves that people were being cared for by staff who had the appropriate skills and knowledge.

We asked a visitor whether in their view staff had the necessary knowledge and skills to care for people, they told us, "Staff are not trained up in dementia." They went onto say that not all staff were effective in distracting people when their behaviour became challenging and in their view some staff did not have the necessary knowledge.

Staff told us that a majority of training was through e-learning. One member of staff told us, "E-learning isn't good enough, with that you watch a video and answer questions. If people come into deliver training you can ask questions." Staff records we looked at showed staff had completed training using e-learning on topics which included The Mental Capacity Act 2005 (MCA), infection control, diversity and equality and food hygiene and dementia. Certificates detailed the percentage staff had gained upon completing the course, which showed in a few instances staff had attained below 50%. We asked the manager if staff attainment was reviewed by them. We were advised it was not, this further demonstrates that staff competency and development is not considered.

These were breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A member of staff we spoke with told us that during the first three months of their employment they had met with the manager on one occasion to discuss their progress. Staff we spoke with told us their induction had consisted of training in moving and handling people safely, fire safety and infection control.

The manager was working with the support of the local authority to bring about identified improvements to the service, which they told us included the introduction of the Care Certificate. The Care Certificate is a set of standards for care workers that upon completion should provide staff with the necessary skills, knowledge and behaviours to provide good quality care and support. We found that a number of staff had commenced work on the Care Certificate; however there was no evidence that the work being completed by staff was being assessed.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The demonstrated a good awareness and understanding of MCA and when this should be applied.

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. We found three people were subject to a DoLS and some people's applications were currently being considered.

Records showed that people who had a DoLS in place had regularly meetings with a 'paid person's representative'. They monitored the implementation of the DoLS and as part of their role spoke with staff and viewed the person's records which recorded how staff implemented the DoLS. This showed that the provider worked with outside agencies to ensure people's care was in line with legislation.

Staff we spoke with were aware of the MCA, a member of staff described it, and "It's acting in the best interests of residents, seeking their consent, not imposing what you think. People's capacity does change." However the application of this into practice was not consistent amongst the staff. Risk assessments identified where people were at risk of falling and staff were proactive in ensuring people's safety, however our observations found that this in some instances this restricted people's decisions. People when they stood up were encouraged to sit down by staff, instead of exploring other options, such as whether the person needed to go to the toilet, or whether they wanted to walk around and stretch their legs.

People we spoke with told us they enjoyed the food, one person said, "The chef is very good, I enjoy the meals." Visitors who were visiting their relatives told us that they were confident that the meals provided were of a good quality. One visitor told us they sometimes shared a meal when visiting and they found the meals to be tasty and well presented.

Upon arrival in the morning we found people were asked what they would like for breakfast., a majority of people chose to have cereal with some choosing to having scrambled eggs and baked beans with toast to follow. The lunchtime meals on the days of our inspection looked appetising and were well presented and we noted that people ate heartily and appeared to enjoy their meal.

People's dining experiences could be improved and we found that our initial feedback following the first day of the inspection had been taken on board with improvements being made which we observed on the second day. On the second day people were supported to the dining table in a timely manner, which meant they did not sit at the dining table for a lengthy period of time before their meal was served. The dining

tables were laid with mats and cutlery on the second day, however there were no table cloths or condiments to create a sense of dining to support people to recognise that it was lunchtime especially for those who were confused or dis-orientated because they were living with dementia.

We noted that some people remained in the entrance foyer to eat their meals, seated on armchairs with a table; we were concerned that people's dignity was not promoted as this was a public area where visitors were received into the service. A visitor told us that their relative always chose to eat in the entrance and never went into the dining room and lounge by choice.

We spoke with the chef who told us a majority of meals were homemade and that people's likes and dislikes with regards to food were well known by themselves and staff. They told us they provided tailored diets to people with specific needs, which included a soft diet for those who experienced difficulty with swallowing along with diets to support people in managing their diabetes.

