Eastfield Residential Home Limited

Eastfield Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Eastfield Residential Home is a care home providing accommodation and personal care for up to 25 people with a mental health condition. At the time of our inspection 23 people lived at the service.

People's experience of using this service
Records were not up to date and checks in place to monitor the quality of care being provided had not identified or addressed the concerns found. Improvements had not been made since the last inspection in relation to governance and oversight.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Risks to people were not always identified and managed. One area of the recruitment process required improvement to ensure safe and robust recruitment of new staff. Medicines practices were still not robust.

Staffing levels were low, and the service struggled to maintain a stable staff team. Staff did not feel valued or that their opinion mattered. Staff had not been supported in their roles and there were no records to demonstrate discussions regarding changes in institutionalised practices or culture since our last inspection. We found institutionalised practices were still in place.

There was a notifiable incident that happened at the service that should have been notified to Care Quality Commission (CQC) but this had not been done.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 2 April 2020). There were six breaches in regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
We undertook this focused inspection to check whether the Warning Notice we previously served in relation to regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been complied with and whether the provider had fulfilled their action plan to achieve compliance with legal requirements. This report only covers our findings in relation to the Key Questions Safe, Effective and Well-led.

The ratings from the previous comprehensive inspection for those key questions not looked at this visit were used in calculating the overall rating at this inspection. The overall rating for the service has remained the same as the last inspection, requires improvement.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link Eastfield Residential Home on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to record keeping, consent to care, the management of risks, staffing, safeguarding, person-centred care and monitoring of improvements.

We have written to the provider and they have submitted an improvement plan. We will work closely with the provider to monitor their improvements.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special measures
The overall rating for this service is 'Requires improvement'. However, we are placing the service in 'special measures'. We do this when services have been rated as 'Inadequate' in any Key Question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services in special measures. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within six months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Eastfield Residential Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
One inspector carried out the inspection.

Service and service type
Eastfield Residential Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. A registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the provider short notice of the inspection on the day of our visit. We did this to discuss the safety of people, staff and inspectors with reference to Covid-19.

What we did before the inspection
We reviewed information available to us about this service. This included details about incidents the provider must notify us about, such as safeguarding incidents. We sought feedback from the local authority. We used the information the provider sent us in the provider information return. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection

We spoke with the registered manager. We looked at seven people's care records. We also looked at people's medication administration records and a selection of documentation about the management and running of the service. We looked at recruitment information for one member of staff.

After the inspection
We wrote to the provider to ask for an immediate response to the concerns we found. We continued to seek clarification from the provider to validate evidence found. We spoke with three people living at the service, three members of staff, and two relatives by telephone, to ask for their views of the service. We also spoke with one visiting professional.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At our last inspection the provider had failed to robustly assess the risks relating to the health, safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People continued to be placed at increased risk as risk assessments and care plans lacked detail and guidance for staff to respond to risk effectively. This included behaviours which the staff found difficult to manage.
● People's health related risks were not safely managed. Assessments in relation to specific medical conditions continued to be insufficient to reduce risk.

Whilst we found no evidence people had been harmed, people had been placed at risk of harm as a result of the issues we found. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Fire safety measures were in place. A new fire risk assessment had been completed and regular practice fire evacuations took place.

Using medicines safely

At our last inspection the provider had failed to ensure the safe administration of medicines. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst some improvement had been made at this inspection, this was not in all area's and the provider was still in breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Recording of the application of topical medicines such as creams had improved. However, some gaps in

recording still remained.
● Medication processes in place were not clear. There were a number of different medication policies in place and it was unclear which policy the provider was currently following.
● Clear recorded processes for people to access medicines on a night-time were not in place.

Whilst we found no evidence people had been harmed, people had been placed at risk of harm as a result of the issues we found. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Protocols to guide staff when 'as and when required' medicines should be administered were now place.
● Regular temperature checks for the storage of medicines were now in place.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to ensure systems and process were in place to prevent and protect people against the risk of abuse and improper treatment. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Not enough improvement had been made to ensure people were safeguarded from financial abuse. Care records and financial arrangements were still not clear.

We found systems were still not in place to prevent and protect people from abuse and improper treatment. This was a continued breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Staffing levels were insufficient to effectively meet people's needs. The provider struggled to retain staff and continued to rely heavily on agency staffing.
● The registered manager had not implemented an assessment tool for the calculation of staffing levels required to support people at the service. This meant they remained unassured the staffing structure in place was adequate.
● Staff told us that the service relied heavily on agency staff and permanent staff were constantly leaving. Some staff were asked to work extremely long shifts to cover the rota.
● Staff recruitment processes were in place. Though more detail regarding previous employment history was needed to ensure safe recruitment practices.

We found systems were not in place to ensure sufficient levels of staffing were in place. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

At our last inspection the provider had failed to ensure a safe and clean environment to prevent the spread of infection. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act

2008 (Regulated Activities) Regulations 2014.

Improvement had been made at this inspection and the provider was no longer in breach of regulation 12 (Safe care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were observed wearing suitable Personal Protective Equipment (PPE) which met current guidance.
● Minor infection control issues were identified such as chipped paintwork. The registered manager advised the service was undergoing a programme of refurbishment and redecoration which had been placed on hold during the covid-19 pandemic.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance

At our last inspection the provider had failed to ensure consent was sought in line with the principles of the Mental Capacity Act 2005 (MCA). This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The 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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA.

