County Healthcare Limited

Eastlands Care Home

Inspection report

Beech Avenue
Taverham
Norwich
Norfolk
NR8 6HP

Tel: 01603261281
Website: www.fshc.co.uk

Date of inspection visit:
06 October 2020
07 October 2020
09 October 2020
12 October 2020
16 October 2020

Date of publication:
09 April 2021

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
Eastlands Care Home is a residential care home providing personal care to 24 people aged 65 and over at the time of the inspection. The service can support up to 35 people.

People's experience of using this service and what we found
At this inspection we found a continuation of failings at this service. Sufficient action had not been taken to address the two breaches of the regulations found at our last inspection. At this inspection in October 2020, we found an additional four breaches of the regulations.

Management of risk remained poor. Risks relating to people's health and wellbeing had not always been identified, planned for and managed. Risk assessments in place were not reflective of people's most current care needs.

Reviews of accidents and incidents were not always completed, and those that had been completed were not effective in identifying lessons learnt.

There was poor planning and assessment of risks relating to COVID-19. There were no risks assessments in place for those who were clinically vulnerable, and guidance issued was incorrect.

The management of people's medicines remained unsafe, and medicines errors had increased. Topical medicines were found to be unsecured and there was a lack of written guidance in relation to people's medicines.

Infection control practice was poor, and areas of the home were found to be dirty. Premises and equipment were not appropriately maintained.

People were not adequately safeguarded from potential abuse. Some staff had not received training in safeguarding and policies in relation to safeguarding had not been updated.

Most of the staff working at the service were agency staff. Whilst there were enough staff, we were not assured they had the right skills and knowledge to perform the role expected of them.

Quality monitoring systems to measure the quality of service being delivered remained ineffective. The lack of managerial and provider oversight led to a decline in the service being delivered.

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 13 February 2020) and there were two breaches of the regulations which were safe care and treatment and good governance. At this inspection we

found the provider remained in breach of these regulations with a further four additional breaches.

Why we inspected
We received multiple concerns in relation to medicines management, risk management and governance. As a result, we carried out a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. Therefore, we did not inspect them. Ratings from the previous comprehensive inspection for those key questions were used to calculate the overall rating at this inspection.

The overall rating for this service has changed from requires improvement to inadequate. This is based on the seriousness of concerns found at this inspection.

We have found evidence that the provider needs to make significant 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 report.

You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Eastlands Care Home 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.

At this inspection we have identified breaches of regulation in relation to safe care and treatment, safeguarding service users from abuse, premises and equipment, good governance, staffing and notification of incidents.

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

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.

Eastlands Care 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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted as part of our Thematic Review of infection control and prevention in care homes.

Inspection team
This inspection was carried out by two inspectors, a pharmacist inspector, and an assistant inspector who worked remotely.

Service and service type
Eastlands Care 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 did not have a manager registered with the Care Quality Commission. This means the provider is solely legally responsible for how the service is run and for the quality and safety of the care provided. There was, however, a manager in place and they are referred to as the manager throughout this report.

Notice of inspection
We announced our inspection the day before the site visit. We did this due to the current COVID-19 pandemic. The short notice period gave the manager time to discuss any safety concerns and enabled them to start making some preparations for our inspection, for example, ensuring a room was available for the inspection team.

What we did before the inspection
We reviewed the information we had received about the service since the last inspection. We sought

feedback from the local authority and professionals who work with the service.

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 us 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 used all of this information to plan our inspection.

During the inspection
Due to the COVID-19 pandemic the visit to the service was carried out by two inspectors and a pharmacist inspector over a shorter period; this was to manage the associated risks. The rest of the inspection was carried out remotely by the lead inspector who reviewed documents related to the care provided and the management of the service. The inspection activity took place between 7 October 2020 and 16 October 2020.

