Thames Williams Care

# Everley Residential Home

## Inspection report

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23 June 2020
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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

| | |
|---|---|
| Is the service safe? | **Inadequate** |
| Is the service well-led? | **Inadequate** |

# Summary of findings

## Overall summary

About the service
Everley Residential Home is a residential care home providing personal care and accommodation to people aged 65 and over who may also be living with dementia or physical disabilities. The care home is registered to provide support to 16 people in one adapted building, at the time of inspection 13 people lived at the home.

People's experience of using this service and what we found
Care and treatment was not provided in a safe way. People were not protected from potential harm and abuse. Abuse or improper treatment was not always reported and investigated. Medicines were not managed safely.

The provider's systems failed to identify that care and treatment was not provided in a safe way. Audits did not identify concerns with risks to people, safeguarding, peoples right to life, medicines, care plans and recruitment.

Staff did not always feel listened to by the management team. Staff concerns were not always acted on. Staff practice was not effectively monitored.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
Rating at last inspection and update
The last rating for this service was requires improvement (20 June 2019). At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
The inspection was prompted in part due to concerns received about safeguarding and governance and in part due to a notification that related to an allegation of abuse. A decision was made for us to inspect and examine those risks. The information CQC received about the incident indicated concerns about the management of risks. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.
We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.
The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.
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 Everley Residential Home on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so. However, the provider had failed to notify CQC of events that occurred in the service in line with legal requirements. This was a breach of regulation and we would usually issue a fixed penalty notice. We did not take this action at this time but will continue to monitor the service.

We have identified breaches in relation to safe care and treatment, infection control and the environment, safeguarding, governance, the registered managers ability to carry out the regulated activity and a failure to notify at this inspection.

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 work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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?

**Inadequate**

The service was not safe.

Details are in our safe findings below.

### Is the service well-led?

**Inadequate**

The service was not well-led.

Details are in our well-led findings below.

# Everley Residential Home

**Detailed findings**

## Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by two inspectors.

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

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave a short notice period of the inspection because of the risks associated with Covid-19. This meant we could discuss how to keep everyone safe during the inspection.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority 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. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with four people who used the service and three relatives about their experience of the care

provided. We spoke with six members of staff, the provider and the registered manager.

We reviewed a range of records. This included three people's care records and medication records. We looked at three staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Inadequate

# Is the service safe?

## Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse;
• Systems and processes were not established and operated effectively to prevent abuse of people living at the home.
• There had been an incident where a person was exposed to risk from another person who lived in the home. The registered manager had failed to implement a robust risk assessment. There had then been two further incidents documented where a second person was exposed to the same risk. A staff member said, "Things don't get dealt with, they [management team] wait for things to happen before anything gets done, you are supposed to see things happen and stop it".
• A behaviour record sheet showed six occasions where one person, who lived in the home, had been verbally aggressive and threatening towards staff and people. There were a further six incidents where the person had made threats to harm the staff. Care plans and risk assessments in place were inadequate and did not support staff to safely manage the person's behaviour. As a result, people and staff were exposed to the risk of immediate and ongoing harm.
• Staff told us they had reported concerns for people's safety to the registered manager and they had not been acted on. The registered manager told us they were not aware of any concerns. However, staff had recorded in people's daily records where they had reported safeguarding incidents to the registered manager. The registered manager had failed to act on these concerns and therefore exposed people and staff to risk of harm. The provider was reviewing incidents to decide if any of them needed to be reported to the local authority safeguarding team or notified to CQC.

This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Using medicines safely
• The registered manager failed to mitigate known risks to people. This meant they failed to ensure care and treatment was being provided in a safe way putting people at risk of poor and unsafe care.
• Staff said they were not able to effectively follow a risk assessment that had been put in place to keep people safe. Staff told us they had raised this with the registered manager and provider. We discussed this with the registered manager and provider, and they told us they were not aware of any staff concerns. However, there were documented incidents in daily records, which evidence the risk assessment was not effective.
• Care plans and risk assessments contained conflicting information about peoples support needs. This meant staff did not always have the most up to date information about how to support people.
• A Covid-19 check list had been put in place to enable staff to work safely in the home. We found this was