Throughout the day drinks were served and people were encouraged to drink. People's care plans in some instances had identified that people's fluid intake should be recorded, however there was no clear rationale for this nor was there evidence that people's fluid intake was being consistently recorded and the action staff should take should the person's fluid intake not be sufficient.

We found evidence of the service working with speech and language therapists (SALT) where people had been identified as having difficulties with swallowing. In some instances people had been prescribed by SALT 'thickener' to be added to their drinks to reduce the risk of choking. We found however people's care plans did not always include clear guidance for staff as to how they should support people with eating who had swallowing difficulties. For example with regards to the consistency of food to be given, or the best position for the person to eat safely, which meant people, may not always receive consistent and safe support. People who required support to eat their meals either within their room or the dining area were supported by staff.

Nutritional assessments had been completed however these were not followed through into the person's care plans. For example, how staff were to support and care for people to promote a healthy diet and promote the integrity of people's skin to reduce the likelihood of their developing pressure ulcers. In some instances care plans identified that people should be regularly weighed, however the document for recording people's weight was held centrally within the office and there was no evidence as to how this information was used in the reviewing of people's needs.

People's records reflected the involvement of health care professionals in monitoring and maintaining people's health, with visits being recorded to have taken place by GP's and district nurses. People's care plans and records were written and recorded in such a way that it was difficult to get an accurate and up to date picture of people's current needs, which meant there was potential for people to not receive the care they needed. For example one person's records detailed a nurse had contacted a speech and language therapist due to a person's weight deteriorating. The record showed that the nurse had been advised that a new referral would need to be made, there was no evidence that this had been followed through within the record, however another record detailed that appropriate action had been taken.

A visitor told us that they did not always find that staff responded to their relative's needs, and had had to bring their concerns to the attention of staff, They told us that once their concerns had been raised staff had responded by contacting the appropriate health care professional.

People had access to a range of health care professionals, who worked with staff to provide on-going health

care support. Records showed people had visited opticians, chiropody and had attended specialist health care appointments.

Requires Improvement

Is the service caring?

Our findings

A visitor told us that their relative would enjoy staff spending time with them holding their hand, however felt that there were insufficient staff to provide this care. Another visitor told us that their relative until recently had lived at the service and that the staff have been very kind and caring towards them during their final days. They told us, "The staff couldn't have done better for my [person's title]." A visiting friend told us, "[person's name] has told us they like it here, they don't want to return to their previous home."

A member of staff shared with us their view as to the care provided, "The care is good but more could be done - staff training and coping strategies for when people are agitated."

We saw positive interaction between people using the service and staff, for example staff spending time talking with people. Many of the staff were enthusiastic in their approach to people, smiling and providing encouragement. However this was not always the case with staff focus being on the completion of tasks, as opposed to always considering people as an individual and providing person centred care and support.

Visitor's views were mixed as to their involvement and understanding of the needs of their relatives, in the main people told us that the staff had spoken with them about their relatives health and kept them informed of any changes.

We observed staff encouraging people to make decisions about how they were supported on a day to day basis. We observed a staff member verbally discussing the approaching lunch with a person who used the service. The staff member supported the person to make a decision about where they ate their lunch and we saw that the person was supported to eat their lunch remaining in the armchair as they had requested.

We heard staff asking one person after lunch if they would like to rest in the afternoon and lay down on their bed, the person said that they would and staff supported them to their room. In some instances people had made decisions which were recorded within their care plans and records.

Some people's records included a DNAR (Do Not Attempt Resuscitation). These had been done with the involvement of relatives and health care professionals. This showed that people's choices and decisions were supported and would be acted upon when needed, however these were not always supported by an advanced care plan which identified people's preferences for end of life care.

We were concerned that people's privacy and dignity was not always promoted as some people ate their meals in the entrance foyer, which meant they were visible to visitors. We also saw that staff walked through this area to gain access to other areas of the service, which included the housekeeper carrying through laundry.

