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Eastcroft Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
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
Eastcroft Nursing Home is a residential care home providing personal and nursing care to up 20 people. The service provides support to older people and those who live with dementia. At the time of our inspection there were 16 people using the service.

People's experience of using this service and what we found
Risks to people's health and welfare had been assessed but some risk assessments lacked detail and did not always contain enough information for staff to follow to provide people with safe care and treatment. Staff did not always follow the guidance provided by health care professionals.

The provider did not check that staff who administered medicines were competent to do so. The provider had no system in place to maintain oversight of staff training and failed to detect the low levels of pass rates for some. The provider did not have robust procedures in place to ensure the safe recruitment of staff. We observed some poor hygiene practices on the inspection day.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. We found the provider was not consistently working within the principles of the Mental Capacity Act. Capacity assessments and best interest decisions were not decision specific. We observed that the way in which people were supported at times restricted their choices.

People's needs were not always adequately assessed by the provider to ensure they could be met by staff when admitted to Eastcroft Nursing Home. The design of the home did not take into account the needs of those who lived with dementia. We have made a recommendation about this.

People did not always receive care which was respectful or dignified. We were told that on occasion, people were wearing clothes that belonged to others in the home. There were no individually designated incontinence fixation pants and we found some of the language used in care plans to be disrespectful to the person. The provider did not routinely seek people's feedback about the care they received. However, we observed that staff were patient and kind with people.

Care plans did not accurately reflect people's needs and they lacked guidance for staff about how to deliver person-centred care. Staff provided a limited amount of activities to people and these did not include the needs of those cared for in their room.

The provider failed to develop effective governance and quality assurance systems to assess the quality and safety of the support people received. There was limited oversight of the day to day operation of the home and a lack of audit of incidents to determine trends and themes. This meant there was no opportunity for staff to learn from incidents or for the provider to take actions to improve the care people received. The

provider had not always notified CQC of incidents or accidents which is a requirement of their registration.

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 29 January 2019).

Why we inspected
The inspection was prompted in part by notification of an incident following which a person using the service sustained a serious injury. This incident is subject to further investigation by CQC as to whether any regulatory action should be taken. As a result, this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk. This inspection examined those risks.

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.

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

Following inspection, the provider told us they adapted the eating and drinking guidance issued guidance by a speech and language therapist with immediate effect. They initiated a new staff training programme. They are cooperating with the local authority to address shortfalls found on this inspection.

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 keeping people safe from risk of harm, staff recruitment and training, medicine management, capacity and consent, person centred care 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
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 continue to monitor information we receive about the service, which will help inform when we next inspect.

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

Eastcroft Nursing Home

Detailed findings

Background to this 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 undertaken by 2 inspectors, a nurse specialist advisor and an Expert by Experience. 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
Eastcroft Nursing Home 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. Eastcroft Nursing Home is a care home with 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 looked at all the information we had received about and from the home. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with10 family members about their experience of the care provided. We spoke with 7 members of staff including the registered manager and manager. We received feedback from 3 healthcare professionals.

We reviewed a range of records. This included 5 people's care and support records and medicine administration records. We looked at 7 staff records in relation to recruitment and training. We also reviewed a variety of records relating to the management of the home, including policies and procedures, staffing rotas, accident and incident records, safeguarding records and reports.

Inadequate

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 inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

● People were placed at significant risk of harm, as staff did not always follow guidance set out by healthcare professionals. A member of staff was assisting a person to eat and we observed there was a bread sandwich on a plate next to the person. The member of staff described to us how they would support them to eat this if they requested it. We subsequently confirmed with a speech and language therapist that this was not in line with their eating and drinking guidance and placed the person at significant risk of choking. We sought assurances from the manager that this practice would stop without delay and also referred the matter to the local authority safeguarding team.

● People cared for in bed were unable to access their call bells placing them at risk of harm, as call bells were placed out of their reach. We could not be assured people were safe or did not require staff support. A staff member said, "We make sure we check on those [cared for in bed] every 1 or 2 hours." Staff confirmed that these checks were not regularly recorded and we could not be assured checks were being undertaken.

● Not all risks to people were appropriately assessed or identified, such as additional risks and care needs associated with specific health conditions. Risk assessments which were in place lacked guidance for staff on how to support people safely. Whilst we found no evidence people had been harmed, and most staff we spoke with demonstrated they understood people's needs, this lack of guidance meant there was a potential risk that people were not provided with consistent and safe care.

