SSB Carehomes Limited

Eagle Nursing Home

Inspection report

The Old Rectory
High Street
Lincoln
Lincolnshire
LN6 9DL

Tel: 01522868403
Website: www.ssbcarehomes.com

Date of inspection visit:
19 April 2018
23 April 2018
06 June 2018
07 June 2018

Date of publication:
03 September 2018

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We undertook a comprehensive inspection on 20 and 23 April 2018. The inspection was unannounced. On 05 June 2018 we received information of concern from the local authority. In response to these concerns we undertook additional inspection visits to the service on 06 and 07 June 2018.

Eagle Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service is registered to provide accommodation for up to 29 older people or people living with a dementia type illness or mental health problems. On day one of our inspection there were 23 people living in the service.

There was a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons. Registered persons have the legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. Since our inspection the registered manager left the service.

We last inspected the service in January 2017. The service was rated requires improvement.

On this inspection we found five breaches of the regulations. This was because the registered provider failed to ensure that there were systems and processes in place to assess, monitor and improve the quality and safety of the service to keep people safe.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from

operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

There was not always enough staff on duty with the right skill mix to keep people safe and respond to their care needs in a timely manner. People were at risk of harm from poor infection control practices, environmental issues and poor management of risk factors. Medicines management was not always practiced safely.

The provider followed national guidelines to lawfully deprive a person of their liberty. Care staff often worked on their own initiative without supervision and visible leadership. People were not always provided with their choice of food or with a balanced and nutritious diet.

People and their relatives were not involved in planning their care. Care was not person centred, but was task orientated. Staff had little insight into the needs of people with cognitive problems and poor spatial awareness. There was a high staff turnover and people did not always know the staff looking after them. Staff treated people with dignity.

People did not always receive personalised care that was responsive to their needs. Staff did not acknowledge their likes and dislikes. People lacked social and emotional stimulation. Individual faith beliefs were acknowledged. People received compassionate care at the end of their life.

There was a lack visible leadership and effective role models to support inexperienced staff. The provider did not have a clear vision or philosophy to promote a positive culture. The providers approach to quality assurance and clinical governance processes were inconsistent and ineffective and did not lead to improvements in the care people received. The provider did not carry out the correct safety checks when recruiting staff.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There was not enough staff on duty with the right knowledge, skills and experience to keep people safe.

Staff did not always follow safe infection control practices and the service was not clean.

People were at risk of harm from unsupervised falls.

The provider did not always follow safe staff recruitment practices.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were not always provided with a nutritious and balanced diet.

The signage throughout the service did not meet the needs of people who were visually impaired or had cognitive problems.

Appropriate steps were taken to lawfully deprive a people of their liberty.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People and their relatives were not supported to be involved in planning decisions about their care.

There was a high staff turnover and people did not always know who was looking after them.

When people were receiving personal care staff respected their dignity.

Is the service responsive?

Inadequate

The service was not responsive.

People did not always receive personalised care that was responsive to their needs.

People were not always treated as an individual, but as a task to be done.

People were not encouraged to take part in hobbies and pastimes.

The service provided care to people at the end of their life.

Is the service well-led?

Inadequate

The service was not well-led.

There was little evidence of visible leadership and good role models to support new and inexperienced staff.

There was not a clear vision to deliver high quality care and promote a positive culture.

Systems to monitor the quality of the service were insufficient.

Eagle Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This comprehensive inspection took place on 20 and 23 April 2018 and was unannounced. The inspection team consisted of one inspector, an assistant inspector 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. On 05 June 2018 we received information of concern from the local authority. In response to this information we conducted additional inspection visits to the service on 06 and 07 June 2018. On these dates the inspection team was made up of two inspectors. We have gathered the findings from our visits in April 2018 and June 2018 to inform this report.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made judgements in this report.

Before the inspection we reviewed any information we held about the service. We reviewed safeguarding alerts and notifications that had been sent to us. A notification is information about important events which the provider is required to send us by law.

During our inspection in we spoke with the registered manager, the area operations manager, the provider, the clinical lead, one registered nurse four members of care staff, two agency care staff, the cook, two housekeepers, the activity coordinator and five people who lived at the service and two visiting relatives. We also observed staff interacting with people in communal areas, providing care and support.