not being followed. We discussed this with the registered manager and provider who were not aware staff were not following this. This placed people are risk of harm. Up to the day of inspection, there had been no confirmed cases of Covid-19 in the home.
• One person self-administered their medicines and stored them in their room. A risk assessment was in place and identified the person may not store their medicines safely. We saw the persons medicines were not locked away and their bedroom door was open. This meant the risk had not been mitigated and other people could gain access to the medicines with a risk of consuming them. We discussed this with the provider who gave the person a key to their bedroom door so it could be locked.
• There were two occasions where the medicines did not balance with what should have been left in stock. CQC had been alerted to one of these instances by a whistleblower. We discussed this with the provider who investigated. In both instances, the medicines did not balance with what should have been in stock with no explanation as to why. There was no evidence anyone had been harmed because of this.
• There was no open date on people's prescribed creams so there was no way for staff or people to know if the creams were in date and safe to use. Furthermore, prescribed creams were not stored safely. This means other people could gain access to the medicines with a risk of consuming them. We discussed this with the provider who said they would ensure all prescribed creams were kept securely.
• Where medicines were given to people covertly, appropriate documentation was in place. However, this had not been reviewed to ensure it was still relevant and in the persons best interest. Covert medication is the administration of any medical treatment without the person knowing.
• Where people required medicines on an 'as and when required' (PRN) basis, there were protocols in place for staff to follow to ensure people received these as prescribed. However, there were some PRN medicines that did not have a protocol. Staff were able to tell us how they ensured they gave people their medicines safely.
• Staff told us they received medicines training and competency assessments. Some staff said they did not feel the competency assessment were in depth and they did not receive feedback about their practice. Staff felt the feedback would help encourage their learning and development.

This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
At our last inspection the provider had failed to ensure the premises and equipment was maintained to appropriate standards of hygiene. This placed people at risk of infection and environmental health issues. This was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some improvements had been made in regard to the premises and equipment, however we identified concerns in relation to the environment and infection control practices at the inspection. Therefore, the provider is still in breach of regulation 15.

• Improvements had been made to the premises and action plans were in place. However, there was a large hole in the floor of a cupboard. This had not been identified by the provider as an area that needed addressing until an external professional had visited the home and raised it.
• During the last inspection, the utility room was used for washing and drying clothes but also for cleaning toileting equipment. The staff had told us they could not prevent splashes from the sink coming into contact with clean laundry. During this inspection no changes had been made to the laundry room. The provider had a plan for building a new washing facility, but no changes had been made to prevent cross contamination. Staff told us they were careful to avoid splashes. This meant there was a risk of cross contamination.

• There was a bag of clinical waste in the garden that should have been disposed of in a clinical waste bin. We discussed this with the registered manager who said they would remove it. Clinical waste is the term used to describe waste produced from healthcare and similar activities that may pose a risk of infection.
• Staff were not always wearing personal protective equipment correctly, in line with the government guidance for preventing the spread of Covid-19. We raised this with the provider who said they would initiate more spot checks and ensure staff were aware of the most up to date guidance.

This was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
• During the last inspection we identified concerns with staff recruitment checks. At this inspection we still had concerns about recruitment checks.
• We saw gaps in employment history that did not have an explanation. There was no education record for three staff. A reference for a staff member referred to someone else and the reference for staff member did not state the place of work from which the referrer came from. This meant recruitment processes were not always effective in ensuring staff were suitable for the roles prior to employment. We discussed this with the provider, they took note as part of their overall action planning for the service.
• Staff did not feel there were enough of them on shift to support the people who lived at the home. Staff told us this was because two people in the home were posing risks that were not manageable with the current staffing levels. They told us they needed more staff in order to safely support these people. We discussed this with the provider who agreed, and during the inspection was able to acquire additional funding and increase staffing levels.

Learning lessons when things go wrong
• As mentioned above, incidents and safeguarding concerns had been recorded but there was no clear analysis to identify themes and prevent future occurrences.
• Staff understood their responsibilities to raise concerns. However, some staff said they did not feel able to talk to external agencies about concerns and when they raised things internally they were not listened to. This meant areas of concern could not be addressed and lessons could not be learnt. A staff member said, "I feel we tell management things, but unless they witness it themselves, then it doesn't get listened to."

