Forthmeadow Limited

Eastwood House

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Eastwood House is a residential care home providing personal care to 16 people aged 65 and over at the time of the inspection. The service can support up to 19 people.

People's experience of using this service and what we found
There were widespread and significant shortfalls in the way the service was led. There were three breaches of the Health and Social Care Act 2008 (Regulations) 2014.

People's care records did not always reflect their current care needs and increased the risk to people's health and safety. People were at risk from infections because the infection prevention and control processes were not always effective. The environment in which people lived and staff worked was not appropriately maintained in places. The provider had not acted to address this. People were not always supported by sufficient numbers of suitable and experienced staff because there were not enough permanent workers employed by the home.

Governance and management systems were not always reliable and effective. The home lacked the drive for improvement to address many of the significant concerns we raised during our last and this inspection. Support for staff from management was inconsistent. The provider did not have up to date policies and procedures in place for staff to follow.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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 29 October 2019) and there was one breach of regulation. The provider was asked to complete an action plan after the last inspection to show what they would do and by when to improve. The provider had failed to complete an action plan.

At this inspection not enough improvement had been made and the provider was still in breach of regulations.

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 16 and 17 September 2019. A breach of legal requirements was found. The provider had not completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment.
We undertook this focused inspection to check they had now met legal requirements. This report only

covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements. The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the Safe and Well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to assessing and managing risks to people, infection prevention and control processes and the management and governance of the home at this inspection.

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

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
The overall rating for this service is 'Inadequate' and the service is therefore 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 6 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 rating, 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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Eastwood House

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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by one inspector.

Service and service type
Eastwood House 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 in place who recently had applied to become registered with the Care Quality Commission.

Notice of inspection
This inspection was unannounced. We called the service 5 minutes before the inspection. This was because we wanted to make arrangements to enter the service safely during the COVID-19 pandemic.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. 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. We took this into account when we inspected the service and made the judgements in this report. We sought feedback from the local authority, professionals who

work with the service and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We used all of this information to plan our inspection.

During the inspection
We spoke with three members of staff including the manager, senior care worker and kitchen staff. We reviewed a range of records. This included three people's care records and multiple medication records. We looked at five staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at staff rotas, training data, quality assurance records and a range of policies and procedures. We spoke with five relatives of people who were using the service and with four staff members.

Inadequate

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 improvements. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

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 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People were not safe, risks to people were not always assessed, monitored and managed to keep them safe.
- Risk assessments were in place; however, these were not always comprehensive or up to date. For example, kitchen staff told us one person required liquidise diet because they were at risk of choking. The information within the risk assessments stated the person preferred 'finger food' and required 'soft diet'. Lack of accurate recording put people at risk of receiving inconsistent care.
- Some people required to have pressure relief mattress to prevent them from developing sore skin. The pressure, in two separate mattresses, was set to the wrong setting. Detailed risk assessments were not in place to guide staff on how to ensure the mattresses were set to the correct setting. This meant people were at increased the risk of developing sore skin.
- The information about risks to people's safety was not always accessible for new or agency staff. Information about people's needs was held electronically. Staff told us the access to the information was limited due to work pressures and lack of time. One staff said, "It is hard to read the care plans because we are busy all the time, there is only one laptop for us to use, there are folders in the staff room but we don't get enough time to read them". This placed people at potential risk of harm.
- People had personal emergency evacuation plans (PEEPs) in place. However, the information within the plans was limited and did not give staff enough guidance on how to evacuate people from the home in case of fire emergency.
- The provider's fire risk assessment was out of date and we found evidence staff did not take part in regular fire drills. Staff are required to complete a fire drill at least once a year. This meant we could not be sure staff were effectively trained in the fire evacuation procedures.

Preventing and controlling infection.

- There were not always safe and effective measures in place to reduce the risk of the spread of infection and COVID-19.

●We were informed prior to the inspection that the local Infection Prevention and Control (IPC) nurse had carried out an audit of the home and had raised concerns about infection control measures. The provider was required to address these issues and to report their progress to the IPC nurse. We will be monitoring the progress of these improvements.
● The home did not always appear to be clean and well kept. There were not enough cleaning hours to complete day to day cleaning. Domestic staff finished their shift, usually at around 1.30pm. Care staff were then expected to do the cleaning, however due to low numbers of staff on duty, effective cleaning did not take place. This placed people at risk of catching and spreading infection.
● We were somewhat assured that the provider was meeting shielding and social distancing rules. Staff attempted to ensure that social distancing was adhered to. We did note at lunchtime this did not always happen and it could increase the risk of the spread of COVID-19.
● We were not assured the provider's infection prevention and control policy was up to date. Provider's COVID-19 policy had not reflected latest government guidance. This placed people at increased risk of catching COVID-19.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Our last inspection in September 2019 found that the condition of some communal bathrooms was poor. This included an area around the bath where tiles had fallen off making it difficult to clean thoroughly. At this inspection we found the provider had failed to make necessary improvements to the condition of the bathroom to allow effective cleaning. We saw missing and damaged grout to the tiles at the head of the bath with significant gaps in between tiles.
● Despite some improvements made to the home, we found other areas within the home which were in a poor condition and could not be effectively cleaned, putting people at risk of infections. We saw water damage to the bath panel in another bathroom, damage to plaster work and paint work in people's bedrooms and stains to the wall in the communal shower room and toilets.
● People were at increased risk from water related diseases from water outlets which showed a build-up of scale. The provider did not have any processes for regularly checking the water outlets for any lime scale build up or plans for regular de-scaling of the water outlets.