We looked at a range of records related to the running of and the quality of the service. These included four staff recruitment and induction files, staff training information and arrangements for managing complaints. We looked at the quality assurance audits that the registered manager and the provider completed. We also

looked at care plans for ten people and medicine administration records for 23 people. Following our initial inspection in April 2018 the registered manager provided us with information that was not made available to us during our inspection. When we returned in June 2018, we found it difficult to access some of the documents we requested.

Inadequate

Is the service safe?

Our findings

Staff had access to safeguarding and whistleblowing policies and told us how they would identify signs of abuse. For example a staff member said, "I know people and their normal ways. I would escalate concerns to the registered nurse or [name of registered manager]. I would get a second opinion." Another member of staff told us that they had recently raised safeguarding concerns with the area operations manager and had whistle blown to CQC about bullying and abuse in the service. However, other staff that we spoke with did not know how to raise concerns out with the service such local authority team.

People who lived in the service did not always feel safe. For example, one person told us that they were concerned about their own safety when they were in their bed at night and said, "I don't feel particularly safe at night. There are four men who just wander about and knock on doors. They [staff] don't care." They told us that since residents of the opposite sex had wandered into their bedroom unsupervised that they now had a key to their bedroom and slept with their door locked. This person had also been confronted by another resident in a communal area and said, "There's one chap. I've got a bruise on my arm; he cornered me downstairs and caused the bruise. I smacked him across the face. The staff don't take much notice." Another person told us that they kept their bedroom door locked as they did not want to be disturbed at night. There was a potential risk to other people as nothing had been implemented to manage this risk.

People were not protected from risks associated with the environment. We identified several avoidable hazards. For example, some carpets were damaged; there were uneven floor surfaces and sloping floors in corridors. There was no signage warning of these hazards. The safety mechanism on a sash window in one person's bedroom was broken and their window was propped open with a cushion. There was a risk that the window may close suddenly and the person may be injured. Our observations posed a significant risk of harm particularly to people who were frail, lacked spatial awareness or has difficulty mobilising.

Utility safety checks were regularly carried out and fire alarm and firefighting equipment was checked once a week. However, legionella checks were unavailable from 2016 onwards. The provider had no way of knowing if the water was safe.

Medicines were not managed safely. Staff had access to policies and procedures on the safe management of medicines. However, we found that staff did not always follow the correct procedure when receiving medicines into the service and recording and administering medicines. The dispensing pharmacy had recently introduced a new method of administering medicines. Each individual medicine was dispensed in a pod with the name and dose of the medicine, the person's name, date of birth and photograph on it. One person's medicine had not been dispensed by the pharmacy and the person went without their medicine for five days before an agency registered nurse identified the omissions. The registered nurses involved had not followed the correct procedure and had not carried out the necessary safety checks. They had administered the medicines from the individual pods and had not looked at the person's medicine administration record (MAR) beforehand. Furthermore, proper safety checks had not been carried out when medicines were received into the service.

We asked people if they took medicines and if they knew what they were for. A person told us, "I take some tablets, I do take a bone tablet, but I don't know what the others are for. One is pink and one is yellow."

The provider did not comply with safe infection control practices. For example, one person was not offered to wash their hands after using the commode. We observed a member of care staff carry a commode basin with urine and without a lid from the person's bedroom to bathroom further down the corridor. They emptied the contents into the toilet rather than use the designated sluice. Furthermore, the staff member did not wear protective gloves when emptying the commode basin. Their actions put staff and people who lived in the service at risk of cross contamination from splashes.

Care staff were unable to use the sluice as the housekeeper's cleaning trolley and mop buckets were inappropriately stored in the sluice room blocking access to the sluice machine and sink.

There was no dirty – clean flow of laundry in the laundry room. There were bags of soiled laundry stored on the floor. We noted that the wall behind the washing machine was damaged and there was rubble on the floor. There was no handwashing sink in the laundry. All of this posed an infection control risk, which in turn was a risk to people using the service.