Inadequate

# Is the service well-led?

## Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

At our last inspection the providers systems and processes were not robust enough to demonstrate the service was operating effectively. This placed people at risk of potential harm.
This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had not been made at this inspection and the provider is still in breach of regulation 17.

• The registered manager had not assessed the risks relating to health, safety and welfare of the people living in the home. People were therefore exposed to risk.
• Serious concerns about people's safety were identified during the inspection and the registered manager said they were not aware of them. This meant the systems and processes to monitor the safety and quality of the service were not effective.
• Systems and processes were not established and operating effectively to investigate abuse or improper treatment. Safeguarding incidents had not always been alerted to the relevant authorities or investigated appropriately. As a result, people were exposed to the risk of immediate and ongoing harm.
• The registered manager and provider failed to recognise people's right to life, in line with Article 3 of the human rights act. Do not resuscitate forms had been implemented for all people living in the home in light of Covid-19. Systems and processes failed to recognise the correct assessment process had not been followed.
• Concerns were identified with records relating to people's care and support needs. Audits had failed to identify this, therefore not ensuring risks were effectively assessed, monitored and mitigated.
• Medicines systems and processes did not operate effectively. Some audits of medicines had taken place but did not identify all of the concerns we found. This meant audits were not effective.
• Audit systems and processes had not identified the errors we found in recruitment processes.
• Systems in place to monitor staff practice did not identify staff were not complying with government guidance in relation to PPE.
• There were ineffective systems in place to ensure staff were able to raise concerns. Staff lacked confidence in the registered manager and providers ability to manage their concerns as there had been a failure to act

appropriately when staff had spoken up. A staff member said, "Nothing changes when we raise things".
• Staff understood whistleblowing and told us they knew who they could report concerns to inside and outside of the organisation. However, staff did not always feel able to approach outside organisations for fear of repercussions. This meant the service did not promote a supportive, fair, transparent and open culture for staff. A staff member said, "A lot of the staff won't tell you [CQC] what they think".

The lack of robust quality assurance meant people were at risk of receiving poor quality care. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager lacked the skills, competence and knowledge to manage the carrying out of the regulated activities. This was a breach of regulation 7 (Requirements relating to registered manages) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The registered manager and provider had not notified CQC of all events which had occurred within the service in line with legal requirements. The provider was in the process of reviewing incidents and notifying CQC in retrospect.

Not notifying The Care Quality Commission of events that have occurred in the service in line with legal requirements, is a breach of Care Quality Commission (Registration) Regulations 2009: Regulation 18.

• Relatives felt they were kept up to date about their loved one's care and support. They told us the communication was open and effective. One relative said, "I've never had any surprises when I visit, and I always know what's happening" and, "They are looking after my [relative] and there couldn't be anything more precious."

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; Continuous learning and improving care
• The provider responded positively to the inspection process and had begun to investigate what had gone wrong in the home. Staff meetings were being arranged to give everyone the opportunity to speak up about their concerns. Incidents were being reviewed so appropriate actions and investigations could take place. This showed they understood their responsibilities in relation to duty of candour.

Working in partnership with others; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• The registered manager and provider had been engaging on a regular basis with the local authority during the Covid-19 pandemic.
• There was involvement with community professionals to make sure people's healthcare needs were met. We observed professionals visiting the home on the day of inspection.

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<br><br>Known risks were not mitigate to people. This meant a failure to ensure care and treatment was being provided in a safe way putting people at risk of poor and unsafe care. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 15 HSCA RA Regulations 2014 Premises and equipment<br><br>The premises and equipment was not maintained to appropriate standards of hygiene. This placed people at risk of infection and environmental health issues. |

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 18 Registration Regulations 2009 Notifications of other incidents<br><br>Notifications of all events which had occurred within the service had not been notified to CQC in line with legal requirements. |

**The enforcement action we took:**

We did not pursue a fixed penalty notice due to the impact of COVID-19.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>People were not always protected from the risk of abuse and avoidable harm. |

**The enforcement action we took:**

We served a notice of decision to impose conditions on the provider's registration.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>There were insufficient governance systems in place to monitor and improve the quality of the service. |

**The enforcement action we took:**

We served a notice of decision to impose conditions on the provider's registration.