- Best interests decision making principles were not being followed. Decisions were being made without consideration of whether it was in the person's best interests or the least restrictive option.
- Some records of capacity assessments and decisions being made in people's best interests had been introduced but these were of poor quality. Decisions lacked clear information, including clarity around the management of people's finances and belongings.
- Staff and the registered manager continued to lack knowledge about the MCA and how to apply it.

Failure to ensure consent to care in line with the law was a continued breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

At our last inspection the provider had failed to ensure staff were suitably trained and supported in their role. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were not sufficiently supported in their roles. Whilst annual appraisals and supervisions had been introduced, these were of poor quality and were not meaningful. Supervisions did not demonstrate staff development and understanding of improvements that were needed.
● Staff had accessed some online training during the covid-19 pandemic. However, staff continued to not be suitably trained to fulfil their roles. Only two staff members had training in areas such as diabetes, epilepsy, and fire safety. The registered manager said further training would be accessed after the covid-19 pandemic.

● Agency staff were now inducted into the service. This was a short induction which referred to health and safety processes. Staff told us it was hard when agency staff were working as they didn't know people well or fully understand people's needs.

Failure to have sufficiently trained and supported staff was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet

At our last inspection we found that there was an institutionalised approach to care which was not person-centred. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were still restrictions in place including people only being able to access drinks at certain times and in certain areas. Although the registered manager told us that access to fluids was no longer restricted, the facilities available for this were not always stocked up. The registered manager told us the resident's kitchen was checked regularly and people were encouraged to make their own drinks. When the kitchen was checked there was no milk in the fridge and no cups to make a drink with.
● 'Drinks rounds' where people got provided with drinks at set times were still in place throughout the day. People still had to go to the dining room to have their drink at these times. Drinks would not be provided for people to have in their rooms. Staff told us snacks were not always made available during the day such as crisps, biscuits or fruit.

An institutionalised approach to care that was not person-centred to people's needs was a continued breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● Concerns had been raised by a professional regarding the timely access to medicines for one person.

● A visiting professional told us about a recent medication error. The provider's medication processes did not identify this error before it was brought to their attention.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law;
● Care plans continued to fail to provide clear guidance for staff to follow on how to deliver effective care to meet people's diverse needs.
● People's assessments were not always detailed or reflected their individual needs.

Adapting service, design, decoration to meet people's needs
● The environment was still undergoing some refurbishment. Some areas had been decorated since the last inspection. Some areas required further improvement, but this had been placed on hold during the covid-19 pandemic.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection the provider had failed to implement systems to monitor and improve the quality of the service, which meant people were at risk of harm and of receiving a poor service. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● This is the second time that the service has been rated as requires improvement. We have previously taken enforcement action, but the provider has not made sufficient improvement. Governance systems and processes were not always effective and the provider oversight and engagement in the service was not adequate enough.
● There was a continued lack of oversight of records and processes to ensure the service was being run safely and in line with relevant regulations.
● The registered manager continued to lack the appropriate knowledge and understanding of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the Care Quality Commission (Registration) Regulations 2009 and other relevant best practice guidance.
● Audits in place did not drive forward improvements. Governance systems had failed to identify the concerns we found during the inspection. Action plans were not updated to reflect completed actions and allow for effective oversight and monitoring.
● A significant amount of records were not current or well maintained and they lacked relevant information. This included missing information in medication records, supervisions, care plans, daily notes and best interests' decisions.

Failing to have well maintained records and robust systems in place to identify concerns and act on these was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager had failed to notify the CQC of a notifiable incident that happened in the home.

This was an allegation of abuse.

This was a breach of regulation 18(2) of the Care Quality Commission (Registration) Regulations 2009. We are dealing with this matter outside of the inspection process.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- There were no records of consultation with people, staff or relatives about our last inspection. Some staff told us they had read it on the internet.
- Staff meeting minutes or supervision records did not reflect discussions about the culture of the service and how this needed to change.
- Staff did not feel valued. Some staff we spoke with felt the registered manager liked things being done a certain way and staff were not encouraged to share new ideas. Communication between staff and management was poor.
- People we spoke with told us they were happy with the service. However, one person told us there was a set of rules they had to abide by.
- Relatives we spoke to, told us they felt people who lived at Eastfield Residential Home were happy.

Working in partnership with others

- The service worked with key organisations such as the local district nurses and community psychiatric nurses.
- Further development of working in partnership with key organisations including the local authority and safeguarding teams was required to ensure good outcomes for people.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care There was an institutionalised approach to care which was not person-centred to people's needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's consent to care was not sought in line with the Mental Capacity Act.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Failure to recognise or reduce risks to people. Medicines processes were not robust to keep people safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes were not in place to protect people from abuse and improper treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 17 HSCA RA Regulations 2014 Good

personal care	governance Governance systems were not in place to ensure quality and oversight of the service provided. Records were not well maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient numbers of suitably qualified, competent, skilled and experienced staff to meet people's needs.