Eastbourne Grange Limited

Eastbourne Grange

Inspection report

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Eastbourne
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Tel: 01323733466

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Eastbourne Grange is a residential care home in an adapted building, providing personal care for older people including people who were living with dementia and memory loss. The service can support up to 25 people. At the time of the inspection there were 19 people living at the home.

People's experience of using this service and what we found
Peoples care needs had increased. Eastbourne Grange provided support to people with advanced dementia, some with increased level of care and support needs. This impacted on staff as people needed a higher level of support.

Safe recruitment had not been maintained. Documentation was not in place to ensure the provider could be sure staff were safe to work in the home. There were not enough trained staff to administer medicines in accordance with people's prescriptions. Only one senior carer and the registered manager were currently able to give people medicines when needed. There were no medicine audits or checks being completed. This meant issues related to safe medicine storage had not been promptly identified.

Accidents and incidents were not being robustly monitored. Actions had not been implemented following a suspected head injury and it had not been identified when an accident had not been reported externally to the local authority

Infection prevention control measures were not being followed in line with current government guidance. Staff were not wearing masks and no rationale or risk assessment had been recorded in relation to this decision.

The provider had not ensured there was adequate oversight of the service or support in place for the registered manager in light of a number of staff vacancies. New staff were not experienced and lacked the skills to provide care without being supported by other staff. This meant the registered manager was having to cover care tasks and administer medicines. This had impacted on the registered manager completing checks and audits to ensure the safety and management of the service had been maintained.

There was not an effective system in place to manage the environment and to review overall maintenance and safety in the home. A number of checks had not been completed in line with required timescales, this included water safety checks and fire safety. Window restrictors had not been checked and serviced. Fire safety systems needed to be improved to ensure people were safe. and staff were appropriately trained to respond to an emergency and evacuate people in the event of a fire.

The provider had failed to ensure there was adequate governance at the home. Auditing was not robust or consistently completed. Required checks had not all been completed. Care documentation needed to be

improved to ensure care plans and risk assessments provided the most up to date information. When decisions had been made, for example, regarding medicine administration or in relation to PPE, no risk assessment or rationale had been recorded.

Improvements were being implemented in relation to people's consent and best interest meetings being recorded when needed. 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. The registered manger had been working with the local authority to ensure best interest meetings and capacity assessments where in place to support decisions made.

Relatives spoke positively about the service and the care their loved one received. People told us they liked staff but would like more consistency as they felt they responded better to staff they knew and trusted.

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

Rating at last inspection
The last rating for this service was good (published 15 July 2021). At this inspection breaches were identified. The service has now been rated as requires improvement.

Why we inspected
The inspection was prompted in part due to concerns received about staff recruitment and training, moving and handling guidance not being followed, how decisions about people's care are made and medicine practices. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

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.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

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

Enforcement and Recommendations
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 monitor the service and will take further action if needed.

We have identified breaches in relation to safety, staffing, recruitment, infection prevention control and good governance. 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 request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will

continue to monitor information we receive about the service, which will help inform when we next inspect.

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	**Requires Improvement**
Is the service well-led? The service was not always well-led.	**Requires Improvement**

Eastbourne Grange

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 Health and Social Care Act 2008.

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
The inspection was carried out by one inspector

Service and service type
Eastbourne Grange is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Eastbourne Grange is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We also contacted the local authority market support team for feedback. We used all this information to plan our inspection.

During the inspection
We spoke with four staff including the registered manager and care staff and eight people living in the home, we also spoke to one relative during the inspection. We reviewed a selection of records. This included three people's care plans in full and a further two to look at specific areas in relation to their care needs. We also reviewed documentation in relation to people's safety, including medicine administration, fire safety, accidents, incidents and risk assessments. We looked at staff recruitment and supervision and a variety of records relating to governance and the management of the service. Following the inspection, we spoke with the provider and also requested some documents which could not be located during the inspection be sent by email.

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 our last inspection we rated this key question good. At this inspection the rating has changed 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.

Systems and processes to safeguard people from the risk of abuse

- Improvements were needed to ensure people were protected against the risk of abuse. Staff told us if they had any safeguarding concerns they would speak to someone senior. One told us, "I would not be confident enough to raise a concern myself, I would go to the manager."
- A system was in place when accident and incidents occurred. This included completion of an accident form on the electronic care system. When monthly analysis was completed, this had not identified when follow up actions had not been completed, for example, following a head injury or when a required referral to the local authority had not been completed.
- We found one incident which had not been referred to the local authority, the registered manager has informed us following the inspection this has now been correctly referred.
- The registered manager had identified when a referral to the falls team may be beneficial for example, following a change to a person's health or mobility.

