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Eastbrook House

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
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

This inspection took place on 21 and 22 August 2018 and was unannounced.

Eastbrook House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Eastbrook House accommodates up to a maximum of 43 people in one adapted building. At the time of this inspection there was 39 people living at the service.

There was a registered manager in post at the time of this inspection. However, the registered manager was away on annual leave. 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 the last inspection on 27 and 28 September 2016 the service, although rated 'Good' overall, was found to be in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The management and administration of medicines was not safe. There was incomplete recording and monitoring of people's food and fluid intake and re-positioning charts for people at risk of malnutrition and pressure sores.

Following the last inspection in September 2016, we asked the provider to complete an action plan to show what they would do and by when to improve each of the key questions to at least good. At this inspection we found that the provider had made significant improvements to ensure the safe administration of medicines. Re-positioning charts were comprehensively completed as required. However, we identified concerns relating to the lack of meal choices people were offered especially at lunch time and we found very little improvement in the way in which food and fluid charts were completed and monitored to ensure people who were at risk of malnutrition and dehydration were supported appropriately.

At the last inspection we found 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. During this inspection we found little improvement had taken place especially after the last inspection the registered manager had assured us that improvements in this area would be implemented. Following the inspection the registered manager sent us information in relation to the improvements they had implemented following this inspection.

Fluid charts were put in place to monitor people's fluid intake where this was an identified need. However, we found that these were not completed comprehensively to fully monitor people's intake and take appropriate action where poor fluid intake was noted. However, we saw that people were appropriately hydrated and always had access to a variety of hot and cold drinks.

Care staff continued to demonstrate a clear and in-depth understanding of abuse, how to recognise signs of abuse and the steps they would take to ensure people were protected and kept safe and free from abuse.

Risk assessments continued to identify and assess risks associated with people's health, care and support needs. Guidance and information was available to all staff on how to reduce or mitigate all assessed risks so that people were kept safe and free from harm.

We observed sufficient numbers of staff available to appropriately support people with their health, care and social needs. However, staff that we spoke to felt that due to additional tasks allocated to them in the absence of laundry and kitchen staff, this impacted on their workload and ability to appropriately care and support people.

We observed people to have access to a variety of drinks and snacks to support their hydration and nutrition needs. On the first day of the inspection, people were observed enjoying their food and were seen to eat well. However, on the second day of the inspection, we observed people not to eat so well and a large amount of waste returned to the kitchen. We saw that food had not been presented well and people did not seem to like the taste of the meal that they had been given.

The provider continued to follow robust recruitment practises to ensure that only staff assessed as safe to work with vulnerable adults were recruited.

All staff demonstrated a good level of understanding of the Mental Capacity Act 2005 (MCA), Deprivation of Liberty Safeguards (DoLS). Records confirmed that people, where possible, had consented to the care and support that they received and where people were not able to make such decisions, relatives had been involved in the decision-making process.

Care staff continued to be supported through on-going training, regular supervision and annual appraisals to enable them to carry out their role effectively.

Care plans were detailed and person centred which gave specific information and guidance to care staff on how to meet people's identified needs and wishes. We saw that care staff knew the people they supported very well.

We observed people and relatives had established positive and caring relationships with care staff who knew them and their relatives very well and supported not only the person but their relative as well.

The provider had displayed their complaints policy which detailed guidance on how people and relatives could lodge a complaint. People and their relatives knew who to speak with if they had any concerns or issues to raise.

The provider had a number of processes in place to monitor and oversee the quality of care that was provided to people. However, the provider did not robustly follow their own governance systems as the inspection process highlighted issues that the service should have identified and addressed themselves. We have made a recommendation about ensuring robust and complete governance systems are adhered.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. People and relatives told us that they and their relative felt safe living at Eastbrook House. Care staff demonstrated clear practices to be followed to keep people safe and free from abuse.