● We were not assured about the provider's approach to fire safety. There were no personal emergency evacuation plans (PEEP) in place for 2 people, both of whom would require a significant level of assistance to evacuate the building in the event of a fire. The fire 'grab bag' contained PEEPs for 5 people who no longer lived at the home. This meant that in the event of a fire, valuable time could be lost as the fire and rescue service continued to search for them.

The provider failed to ensure that people were provided with safe care and treatment. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the provider told us they strictly adhered to guidance from healthcare professionals. They have not provided any further updates on other matters of concern.

Staffing and recruitment

● The provider did not have robust procedures in place to ensure safe recruitment of staff. Staff records were incomplete and some lacked interview notes and references. References submitted following the inspection did not identify reasons for the applicant leaving their employment.

● We were not assured that the provider robustly explored staff's conduct or competence in their previous roles and no interview notes were available to review. Staff recruitment references did not identify the

professional relationship with the applicant and it was not clear whether any of these were from a previous employer.

The provider failed to ensure that persons providing care were competent and experienced to deliver safe care. This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staffing levels did not take into account people's fluctuating needs. Staff deployment was not always effective, and people cared for in their bedrooms were not always engaged. The provider did not have effective systems to monitor and assess people's changing needs or dependency levels. On the day of inspection, there was 1 nurse and 3 carers on duty. The manager told us when there was full capacity, this was adjusted to 1 nurse and 4 care staff.
● Disclosure and Barring Service checks (DBS) for staff were in place. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Using medicines safely; Preventing and controlling infection
● Medicines were not safely managed, and safe hygiene practices were not always followed by staff.
● There were no systems in place to ensure medicines were administered by competent staff. The registered manager was unaware of the necessity to ensure that all staff responsible for administering medicines had a regular review of their knowledge, skills and competencies relating to managing and administering medicines.
● Medicines were not administered safely or in line with national best practice. Clinical staff completed people's medicine administration records (MARs) retrospectively. We observed after morning administration, a nurse completing MARs in the reception area and they confirmed that they had been assured all people had taken their medicines. However, we subsequently found a person's medicines on their bedside table which meant they did not take them earlier on. In the afternoon we saw a different nurse signing MARs retrospectively.
● The provider was not promoting safety through the layout and hygiene practices of the premises. There were soiled incontinence pads left in some bedroom bins. Some commodes had lids which were stained and there was faecal matter on the seat of a communal toilet. One person's commode in their bedroom was left unemptied and with the lid open for several hours, despite it containing a significant amount of faecal matter.
● We observed poor hygiene practices when medicines were being administered. Staff did not follow safe hand hygiene practices and equipment used to cut medicines was not cleaned each time it was used and was left on the top of the medicines trolley still with a residue of medicines on it. This meant there was potential for people to receive medicine which was contaminated by other medicines.

The provider failed to ensure medicines were safely administered, that staff were competent to do so and safe hygiene practices were followed. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider's approach to visiting at the home did not align with Government guidance at the time of our inspection. They adapted a blanket policy for which there was no evidence that people or their family members were consulted on it. Visitors to the home were discouraged from visiting unannounced, had to book a time slot prior for their visit and were required to take a COVID-19 test on the doorstep before being allowed entry. Visiting took place in people's rooms, rather than in communal areas.

Learning lessons when things go wrong

● Lessons were not learned when things went wrong. Accidents and incidents were not always reported, recorded and acted on appropriately. There was no process in place to review these events for any patterns or trends. This meant opportunities to learn lessons were lost.

● Accidents and incidents were recorded by the same person, rather than by those who witnessed them. The person responsible for recording incidents told us that wounds, skin tears and unexplained bruising were recorded on body maps only and were not recorded as incidents, therefore not investigated or analysed. They told us only falls were recorded on incident forms and these were not reviewed. However, our review of these incident forms recorded repeat behaviours which included people punching staff and pulling their hair. In the absence of any review, there was no guidance for staff about how to manage these repeat occurrences.

●We asked the manager about their oversight of accidents and they said, "Looking at group trends is not very person-centred, I prefer to look at the individual incidents." They told us they reviewed each person's individual records to view any recorded incidents, however there was no evidence that they did this.

The provider did not have an effective system in place to review, investigate and learn from incidents to prevent further occurrences. This put people at risk of potential harm. This is a breach of regulation 12 (safe care and treatment) the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● Staff understood how to protect people from abuse. Staff knew how to whistle blow and told us they would raise concerns with the local authority and CQC if they felt they were not being listened to or their concerns were not acted upon. A staff member told us, "I would go to the manager. If they don't do anything I would go back and check. [Registered manager] normally gives us the feedback."