There was an unpleasant odour in most areas of the service, including corridors and people's own bedrooms. The registered manager told us that several male residents urinated in inappropriate places and the carpets now needed to be replaced. A member of staff said, "The home is clean except for the carpets. Residents urinate on them and we can never fully get the stains out. The smell has improved recently."

Kitchen hygiene and safety checks had not been carried out since December 2017. On our visit on 06 April 2018 we looked at the standard of cleanliness and hygiene in the kitchen. We identified numerous areas of concerns including dirty and damaged fridges, uncovered food stored in a fridge, a faulty dishwasher, a mop soaking in dirty water from the previous day, food kept warm long after lunchtime service and the kitchen used as a thoroughfare by staff accessing the outside smoking area. Following our inspection we notified the local environmental health officer who under took an inspection. The provider's rating changed to the maximum score of five stars to one star. When we returned in June we noted that the provider continued to display their five star rating.

We found that lessons had not been learnt from previous incidents. Two people had absconded from the service unsupervised in May 2018. One person left the premises via a fire door and was found in the home's garden. They had been assessed at medium risk of exiting the building
unsupervised, but there was not an action plan in place to address how they would be prevented from exiting the premises and kept safe. Another had left the service unsupervised on 23 May 2018, by climbing out an unlocked window in the bottom lounge. The person accessed the local community and was reported by a local resident that they were knocking on doors. Their risk of exiting the building unsupervised was not assessed and there was not a care plan in place to prevent a reoccurrence and keep them safe from harm. On 25 May 2018 the person left the building again by the same window. This incident had not been recorded in their care file. This demonstrated that although the provider was aware of the risks the unlocked window posed to people, they did not take steps to manage the risk. On 7 June 2018, it was identified that the same risk was in place as the windows had not been restricted in any way, still placing people at risk.
There was a higher than expected number of accidents and incidents recorded and there was a recurrent theme. For example in March 2018 eleven recorded incidents had predominately involved confrontation between people with cognitive difficulties and staff. There had been 13 accidents, mainly due to recurrent falls. In four of these accidents people sustained bruising and one person was taken to hospital. When we looked at the incident book for May 2018 we found that there continued to be a high incidence of falls and

noted that one person had three falls on the same day. There was no evidence that lessons were learnt from these accidents and incidents and people continued to be at risk of harm.

Failure to suitably assess risks to the health and safety of people who received care and treatment and to do all that was reasonably practical to reduce such risks was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who lived in the service and their relatives told us that there was not always enough staff on duty to meet their needs. One person told us, "Some morning there are only two staff on." They went on to tell us about their experience of agency staff and said, "Lots of agency workers here. They can't get to know you." Relatives also felt that staffing levels were poor, especially at night and weekends. One relative said, "There are two on at night. I don't know how it's supposed to work. If they are putting someone to bed the others are left alone. There is too many agency staff. They don't know them [people who live in the service] and know their different ways." Another relative said, "It's usually by Saturday and Sunday that it's been bad."

They provider had not ensured that there were always sufficient staff on duty to care for peoples' needs and keep them safe from the risk of harm. On 06 April 2018 the registered manager told us that ensuring safe staffing levels was challenging. We learnt that when staff left their post the registered manager was unable to recruit to vacant posts or cover the gaps in the duty roster with agency staff. The previous weekend the registered manager had worked a night duty as a care worker as the staffing agency had let them down at the last minute. When we returned on 06 June we found that the staffing situation had deteriorated significantly. The provider had not paid their agency staffing bill the previous week and was unable to request staff to cover vacant shifts from the agency.

The provider did not use a nursing or care dependency tool to calculate the number and skill mix of staff needed to meet the individual needs of people in their care. The registered manager said, "We didn't have a dependency tool. The staffing levels depend on the number of staff available." Therefore, there were no reliable indicators to inform safe staffing levels and ensure that people had their care needs met safely.

We spoke with a recently appointed cook, who had no previous experience of cooking in a health and social care environment." The head cook was absent from work and the cook was left to work on their own initiative without support. They were responsible for breakfast, lunch and preparing sandwiches and cakes for teatime before they went off duty at 2.30pm. Furthermore, there was not a kitchen assistant employed at the service, and the cook was also responsible for dishwashing and cleaning the kitchen before they went off duty.