We heard one person say, who was sat at a dining table with their meal in front of them, "What is it, can someone tell me?" Staff did not respond, we spoke with the person and advised them what food was on their plate and its location. People's meals were presented well, however in some instances people needed

assistance, such as having their food cut so that they could eat independently, staff were not overly quick to provide this support, and we saw people struggle for some time to eat.

One person who ate their meal in the entrance foyer was reluctant to eat, a member of staff on three occasions whilst walking past them advised them to eat as their meal looked nice. The person did not engage with the member of staff, and on one occasion the staff member was heard saying, "[person's name, eat your dinner it looks nice." The member of staff said this whilst they stood next to the person, readjusting their own clothing. This did not reflect a member of staff who considered the person's dining experience. A second person who was eating their lunch in the entrance foyer said to a member of staff, "I'm cold." The staff responded by saying, "Eat your dinner, it will keep you warm."

Visitors told us that their relatives always appeared clean and looked after and were well-presented when they visited, and included, "My [person's title] is always clean, she always took great pride in her appearance."

Requires Improvement

Is the service responsive?

Our findings

A visitor told us that they did not always find that staff responded to their relative's needs, and had on some occasions brought to staffs attention concerns about their relatives health and welfare, which were then responded to. A second visitor told us that staff were good in keeping them appraised of changes to their relatives health and felt the staff were good in communicating with them. People's changing needs however were not always accurately reflected within their records.

The reviewing and planning of people's care was not sufficiently responsive to enable staff to meet people's needs. We found evidence that daily records identified that a person's relatives had been contacted when they had been admitted to hospital. We found that when the person returned to the service an assessment of their revised needs had not been carried out to determine their physical and mental well-being or document how the person's ongoing needs were to be managed.

People care plans were regularly reviewed; however we found that the review did not identify that care plans were not always being followed, which meant the response of staff in meeting people's needs was not robust. One person's care plan detailed that the person's blood pressure should be monitored monthly, when we asked for the records recording the person's blood pressure we were initially told that the person declined to have their blood pressure taken. We therefore suggested that the person's decision to decline having their blood pressure taken would be recorded. When we questioned this again later we were told that the person's blood pressure was not being taken.

A person's care plan identified that they were unable to use the call bell to request staff assistance and therefore staff were to carry out regular checks on the person. The persons care plan provided inconsistent information, by stating staff should carry out checks every 15 and 30 minutes. Whilst the care plan detailed that staff should carry out checks on the person it was not clear what they were checking for. The person when we spoke with them told us, "People come and nod as though I am in a glass cage." They said they did not feel isolated (as they were cared for in bed); however they went onto say, "I'd like someone to talk too." We noted there was a monitor in the room which detected sound and may have supported a comment they made, "I have no freedom, no privacy – walls have ears." We spoke with a visitor about their relative who told us that they believed their relative's needs were met and they had that day been approached by the manager about their relative to talk about their care.

We noted that a person's records regularly recorded that they regularly had a wash in bed as early as 5.30am in the morning, the person due to their capacity to make decisions may not in all instances have been able to make a decision. We discussed this with the manager and asked whether night staff were asked to ensure a certain number of people were assisted to have a wash or bath prior to the morning staff arriving. We were shown a chart on the wall of the office, which detailed the days people were bathed and suggested who was responsible, such as day or night staff. We suggested to the manager that this did not promote person centred care, they advised us the chart was for guidance only.

We saw someone being supported to stand from an armchair to a wheelchair by staff using a rotunda, which

helps people to stand and manoeuvre. Staff asked the person to stand and provided guidance. However the person indicated by sound that they found this to be uncomfortable. Staff did not appear to consider the person's frailty and that they had spent some time sitting down which could affect their ability to move. After several attempts staff used an alternative piece of equipment which provided full assistance to the person. We asked staff whether they had considered whether the person was in pain, to which we did not receive a response. We asked the person if they were in pain and they told us that their back hurt. We spoke with the nurse later in the day and found that this information had not been shared with them and therefore potential pain relief had not been made available to the person.

