Mrs Rosalind Virasinghe

Eastside House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 25 August and 14 September 2016 and was unannounced. The service met all of the regulations we inspected against at our last inspection in January 2014.

Eastside House is a care home for up to sixteen people that specialises in the care and support of older people and people living with dementia. There were three vacancies when we inspected.

There was a registered manager in post at the service. A registered manager is a person who has registered with the 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.

People and their representatives provided good overall feedback about the service. There was particular praise for how people's health needs were addressed. The service supported people well with healthcare matters and acted on the advice of healthcare professionals. There was evidence of effectively addressing some aspects of concern around some people's health.

People were treated in a respectful and individualised manner that recognised their needs and preferences. For example, people's support needs around nutrition and hydration were recognised and addressed. Attention was paid to people's safety, and the service took action when safety issues were identified.

There was a calm and friendly atmosphere at the service. There were enough staff working at the service to keep people safe and uphold good standards of cleanliness. The registered manager and the owner worked closely with staff and people using the service to help ensure appropriate standards of care and support were provided. The service encouraged concerns to be raised informally and responded to them.

The service encouraged people to keep in contact with friends and family, and to have visitors. People's cultural backgrounds were considered as part of the care provided.

There was sufficient ongoing training and support of staff to equip them with the skills needed for their roles, particularly due to the owner's investment in ongoing training for all staff in a national care qualification.

We made two recommendations in this report based on minor concerns identified during the inspection. We recommended that the registered people look into specialist training on safer recruitment of staff, as written references were not consistently in place for new staff before they started working at the service. We also recommended that specialist activity guidance be sought, particularly with a dementia focus, to broaden staff awareness and skills on how different people using the service may engage.

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. Attention was paid to people's safety, and the service took action when safety issues were identified. There were procedures in place to prevent abuse and take appropriate action if abuse was alleged.

There were enough staff working at the service to keep people safe, uphold standards of cleanliness, and support people with prescribed medicines.

The service undertook recruitment checks of prospective staff but these were not consistently robust as staff were sometimes employed before all written references were acquired.

Is the service effective?

Good

The service was effective. People and their representatives told us that staff provided them with good support. There was sufficient ongoing training and support of staff to equip them with the skills needed for their roles.

The service supported people well with healthcare matters and acted on the advice of healthcare professionals. People's support needs around nutrition and hydration were recognised and addressed.

There was ongoing work to ensure that the service worked consistently in line with the principles of the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring. The service had a calm and friendly atmosphere, and people were treated in a respectful manner.

The service encouraged people to keep in contact with friends and family, and to have visitors. People's cultural backgrounds were considered as part of the care provided.

Is the service responsive?

Good

The service was responsive. People were provided with care and

support that recognised their individual needs and preferences.

The service encouraged concerns to be raised informally and responded to them.

Activity and stimulation was provided by the service. We have recommended raising staff skills further in that respect.

Is the service well-led?

Good

The service was well-led. There was much positive feedback about how the service was managed.

There was a positive, person-centred culture in place in which quality and risk were audited through the registered manager working closely with staff and people using the service.

Eastside 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 checked 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 was an unannounced inspection which took place on 25 August and 14 September 2016. The inspection team comprised of one inspector and an expert by experience. This is a person who has personal experience of using or caring for someone who uses this type of care service. The second visit took place to involve the registered manager, who was on leave on the first day of the inspection.

Before the inspection, we considered information we held on our database about the service and provider. We also checked the Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they planned to make.

There were 13 people living at the service at the time of our visits. We spoke with three people, five friends or relatives, five staff, the registered manager and the owner. We also received feedback from two community healthcare professionals in-between our visits.

We observed care delivery in communal areas, and we checked selected areas of the premises. We looked at care records of three people using the service, personnel files of three staff, along with various management records such as quality auditing records and staff rosters.

In this report, we have used the term 'representative' to indicate a friend or relative of someone using the service.

Good

Is the service safe?

Our findings

People and their representatives told us the service was safe. People's comments included, "I can't grumble about the care; the young girls are marvellous" and "I like it very much here." A representative told us, "I feel she is very safe here; they are very careful about things." Another representative told us that their relative used to fall before moving into the service, but did not now. "I go home feeling relieved that she's safe," they said. A third representative echoed this, saying that after visits they did not have to worry "one little bit."