Risk assessments identified people's risks associated with their health and care needs and gave guidance to staff on how to reduce or mitigate known risks to keep people safe from harm.

Administration and management of medicines was found to be safe.

The provider followed robust recruitment processes to ensure only staff assessed as safe to work with vulnerable adults were employed.

Staffing levels were observed to be sufficient to meet people's needs. However, some care staff did express concern when additional duties were expected of them which impacted on their caring role.

Learning and improvements were reflected on and implemented where accidents and incidents were recorded.

Is the service effective?

Requires Improvement

The service was not always effective. People were not always offered a choice of meal especially at lunchtimes.

Care staff were regularly supported through training, supervision and annual appraisal to effectively carry out their role.

Pre-admission assessments were completed by the provider to ensure that the service could effectively meet the needs of the person.

People had access to a variety of drinks and snacks to support their hydration and nutrition needs. Where people required specialist diets or support this was provided.

The service followed the key principles of the Mental Capacity Act

(2005) when delivering care and support to people.

Is the service caring?

Good

The service was caring. We observed people to be treated with care, dignity and respect. People had developed positive relationships with the care staff that supported them.

People told us that they were always involved in all day to day decisions about the care and support that they received. We observed this in practise throughout the inspection.

People's preferences and wishes about their care and support needs were clearly documented within their care plan.

People's independence was promoted where possible.

Is the service responsive?

Good

The service was responsive. Care plans were detailed and person centred and gave care staff an insight into people's history and significant life events.

People received personalised care that was responsive to their needs.

People and relatives knew who to speak with if they had a complaint and were confident that their concerns would be appropriately dealt with.

People's end of life preferences and wishes had been noted in their care plan.

Is the service well-led?

Good

The service was not consistently well-led. The provider completed a number of audits and checks to monitor the quality of the service. However, these were not always formally recorded.

The service was aware of issues in relation to meal choices, however, the identification of this issue had not been recorded and there were no action plans in place to address the issue. Recording issues in relation to the completion of fluid intake charts had not be identified by the service.

People and relatives knew the registered manager and other senior managers and were complementary on how the service was managed.

Staff felt supported by the management team who displayed good competency and appropriate values for their roles.

People and relatives were given the opportunity to engage and give feedback about the quality of care that they received.

The service worked in partnership with other agencies and health care professionals to support the provision of holistic care and support.

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.

This inspection took place on 21 and 22 August 2018 and was unannounced.

The inspection team consisted of one inspector, two pharmacist inspectors and two experts 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 the inspection, we checked for any notifications made to us by the provider and the information we held on our database about the service and provider. Statutory notifications are pieces of information about important events which took place at the service, such as safeguarding incidents, which the provider is required to send to us by law. We also looked at action plans that the provider had sent to us following the last inspection in September 2016.

During the inspection we observed how staff interacted and supported people who used the service. We spoke with seven people using the service, ten relatives and friends and nine staff members which included the health, safety and training manager, deputy manager, two heads of care, one senior carer and four care staff.

We looked at the care records of seven people who used the service and medicines administration record (MAR) charts and medicines supplies for nine people. We also looked at the personnel and training files of six staff members. Other documents that we looked at relating to people's care included risk assessments, medicines management, staff meeting minutes, handover notes, quality audits and a number of policies and procedures.

Good

Is the service safe?

Our findings

People and relatives told us that they felt safe living at Eastbrook House. Comments from people included, "I feel safe with plenty of staff to look after me", "Great being here, I feel safe" and "I feel safe and the carers are very nice." Relatives responses included, "I feel my relatives is safe, a lovely home with good staffing levels", "Yes, they are very good on that. [Relative] is not usually prone to falling, but they know her foibles, she wants attention and makes out she's going to fall, so, they're well aware of the potential risks" and "Yes, they do; they're very careful. My [relative] walks with a frame and is very tottery on her feet and is partially sighted."