● The manager understood their responsibilities to safeguard people from abuse. However, they did not have systems and processes in place to help identify and consistently report concerns. The local authority safeguarding team told us the provider did not always alert them to safeguarding incidences. Some incidents were reported to them by the local hospital, police or family members.

● Family members told us that staff provided safe care. One family member told us, "I am pleased they are keeping my [relative] safe."

Inadequate

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 our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

- Staff had not completed all of the provider's mandatory training or induction, and we could not be assured they were competent to deliver effective care. The registered manager delegated the day to day management of the home to the manager. There was no available evidence that the registered manager assessed the delegated person's competence to undertake that role.
- We found significant concerns related to the training completed by staff. Staff training records demonstrated a very high failure rate, some of which related to training specific to nursing staff. The manger told us they were unaware of this and said, "That's not good, I will have to speak to them." We were unable to confirm whether staff were trained in fire safety since the provider failed to submit records related to fire safety training requested by the inspector following inspection.
- We requested 5 staff training records after the inspection, but these were no longer available to review. The manager informed us they had terminated their training contract and all training records for staff were no longer accessible. They said all further training would be with a new contractor. Whilst practice we observed on the day did not give us cause for concern, the provider did not ensure all staff were appropriately trained which put people at risk.
- Not every member of staff had completed the Care Certificate or other relevant qualification in care, which was contrary to the provider's own induction programme. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme. This posed a risk to people as staff were not adequately trained to provide safe care.
- There was no evidence of training or induction done by 1 member of nursing staff. The manager told us, "They have not begun their training yet because they have only recently started." However, we subsequently confirmed that they were working at Eastcroft Nursing Home for almost 4 months prior to the inspection. This presented a risk to people at the home as this person's competence was not assessed.

The provider failed to ensure there were appropriate processes in place to assess and check the competence, skills and experience of staff to undertake their role. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 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 MCA. 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 appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● The provider was not working within the principles of the MCA. Some staff interactions with people demonstrated that the principles of the MCA were not consistently embedded in their practice.
● People did not always receive care in the least restrictive way. Throughout the day, we noted people's walking aids were placed out of their reach. A member of staff told us "We move them out of the way so they can't use them as we need to be with them [to prevent falls]." We also saw side tables were placed over people's chairs at times other than when they were drinking or eating. Whilst it is the provider's responsibility to ensure people are safe, no consideration was given to exploring alternate methods of keeping people safe, whilst ensuring their freedom of movement, choice and control were respected.
● Mental capacity assessments and best interest decisions records were generic and not always decision specific. They did not evidence the discussions which took place with people and their representatives to determine the outcome or record the least restrictive practices considered.

The provider had not acted in accordance with the requirements of the Mental Capacity Act 2005. This was a breach of Regulation 11 (Need for Consent) of The Health and Social Care Act 2008 (Regulated Activities) Regulations.

Adapting service, design, decoration to meet people's needs
● The design and decoration of the home did not always meet the needs of people who lived with dementia. It is generally recognised that people who live with dementia are best cared for in an environment designed and adapted to help reduce their anxiety and potential triggers for distress.
● There were no meaningful, sensory or stimulating destination places around the home for people to visit or engage with when they walked with purpose. There were no clear signs placed at key environmental points for people to orient themselves. We discussed the potentially positive impact on people of measures, such as the use of memory boxes, with the registered manager. He told us, "Memory boxes do not have a place in this home. I have experience, I know what they want, I know them all well'

The provider failed to do everything reasonably practicable to ensure that people received person-centred care which reflected their individual needs. This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● The provider used nationally recognised assessments, including a Waterlow score, which assessed the person's risk of developing a pressure ulcer. However, a person's Waterlow score which had previously been recorded monthly, was not updated in the 6 months prior to this inspection, despite them being identified as being at very high risk of developing a pressure ulcer.

● People were seen as required by a GP, who visited the service every week. We also saw that at times, people were seen by a district nurse, tissue viability nurse, nurse specialist in tube feeding and a speech and language therapist.

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

● People were supported to eat and drink enough to meet their needs. People were weighed each month and there were no significant fluctuations in their weight.