There were enough staff working at the service to keep people safe. Staff told us that there were always four staff working during the morning, three in the afternoon and two at night. The owner confirmed this to be the case. She added that there were two cleaners working five days a week plus kitchen staff, and that these staffing levels had not been reduced despite the current room vacancies at the service. We checked recent rosters and found these to confirm the staffing levels. We saw no situations where there were not enough staff to meet people's needs. For example, call bells were answered quickly, and lunch was provided in an unhurried fashion.

Attention was paid to people's safety, and the service took action when safety issues were identified. A representative told us of actions taken to minimise the risk of their family member having a fall, for example, by ensuring they had well-fitted footwear. Staff also knew of actions taken. We saw staff safely supporting people to move around and transfer between seats. Appropriate supporting equipment such as a mobile hoist and a handling belt were used where appropriate, and we found that these had been professionally checked. We saw someone being reminded to use the call-bell available in the room, which we were told was in line with their care plan as they were at risk of falling if they mobilised independently. There were records of the service reporting faulty equipment to the manufacturer.

People's care files included overarching risk assessments, for risk areas such as skin integrity, falls, nutrition and social isolation. There were more detailed risk management plans where the level of risk was identified as significant.

The service's accident book contained pertinent information about the facts of the accident, recommendations to minimise the risk of reoccurrence, and the registered manager's sign-off.

The service provided people with support to manage their medicines. People told us they received medicines on time. One person said, "The girls are very strict. If I say I want to take them later, they say no, you must take them whilst I am here." We saw staff checking that people had taken medicines before leaving them. The staff who administered medicines were appropriately trained and this was refreshed annually.

We checked people's medicine administration records (MAR) and found them to be fully completed and up-to-date. There was guidance for staff on when to offer as-needed medicines to specific people. There were records of medicines coming onto and leaving the service plus regular stock checks. Using these records and by checking remaining stock of separately-packaged tablets and sachets, we found no discrepancies, which indicated that people received their medicines as prescribed. However, we advised the owner that for

a couple of liquid medicines, the number of administrations did not match the amount of stock supplied. This could indicate that prescriptions were not always accurately followed, which could have undermined the effectiveness of the medicine.

The service had procedures in place to prevent abuse and take appropriate action if abuse was alleged. The registered manager knew who allegations of abuse should be reported to in a professional capacity. The induction records and initial training for new staff included discussion on the prevention of abuse. Staff meeting records included reminders on abuse awareness. Staff knew what may be seen as abuse, and explained how they would address any allegations or observations of abuse. They said they could raise concerns with the management team at any time of day or night if needed.

The service took reasonable steps to control infection risks. Feedback was positive about cleanliness, for example, "I have a beautiful room and the cleaners keep it very clean." One person said, "They wash my clothes every single day." Representatives confirmed good standards of cleanliness, one saying the cleaning was "immaculate." We saw designated cleaners working during our visits, for example, cleaning lounge chairs before people started using the lounge. We found no lingering odour in any part of the service throughout our visit, which a representative confirmed as their experience. We noted that the food standards agency provided the service with a five-star rating in 2013, the highest rating available, for kitchen cleanliness and hygiene control there.

The service undertook recruitment checks of prospective staff but these were not consistently robust. Staff confirmed they were interviewed for the role and that the service undertook employment checks before offering them work. Whilst there were identification and criminal record checks in place promptly, for three of the newer staff working in the service, we found that second references had not been acquired before they started work. The registered manager said that this was discussed and pursued with both the staff member and the referee. However, she agreed that there was no record of this occurring by which to demonstrate that reasonable actions to acquire the references had been taken.

We recommend that the registered people look into specialist training on safer recruitment of staff.

Good

Is the service effective?

Our findings

People and their representatives told us that staff provided them with good support. "It's an amazing place" one representative said, attributing this to the smaller size of the care home and the "personal touch" that people therefore received. Another representative told us, "They do a brilliant job." Two of the representatives told us how they'd researched many services before deciding on Eastside House, and that they were happy with their decisions. Healthcare professionals also fedback positively about the service.

The service supported people well with healthcare matters. Comments from representatives indicated good healthcare support that addressed some symptoms, for example, that their relative's "health has improved since she has been here." They added, "As soon as a GP is necessary they get one to come in. I see this with other residents too." Another representative said, "They're very hot on illness." People using the service also told us of good healthcare, for example, "If I need a doctor I know they would get one for me."