At the last inspection we found that the service was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in relation to poor medicines management and incomplete recording and monitoring of people's food and fluid intake and re-positioning charts for people at risk of pressure sores. At this inspection we found that the service had made significant improvements to ensure people received their medicines safely. Re-positioning charts were completed appropriately. However, the service had made very little improvements to the way in which people's food and fluid intake was monitored especially for those people at risk of dehydration or malnutrition. This has been further reported on under the 'Well-led' section of this report.

People received their medicines as prescribed and on time. Medicines were stored securely in locked medicines cupboards or trolleys within the treatment area. We found that opening dates of liquids, creams and eye drops were recorded when these medicines were opened. Records confirmed that medicines were stored at appropriate temperatures.

We looked at nine Medicine Administration Records (MAR's) and overall found recording to be comprehensive and complete. We found that there were separate charts for people who had patch medicines prescribed to them such as pain relief patches and also topical medicines (creams). These were filled out appropriately by staff. For entries that were handwritten on the MAR chart, we saw evidence of two signatures to authorise this. People's allergies to medicines were also recorded appropriately.

Medicines for disposal were placed in appropriate pharmaceutical waste bins and there were suitable arrangements in place for their collection by a contractor. Controlled drugs were appropriately stored in accordance with legal requirements, with daily audits of quantities completed by two members of staff. Controlled drugs are medicines that the law requires are stored, administered and disposed of by following the Misuse of Drugs Act 1971. We observed that people were able to obtain their 'when required' (PRN) medicines at a time that was suitable for them. There were appropriate protocols in place which covered the reasons for giving the medicines, what to expect and what to do in the event the medicine did not have its intended benefit.

Appropriate processes and records were in place for people who were administered their medicines covertly. Best interest meetings had been recorded and the appropriate authorisation had been documented to enable people to receive their medicines administered covertly safely.

The provider followed current and relevant professional guidance about the management and review of medicines. For example, we saw evidence of audits carried out by the provider which included the checking and monitoring of medicine administration records, safe storage of medicines, fridge temperatures and controlled drugs. A recent improvement made by the provider included ensuring that all covert administration forms were up to date and had been reviewed. Medicines were administered by carers that had been trained and assessed as competent to carry out this task and this was reviewed on an annual basis.

Care staff continued to demonstrate a clear and in-depth understanding of abuse, how to recognise signs of abuse and the steps they would take to ensure people were protected and kept safe and free from abuse. One care staff told us, "I would record and report." Care staff also understood the term 'whistle-blowing' and were able to name the CQC and the local safeguarding authority as external agencies to whom they could report their concerns.

The provider had clear processes in place when required to raise any safeguarding concerns to the relevant authorities alongside following appropriate systems to investigate any concerns that were raised. We saw appropriate documentation in place where concerns had been raised about people's safety, the investigation that the provider had carried out and the required actions taken to implement improvements and learning going forward.

Risk assessments continued to identify and assess risks associated with people's health, care and support needs. Identified risks included risk of falls, behaviour that challenged, nutrition, risks associated with specific health conditions such as diabetes and epilepsy, choking and skin integrity. Risk assessments detailed the risk, how this affected the person and the steps staff should take to reduce or mitigate the known risks in order to keep people safe and free from harm. Risk assessments were reviewed on a monthly basis or sooner where significant changes had been noted.

Where people had been assessed as at risk of developing a pressure sore or where they were cared for in their bed, re-positioning charts had been put in place and comprehensively completed to record the frequency of re-positioning and to monitor people's skin integrity to prevent any skin condition deterioration.

Throughout the inspection we observed sufficient numbers of staff available to appropriately support people with their health, care and social needs. However, staff that we spoke to felt that due to additional tasks allocated to them in the absence of laundry and kitchen staff, this impacted on their workload and ability to appropriately care and support people. In a group session with care staff, one member of care staff told us, "It is hard work. There are issues with laundry and kitchen. We are expected to do the laundry once the laundry staff leave and we are expected to do supper as there are no kitchen staff." All care staff present in the group discussion agreed with this and stated that they had informed the management of their concerns but no action had been taken. We fed this back to the managers who stated that whilst they did not believe there to be any significant issues with care staff undertaking these additional tasks, they would further discuss these concerns with the care staff team to see where improvement or resolutions could be achieved.