● We noticed that there was no fresh fruit available for people and all the vegetables in the kitchen were frozen. We queried the lack of availability of fresh fruit with the registered manager and were told, "We don't have it because people don't like it." There was nothing in people's nutrition care plans to indicate this.

● We saw the chef had already prepared sandwiches for supper that evening. We asked the registered manager what those with modified diets would have and they told us they would have soup with bread dipped in as he "Didn't want them missing out on bread." We considered this unsafe practice in the Safe key question of this report.

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

Respecting and promoting people's privacy, dignity and independence

- People were not always cared for in a dignified way. We were told people were at times dressed in clothes belonging to others. A family member told us, "Sometimes [person] is not wearing their own clothes." People did not have their own personal incontinence fixation pants (net pants). We found that these were collectively washed and stored, and not separately allocated to each individual. Whilst they were clean when re-issued to a person, this was not supporting people's dignity.
- We observed some people struggled to access their lunch as their table was not positioned close enough to them. For one person, much of their food spilled down their front as the cutlery they used was not adapted to their needs. Drinks were offered in plastic cups, although there was nothing to indicate that any person was at risk of injury if they drank from a glass.
- We observed some staff did not always engage with those they were assisting with their meal. Instead, they spoke with other people in the room. We saw a member of staff leave the person they were supporting with their lunch in order to answer the telephone. On 2 occasions, we observed a nurse interrupting a person mid-meal whilst seated in the dining area to administer their medicine. We confirmed that this medicine was not time critical and therefore could have been administered in a more dignified and discreet way once they finished their lunch.
- Some of the language we heard did not dignify the person, for example, staff spoke of 'feeding' people.

Supporting people to express their views and be involved in making decisions about their care; Ensuring people are well treated and supported; respecting equality and diversity

- People were not always supported to express their views. For example, they did not have the opportunity to attend resident meetings and provide feedback about the care provided via surveys. The manager told us they did not have resident's meetings because, "Feedback from residents is not reliable. For example [person] is likely to say yes to everything, so that for me is not reliable. Most residents are not able to articulate more complex views." The provider had not considered alternative ways of supporting people to express their views.
- We saw people were not offered a choice of food at lunchtime. Staff told us they already knew what people liked and if they did not like the lunch option, soup was given as an alternative. A member of staff told us they knew one person did not like the vegetable being served. Despite this awareness, no alternative vegetable was offered to the person.
- Staff were kind and patient and we observed some nice interactions between care staff and people. Most family members spoke positively about the caring nature of staff, "They care about each resident and their staff and protect them from harm. I think they are excellent."

Requires Improvement

Is the service responsive?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed 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; 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's needs and preferences were not reflected in their care plans and they did not always have access to meaningful activities. We could not be assured people's needs were being reviewed regularly, as records were only completed when there were changes to people's needs and not the frequency of reviews if there were no changes. There were no care plans in place around people's specific medical conditions, including high blood pressure, Parkinson's disease or different types of dementia.
- Some care plans lacked sufficient guidance for staff. For example, staff were not provided with any guidance about how to support a person when in distress which was an important part of their care. We found that some of the language used in care plans was disrespectful and judgemental. People were said to be 'lying' or 'threatening'. This demonstrated lack of staff's awareness and understanding around how people expressed their emotions or unmet needs.
- Care plans were not always person-centred and did not evidence whether people were engaged in planning their own care. They lacked details of individual likes and dislikes, as well as their preferred routines. The way in which staff used the electronic care planning system resulted in generic plans which did not consider a person-centred approach.
- People were not always provided with activities that met their preferences and interests. We observed long periods of time when those cared for in their rooms did not have any dedicated time with a member of staff. We also observed that staff did not actively engage with people sitting in the lounge area who were less able to communicate. A family member told us, "I don't know what (staff) do to motivate them (residents). They just sit there looking at each other. Some can see the TV but most can't, it always depressed me."

People did not receive care that was consistently person centred, and which considered their individual needs or promote choice and control. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- People's communication needs were not always met and care plans in place did not provide suitable guidance for staff to follow. For example, a person's communication care plan outlined the complex way in

which they communicated, some of which was related to their dementia. However, there was no practical guidance offered to staff around how to support this person to express their needs.
● We found the provider did not follow communication guidelines set out by a speech and language therapist. Staff did not employ the recommended phrases or tools to enhance communication with this person.

People's communication needs were not fully met, and staff did not have appropriate guidance in place to support people with their communication. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns
● People were given a copy of the provider's complaints policy when they moved into the home. This contained information about how to raise any concerns and how they would be managed. The provider was managing a complaint at the time of this inspection.