Failure to employ sufficient numbers of suitably qualified, competent , skilled and experiences staff was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Recruitment procedures were not operated effectively or safely. For example, a registered nurse was appointed to post as an independent agency nurse on the strength of their recruitment documents from their previous employer. The provider had not obtained the required criminal safety checks and references.

Failure to establish and operate effective recruitment procedures is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Requires Improvement

Is the service effective?

Our findings

The registered manager told us that newly appointed care staff undertook the Care Certificate; a 12 week national programme that covered all aspects of health and social care. We spoke with a member of care staff who had been in post for 6 weeks. They told us that they had covered food hygiene and fire safety on their induction, but had not yet started the care certificate.
Non nursing staff were given the opportunity to develop their knowledge and skills and some had completed or were working towards a national qualification in health and social care at level 2 or 3. However, they were not enabled to put their knowledge into practice. For example, the registered nurses were responsible for writing, reviewing and evaluating all the care plans and administering medicine to both the nursing and residential residents.

During our inspection we asked for a copy of the staff training records for the previous 12 months, however, this was not made available to us. This meant we were unable to make a judgement about whether staff had up to date training.

A relative told us that not all staff had the knowledge and skills to look after their loved one, but it was getting better and said, "I've seen improvements since November."

Care staff told us that the registered manager was a registered nurse and was very knowledgeable. A staff member care staff, "She helped me understand [name of person] condition. Another care worker said, "The manager's nursing skills are excellent."

We looked at the personal files for four members of staff and found that their annual appraisals were overdue. In addition we found that staff had not received supervision in the last 12 months. There was a risk that opportunities to monitor the performance and development of staff may have been missed.

The activity coordinator completed an individual record about the each person called "my life". The purpose of this record was to provide staff with insight into the person's past, their likes and dislikes, significant events and family members. However, we saw that some booklets were left blank, or the information was incomplete and staff would be unable to use it as a resource to get to know the person.

People were not always supported to eat a nutritious and balanced diet. The head cook had recently introduced a three week menu plan. However, a newly appointed cook told us that they were unable to follow the menu plan as there was not always enough food stock to cook the planned meals.
During our inspection on 07 June 2018 the provider had brought in an independent hygiene consultant to assist staff to deep clean the kitchen. No provision had been made to cook a meal for people during the kitchen upheaval. Therefore, people were provided with takeaway fish and chips and did not receive a freshly prepared home cooked meal conducive to their individual dietary requirements.

There were no systems in place to monitor a person's food and fluid intake. The lack of record keeping could lead to staff not recognising if a person was at risk of malnutrition and dehydration. People were therefore at

risk of not being referred for appropriate healthcare specialist support.

We asked people and their relatives if the food was of good quality and to their liking. A person told us that they were not satisfied with the meals provided and said, "The food is not brilliant. It's all mixed up. I like plain food. The teatime sandwiches are a bit dry." Another person told us that they did not always have a choice at mealtimes and said, "Its hit and miss. Sometimes they are well organised and ask what would you like."

When a person was first admitted to the service their food likes and dislikes were recorded and a copy was kept in the kitchen. However, we saw that people were not always given a choice and their preferences were not always respected. A relative who was a daily visitor to the service told us that people were offered the same meal at teatime, sandwiches and mousse and said, "They never have fresh fruit." The relative told us that stew cooked by an inexperienced cook was tough and people were unable to eat it. They brought this to the provider's attention and their loved one was provided with an alternative meal. However, other people in the service were not offered an alternative to the tough stew. There was no provision of an alternative menu for people who had difficulty chewing or swallowing their food who were also given stew for lunch.

Staff referred people when they required support or advice from other health and social care agencies. A registered nurse told us that they had contacted the community tissue viability specialist nurse when a person had acquired tissue damage.

People were supported to access their GP, dentist and optician. One person said, "I've had some new teeth and I also get my glasses. I'm due a new pair anytime now." Another person told us if they needed to see their doctor that a member of staff would take them to the surgery.

However, people were not provided with information and support to assist them to live a healthy lifestyle. We found little evidence that they had access to exercise and only people who could mobilise independently were enabled to walk in the garden. One person told us, "I keep myself fit. I exercise my legs if I'm sat in the right place." Another person said, "I go round the garden." The weather was warm when we visited in June and we found that there was no available advice on how to keep cool in hot weather or avoid becoming dehydrated.