The provider continued to follow robust recruitment practices to ensure that only staff assessed as safe to work with vulnerable adults were recruited. A number of checks were carried out to ensure the suitability of staff to work which included disclosure and barring criminal record checks, proof of identity and conduct in previous employment.

Incident and accident records detailed the nature of the incident, who was involved, the actions taken and where appropriate follow up actions required. The registered manager completed monthly reports which were sent to the Care Home Assessment Team (CHAT) to monitor the number of falls, incidents and deaths recorded on a monthly basis. The CHAT consisted of nurses, occupational therapists and geriatric consultants, who supported the home with acute illnesses to prevent any unnecessary hospital admission. However, the accident and incident record file was disorganised and summary records which would enable the registered manager to analyse and evaluate incidents and accidents had not been recorded in a periodic way. Therefore, it was difficult to identify any trends or patterns so that learning and improved practises could be implemented. We brought this to the attention of the managers who assured us that this would be addressed immediately.

The safety of the building was routinely monitored and records showed appropriate checks and tests of equipment and systems such as fire alarms, emergency lighting, gas and electrical safety, legionella, lifts and hoisting equipment were undertaken.

Each person's care plan contained a Personal Emergency Evacuation Plan detailing how the person was to be supported and kept safe in the event of a fire or other emergency. The provider had appropriate contingency plans in place to support any emergency event.

People were protected by safe infection control procedures and practices. The home was clean and well maintained on the day we visited. Staff had access to personal protective equipment which included gloves and aprons.

Records confirmed that all care staff had received food hygiene training. We saw that all food preparation and storage areas were clean and appropriate food hygiene procedures had been followed. This included cleaning schedules, specific food preparation areas for meat and vegetables, records of cooked food temperatures and food storage temperatures.

Requires Improvement

Is the service effective?

Our findings

People and relatives found care staff to be appropriately trained and skilled in carrying out their role. People and relatives told us that care staff knew the people they cared for and supported them in a way which assured them that people's needs were effectively met. Relatives feedback included, "Yes I do. I've seen them dealing with the other residents and they are good. I've seen how they handle the equipment etc." and "Yes, I do. They've always given me that impression in the way they behave and talk."

At the last inspection we found 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. During this inspection we found very little improvement had taken place especially after the last inspection the registered manager had assured us that improvements in this area would be implemented.

A weekly menu was on display outside the kitchen which detailed the main meal and an available alternative if people did not want the main option. Meal preferences and menu choices were also discussed at residents' meetings. However, during lunchtime, on both days of the inspection, we observed that people were not offered a choice and meals were served from the kitchen and given to people without any sort of involvement from the person. Menus including pictorial menus were not available to people in any of the communal areas. Specifically, for the lunch time meal, people were not asked the day before or on the day what they wanted to eat from the options available. People, especially those living with dementia who may not be able to retain any information relation to choices they may have made prior, were not shown any visual meal choices to enable them to choose what they wanted to eat. Care staff also confirmed that people were not normally asked for their choice or preference of the meal they wanted to eat.

We asked people and relatives their feedback about the food and whether they were offered any choice. Three people told us that they were not offered any choice. Comments from people included, "Very little choice but well cooked, clean and hygienic presentation", "Food could be much better, not much choice and I don't feel meals are balanced", "Meals are okay, staff get to know what I want" and "Not much choice on food. It is alright. Every day there is a cooked meal. Plenty of hot and cold drinks!"