People's care plans were not reflective of their lifestyle choices to enable staff to provide personalised care; as people and their relatives had not been asked about what was important to them and their expectations of the service in delivering their care. People's records did not include information about their lives prior to moving into the service, such as their hobbies, interests, work, family lives and experiences. This information would be of particular use to supporting people living with dementia by supporting them to take part in meaningful activities.

The service employs an activity organiser to provide activities for people using the service, however during our inspection they were utilised on the first day to support someone to attend a hospital appointment, and on the second day due to staff sickness provided personal care and support to people, until the commencement of the afternoon shift of staff, where they were then able to provide activities.

These were breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found little evidence of people's social stimulation and activity recorded within their records, which showed a lack of person centred and holistic approach to people's care and welfare.
The service employed an activities organiser; however on both days of our inspection they worked as a member of care staff, supporting people with their daily care.

On the first day of the inspection people sitting in the lounge/dining room had music playing in the background throughout the day, whilst on the second day the television was on. During our inspection staff were not seen to ask people what they wanted to listen to or watch, our observations were that people were not engaged in the television programmes. For a majority of the time, most people sitting in the lounge and entrance foyer, sat in their armchair with their eyes shut, whilst a few people spoke with the person sitting next to them. People in some instances were not able to move around the service independently without the support of staff, and therefore were dependent upon staff for their stimulation and entertainment. On the afternoon of the second day of our inspection, we saw the activity organiser having a game of dominoes and cards with one person, whilst a second member of staff sat looking at a newspaper a different person.

Visitors told us that they knew how to raise concerns; however people had mixed view as to whether their concerns would be listened to or acted upon. One visitor told us when asked if they had made a formal complaint, "I don't want to rock the boat. My concerns are addressed. They went onto say, "Overall I am quite satisfied, and it's improving."

We looked at concerns and complaints which had been received by the provider, we found complaints were recorded, however the response to people's concerns was not consistently documented and it was therefore unclear as to whether the provider had responded.

We found evidence that concerns had been used to take action to bring about improvement. A concern had

been raised that staff were not completing documentation and records when they completed tasks, but completed records at the end of the shift. The manager had taken action and had visited the service to carry out an unannounced visit, and found that the persons concern was upheld. The manager had taken action by providing written guidance for staff as to the expectations of staff in completing records. The manager told us that a further check would be carried out by them to monitor the progress.

A visitor had raised concerns as to the quality of the care their relative and others who used the service received, which they had observed when visiting. We saw that the manager had taken action, which had included the introduction of an allocation sheet, which detailed which staff were responsible for the delivery of care of named people, it also identified who was responsible for monitoring the welfare of people who remained in their room and allocated breaks to staff.

The CQC had received information of concern which we asked the provider to investigate and to provide a response to us. The provided responded to our request and assured us that the issues raised were investigated, which had included a concern that the quality of the food was poor, the provider advised us that food quality was good and that they had involved nutritionists and dieticians in menu development. The quality of the food during the inspection was of a good quality consistent with the information provided by the provider.

Requires Improvement

Is the service well-led?

Our findings

Eastfield Lodge Care Home has not had a registered manager in post since May 2015 when the previous manager resigned their employment. The current manager who has been in post since then told us of their intention to submit an application to the CQC to be registered and that they were waiting for their DBS check which they had applied.

This is a breach of Regulation 5 of the Care Quality Commission (Registration) Regulations 2009.

We spoke with the manager and a representative from the human resource department about the service, and the provider's involvement and oversight of the service. We were told that visits by the provider were infrequent and that where visits did take place there was no written record as to issues discussed. This impacted on the ability of the manager to bring about changes as a clear and effective communication and support system between themselves and the provider was not in place. The provider did not have a system to ensure themselves that the service they were providing was governed well and that they were meeting their obligations.

