Anchor Hanover Group

Eastlake

Inspection report

Nightingale Road
Godalming
Surrey
GU7 3AG

Tel: 01483413520
Website: www.anchor.org.uk

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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
Eastlake is a residential home providing accommodation and personal care for up to 53 people aged 65 and over. Some people living at the service are living with dementia, others are elderly and frail or have medical conditions that require them to live in this type of service. At the time of our inspection, there were 53 people living at Eastlake.

The service is divided into four units. Each unit has its own lounge and dining area. There is a level communal garden for everyone to use.

People's experience of using this service and what we found
Whilst people spoke positively of the level of care and support, we found shortfalls in governance arrangements. Systems and processes were not fully aligned towards clearly formulated goals. For example, smooth and seamless transition of care was a goal for when people left hospital, but there were no clearly defined systems and processes to facilitate this. This also applied to other fundamental goals including person-centred care, risk management, and partnership work. Robust, reliable, and sustainable systems must be established to deliver these goals.

There was a framework for risk management and control. However, this was inconsistently applied. Audits did not consistently identify shortfalls. There was an accident/incident reporting system, but this was not fully utilised. Underlying causes of incidents and accidents were not fully considered.

We identified some strengths in partnership working, particularly with visiting professionals, including GPs. On the other hand, there were weaknesses in communication so that care was more joined up. The provider had begun some work to make improvements.

People were supported to engage in home life and maintain contacts with family and friends. Local schools, and other members of the community were invited to chat and sing with people. People remarked on this, clearly appreciating the connection with different generations and their local community.

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.

People told us they felt safe living at the home. Relatives of people living at the home told us they felt their loved ones were safe.

Staff were recruited safely, and the relevant checks had been carried out on staff before they started work.

Staff we spoke with understood what constituted abuse and knew what actions to take if they felt someone

at the home was being abused. There was a safeguarding policy in place for the staff to refer to.

We observed the home as clean and well kept. We were assured that the provider was supporting people living at the service to minimise the spread of infection.

Rating at last inspection and update
The last rating for this service was good (published 04 February 2020).

Why we inspected
We received concerns in relation to the provider's risk management framework, including management of medicines, incidents, falls, leadership, and the general governance. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

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.

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

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

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

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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Eastlake

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 team consisted of 2 inspectors, 2 regulatory coordinators and an Expert by Experience who spoke with people's relatives by telephone. 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
Eastlake 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. Eastlake 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 reviewed 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. 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 used all this information to plan our inspection.

During the inspection
We spoke with 8 people who used the service and 10 relatives about their experience of the care. provided. We spent time observing how staff interacted with people and we spoke with 15 staff. This included service director, the registered manager, deputy manager, team leaders, senior care staff member and care staff. We reviewed a range of records at the inspection visit. This included 13 people's care records, multiple medicines records, staffing, operational policies, quality assurance and management records. Following the inspection, we continued to seek clarification from the provider to validate evidence found.

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.

Using medicines safely

● Arrangements for some medicines were unsafe. We found 2 people were prescribed rescue medicines to be used in emergencies, but staff were not trained and competent to be able to administer them which put people at risk of harm. The rescue medicines had been prescribed to treat prolonged seizures. Prolonged or repeated seizures can increase the risk of status epilepticus (medical emergency) if they are untreated.

● Staff did not always follow good practice while administering medicines. On the day of the inspection, we observed that a member of staff did not sign medicine administration records (MARs) as soon as possible after each person had taken their medicines. The staff member administered medicines to everyone in their care and then signed for all the medicines at the end of the medicines round. This increased risk of medicines errors which put people at risk of harm.

● Medicines care plans were not always in place or person-centred. Care plans did not always have information on how to monitor and manage the side effects of high-risk medicines such as anticoagulants and insulin. People who take anticoagulants need frequent monitoring to ensure that the effect is within a safe range. A person-centred care plan should be available for anyone using insulin, which details their insulin needs, arrangements for monitoring, risk assessments and details of who is responsible for managing their diabetic care and administering their insulin. This is also true with 'high-risk' medicines because of the possible adverse side-effects. People require frequent tests (blood or other tests) and reviews, and doses may need to be adjusted to ensure they do not cause harm. Therefore, we could not be assured people were receiving safe care and treatment.

Medicines were not always managed safely which put people at risk of avoidable harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● During and after the inspection, the provider took appropriate action to mitigate potential risks in relation to rescue medicines. They secured qualified nurses from a recruitment agency to provide a 24-hour onsite support for staff until staff had received training and were assessed competent to administer the specified rescue medicines.

● Staff knew how and when to administer 'when required' (PRN) medicines. There were PRN protocols in place which included clear guidance for staff on when and how to administer those medicines. We saw staff followed them.

● There were systems for ordering, administering, and monitoring of medicines. Medicines were stored securely, and records were appropriately kept. We found that room and fridge temperatures were appropriately monitored.

Assessing risk, safety monitoring and management

● Risks were not consistently assessed, monitored, or mitigated for people's safety in a timely manner. We identified that 2 people were at risk of hypoglycaemia and hyperglycaemia due to living with diabetes. Whilst diabetes care plans were in place, there was no specific guidance for staff on how to minimize individual people's risk of hypoglycaemia and hyperglycaemia, how to recognise any concerns and what staff should do to ensure people received timely support. Whilst the provider has submitted updated care plans, these are still work in progress. Therefore, people were at risk because the provider did not have protocols to support staff to recognise relevant symptoms and take appropriate action.

The provider had failed to assess and mitigate risks to people living with diabetes. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Other risks to people were identified and assessed with individual risk management plans in place. For example, people had access to care equipment as needed. This included pressure relieving equipment for people at risk of skin breakdown or, movement sensors for those at risk of falls. Risk assessments and management plans were in place and were regularly updated in response to people's changing needs.