On the second day of the inspection, we observed people not to eat so well and a large amount of waste returned to the kitchen. We saw that food had not been presented well and people were seen to not like the taste of the meal that they had been given. Where people had not enjoyed the meal we saw care staff offer and provide an alternative meal. We highlighted all of our concerns to the senior managers. Both managers confirmed that meal choices was an area that they had identified as requiring improvement. They also told us of identified discrepancies with food quality and presentation between the two cooks who worked on different days which needed to be addressed.

Following the inspection the registered manager provided information regarding the improvements they had immediately implemented following our feedback, as well as plans in place to further improve people's meal time experiences which included a formal process in which people were offered choice and

alternatives at mealtimes.

Relatives feedback was positive in relation to the quality of food and included, "Excellent meals. [Relative] had put on weight, now needs reduction in calories to lose this excess", "I think so, yes. I was there last time when they were having lunch, and she was eating well" and "When I've been there at mealtimes, everyone seems to be eating their food; I think the food is adequate to good; it meets the standard I would think of a care home."

Throughout the inspection we observed people to have access to a variety of drinks and snacks to support their hydration and nutrition needs. On the first day of the inspection, people were observed enjoying their food and were seen to eat well. Where people required individual support with their meals this was provided in a dignified and calm manner. Lunch time for people requiring support had been adjusted to ensure people received support which allowed for staff to have the appropriate time to spend with the person without having to rush them.

Where people required specialised diets or had specific dietary requirements, the cooks and care staff were aware of these and ensured that people were provided with appropriate meals to meet those identified needs. The service monitored and documented people's weights, food and fluid intake and repositioning where this was an identified need. However, for fluid charts, the person's recommended minimum daily fluid intake had not been documented and charts had not been totalled at the end of the day to confirm what the person's fluid intake had been so as to enable staff to monitor and take action where poor fluid intake had been noted.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 authorisation 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 found that the service followed and implemented processes in line with the principles of the MCA.

Care plans contained appropriate documentation which assessed people's capacity or lack of to make specific decisions such as DNACPR, covert medicine administration and support with personal care. Where people lacked capacity, best interest decisions had been clearly documented with the involvement of relatives and health care professionals. Where people were deprived of their liberty the registered manager had made appropriate applications to the local authority for DoLS to be considered for authorisation. Outcomes for the authorisations had been documented within the person's care plan.

Consent to care had been documented and we had seen records confirming this during the last inspection. However, at this inspection consent documentation had been removed from care plans and archived. However, people and relatives told us that they had consented to the care and support that they and their relative received. Senior managers stated that they would look at ensuring consent to care was clearly documented within care plans where appropriate.

Care staff demonstrated a good working knowledge of the MCA and DoLS and how the key principles

translated into how they supported people with their health and care needs. One care staff explained, "If they [people] can't do things for themselves, we find a way of helping them. We explain to people what we are doing, given them choice and ask for their consent." A second care staff said, "We take into account what they can and can't do and then bring out the best of what they still have left."

The service ensure people were assessed prior to admission to Eastbrook House to ensure that the service could appropriately meet the needs of the person. This included looking at people's care needs, moving and handling requirements and medicine support needs. Care plans were then compiled by the service based on the information gathered which took into account people's own choices and wishes on how they wanted to be supported. Care plans were evaluated and reviewed monthly to ensure they were current and reflective of the person's needs.

Care staff continued to be supported through on-going training, regular supervision and annual appraisals. All newly appointed staff received an induction prior to commencing work. Care staff told us and records confirmed that training was provided in a variety of topics which included safeguarding, medicines administration, moving and handling and dementia care. Care staff also confirmed that where specific training needs had been identified, the provider was proactive in ensuring that care staff received the specific course to support them in their role. One care staff told us, "They [provider] is quite hot on training. You can ask for training and they give it to you very quickly." When we asked care staff about receiving supervision and annual appraisals, all staff confirmed that they were appropriately supported through these processes.

