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 caring? | **Requires Improvement** |
| Is the service responsive? | **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 25 people lived at the service.

People's experience of using this service
People received support which was not person-centred and was institutionalised in approach. 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. The policies and systems in the service did not support this practice.

Risks to people were not always identified and managed. Processes in place for fire safety were not robust. We referred this to the local fire officer. Medicines processes were unsafe and did not follow best practice. Only one staff member had been checked for their competency to administer medicines safely.

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. The registered manager and supporting management team lacked knowledge of best practice and guidance and failed to deliver a service in line with regulations and the law.

Recruitment processes were in place and robust. Staffing numbers had reduced due to a large number of care staff leaving at the same time. Supervision and appraisals had not taken place in line with the home's policy. Staff lacked training and skills to meet people's needs.

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

Rating at last inspection
The last rating for this service was good (published 15 August 2017).

Why we inspected
This was a planned inspection based on the previous rating.

Enforcement
We have identified breaches in relation to record keeping, the management of risks, medicines and infection prevention and control, staffing and their training and support, consent to care and restrictions placed on people and monitoring and improvements at the service 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
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.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

**Is the service effective?**

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

**Is the service caring?**

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

**Is the service responsive?**

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

**Is the service well-led?**

Inadequate

The service was not well-led.

Details are in our well-led findings below.

# 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
Three inspectors and an Expert by Experience carried out the first day of the inspection. An inspector and an inspection manager carried out the second day. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Eastfield Residential Home 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.

The service had a manager registered with the CQC. This means that they 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
This inspection was unannounced on both days.

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 abuse. 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, the deputy manager, the administrator, a senior care assistant, a care assistant and the chef. We also spoke with 15 people who used the service and a visiting professional. We looked at five people's care records in full. We also looked people's medication administration records and a selection of documentation about the management and running of the service. We looked at recruitment information for three members of staff, staff training records and records of complaints.

After the inspection
We received further information from the provider via email to verify information they told us during the inspection.

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

- People were placed at increased risk as risk assessments and care plans lacked detail and guidance for staff to respond to risk effectively.
- Incidents, such as behaviours the service found difficult to manage, were not always recorded and monitored, to check whether these incidents were being dealt with effectively and to prevent reoccurrence.
- People's health related risks were not safely managed. Assessments in relation to specific medical conditions were not in place. Staff were not provided with up to date records to support people or respond to risk.
- People were at risk in the event of a fire as fire procedures were not robust or up to date. The fire risk assessment was not reflective of the full layout of the building, which included an extension containing people's bedrooms.
- Staff and the registered manager, lacked knowledge and understanding of evacuation procedures and how they would support people safely in the event of a fire emergency situation. We shared these concerns with the local fire service.

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 breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

- Medicines arrangements were not safe. The registered manager and staff, who were responsible for the administration of medicines, lacked knowledge and understanding of best practice in medicines procedures. We observed staff were not competent at administering medicines safely.
- People were placed at increased risk as staff lacked knowledge and understanding regarding the side effects of the medication they were taking and when certain medicines should be administered, for example, before food.
- There were gaps in the recording of when medicines and creams had been applied which meant the registered manager could not be sure people had received their medicines. The time was not always recorded when time specific medicines had been given.
- Documentation used to support the administration of medicines was not in place. This included protocols to guide staff when 'as and when required' medicines should be given and body maps to show where creams should be applied.
- Procedures in place for the management of controlled drugs were not robust.

We found no evidence people had been harmed. However, medicines were not being effectively managed and this placed people at increased risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● Some equipment and furniture was worn and would not prevent the spread of healthcare related infections.
● Best practice was not always followed in relation to infection control. This included effective hand washing facilities and sealed flooring to allow effective cleaning.

We found no evidence that people had been harmed. However, infection control was not being effectively managed and this placed people at increased risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● People were not always safeguarded from the risk of abuse. Whilst staff demonstrated an awareness of safeguarding procedures, poor financial procedures in place increased the risk of financial abuse.
● Care practices meant people were restricted in terms of access to money, food, drinks, cigarettes and their belongings. We shared our concerns with the local authority safeguarding team as we felt this approach demonstrated an institutionalised approach to people's care.

We found systems were not in place to prevent and protect people from 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.

Staffing and recruitment
● There were not enough staff available to meet people's needs. Staff had left the service in previous months and this had a direct impact on the number of staff on duty. Although agency staff were being used, staffing levels had reduced by 50 percent on some shifts.
● The registered manager did not have an assessment tool in place for calculating the staffing levels required to support people at the service. They could not be assured the staffing structure in place was adequate.
● Staff recruitment processes were in place; appropriate checks were carried out to protect people.

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

People can only be deprived of their liberty to receive care and treatment 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, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.
- Restrictions on people had not been authorised and there were no records of capacity assessments or decisions being made in people's best interest. This included management of people's finances and belongings.
- Some applications to deprive some people of their liberty had been made. However, capacity assessments had not been completed for those people who may have also required an application.
- Staff and the registered manager lacked knowledge about the MCA and how to apply it.

Failure to ensure consent to care in line with the law was a 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
- Staff were not sufficiently supported in their roles. Staff had not received an annual appraisal and staff did not receive frequent supervisions.
- Staff were not suitably trained, nor did they have their competency checked to ensure they could effectively meet the needs of people. No staff had their competency checked for moving and handling and only one member of staff who administered medicines had their competency checked within the last year.
- Staff training was mostly out of date. Of the 16 staff working at the service, only five had attended training in mental health. The registered manager had not attended training on the safe handling of medicines or the MCA since 2015.
- Agency staff were not inducted into the service to ensure they understood the needs of people. This was

not in line with the provider's own policy.