The design and decoration showed a lack of consideration for the individual needs of people. We noted that signage throughout the service was inconsistent and confusing. Some bedroom doors were numbered, others had a photograph of the person with or without their name and others were given names of flowers and trees with a photograph attached. People had not been involved in how they identified with the signage for their bedroom. This imposed a risk that people may not identify with their bedroom door and enter other people's bedrooms without their permission.

There were several notice boards in the main hallway. The majority of notice boards were set about eye level, and would be difficult to read for people of small stature or who are dependent on a wheelchair to mobilise. In addition, most of the information was in small print and there was no alternative easy read format available. People with visual or cognitive problems would have difficulty reading and understanding this information.

Opposite the entrance to the dining room there was a wall mounted wipe clean board with the daily breakfast, lunch and teatime menu written on it. The board was not well written and was difficult to read. There were photographs of various foods on the board, but most of these did not relate to the menu choice

available and people with cognitive impairment may find this confusing.

When fixtures and fittings were broken or damaged they were not repaired. When we visited in June we found that one en-suite toilet had been out of order for over two weeks. The passenger lift has been out of order for several weeks and people were unable to summon it from the ground floor or access it independently. There was no notice on display to alert people that it was not working.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Where a person was unable to make a decision for themselves, we saw that in some instances their Lasting Power of Attorney had been involved to speak on their behalf.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Prior to our inspection we requested and received information from the local authority mental capacity team about the number of current DoLS authorisations granted to people living in the service. On day one of our inspection there were 18 people living in the service who were lawfully deprived of their liberty.

Requires Improvement

Is the service caring?

Our findings

We observed interactions between care staff and people who lived at the service were pleasant and staff spoke kindly to people. However, we noted that staff were busy and did not always give a person time to answer when they asked them a question. Furthermore, staff did not use alternative forms of communication such as picture cards with people with cognitive problems to help them understand.

We found that due to the high staff turnover people often did not know who was looking after them. One person commented on this and said, "They [the staff] keep changing, that's the trouble here, the staff." We were told by the registered manager that the majority of people living in the service had some form of dementia. Their relatives shared with us how important it was that the person knew the staff that were caring for them. A relative told us that their loved one got on well with staff and said, "The majority of staff has a good relationship with [name of person]. There's occasionally one from the agency." Another relative said, "It all comes down to the staff, they [name of person] are better if they know the staff who are caring for them. It's better if they are not strangers."

People and their relatives had not been asked for their feedback on the service. They told us that they had not been invited to complete satisfaction surveys or give their verbal feedback on the service. A relative said, "I'm not really asked for my feedback. If there was something I wanted to say, I would say it to them. I believe in saying what's wrong and what's right and they will listen."

People and their relatives were uncertain about the future of the service and told us that they expected to be invited to a meeting with the provider as they had heard that the service was up for sale. One person said, "I've got used to it [the service] now, but they're going to sell it." One relative said, "There is going to be a meeting. The owner said that he might have to sell the home." We asked to see a record and minutes of all meetings with people and their relatives since our last inspection in January 2017, but these were not made available to us.

Information on independent advocacy services was on display at the main entrance. An independent advocate acts on behalf a person who is unable to make decisions for themselves. For example, when they move from their own home into a care home. No one living in the service had an advocate appointed to them.

Care staff told us that people were treated with dignity and respect. A member of staff said, "I treat them as my own family. I give them good care, clean clothes and make sure their teeth are clean and they have their makeup and deodorant. It makes a difference if you chat during care and listen." People were supported to personalise their bedrooms and make them homely. We saw that some people had photographs of their family and ornaments from home on display. People and their relatives told us that if they wanted to meet in private that they went to their bedroom or weather permitting sat in the garden. We noted that there was no spare seating in the lounge areas for visitors or additional seating in individual bedrooms.

Inadequate

Is the service responsive?