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

- People felt safe living at Eastbourne Grange, one told us "I am looked after and feel fine here." A relative told us, "I realised very quickly that the fundamental thing is that they are safe. And I know [person's name] is safe here. The staff are really kind to them, they are well looked after."
- People living at Eastbourne Grange had a range of needs. Some people required a high level of support and care due to their dementia. Staff told us people's needs had increased recently as people's health had declined. This had impacted on staff as they were having to provide more support to people, for example with personal care, assistance at mealtimes and with mobility.
- Risks to people had not been consistently assessed to ensure people maintained their safety.

When changes had occurred, for example in the way a person was receiving their medicines, or self-administering medicines which were not safely locked away, this had not led to an appropriate risk assessment being completed. Following the inspection, the registered manager has confirmed systems have been implemented to ensure medicines are safely locked away at all times.

- Fire safety had not been managed safely. The home did not have an up to date fire risk assessment. We informed the provider during the inspection that this needed to be in place. Action was taken following the inspection to ensure an up to date fire risk assessment was completed.
- People had individual Personal Emergency Evacuation Plans (PEEPS) however, these did not adequately include how people who had limited mobility would be safely evacuated from the building as staff had not been trained to use evacuation equipment. Following the inspection, the registered manager confirmed training has been arranged.

● Evacuation plans included that one staff member was to remain with evacuated people in the garden to support those with dementia and prevent people re-entering the home. Staffing levels at night were currently two staff. Therefore, it was not clear how people requiring assistance with mobility would have this provided. The provider needed to ensure evacuation plans reflected people's current needs.
● Maintenance records for the building had not been maintained. The maintenance person had been off work and checks had not been completed in their absence. This included water safety and temperature checks. A current legionella safety certificate could not be located. The provider has confirmed this has been arranged following the inspection.
● Although a monthly walk around to check for maintenance issues was completed, this did not include checks to ensure window restrictors were in place or maintained.
● There was limited evidence of provider oversight at the home, to monitor safety or to support the registered manager.

The provider had not ensured people received safe care and treatment. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 MCA 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 when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Conditions related to DoLS authorisations were being met.
● The registered manager had been working with the local authority to ensure best interest meetings and mental capacity assessments where in place to support decisions made. For example, for decisions in relation to gated entry to some rooms. Work in this area was still ongoing, with families being involved in best interest decisions.

Using medicines safely
● There were not enough medicines trained staff to ensure people received their medicines as prescribed. At the time of the inspection all medicines were being administered by one senior carer or the registered manager.
●There were no staff working at night who were able to administer medicines including 'as required' (PRN) medicines. This meant people who required PRN medicines at night, for example for pain relief could not have these provided if required.
● The senior carer currently came into work early to give people their morning medicines and people were given their night medicines before they went off duty.
● One person who was experiencing a lot of pain was being given their dispensed medicines in a pot to take at a later time at night. We were told that some pain relief was given to the person in a blister pack which they person confirmed was kept in a drawer in their bedroom to take at night if needed. This is not following best practice for medicines administration. No risk assessment was in place for this and medicines were not being locked away safely until needed. Although this person had full capacity and was able to self-medicate,

it was unclear why risks had not been identified and actions taken to ensure medicines were stored safely at all times. This put people at risk as medicines were accessible to anyone who may enter this bedroom.
● Medicines audits had not been completed over recent weeks. Staff told us they had not had time to complete the audit as they were busy administering medicines and reviewing care plans.
●Temperatures were not being consistently monitored in relation to safe medicine storage. Staff told us the fridge thermometer was not working, on examination the thermometer required a new battery, this was rectified during the inspection.