Records confirmed attention to people's healthcare needs. One person needed a blood test which we saw was in the service's dairy for follow-up at the appropriate time. There was evidence of routine health appointments such as with chiropodists, along with specialist input where needed such as with psychiatrists. We saw evidence that the service acted on the advice of healthcare professionals. For example, one person had put on weight since moving into the service underweight. The registered manager described ways in which that person had been specifically supported, for example, through providing small amounts of high protein foods at frequent intervals. Records in another person's file showed that weight loss concerns had been reported to a dietitian for advice. After following the advice, the dietitian had further written to state the person was now at low risk of malnutrition and had gained weight.

The owner told us that the service liaised with the local district nursing team where needed. The service had therefore acquired pressure-relieving equipment where people were identified as at risk of developing pressure ulcers. We received positive feedback from a healthcare professional about how the service supported people to be healed of any ulcers that they may, for example, have moved into the service with.

Feedback about food and meals was generally positive. People's comments included, "The food is very good" and "It's easy to digest." One representative told us of the service suggesting minor changes to the food they brought so as to help the person eat better. Another told us of how the service had supported their family member to gain weight. A third had no concerns and described "the way they set the table" and the salmon dishes as an examples of the homely approach of the service.

The service had a two-week rolling menu of home-cooked meals. The registered manager advised that it had been designed with input from healthcare professionals so as to ensure nutritional value. She showed us records the food each person needed or preferred, including in terms of health, religion or culture. Records of the food eaten by each person at each meal indicated that these diets were followed.

We saw that people were provided with good support at mealtimes. Lunch was delivered and served in a considerate manner. Staff interacted well with people when supporting them to eat so as to enable

sufficient nutrition and to eat at their own pace. Where one person could not manage their eating equipment after a while, staff noticed and provided them with enough support in a manner that did not bring attention to the difficulties the person was having. Staff told us of ways in which they encouraged and helped people to eat well. There was consistency between what the owner and staff told us about what support people needed and what was provided. This helped to demonstrate that people's support needs around nutrition and hydration were recognised and addressed.

The premises was pleasantly decorated, and the bedrooms seen showed that people were encouraged to personalise as they wished. A representative said they had "never seen such beautiful rooms," adding that their relative had a complementary phone and TV supplied. One person told us, "The garden is lovely and I use it too." We saw someone sitting outside reading, and staff checking on them.

Staff told us of receiving good support and guidance for their work. The registered manager told us that she worked closely with all staff and people using the service and so much of the guidance and support of staff took place on an everyday basis. However, we also saw that supervisions meetings for each staff member were occurring every quarter and that formal staff meetings took place every other month. This was sufficiently frequent.

The service had a two-day staff induction and shadowing process that followed a one-day external training course on essential care practices. Individual induction records included focus on safety, appropriate values and treatment of people using the service, people's specific needs, and ongoing training. Whilst the process was not specifically matched to the new national Care Certificate, the registered manager told us that this was covered within the national care qualifications that most staff including night staff were currently pursuing thorough the support of the service. She added that that two of the current staff team had national care qualifications.

A staff member told us about recent dementia training that was provided to all staff in a classroom setting. They gave us examples of how this helped them understand people's specific dementia care needs and symptoms. Records confirmed that care staff had attended training on dementia.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager told us she had attended recent managers' training on the MCA as hosted by the local authority. This had clarified that no-one was currently in need of a DoLS as, with safe support, everyone was free to leave the service. We saw nothing indicating that a DoLS ought to have been in place for anyone.

The registered manager showed us guidance provided to staff on the MCA, for example, on best interest principles and least restrictive practices. Staff told us that they asked people for their consent to care. They respected refusals but tried again later depending on the extent to which the care was in the person's best

interests.

However, we did not see assessment of people's capacity to consent to care decisions in the service such as for the use of bed rails. Instead, the person's representative was asked to sign forms about their use. Whilst this showed transparency and evidence of working towards best interest principles, it was not in line with the requirements and guidance of the MCA. This was because there were no records of attempting to assess the person's capacity to make the decision for themselves before recording a formal best-interests process if the person was assessed as unable to consent to the decision. Following our visits, the registered manager provided evidence of gaining appropriate consent.

Good

Is the service caring?

Our findings

People and their representatives told us the service was caring. People said, "They look after you" and "They're very good at care." Representatives' comments included that staff are "patient", "lovely" and "wonderful, very empathetic." A healthcare professional also commented positively about how caring the service is, particularly in respect of handling people's increasing healthcare needs.