Our findings

People had individual care plans for different aspects of their care. However, we found that their care plans did not always accurately reflect the care that people received. For example, one person was sat in an armchair facing their bedroom window, with their feet on a full size topper mattress. We were told conflicting reasons for this. A member of care staff said it was to stop them from standing up from their chair. A registered nurse told us that it was at the request of their relative. We looked at their care file and there were no risk assessments, capacity assessments or best interest decision to use the mattress as a form of restraint or a record of the daughter's request recorded. This was a form of restraint and placed the person at unnecessary risk. A topper mattress is a specially designed foam mattress placed on top of a normal mattress to relieve pressure on a person's skin.

Another person had injured their legs when they became trapped between their bed rails and mattress. They had not been risk assessed for the safe use of bed rails before or after their injury and there was no guidance for care staff in their tissue viability care plan.

People did not always receive care that was individual to their needs. We found that care was task orientated rather than person-centred and people were viewed as a job to be done. For example, a member of care staff told us that there was a shower record sheet that highlighted the day of the week a person was allocated for their shower. They said, "We're very busy. We have to get everybody up." One person we spoke with told us, "I have a shower, about once a fortnight I think it is. Odd times I have a bath. Someone [staff] helps me."

Mealtimes were task orientated. People who required assistance to eat their meals or had swallowing difficulties were provided with their meal first. However, they were not invited to eat at a dining table with their peers, but remained seated in their armchair in the lounge or in their bedroom. We noted that the dining area could only accommodate ten people.

Staff exchanged information about people and their care through shift handovers and recorded messages to each other in communication book. For example, we saw a reminder that one person's hairdresser was visiting. Registered nurses recorded outpatient appointments and planned visits from health and social care professionals in the office diary. However, the registered nurse told us that it was difficult to handover to agency nurses who did not know the people in their care as there was no handover time. This placed people at risk of receiving inconsistent care.

During our inspection we found little evidence that people were supported to participate in meaningful activities. Most of the care staff on duty did not engage with people who were sat in the lounge areas. One person we spoke with told us, "I go into the garden and sit. I used to go to the post office, but since I broke my hip I have to wait for someone else to go. There are some ladies who never get out of their chairs. They are vegetables." Relatives told us that their loved ones did not have enough activity to occupy them. One relative said, "There is nothing to stimulate them. The activity coordinator doesn't interact with them."

Failure to provide people with person centred care that reflected their needs and preferences was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported to attend an ecumenical service every two weeks. This took place in the service by a local Baptist minister. Staff respected people's individual beliefs. For example one person had an advanced decision to refuse treatment (ADRT). This clearly explained that the person refused to have a blood transfusion or blood products as it was against their religious beliefs. Staff also respected that they did not want to be involved in Christmas or birthday celebrations.

People were provided with information on how to make a complaint about the service. However, the information did not direct people to the Office of the Local Government Ombudsman if they were unhappy about the outcome of their complaint. We saw that a copy of the complaints policy was on display near the main entrance.

The relatives we spoke with both had occasion to make a complaint. One relative said, "They hadn't got him dressed properly. It was agency staff. It was handled appropriately." Another relative said, "I complained to the manager and wrote to the owner. It was about [staff] uniforms." We noted on day one of our inspection that some staff did not wear a uniform through choice. One member of care staff wore soiled trousers and a crushed T-shirt. This would make it difficult for people to identify that this individual was a member of staff.

Staff told us that they knew what to do if a person or their relative raised a concern or complaint. However, one person told us that their bedroom was cold in the winter, but the problem had not resolved and said, "They [staff] can't do nothing about it." Relatives told us that they would not hesitate going to the manager if they wished to raise a concern

We looked at the compliments and complaints file. We saw where a relative had recently made a complaint that it had been fully I investigated, statements taken from staff involved and the complainant had received a letter of apology.

Care staff told us that they supported a person's family when they were at the end of their life. A member of care staff said, "It's important to help the families. I have empathy for bereaved relatives."

Some people were supported to record their final wishes on an advanced care plan, such as if they had a Do Not Attempt Cardio Pulmonary Resuscitation order, where they wanted to die and where they would like their funeral service. We saw where a person was unable to discuss this that staff had involved their closest relatives.

Inadequate

Is the service well-led?