End of life care and support
● No one was receiving end of life support at the time of the inspection. People's end of life wishes were recorded in their individual 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 our last inspection we rated this key question good. At this inspection the rating has changed 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

- Quality assurance systems in place did not identify the issues we found during the inspection and the manager did not have effective oversight of the safety or quality of the care provided. This included inconsistent care and risk records lacking relevant information about people's health needs and ways in which to mitigate their individual risk. The lack of oversight and clear care and risk management plans placed people at risk of harm, for example, the way in which staff did not apply a person's eating and drinking care plan.
- Continuous learning was not promoted within the service. There were no systems in place to analyse and learn from incidents. This meant that there was little opportunity for staff to increase their knowledge regarding how to care for people safely. For example, people's falls risk assessments were not updated to indicate any learning from the way in which they fell. The provider failed to follow their own falls policy to routinely review the overall pattern and trends for service user falls to inform revisions in policy, protocols and procedures and/or staff training on falls.
- The provider had no system in place to maintain oversight of staff training and told us they reviewed individual training records for each member of staff. The manager confirmed that they did not have a way in which they could view all staff training at a glance, including completed, overdue and success rates.

The provider's quality assurance systems and processes did not enable them to effectively assess and monitor the care provided in order to consistently improve the quality and safety of the service. This was a breach of regulation 17 of the Health and social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager or provider had not always correctly submitted notifications to CQC. Services providing health and social care to people are required to inform the CQC of important events that happen in the service. This is so we can check that appropriate action had been taken.
- We asked the provider to submit statutory notifications in relation to unsafe care which we observed on the inspection, as well as in relation to a police incident notified to CQC by the local authority. They failed to do this in a timely manner. We reviewed the provider's record of accidents and incidents and found that not all incidents which resulted in injury to a person were notified to CQC as required. For example, where a person caused injury to themselves when they pulled a Christmas decoration down on themself. The local authority shared their concerns with CQC about the provider's failure to submit notifications to them, some of which related to significant safeguarding concerns.

Notifiable incidents were not always being submitted to the CQC which is a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● People were not engaged by the manager. Resident meetings were not facilitated which meant people were not routinely involved in planning their care. The manager told us, "People have no interest in having them (meetings)." There was no evidence to suggest that alternative ways to engage people in different aspects of the service were explored.

● We received mixed feedback from healthcare professionals about their engagement with Eastcroft Nursing Home. One professional told us that the registered manager engaged well and contacted the surgery where there were concerns about people's health. However, other healthcare professionals told us it was difficult to encourage the manager to engage in training for staff offered by the primary care network.

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 Care Quality Commission (CQC) sets out specific requirements that providers must follow when things go wrong with care and treatment. This includes informing people and their relatives about the incident, providing support, truthful information and an apology when things go wrong. It was unclear whether the provider consistently applied their responsibilities under the duty of candour. The local authority informed us that family members were not informed about an unexplained injury to their relative.

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

● The culture at the service did not support people's safety, choices or the management of risk. There was a lack of accountability and responsibility and the provider failed to promote a culture where people were consistently treated with dignity and respect.

● Relatives told us they could not comment on the general culture within the home since the way in which their visits were prescribed, they were escorted from the front door directly to their relative's room for the duration of their visit.

● Staff told us they felt valued. Staff comments were, "I feel that what I do is respected. They [manager] talk to us about our performance; encourage us and offer praise" and "I would like to think that I am valued."

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
Treatment of disease, disorder or injury	Notifiable incidents were not always being submitted to the CQC.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	People did not receive care that was consistently person centred, and which considered their individual needs or promote choice and control.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	The provider had not consistently acted in accordance with the requirements of the Mental Capacity Act 2005.

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
Treatment of disease, disorder or injury	The provider failed to ensure that people were provided with safe care and treatment and that medicines were administered by competent and experienced staff. They failed to ensure that The provider did not have an effective system in place to review, investigate and learn from incidents to prevent further occurrences.

The enforcement action we took:

We imposed a condition on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider's quality assurance systems and processes did not enable them to effectively assess, monitor and consistently improve the quality and safety of the service.

The enforcement action we took:

We imposed a condition on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed
Treatment of disease, disorder or injury	The provider failed to ensure there were appropriate processes in place to assess and check the competence, skills and experience of employees required to undertake their role.

The enforcement action we took:

We imposed a condition on the providers registration.