We saw staff being kind, caring and attentive towards people using the service. We heard staff being polite and engaging, for example, thanking people for doing things, and smiling at people. We heard that one person was in pain, and saw records showing that staff had proved them with some medicine for that. There was a calm atmosphere in the service that benefitted the wellbeing of people using it. Some representatives confirmed this to be what they saw when visiting.

People told us they were treated respectfully. A representative said that "it is paramount in this place." Another told us of staff noticing, for example, when their relative needed their nails cut. They added that the service ensured clothing was looked after and did not end up in other people's rooms. We saw staff knocking on bedroom doors and asking if they could come in, and supporting people to eat meals in a friendly and engaging manner. Staff meeting records included reminders on different ways by which to treat people respectfully.

However, interactions with people were occasionally task orientated. We saw two occasions where two staff supported people to transfer between seats. Whilst the person's consent to transfer was sought and they showed no anxiety about the support provided, staff did not talk with the person during the transfer so as to provide ongoing reassurance. Someone receiving care in their room was checked on and spoken with for a few minutes; however, the malfunctioning TV picture and accompanying clicking noise in their room was not noticed until we intervened to have it corrected and the volume increased to a level that the person said they could hear properly.

Two representatives noted that some staff could not converse that well in English. One told us that staff communication was good despite this. The other said, "They are very good but better English would help them to better understand and converse with the residents." Our discussions with staff confirmed that some could not always converse well in English, however, they could convey caring approaches. The owner told us that all staff were enrolled for a national qualification in care course which would include, where needed, a component of enabling and improving their English language skills. This was because the training body recognised this was often necessary in the care sector.

One person told us that staff "only tell us about what we need to know. They don't gossip to us." We saw that staff had signed confidentiality agreements. This indicated respectful approaches and helped to keep people's personal information confidential.

Some staff told us of being aware of people's life histories through talking with them. This helped to develop positive and trusting relationships, and could help staff understand people's specific behaviours where they

have dementia. Most representatives told us that staff understood their family member's specific dementia needs, for example, on how to reassure one person when they believed they needed to leave the service.

Staff demonstrated knowledge of people's cultural backgrounds and what impact this had for them. "It helps with interaction," one staff member said. We saw that cultural and religious needs were clearly identified for food preparation purposes.

People were encouraged to be independent within a safe environment. People's care plans were written this way. Staff told us of one person using the passenger lift independently. We saw some people handling their own medicines under staff supervision.

The service encouraged people to keep in contact with friends and family, and to have visitors. One person said, "My daughter can contact me anytime." A representative told us, "I am free to visit when I like." Another told us that staff went the "extra mile" to make them welcome in the service, and that their family member phoned them regularly from their room. A third representative explained that that they could take their representative out but that if they were away, staff still supported the representative into the community. They added that staff went with their representative to the hospital if they could not attend themselves.

People's representatives told us of being kept informed of important aspects of their family member's care, for example, "I get feedback all the time." They confirmed that they had been asked to review their representative's care plan. We saw records confirming the involvement of representatives in these reviews.

Good

Is the service responsive?

Our findings

People and their representatives told us of receiving personalised care. One person said, "I like reading and they make sure that I have plenty to read." Another person told us that staff "do what I ask." A representative said, "My mum loves her baths so much so they allow her to stay a little longer in there, which she likes very much." Another representative spoke of staff attending to activation of the call-alarm system "straight away."

Staff we spoke with knew people's individual needs and preferences, for example, how the person liked to interact, what their food and drink preferences were, and how any health conditions affected the person.

On our arrival, we saw a handover taking place between day and night staff. This process enabled updates to be provided on each person using the service so that incoming staff were made aware of recent care and any changes. For example, one person had not eaten much, so incoming staff were aware that they needed greater support.

People's care files showed that the registered manager assessed people's needs and preferences before they were offered the opportunity to use the service. Information was sought from the person where possible, their representatives, and relevant healthcare professionals. The owner told us that not only was it important that they could meet the needs of anyone offered the service, but that the person fitted in with other people using the service. The files of people who had recently started using the service showed that care plans were promptly set up based on the needs assessments and taking into account assessments of risk.

People's care plans were kept under review and updated when needs and preferences changed. For example, one person's plan updated on how they mobilised, their food and drink preferences, and the increased support staff needed to provide with meals. There was a substantive individualised end-of-life care plan in place for one person that reflected their current needs and preferences.