Our findings

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. However, the provider's Statement of Purpose stated that the manager was waiting to be registered with CQC. The manager was registered with CQC since September 2017. Following our inspection in April 2018, the registered manager left their post at Eagle Nursing Home. The area operations manager then took on the role of acting manager.

People and their relatives were provided with a copy of the statement of purpose (SoP). However the SoP was not kept up to date. For example it referred to the national minimum standards (NMS). NMS was replaced by The Health and Social Care Act 2018 regulation in 2010.

Staff did not work together to promote a positive culture within the service. There were two staff teams who worked opposite shifts to each other and they did not get on. Neither team would help the other team out when support was needed. We were told that some staff looked at the duty rota to see who they would be working their next shift with and if they did not like the staff member working they would refuse to work the shift. Relatives told us that they were aware of the tension between members of care staff as staff talked about the service's problems in front of them.

There was a clinical lead in post who was a registered nurse. The registered manager told us that she was unaware of what the clinical lead's role was and they did not have a job description. The registered manager said that they expected the clinical lead to be a visible role model and work with care staff. We observed that when the clinical lead was not administering medicines they were in the registered manager's office doing paperwork.

This was located off the main lounge – dining room. The door to the office was closed most of the time and acted as a barrier to observation and communication. The clinical lead and registered manager had no way of observing people in their care and were not accessible to people, their relatives and members of staff.

Staff had access to policies and procedures. A member of staff said, "I can access and read the policies." However, the policies were stored in an annexe in the grounds and not easily accessible to staff.

The provider was in financial constraints and was unable to pay their bills. This had an impact on the people who lived at the service. For example, on the 06 June 2018 the provider had not paid their weekly continence pad bill and had not made alternative arrangements to ensure on-going supplies of this product. Due to the goodwill of another health and social care provider, supplies were provided at short notice. This placed people at risk of not receiving the support they required.

When we visited in April 2018 the CQC rating from last inspection was not on display. We brought this to the registered manager's attention. When we returned in June we saw that a copy was on display near the front

entrance to the home.

The people who lived in the service and the relatives spoke highly of the registered manager. They told us they knew their name and could approach them unless they were busy. A relative spoke of a recent meeting chaired by the registered manager. The provider was also present. The relative told us, "I think if [name of registered manager] was left to do what needs to be done, and then it would be a well led home. The owner tends to jump in and say other things. At the residents' meeting all he talked about was himself." There were no minutes taken at this meeting. Some staff told us that they could approach the registered manager if they had a problem. Whereas other staff said that they found the registered manager unapproachable and disorganised and did not feel supported by them.

Action had not been taken to address known issues. The annual business plan for 2017 identified areas of the service that required redecoration and improvement. We found that from January to May the provider had recorded if a task had been completed or not. We found that the majority of identified improvements had not been actioned. From June 2017 onwards the plan had not been maintained and there was no record that any improvements had been made in the remaining seven months. The ultimate aim of the development plan was recorded as, "For the Eagle to become a nursing home which is recognised by all for the high quality of care it gives and that the beds are full all the time."

The providers approach to quality assurance and clinical governance processes were inconsistent and ineffective. The inspection team asked the provider several times for documents that would support the good governance of the service. However, we did not receive all of the documents we requested and those we did receive lacked detail. For example, we saw that the score for the internal kitchen audit undertaken on 24 April 2018 was 55.9 percent. On 06 June 2018 we asked to see the action plan and were informed by the provider that it was missing. We noted that the service had scored 99 percent at the previous kitchen audit undertaken in October 2017. The provider was unable to account for this dramatic deterioration in the environmental standards in kitchen. We found no evidence that the standard of cleanliness in the service was regularly reviewed. The last cleanliness spot check was undertaken in November 2017 and we found that areas to action remained outstanding from the previous spot checks. In addition, the night-time cleanliness checks had not been recorded as done since February 2018. People were at risk of harm as the provider had not taken a robust approach to measuring the quality standards of the service.

We found that the provider had a poor relationship with external agencies such as the local safeguarding authority and the local authority contracting team. Before our inspection the local authority provided us with copies of their quality monitoring visits. We found that the provider did not cooperate with their request for improvements to the standard of care people received.

Failure to provide systems and processes that assess, monitor and improve the quality of the service is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014