People were effectively supported with their access to health care. Where people required professional input in relation to their health and care needs, care staff and senior managers were aware of how to access the additional resource where required. Eastbrook House also worked in partnership with the local Care Home Assessment Team. The care plan clearly documented visits, dates and outcomes from a variety of health care professionals such as the GP, chiropodist, district nurses, phlebotomists, opticians, dieticians and advocates. We saw records confirming health appointments for people who were supported to attend these.

Care staff and senior managers told us that they reported any changes in the health or care needs of the person immediately through daily recording and weekly handover records to the head of care and senior managers. All staff were required to read and sign to confirm that they had read the weekly handovers which gave pertinent information about each individual person and where follow up action for specific areas were required.

People, with support from their relatives and friends had arranged their own rooms and we saw evidence of people having a comfortable personalised space with some of their own furniture, personalised items, photographs and artwork. Since the last inspection, the provider had carried out extensive building work to the communal living areas of the home creating a more open and accessible space for people to use. Each person's bedroom had their name, photograph and the names of their key workers making it easily recognisable especially for people living with dementia.

Good

Is the service caring?

Our findings

People and relatives confirmed that care staff were very caring and respectful. We asked people and relatives whether they found care staff to be caring and we received very positive response which included, "Very caring staff. Anything I want, they will get", "Very caring staff. The carers keep a good eye on everyone", "Carers are fantastic" and "Carers are very good. Very supportive." Relatives comments included, "Staff are caring and there always seems to be plenty of staff", "Very happy with the care. Couldn't wish for better people" and "Very caring, yes. They make a fuss of everybody and they know everyone really well."

We observed people and relatives had established positive and caring relationships with care staff who knew them and their relatives very well and supported not only the person but their relative as well. Care staff were cheerful and were seen to encourage people with daily living and promoting their independence. Care staff were also seen to be observant as people tried to be as independent as possible. During mealtimes we observed care staff to be patient and gentle. Where people were non-verbal we saw care staff read people's non-verbal signals and respond in a way which was reassuring and encouraging through touch and voice.

People and relatives were observed to be involved in their care and the care of their relative. We saw heads of care, senior care staff and care staff liaising with and between people, relatives and professionals. People and relatives confirmed that they were actively involved in making decisions about their care which included day to day decisions and choices. One person told us, "Staff will help if required. Am fairly independent." One relative said, "I was involved in the planning. I had a say in all aspects of the care required."

People told us they were always treated with dignity and respect and that care staff made sure that their dignity was always maintained. One person told us, "They knock before coming in to the room. They respect privacy and help with personal care." Relatives also confirmed that care staff always ensured privacy and dignity was maintained and that people were given the due respect they deserved. One relative said, "Very happy with the care given to my relative. Not aware of any privacy issues."

We observed care staff practices throughout the inspection and we saw that people's privacy and dignity was upheld through a number of ways which included knocking on people's doors before entering, respectfully addressing people when speaking with them and maintaining confidentiality. Care staff demonstrated a sound understanding on how to ensure people's privacy and dignity was always maintained. One care staff explained, "We tell them [people] what we are doing. We make them comfortable. It's all down to your communication and approach."

We observed care staff promoting people's independence where this was practicably possible. Care staff were able to explain the importance of ensuring people were supported to be as independent as they could be. One care staff said, "We give them options to try and do things themselves, we encourage them and we give them freedom of choice. But we make sure that we never put people at risk of harm."

Care staff demonstrated a good awareness of supporting people from different backgrounds, varying

religious and cultural backgrounds and supporting people who may identify as being lesbian, gay, bi-sexual or transgender. One care staff told us, "There is no difference. Everybody is equal." People's needs and wishes in relation to religious and cultural requirements had been documented within their care plan.

Good

Is the service responsive?

Our findings

Care plans were detailed, person centred and responsive to people's needs and wishes. Each care plan gave detail and guidance on how the person wished to be supported in specific areas such as communication, night time, bathing and washing, social/recreational and eating and drinking. A summary care plan was available at the start of the care plan for quick reference with in depth detail available further on in the care under each specific heading. Each section detailed the person's assessed need, the person's view, the aim of the care to be provided and clear staff instructions on how to support the person. Care plans were reviewed monthly or sooner where people's needs had changed.