There were mixed views on the activities provided by the service. One person said, "The activities are not here. No exercises, very boring." A representative said there was "not a lot of stimulation" for people using the service. Two other representatives felt that social interaction with people at the service did not happen often, albeit staff interacted "very nicely" when they did spend time with people. They felt that staff had potential to provide better activities but lacked knowledge on what could be provided. However, two other representatives were happy with what was provided. One gave examples of large-print books that were brought into the service and the films shown. Another said that their family member simply would not join in with much.

The owner told us of three different weekly visitors. One provided mobility exercises, one was a hairdresser, and one provided songs from a local Pentecostal church. There were some mixed views about the approach of the church, which we fedback to the owner. Staff also played games and provided manicures to people. Records showed that one person sometimes attended a day club.

The registered manager described various different activities that had been provided to people as a group or individually, for example, ball exercises, old films, and reminiscence sessions. Doll therapy had been tried as a result of the recent dementia training but only one person engaged. She could describe people's different activity preferences. It was therefore clear that effort was made to find ways to engage with people using the service relative to their particular interests and abilities. However, the registered manager agreed with our recommendation to discuss further activity provision, especially with a dementia focus, with the national care qualification trainer so as to broaden staff skills in this area.

Most people and their representatives told us of not having needed to complain, but of knowing how to do so and finding the management team to be receptive. For example, one person said, "I would talk to the manager or my daughter." Representatives confirmed that the registered manager and owner were approachable. One representative said that the management team always made time for them and wanted to hear their views on the service.

The complaints procedure was included in the information provided for people and their representatives. It was also clarified in the staff handbook, for staff to be clear on what was expected of them if someone expressed dissatisfaction with the service. The registered manager told us there had been no formal complaints. She gave an example of a representative informally expressing dissatisfaction about a lack of support from staff, which was then discussed at the next staff meeting to ensure there was no reoccurrence.

Good

Is the service well-led?

Our findings

There was good feedback about how the service was run. One person told us that the owner is "very good." A representative told us, "They know what they do and they do it well." Another representative said, "I feel the management here control the staff very well," going on to cite examples of cleanliness and a nice atmosphere. Staff comments included that the management team were approachable and "do everything for the clients," indicating a high standard of service and positive culture. We also received positive feedback from healthcare professionals, and the local Healthwatch organisation reported positively from their visit to the service the previous year.

We were shown surveys that had been returned to the service in the last year. Four healthcare professionals provided positive feedback about the service a few weeks before our inspection. Some people using the service and their representatives also fedback positively in surveys at the start of the year. There was nothing in particular for the management team to follow up on from these surveys.

The owner informed us she was present seven days a week. Her current roles included providing meals in the recent unexpected absence of the cook. She demonstrated good knowledge of people's individual needs and how a personalised service was provided. She explained the registered manager's responsibilities, including medicines management and assessing the needs of people who may move into the service. She was particularly pleased that the registered manager had chosen on a non-working day to visit someone who had moved from the service to a hospital, to re-assess their needs and enable them to move back to the service. Records and feedback from staff and a healthcare professional indicated that the person's quality of life had improved as a consequence of this and ongoing support from the service.

The registered manager told us that she audited quality and risk mainly through working closely with staff and people using the service. She showed that recorded audits of medicines management took place. Safety was reviewed through an annual service-wide risk assessment that was backed, for example, with regular checks of specific systems such as the fire equipment, call-bells and water temperatures.

The owner told us that retaining staff was an area of challenge. The service was committed to supporting staff to achieve national qualifications in care (known as QCFs, formerly NVQs), but some staff moved on after this investment in their skills and abilities. However, other staff had worked at the service for a number of years.

We were shown records of three staff meetings for 2016. These covered guidance for staff on such matters as effective communication, abuse awareness, and infection control procedures. They included updates on staff support such as with impending training courses. There was also discussion on the current needs of each person using the service. One meeting fed back on strengths and areas for improvement arising from a local authority monitoring visit. These processes helped to improve the quality of care being provided.

The owner and registered manager are legally obliged to send us notifications of incidents, events or changes that happen to the service within a required timescale. This helps us to monitor any trends or

concerns. There had been no recent notifications. However, our checks at the inspection found that there was no recent cause to notify us. The registered manager could explain situations where a notification was required. Therefore, we were confident that notifications were being sent to us appropriately.