● There were appropriate plans in place in the event of an emergency. Health and safety checks, including fire safety checks were carried out regularly.

● Personal Emergency Evacuation Plans (PEEPS) had been completed for each person. PEEPS provided staff or the emergency services with detailed instructions about the level of support a person would require in an emergency, such as a fire evacuation.

Learning lessons when things go wrong

● Lessons were not always learnt from incidents that happened. The accident/incident reporting system did not always support staff to understand and identify immediate and underlying factors contributing to incidents, taking full account of human and organisational factors. Prior to the inspection, a medicines incident had occurred, but the provider failed to investigate the incident and to take action to mitigate the risk of a recurrence or similar incidents. Therefore, the provider was not making sure lessons were learned to improve outcomes for people.

The provider had failed to operate their governance systems effectively to identify lessons learned from incidents and accidents which put people at risk of harm and similar incidents occurring in the future. This was a breach of regulation 17 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. Any conditions related to DoLS authorisations were being met.

Systems and processes to safeguard people from the risk of abuse

● The provider had systems to help protect people from the risk of harm and abuse. People told us they felt safe with the service provided. One person said, "I feel very at home here, they look after us very well."

● Staff demonstrated a good understanding of the various forms of abuse, how to recognise them and how to report them. Staff had received safeguarding training to ensure they had the skills and ability to recognise when people may be unsafe.

● There was a safeguarding policy and procedures, and staff were aware of these. Staff were aware they could contact the local authority safeguarding team and CQC when needed.

Staffing and recruitment

● Staff had been recruited safely. Pre-employment checks had been carried out, including references, proof of identity and Disclosure and Barring checks (DBS). DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

● There were enough staff on duty. When people requested support staff attended to their requests swiftly. One person told us, "I have a buzzer on my wrist, and they always come quickly if I need to press it, which isn't often. I never have to wait terribly long."

● There were enough staff to serve food during lunch, however, they were also answering buzzers at the same time. We assessed their deployment could be improved. It would have been more satisfying to see staff having time to sit and generate a bit of conversation with people.

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.

● 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 using PPE effectively and safely.

● We were assured that the provider was responding effectively to risks and signs of infection.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

People were able to receive visitors without restrictions, in line with best practice guidance.

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; Working in partnership with others

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

● Governance processes were not operated effectively. There was a programme of regular audits to assess quality, in areas such as health and safety, care plans, and medicines, but this did not identify the issues found during our inspection visit. In some examples, people's care plans did not always include important personal information about them, and individual risks had not always been identified to ensure management plans were in place to prevent harm.

● The provider did not always use systems to manage performance effectively. They did not always escalate risks and issues and identify actions to reduce their impact. For example, whilst the provider had accurately identified shortfalls with arrangements for managing rescue medicines, this had not led to a coherent plan of action to mitigate risk.

● The provider did not always create a learning culture. Accident forms were completed when people had falls. Whilst these incidents were analysed, there was no process in place for tracking progress against intervention plans to ensure any actions identified were implemented. Therefore, we could not be assured the provider had the means to check if interventions were having the desired effect and continued to be acceptable to the respective people.

● The provider did not always operate effective governance processes with partner organisations. Whilst there was evidence of partnership work, communication was not always effective. We found the provider to be without robust escalation mechanisms where there were escalating concerns. Notably, there were issues with seamless transition of care for people when they left hospital. The registered manager told us occasionally people were discharged from hospital with incomplete or delayed discharge summaries. However, no meaningful action had been taken to implement systems to improve performance in this area.

The provider and registered manager failed to operate a robust system to monitor the quality and safety of the service provided. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● The provider actively encourage feedback about the quality of care. A survey had been sent to staff, and the provider was acting on staff's feedback, especially when staff provided negative comments.

● Relatives of people told us they were involved in the service. One relative told us the service was well managed and management were ''pretty good'' and were ''very involved'' and had no concerns as their

relative was well cared for. They felt they were well informed and would be updated of any changes as and when needed.
● The registered manager was involved in the community, bringing in local schools, Guides and Brownies to chat and sing with people.
● Records showed, where appropriate, advice and guidance were sought from health and social care professionals. This included referrals to specialist teams and regular contact with community nurses and GPs.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people;
● We asked staff about the culture of the service and received mixed responses. However, there was a strong view, that staff did not feel respected, supported, and valued. There were some similarities with the results of a staff survey, that ended on 26 September 2023. Staff told us when they raised concerns, these were not taken seriously. We shared this feedback with senior leadership.
● Staff interacted with people in a kind and considerate manner, treating them with dignity and respect. There were 2 calm and enchanting cats who wandered about and curled up beside people, who clearly loved them, stroking them and enjoying their company. The animals were very popular with the people, and several remarked that it made them feel very much at home.
● Relatives spoke in complimentary terms about the registered manager. They told us, the registered manager was, "responsive". A relative said, "There are regular meetings, that relatives can attend too. I do go sometimes, and I once suggested [improvements], and this was carried out."

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 and provider representative told us they were always honest with people if things went wrong and, where appropriate, would make referrals to the local authority safeguarding team. Staff also understood the importance of reporting accidents and keeping families informed.
● Relatives we spoke with were particularly complimentary about how the service engaged with them when there were concerns about their loved ones.

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 Care was not always provided in a safe way. Arrangements for some medicines were unsafe. Furthermore, risks were not consistently assessed, monitored, or mitigated for people's safety in a timely manner. 12(2)(a) (f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance We found shortfalls in governance arrangements. There were insufficient arrangements to respond appropriately and in good time to risk. Regulation 17 (1) (2)