Some people living at Eastbrook House were unable to communicate in English and could only speak in their mother tongue. Languages spoken included, Turkish, Greek and Swahili. We observed certain care staff could also speak the listed languages and were able to communicate with people enabling them to clearly express their needs which care staff could appropriately respond to.

The provider completed life history work for each person which was formulated into a 'map of life' and a 'lifestyle profile.' These life stories included information about the person's family, significant events and dates, personal interests, routines and rituals and the person's end of life wishes. These documents enabled care staff to gain a better understanding and appreciation for the people that they were caring for so that care and support could be provided in a responsive way taking into account people's backgrounds and experiences.

Staff understood what person-centred care was and were able to explain what this meant for the people that they supported. One staff member told us, "Each individual is an individual and should not be treated as a group of people."

An activity person was in post supporting people with their social and recreational needs. An activity board, on display in the main corridor, listed a variety of activities scheduled for the week. On the first day of the inspection we observed some of the listed activities to take place. On the second day of the inspection we saw that in the absence of the activity co-ordinator, the listed activities were not initiated. However, we did observe care staff to be engaging and interacting with people through music and dance. The health, safety and training manager explained that the activities listed did not always take place as scheduled as it was dependent on what people wanted to do and get involved in. The activity co-ordinator would change things around depending also on people's mood.

The activity co-ordinator had compiled an activity plan for each person which detailed their likes and dislikes in relation to activities and what they liked doing. This allowed the service to structure activities and stimulation around people's preferences. Daily activity records were available for each person which detailed the activity they had participated on any particular day. Examples of activities included, outings for pub lunches, painting, reminiscence, quizzes, entertainers and gardening. People and relatives gave positive feedback about the level of activities organised at Eastbrook House. People's feedback included, "I have been on outings, participate in Bingo and other activities" and "I go out to lunch, the park etc. I Intend to

come and visit when I leave here." One relative told us, "[Person] loves activities, bingo, dancing, outings and has great communication with [name of care staff]."

A complaints procedure was displayed at the entrance of the home and detailed the steps that should be taken if people, relatives or visitors had any issues or concerns to raise. A comments and suggestions box at the entrance of the home gave people and visitors an opportunity to make any comments or suggestions. People and relatives confirmed that they knew who to speak with if they had any concern and felt able to raise any concerns they had at any time. People and relatives felt they would be listened to and that their concerns would be addressed. One person told us, "If the office is open, could talk to the manager. Not had to raise any issues, personally." Relatives feedback included, I would complain to one of the managers and I would have a moan, but I don't think I have had a moan" and "I would talk to one of the managers in charge and he would take my concerns seriously. I did tell him once that [relative] had lost something, and it was dealt with."

We looked at the folder that the service held for any complaints that had been received since the last inspection. We found that the service had a complaints register in place which detailed each complaint received, the actions taken, responses sent to the complainant and the date by which the complaint had been dealt with. The home also kept records of all the compliments that they received. There were many compliments from families and relatives with examples of the good care that the service had provided.

People's end of life preferences and wishes had been noted in the advanced care planning section of the care plan. Where people had a 'do not resuscitate' authorisation on file this had been recorded appropriately with their advance care plan. Care plans that we looked at had incorporated detail about how the person wished to be cared for and supported at the end of their life including detail of their proposed funeral arrangements.

Good

Is the service well-led?

Our findings

Eastbrook House is a family run care home. People and relatives knew the registered manager and senior managers well and were complementary of the way in which the home was managed. Throughout the inspection we observed senior managers visible around the home, speaking with people and relatives and getting involved in the provision of care and support where required. People's comments included, "[Senior Manager] sees to stuff. Will argue on behalf of staff and residents" and "I get on with managers. I think that they are okay." Relatives told us, "Lovely managers, can't fault them" and "[Senior Manager] always comes up to chat. Very good."