Failure to have suitably qualified, supported and competent staff was a 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
● People were provided with food and fluids, but their access to them was restricted. People generally told us the food was good. Our observations were that no one was encouraged to drink water or juice; people were only provided with tea and coffee.
●The registered manager told us people were able to make their own refreshments in their own kitchen area. We checked this area and found there were no cups or glasses and the equipment in the room posed a risk to people. People told us this area often ran out of stock.
● People's food and fluid intake was not effectively monitored. One person's care plan stated that their fluids needed restricting. The registered manager was unaware of this information and no restriction or monitoring was in place. We asked the registered manager to check with the GP. On the second day of inspection, seven days later, this had not been checked and no monitoring or restrictions were in place.
● People were being weighed regularly, however people's nutritional intake and needs were not being fully considered.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● Guidance and support from healthcare professionals was not always considered or sought. We identified areas of concern relating to people's health needs which required a referral to their GP to seek advice and guidance.
● Despite our findings, a visiting professional spoke highly about the service, "The staff follow advice well and are very good at working alongside us."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law;
● Care plans failed 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 people's individual needs.

Adapting service, design, decoration to meet people's needs
● The environment was undergoing some refurbishment. Some areas required further improvement, however, most areas were pleasant and homely.
● People's rooms were personalised. People told us they had choice in the decoration of their room, "My room is pink, I love the colour pink so the registered manager said I could have it that colour."

Requires Improvement

# Is the service caring?

## Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- The service was not providing person-centred care or fully respecting people's equality and diversity. Whilst staff demonstrated knowledge of people's personalities and what was important to them, staff were also instructed to maintain rigid care routines.
- Care routines were set by the registered manager and the deputy manager. These included rotas for supporting people with personal care, set drinks times, meal times and set places for where people could sit in the dining room. These care routines demonstrated an institutionalised approach to care at the service. The registered manager told us these routines were not set. However, our observations during the inspection did not support this, and supervision records we reviewed showed that staff were instructed to deliver care in this way.
- People were restricted from accessing fluids and smoking during the night. Although the registered manager stated this is not the case, staff and people confirmed this was regular practice.
- People mostly provided positive feedback about the staff. One person told us, "There are good staff here you know. They are very good to us." However, another person told us, "It depends what mood staff are in."

Supporting people to express their views and be involved in making decisions about their care

- People were not involved in decisions about their care. Staff failed to recognise when people needed support from agencies or families to support them in making decisions.

Respecting and promoting people's privacy, dignity and independence

- People were not treated with dignity and respect. Whilst we observed pleasant interactions between care staff and people, the institutionalised approach to care within the service demonstrated a clear lack of respect for people and their life choices.
- The culture and routines in the home, restricted people's ability to remain independent. For example, people who were independent with personal care routines were on a bathing rota and received support by staff despite them only requiring prompting in this area. People were not allowed to go outside and smoke after a certain time at night.

Failing to deliver care in a person-centred way was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Systems were in place to maintain confidentiality. Care files and other private and confidential information were stored securely.

Requires Improvement

# Is the service responsive?

## Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People received care that was institutionalised and not person-centred. Care routines around food, drinks, personal care, smoking and where people could sit demonstrated the clear lack of a person-centred and individualised approach to people's care.
- Care planning failed to reflect people's person-centred needs. Information was minimal and failed to guide staff as to how to best support people.

Failing to deliver care in a person-centred way was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People were engaged in limited activities within the home such as colouring, card games and quizzes.
- Some people were supported to access the community such as local shops, pubs and cafés.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- People's communication needs were not fully identified or accommodated. Records were not adapted to support people to understand information presented.

Improving care quality in response to complaints or concerns

- Systems were in place to respond to any complaints. The complaints procedure was available within the service.
- People told us they knew how to make complaints. One person told us they had made a complaint and was happy about how it was handled.

End of life care and support

- End of life care planning was recorded in care plans.

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 good. 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.

- There was widespread, significant shortfalls in the way the service was being led, which resulted in multiple breaches in regulation. The registered manager and supporting management team lacked knowledge and skills to deliver a service in line with best practice, guidance and the law.
- Systems in place for identifying and capturing risks and issues were ineffective. Legal obligations such as working in line with the MCA were not being met or understood.
- The principles of good quality assurance were not understood; audits were not actually auditing, and action plans were not time bound or structured to allow effective monitoring.
- Records were not up to date to support people's holistic needs and keep them safe from risk.
- Staff were not adequately supervised, and staff turnover was high.

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

- The culture of the service did not recognise or understand the importance of equality, diversity and human rights. People's needs and choices were overlooked in favour of institutionalised practices.
- Poor, out of date practices were embedded in service delivery. These practices failed to engage people or empower them to make positive contribution to the service.
- Reporting of incidents, issues and concerns was unreliable. Records did not always reflect what people told us.
- Feedback to staff was not clear. Information between the management, staff and people was contradictory throughout the inspection and demonstrated poor communication, openness and transparency.

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

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 registered manager told us they were committed to making the necessary changes.

Working in partnership with others

- The service worked with key organisations such as the local district nurses.
- Further development of working in partnership with key organisations including safeguarding teams and social services 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<br><br>Failure to provide person-centred care. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>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<br><br>Failure to recognise or reduce risks to people. Medicines processes were not safe. Failing to prevent the risk of infection and to have adequate assessments in place for fire safety. |

| 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<br><br>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 personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>Staff were not trained or supported to meet |

people's needs.

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 17 HSCA RA Regulations 2014 Good governance<br><br>Governance systems were not in place to ensure quality and oversight of the service provided. Records were not maintained. |

**The enforcement action we took:**

Warning notice.