The provider had not ensured the premises and equipment used by service users were clean, secure, suitable, properly used and maintained. This is a breach of Regulation 15, Premises and Equipment, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider was facilitating visits for people living in the home and had systems in place to prevent visitors from catching and spreading infections.
● The provider was admitting people safely to the service. We saw staff were using PPE effectively and safely and the provider was accessing testing for people using the service and staff.
● The service had not had an outbreak of Covid-19 during the pandemic.

Staffing and recruitment
● People were not always supported by sufficient numbers of experienced staff.
● There were not enough permanent staff employed at the home. Staff rotas showed occasions where only agency staff were scheduled to work at night. We were not assured agency staff were aware of people's needs and preferences because they had not received robust induction into the home. This put people at

risk of receiving inconsistent care.
● The provider had a dependency tool to establish the number of staffing hours required. However, staff told us they felt understaffed and often 'rushed off their feet', especially during peak times, such as in the morning. Staff told us they were not always able to ensure continuous supervision of people who were at risk of falls. This was because some people often required assistance of two staff, which then left only one member of staff to support other people between the communal areas and people's own rooms across two floors.
● We received a mixed feedback from relatives about staffing levels. One relative told us, "I think the carers are sometimes busy, they don't always have much time to spend with the residents". Another relative said, "Sometimes, they [staff] go that extra mile, other times they don't have the time to do the little tasks like nail care".
● Staff had been recruited in a safe way, with the appropriate pre-employment checks, such as seeking references, had been carried out.

Systems and processes to safeguard people from the risk of abuse
● People were protected from avoidable risk of abuse.
● Staff were up to date in safeguarding training and practice. Staff knew how to recognise if someone was at risk of harm or abuse and what actions they needed to take, such as report it to the management or CQC. Safeguarding concerns had been investigated and reported to the local authority and CQC.
● Relatives told us they felt their loved ones were safe at the home and that longstanding staff were caring and knew people well.

Using medicines safely
● People were supported to receive their medicine in consistent and safe way.
● Medicines were stored correctly, and staff kept accurate records of medicine records. All medicines were checked each day to ensure all medicines were given as prescribed.
● People who needed 'when required' (PRN) medicine had appropriate protocols in place to inform staff when PRN should be given.

Learning lessons when things go wrong
● Accidents and incidents were reported to the management team and investigated thoroughly. Appropriate actions were taken following more serious incidents.

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 requires improvement. At this inspection this key question has deteriorated to Inadequate. 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

- Since our last inspection in September 2019, three different managers had managed the home. This meant there has been inconsistent leadership and governance of the home. There was a new manager in post who had commenced their registration process with us.
- Governance and management systems were not always reliable and effective. Audits had not been used effectively to drive improvement. Audits regarding infection control or maintenance of the home had not identified issues we found at this inspection. The provider did not have processes in place for regular checks of pressure mattress to ensure correct pressure. This meant risks had not been identified or actions completed putting people at risk. We reported on these issues in the Safe part of this report.
- At the last inspection, the provider was asked to provide an action plan for the concerns we raised. The provider had failed to submit an action plan and had failed to take action to address the significant concerns about the environment in which people lived and staff worked. There was little or no evidence of learning, reflective practice and service improvement since our last inspection. The provider had failed to address many of the significant concerns we found.
- Some of provider's own policies and procedures were out of date, lacked detail and contained information no longer relevant to current regulations. The provider's safeguarding policy contained out of date information and guidance and did not reflect local safeguarding processes.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The home lacked a clear vision and strategy to deliver high-quality care and support to people. This has increased the risk of people experiencing poor outcomes.
- Support for staff from management was inconsistent. Staff members felt the manager was not supporting them when this was needed, for example to cover staff shortages. Staff told us they did not feel able to be open when things went wrong. There was a high staff turnover.
- We did receive some positive comments from the relatives of people living at the home; however, these comments focused on the care provided by staff, not the manager or provider. Relatives told us that 'longstanding' staff were very good, they knew people well and were very kind and caring. However, the relatives expressed concerns about frequent management and staffing changes.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The provider told us people were taking part in regular home meetings held by activities co-ordinator, however we saw no evidence to confirm this.

Working in partnership with others
● Despite the manager working in partnership with others, they had not always acted appropriately in response to people's changing health needs. For example, information about people's dietary needs had not been appropriately recorded.

The provider had failed to ensure that effective governance processes were in place to help to identify, monitor and act on the risks to people's health and safety. This is a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The provider used annual satisfaction surveys as a way to obtain feedback from relatives about the service and suggestions for improvement.
● The provider told us they held staff meetings in which staff could share their views and give their input and managers provided updates to staff.
● The manager and staff had worked closely with local primary integrated community services (PICS). Concerns about people's health were discussed with an allocated nurse to ensure clinical support was sought when this was needed.

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
● The manager and provider informed relevant organisations of any incidents, including those incidents that are notifiable to the CQC.
● Relatives told us they were kept informed about any incidents or accidents affecting their loved ones that occurred at the home.

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 15 HSCA RA Regulations 2014 Premises and equipment Systems were either not in place or robust enough to demonstrate effective infection prevention and control measures. This placed people at risk of harm

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm

The enforcement action we took:

We issued a Warning Notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective governance processes were not in place to help to identify, monitor and act on the risks to people's health and safety.

The enforcement action we took:

We issued a Warning Notice.