The manager advised us that a deputy manager had been appointed to support in the day to day management of the service. The appointment was an internal one and further discussions identified that the nurse appointed would continue with their existing duties and would continue to work a shift pattern. The manager confirmed that there was no 'protected time' for the newly appointed deputy to perform their additional role and responsibilities. The manager and representative from the human resource department said they would consider how the role of the deputy could be developed.

Staff meetings had been held and the minutes recorded that staff had been asked to improve the recording of the care and support they provided to people, so that information was recorded at the time of delivering the care and not at the end of working day. The minutes of the meetings did reflect that meetings were used to encourage or to seek the views of staff about the service they provided, to explore how the service could develop and improve.

The manager at our request following the inspection provided information as to the audits undertaken by them to evidence how they monitored the quality of the service being provided. The information forwarded included a monthly assessment undertaken by the manager using the outcomes as identified by the CQC, which ceased to be used by us in October 2014. These were replaced by the Key Lines of Enquiry, as used in this inspection, which shows that the provider has not reviewed the system used to assess the quality of the service.

The monthly assessment had been completed for January and February of this year and showed that the manager had recorded that staff supervisions were taking place, however they were not always recorded and had noted these were to be recorded in the future. The audit identified that people's relatives were to be included in the development and reviewing of people's care plans and that this was on-going. Gaps had

been identified in staff training which had been communicated to the human resource department for planning and scheduling. The audit identified that the area manager had not carried out a quality monitoring visit and there were no action points as to how this was to be addressed, it is unclear as to whether the provider has an identified area manager to undertake this role.

These were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Visitors gave mixed views as to the openness of the service and the communication they received from the manager and staff. Whilst some visitors said that staff were always welcoming and provided clear information about their relatives, others stated that communication was not good. A visitor told us it was their understanding that relative meetings should take place weekly; however they said two had taken place as far as they were aware, but acknowledged that attendance had been very poor. A visitor said they spoke with the manager about their relative, as they were unfamiliar with many of the care staff. They went onto say they didn't know who the new staff were or their role was as they did not wear badges identifying them.

A visitor told us that they had been asked to complete a questionnaire which sought their views about the service, they were aware that the results were displayed on the notice board. We saw these were displayed however there was no information detailing any proposed actions the provider intended to make as a result of the consultation. We asked that the action plan be forwarded to us.

The manager forwarded a document entitled 'how we can improve', dated September 2015, whilst the document identified improvements; there were no timescales for their implementation. The results had highlighted that comments received were generally positive. We found some areas had been identified for improvement which included. The service was reportedly clean during the week; some people felt this was not always the case at the weekend. As a result a cleaner had been employed to work at the weekend. People felt that the menu required improvement and the plan identified that a meeting involving people who use the service had been held and improvements made to the menu. People we spoke with and our observations confirmed that people were happy with the meals provided.

Staff had identified that they would like different methods of training, other than e-learning to be considered, the document detailed that this was being discussed with 'head office', and that training in safeguarding had been provided by an external agency who had visited the service. Staff had identified that whilst supervisions took place, these were not always documented and we found improvements with this had not been made. It was recorded that staff should have the opportunity to meet and to discuss each person who used the service to gather information about their life history, their likes and dislikes, hobbies and interests, we found no evidence that this had been acted upon.

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 Treatment of disease, disorder or injury	Regulation 5 Registration Regulations 2009 (Schedule 1) Registered manager condition The condition requiring a registered manager to be in post to manage the regulated activities for which the service is registered was not met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's care was not person centred and was not reflective of their personal preferences. People's involvement in their assessment and planning of their care was limited and was not reflected in people's care plans.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The leadership and management of the service and its governance systems were not robust, which impacted on the quality and consistency of care being provided and restricted the development of the service. The provider did not have a system to ensure themselves that the service they were providing was governed well and that they were meeting their obligations.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 18 HSCA RA Regulations 2014 Staffing

personal care

Treatment of disease, disorder or injury

Staff did not receive support, supervision and appraisal sufficient to ensure they were able to carry out their duties for which they were employed.