During the inspection site visit we spoke with two people who lived in the service. We also spoke with the manager, deputy manager and regional support manager. During the visit, we also observed the care and support people received. Following the site visit, we had a further conversation with the manager and deputy manager, and we also spoke with the regional operations manager. We spoke with five relatives and three members of staff, two of which were agency.

We reviewed a range of records. This included the care records for four people, and the medicines records for 17 people. We spoke with three members of staff about medicines and observed medicines being given to people. We also reviewed a variety of records relating to the management of the service. These included policies and procedures, incidents, training records, quality monitoring audits and maintenance records for the premises.

After the inspection
We had further contact with the manager to assess and validate the information we reviewed.

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 improvement. At this inspection this key question has now deteriorated to inadequate. 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.

At our last inspection we found the provider had failed to effectively assess and monitor risks to people living in the home which placed them at risk of harm. Medicines were also not managed properly and safely. These findings constituted a breach of Regulation 12 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.

Assessing risk, safety monitoring and management; Using medicines safely

- People had been exposed to risk and avoidable harm as risks relating to their health and wellbeing had not been identified and planned for.
- One person was at very high risk of developing pressure ulcers. We saw records from a healthcare professional to show they should have been repositioned regularly to reduce the risk of developing a pressure ulcer. There was no repositioning chart in place and care records showed a deterioration in the person's skin integrity. In addition, their care plans and risk assessments in relation to their skin integrity did not document the level of risk, or reflect the advice given from the healthcare professional.
- A number of people had lost weight. One person had lost just over 6 kilograms over a period of six to eight weeks. Records showed they were on a food and fluid chart and should have been offered additional snacks. We reviewed the person's food and fluid chart and saw it was not sufficiently detailed, and it had been completed prior to the person having their lunchtime meal. Therefore, we could not be assured they were maintaining a healthy nutritional intake.
- The care plan and risk assessment for a second person who had lost 8.5 kilograms in three months had not been updated to reflect their weight loss. A referral to the GP had been made, but there was nothing to show an appointment had been arranged.
- The manager confirmed people's individual risks in relation to COVID-19 had not been assessed or planned for. This was of concern due to people living in the service all being clinically vulnerable.
- We found toiletries, essential oils and a bottle of steriliser left unsecured throughout the service. These posed a risk of ingestion, particularly to people living with dementia.
- After the site visit, we were informed unoccupied bedrooms were being used to house agency staff. The risk assessment for this arrangement did not fully identify and mitigate any risk in relation to having staff living alongside people receiving care and treatment.
- The service had made safeguarding referrals relating to medicine errors/ incidents when people had not received their medicines as prescribed. During the inspection visit we identified a further recent incident that had not been identified by the service when an incorrect dose of a cardiovascular medicine had been given

to a person. We also found that for medicines prescribed for topical application such as for creams and emollients there were frequent gaps on their Medicine Administration Record (MAR) charts that were unexplained.
● Oral medicines were stored securely and at correct temperatures, however, medicines prescribed for external application such as creams and emollients were not being kept safely to ensure people could not access them and put themselves at risk of accidental harm.
● Information was not always available to staff to enable them to give people their medicines consistently and appropriately; written guidance to help staff give people their medicines prescribed on a when required basis (PRN) was available for some but not for all medicines prescribed in this way. In addition, some of the written information available lacked sufficient person-centred detail. For people who were unable to tell staff about their pain, pain-assessment tools were not in use. Body maps showing staff where and when to apply creams and emollients were often incomplete.
● Records showed that when medicated patches were applied to people's bodies, they were not always applied to different areas in rotation to avoid the possibility of adverse skin-contact effects that might occur when patches are frequently applied to the same position.

We found no improvements had been made to adequately identify, assess, and manage risks relating to people's individual care need, the premises, or medicines. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● An electrical installation report from 2016 showed the condition of some of the electrical wiring at the service was potentially dangerous. The manager confirmed no action had been taken to repair the defects found.
● The manager told us the scales had been broken for a number of months. However, staff continued to use the scales to weigh people instead of implementing alternative measures. This resulted in a delay in referrals to relevant healthcare professionals regarding people's weight loss.