The provider had not ensured people received safe care and treatment. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● People told us "Staff work hard, but it is difficult with so many new staff, they don't know you as well" and "All very nice, they do their best couldn't wish for more." People were aware of a number of staff changes and some felt this was having an impact. Telling us, "I would appreciate someone with more experience"
● Recruitment records for newly employed staff were not robust and did not include all relevant information to ensure fit and proper persons were employed. The registered manager did not have access to all required information for staff working in England on sponsorship as this had been organised by the provider. Recruitment folders did not include interview details and background information. Application forms were either not in place or not fully completed and gaps in education or employment had not been explored. Some of this information was updated and sent to us by the provider following the inspection.
● Although recruitment was ongoing, the provider and registered manager told us it had been very difficult to recruit experienced care staff. A number of new staff had been employed who were new to working in care. Although new staff shadowed current staff before working on their own, there was no formal induction or structured support in place for new starters to ensure they received the support required.
● The registered manager told us they needed a deputy manager to support them, we discussed this with the provider who told us they had looked to recruit to this role but had been unable to find anyone suitable at this time.

The provider had not maintained appropriate recruitment processes. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Following the inspection, the provider sent us some updated recruitment information.

Preventing and controlling infection
● The provider was not using PPE effectively. On arrival at the inspection we found staff were not wearing masks around the home. This included when in close contact with people in communal areas. This was not in accordance with the latest government guidance or supported by latest policies. The registered manager told us they were asking staff to test before they came on shift and therefore did not think it was still required and communication was hampered by masks, particularly for people with dementia.
● Risk assessments had not been completed to support this rationale or to ensure peoples individual needs had been reviewed to ensure this was safe practice. The registered manager confirmed following the inspection masks were being worn by staff.
● There was no cleaning schedule or rota in place to enable the registered manager to have oversight of cleaning tasks completed.

The provider had not ensured people received safe care and treatment. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the registered manager told us current government regulations were being followed and masks were being worn.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed. An IPC audit was being completed monthly

Visiting was taking place and relatives confirmed they could visit whenever they wanted.

Requires Improvement

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 our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics, Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The provider had not completed any formal checks to ensure the service was meeting regulation. There was no support system in place for the registered manager or overarching system to ensure quality assurance was effective. The registered manager was completing a number of non-management tasks which impacted on their ability to carry out and maintain good governance at the home.
- Staff told us they wanted to be able to assist the registered manager but felt that they needed support to develop and learn new skills to enable this to happen. Staff felt this would not be possible until more experienced staff were recruited to cover the care.
- People told us they were aware of a number of staff changes. One said, "New faces every day, I don't know all of them."
- Quality assurance and oversight needed to be improved. Although some audits were being completed, these had not identified some of the issues found during the inspection.
- Accidents/incidents audits had not identified that a required notification to the local authority had not been completed. Medicines audits had not been completed and improvements to maintenance oversight was needed as detailed within the safe section of the report.
- The registered manager told us they were currently going through all staff training records to gain a clearer picture of what training each staff member had completed. This was a lengthy process which included having to go into each staff members training record individually. This meant that it was difficult to maintain oversight.
- The registered manager spent a lot of time covering medicine administration, providing care, and supporting staff, this meant management tasks had slipped over recent months. New staff had not received a formal induction, staff supervision was not being completed, and auditing had not been maintained to an appropriate standard.
- Documentation needed to be improved. Care plans were in place and identified people's needs, however some aspects of documentation had not been updated to reflect changes. We found one example where a care review indicated the person had sustained an injury whilst living at the service, however, no further information could be found recorded in relation to this. We have asked the registered manager to investigate this.
- Care plans were not always updated to include the most recent information for staff, for example, body maps were not consistently completed to identify wounds or bruising following an accident or fall. Follow

up checks after an injury, including a suspected head injury were not being documented. This meant documentation did not illustrate exactly what care and support was being provided for people.

The provider had not ensured good governance of the service. This was a breach of Regulation17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● No relatives or residents' feedback had been sought over recent months. However, a relative told us, "I know I can discuss anything with the manager if I needed to."
● A staff meeting had taken place in June this year. The registered manager told us they planned to have more meetings, but these had not yet been scheduled. Staff told us they liked the registered manager.

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 was aware of their legal responsibilities in relation to duty of candour. and was honest with people when their care had not gone according to plan. A relative confirmed they were always updated if any issues or incidents had occurred.

Working in partnership with others; Continuous learning and improving care
● The registered manager told us they worked with other health care providers to support people's needs. This included falls teams, GP and district nurses.
● Following the inspection, the registered manager supported a referral to the Medicines Optimisation for Care Homes Team to facilitate improvement to current medicines practices.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to provide safe care and treatment to people, including failing to assess and mitigate risks to individuals and the environment. The provider had failed to ensure safe management of medicines and infection prevention control.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure good governance of the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to ensure robust recruitment processes were maintained.