The provider had a number of processes in place to monitor and oversee the quality of care that was provided to people. This included medicine management audits, health and safety checks, care plan audits, observation of care practices and staff file checks. However, apart from the health and safety and medicine audits, all other checks were not formally recorded. The deputy manager explained that the monitoring of quality was an on-going process and that they were constantly reviewing and checking systems and processes to ensure people were receiving quality care. Where issues were identified these were addressed immediately and feedback given to the entire staff team to ensure learning and improvements could be implemented.

The provider did not robustly follow their own governance systems as the inspection process highlighted issues that the service should have identified and addressed themselves. Issues we found included people not being offered meal choices and fluid charts that had not been completed robustly. Fluid charts were put in place to monitor people's fluid intake where this was an identified need. However, there was lack of information about what the person's recommended minimum or maximum daily intake should be. Fluid charts were not totalled at the end of the day to confirm what the person's fluid intake had been, to enable staff to monitor and take action where poor fluid intake had been noted. However, we did note that people were appropriately hydrated and always had access to a variety of hot and cold drinks.

Although senior managers told us they were aware of issues around the meal time experience for people, there was nothing formally recorded to evidence this and there was no action plan in place to detail how the service was going to address this issue. Issues we identified in relation to fluid charts not being completed and monitored had not been identified by the service. Areas for improvement were acknowledged by senior managers and following the inspection the deputy manager sent us examples of comprehensively completed fluid charts which had incorporated the required areas of improvement.

We recommend that the provider and registered manager ensures robust and complete governance systems are adhered to ensure that people receive safe and effective care which is responsive to people's needs.

We observed that senior manager demonstrated clear communication skills and were well informed about what was happening in the home regarding people and staff. Both the health, safety and training manager and the deputy manager, who were present throughout the inspection demonstrated an open and

transparent manner with the inspection team.

Care staff were also complementary about the support that they received from the registered manager and other senior manager and the processes in place to support them in their role. Care staff told us, "Managers do chip in and are on the floor. They are good managers and they have good relationships with relatives" and "They [managers] are okay. They are there for you and are hands on."

Records confirmed that care staff were regularly supported through supervisions, annual appraisals, team meetings, daily and weekly handovers. Care staff confirmed that they felt able to contribute at the meetings with their ideas and suggestion and that these were listened to. However, some care staff felt that even though managers listened to their concerns no further actions were taken especially in relation to staffing levels. Topics discussed at team meetings included, resident updates, care practices, laundry, problems and solutions and staff changes. One care staff told us, "We have them [team meetings]. They can get a bit heated. We discuss issues, kitchen, residents. We learn from each other." Another staff members stated, "We speak out the truth but nothing ever happens."

People and relatives were encouraged and supported to provide feedback and engage about the care and support they and their relatives received. This included an 'open door' policy driven by the management of the home encouraging people, relatives, visitors and healthcare professionals to have an open dialogue with the home at any time. Resident meetings and the completion of annual satisfaction surveys were also processes used to encourage feedback and active participation from people and relatives. The deputy manager explained that relatives meetings were more difficult to organise due to the poor attendance at previously scheduled meetings. The service planned to create regular bulletins for relatives of general areas of interest and information exchange.

The most recent annual satisfaction survey had been completed in 2017. The service was in preparation of sending out questionnaires to people, relatives and stakeholders for the 2018 survey. Feedback seen was positive and no significant concerns had been noted.

The service worked in partnership with other agencies to support care provision. We noted that that the service maintained positive links with a variety of healthcare professionals including GP's, Speech and Language Therapists, dieticians and social workers. The home also worked in partnership with the local authority and attended provider meetings where other providers came together to share practices and learn. Links had also been established with other similar sized, local care homes with whom the provider worked in partnership to share experiences and joint training sessions.