The provider failed to ensure the premises and equipment used by the service was properly maintained and suitable for the purpose for which they are being used. This was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Preventing and controlling infection
● People were not protected against the risk of infection. Current national guidance in relation to the wearing of personal protective equipment (PPE) was not being followed. For example, we observed kitchen staff not wearing their masks correctly.
● The provider's guidance for managing COVID-19 also placed people at further risk due to the incorrect advice given within the document. For example, the guidance stated staff were not required to wear masks if they, and the person they were providing care to were not showing any symptoms.
● Staff were required to wear gloves and aprons when providing personal care, or when in people's rooms. We observed that staff were not always wearing the additional PPE when required to do so.
● On our arrival, there was some confusion about what PPE we should be wearing. It had already been established before the inspection what PPE the inspection team would be wearing. However, we were told to wear additional PPE when we arrived, and then informed we were not required to wear the additional PPE.
● The environment was unclean and unhygienic. We found an established crop of fungi growing in the corner of one of the shower rooms. Bathrooms were generally unclean with debris on the floors, and we also found a number of areas to be very dusty.
● Regular audits of the cleanliness of the service were not undertaken. The last audit in September

highlighted some areas for improvement, but there was no action plan to show when remedial action would be completed by.
● Cleaning schedules had not been adapted to include the additional cleaning required to minimise the risk of transmission of COVID-19.
● PPE was not always stored appropriately. We saw boxes of gloves stored on top of a trolley in a corridor with net knickers on top of the gloves. This meant the gloves were exposed to cross-contamination.
● PPE was not disposed of correctly or in line with the provider's guidance. The guidance stated a pedal bin was available for visitors to dispose of used masks. We were asked to dispose of the masks in a bin by the front door which required the lid to be removed by hand.
● Staff had not received training in COVID-19, and more specifically, in relation to the correct way to put on and remove PPE. In addition to this, only 61% of staff had completed training in infection control.

The provider failed to ensure the premises was clean, and that people were protected from the risk of infection. This was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Systems and processes to safeguard people from the risk of abuse
● Systems to safeguard people from abuse were ineffective.
● Information we held about the service showed an increase in safeguarding incidents, some of which were being investigated by the local safeguarding team.
● Reviews of safeguarding incidents were not thorough, and the manager told us they did not have the time to investigate all of the incidents. This meant systems to safeguard people from the risk of abuse could not be reviewed and improved.
● Not all staff had received training in safeguarding. This was a concern as services are at an increased risk of developing a closed culture due to the pressures of the pandemic.
● There were no posters in the service displaying the contact details for the local safeguarding team, and the provider's safeguarding policy was out of date.

People had not been protected from abuse and the risk of abuse. 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) 2014.

● All of the relatives we spoke with told us they felt their family member was cared for in a safe way. One person's relative told us, "Yes, I do feel [family member] is safe, it is a nice home." However, a second person's relative explained they have raised concerns in the past and the service became more settled with the appointment of the new manager. They added they are now concerned, "it is going to be bad again" as the manager is leaving the service.

Staffing and recruitment
● People we spoke with expressed concerns about the staffing. One person we spoke with told us they did not feel safe with the agency staff when using the hoist, "They leave you swinging around and nearly hit the furniture." They added they are sometime left on the toilet when staff go to help another person. A second person told us, "[The service] needs to get better staff and keep them." They added they have to wait a long time for staff when they have called for assistance.
● Some of the relatives we spoke with told us about concerns regarding the staffing. One person's relative explained, "[Family member] does say sometimes there is not enough staff as [family member] has to wait when [family member] calls the bell." They added their family member does not get a wash when they ask for one.

● Our observations showed whilst there were enough staff, some staff did not appear to know people well. We observed staff did not take the opportunity to interact with people and we saw staff just standing or sitting with people and not speaking with them.
● A majority of the staff were agency staff. The manager told us they had been unable to recruit staff due to the low pay being offered.
● A number of incidents such as medicines errors and allegations of abuse involved agency staff. The manager told us about the checks completed for agency staff, but they could not feel assured by the agencies used that staff had the right skills and knowledge to perform the role expected of them.

Not enough suitably qualified, competent and experienced staff were deployed. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Learning lessons when things go wrong
● Investigations in to incidents were not always undertaken, and investigations that had been completed were not robust and lessons had not been learnt from the 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 now 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.

At our last inspection we found the provider had failed to make enough improvement to achieve compliance with the Regulations and implement robust governance systems. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

No improvement had been made at this inspection and the provider remains in breach of regulation 17.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- There was a lack of oversight from both the manager and the provider which resulted in the decline in care provided to people. Both the manager and regional operations manager told us they had spoken with the provider about getting extra support for the manager so they could make the required improvements within the service. We were told this support was not put in place.
- The regional operations manager told us there were long delays when they had requested items for the service such as lockable medicines cabinets, and requests took a long time to be approved.
- Some relatives told us staff did not always keep them updated about their family member's health and wellbeing. One person's relative told us they were not informed for a number of days after their family member had a fall. A second relative told us the communication from staff was, "Abysmal" during the height of the pandemic, and they only heard via rumours that visiting had started again.

Continuous learning and improving care

- Analysis of incidents did not always take place, therefore, learning opportunities were missed.
- A new quality assurance system was not fully implemented. The regional operations manager told us this meant they did not have a comprehensive oversight of the service. Instead, they had to visit the service in person and go through the records they required, rather than being able to analyse trends in the service, such as incidents.
- There was no schedule in place for regular audits to be carried out, and the audits which were undertaken were not effective at identifying shortfalls in the service.

These finding constituted a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

- The service failed to notify CQC of notifiable incidents as required by law. These included events relating

to people's health and welfare.

This is a breach of regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009.

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

● We could not be assured that duty of candour was met when required. For example, we reviewed the incident records for the people who lost weight; and could not see their next of kin had been informed of the weight loss, or that relatives had been told the scales had been broken for a number of months.

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

● Meetings for people who lived in the service took place, and minutes of these meetings showed people were invited for their feedback about the service.

● Relatives we spoke with told us they had recently been sent a survey asking for their feedback. The formal analysis had not been completed, but the manager told us they had identified some main themes and had written to relatives. They added they had contacted relatives individually if they raised specific concerns about their family member.

● Staff meetings also took place. Meeting minutes showed the manager was addressing concerns such as medicines errors and gaps in care records with staff.

Working in partnership with others

● The service had been working with a number of agencies prior to our inspection due to the widespread concerns. However, this had not had a significant improvement on the quality of the service being delivered.

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 18 Registration Regulations 2009 Notifications of other incidents The provider failed to notify the Commission of reportable incidents. Regulation 18(1) and (2)

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 Processes to protect people from abuse and improper treatment were ineffective and people had been exposed to risk of harm Regulation 13(1)(2)(3) and (4)(d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The premises and equipment used by the service was not properly maintained and suitable for the purpose for which they are being used. People were not adequately protected from the risk of infection and hygiene standards were not maintained. Regulation 15(1)(a)(c)(e) and (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 18 HSCA RA Regulations 2014 Staffing

personal care	The provider did not deploy enough suitably trained, skilled or competent staff to meet the needs of the people who used the service. Regulation 18(1) and (2)(a)

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 The provider had failed to do all that is practicable to mitigate risks to people. Regulation 12(1)(2)(a)(b)(c)(d)(e)(f)(g) and (h)

The enforcement action we took:

Notice of Proposal to impose a condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to assess, monitor and improve the service were ineffective resulting in people receiving poor care. Regulation 17(1)(2)(a)(b)(c) and (f)

The enforcement action we took:

Notice of Proposal to impose a condition