Ealing Eventide Homes Limited

Ealing Eventide Homes Limited - Downhurst

Inspection report

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Date of inspection visit:
26 August 2021
27 August 2021
01 September 2021

Date of publication:
18 October 2021

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Inspected but not rated**
Is the service responsive?	**Inspected but not rated**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Ealing Eventide Homes Limited – Downhurst is a care home for up to 26 older people. At the time of our inspection, 21 people were living at the home. Some people were living with the experience of dementia. The service is managed by Ealing Eventide Homes Limited, a charitable organisation. This is their only registered care home.

People's experience of using this service and what we found
People were not cared for safely. The provider had not always assessed, monitored or managed risks to people, staff and others. There were not always investigations or analysis when things went wrong, to find out what happened and to learn from these. A number of recent safeguarding concerns have shown that the provider had sometimes failed to identify and record any lessons learned following an investigation to reduce possible risks.

We found concerns with regard to staffing levels. The management team was very depleted at the time of our inspection. The home was without a manager and deputy manager and two of the four senior support workers posts were vacant. This had impacted negatively on the safe oversight of all aspects of managing the home. In addition, staffing levels at night were not always safe. This was because the provider had not allocated senior support staff for every night in line with the assessed staffing requirements for the service.

The provider did not have a robust oversight of the service, which meant they had not adequately monitored and assessed the quality of the service which has deteriorated through time. The lack of an effective management team had impacted on addressing the concerns found at the last inspection. At the time of the inspection the nominated individual and the acting deputy manager were managing the service and leading the staff team. However, they did not have full access to the management systems supporting the service delivery and did not have the operational knowledge to provide the assurance that the service would be managed safely and in a responsive manner.

Medicines were not managed in a safe manner. This was because people were not always administered their medicines as prescribed.

Whilst the provider had infection prevention and control (IPC) policy and procedures and had provided staff with infection control training, we found some staff and management did not always comply with safe IPC practices, for example they habitually wore their PPE masks in an unsafe manner. In doing so they put people at risk of cross infection.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. This was because mental capacity assessments were not completed appropriately.

The provider had not always ensured people's care plans reflected their current care needs and care plans did not describe people's wishes as to how they wanted their care provided. There was insufficient guidance for staff on how to provide care in a person-centred manner.

People told us staff were "good" and they felt safe at the home. We observed individual care workers providing support in a caring, polite and respectful manner.

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 (published 20 April 2021) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the service had deteriorated to a rating of inadequate and the provider continued to be in breach of multiple regulations.

Why we inspected
The inspection was prompted in part due to concerns received about the lack of a robust management team. We also received concerns from whistle blowers. These concerns included failure to report safeguarding incidents in a timely way, failure to investigate these and about poor care. We also inspected to see if the provider had made improvements in line with their action plan to address the previous breaches of regulations.

This was a focussed inspection. We have found evidence that the provider needs to make further improvements. Please see the safe, effective and well-led sections of this full report. In addition, we also looked at part of the responsive and caring key questions but did not award a rating for these key questions. So, the ratings from the previous inspection were used to give an overall rating for the service.

We looked at infection prevention and control measures under the safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.
The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Ealing Eventide Homes Limited – Downhurst 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.

We have identified breaches of regulations in relation to person-centred care, consent to care and treatment, safe care and treatment, premises and equipment and good governance 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 meet with the provider to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Inspected but not rated

At our last inspection we rated this key question requires improvement. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question, we had specific concerns about.

Is the service responsive?

Inspected but not rated

At our last inspection we rated this key question requires improvement. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question, we had specific concerns about.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Ealing Eventide Homes Limited - Downhurst

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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was conducted by two inspectors, and a medicines specialist advisor. An Expert by Experience supported the inspection by contacting the relatives (and friends) of people who used the service after our visit. 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
Ealing Eventide Homes Limited – Downhurst 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.

Notice of inspection
This inspection was unannounced on the first day of inspection 26 and 27 August 2021 and 1 September 2021.

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 safeguarding adults' team who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us 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 the judgements in this report.

During the inspection
During our inspection we spoke with the nominated individual who is responsible for supervising the management of the service on behalf of the provider, the acting deputy manager who was the previous activities coordinator, two senior support workers, two care workers, laundry and house-keeping staff. We were introduced to and observed a further three care workers and kitchen staff.

We spoke with five people who used the service, 11 relatives and one person's advocate. We observed care workers interaction with people throughout the inspection and we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

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

After the inspection
We reviewed all the information gathered during our site visits and continued to seek clarification from the provider to validate evidence found, where required.

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.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to robustly assess and mitigate risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

• The provider had not ensured risks to people had been assessed, reviewed or managed. At the inspection in March 2021 we identified that the provider had not assessed risks in relation to accessing the various stairwells around the home. An incident had occurred in 2020 where a person had fallen down one flight of stairs, but robust risk management plans for the stairs were still not in place at this inspection.
• Sensors to alert staff of people's movement had been fitted at various points in stairwells around the home but not on each landing so people could access the stairs without triggering the sensor. The stair sensors were only activated at night, but people who had been identified as requiring supervision to use the stairs could access the stairwells around the home during the day without staff being alerted.
• One person's falls risk assessment identified the person was at high risk of falls and was unsafe to manage stairs independently so needed supervision. During the inspection we saw this person repeatedly using the stairs without supervision as their bedroom was located on the first floor and they were independently mobile around the home.
• Risk management plans were not in place for the use of the lifts. There were no restrictions in accessing the lifts. By using the lifts people were able to bypass doors which required a keycode to use and meant they could access stairwells putting them at increased risk of falls.
• The provider had not developed risk assessments and risk management plans where a person had been identified as living with a specific health risk, for example diabetes. For one person who had diabetes, the only guidance in relation to the condition was that the person did not have sugar in drinks and breakfast cereal. There was no reference to sugar in foods other than cereal and no mention of symptoms or signs of hyperglycaemia (high blood sugar levels) or hypoglycaemia (low blood sugar levels) so staff could be aware and monitor for these complications.
• For one person who had been identified by the speech and language team as requiring thickeners to be added to fluid because they were at risk of choking, there was no risk management plan and guidance about this was not detailed enough to mitigate the risk.
• Risk assessments were carried out in relation to whether people could safely use call bells to call for staff

for support, but these did not always include any direction about what actions were required to reduce risks where the calls bells were deemed as not safe for a person to use. The call bell risk assessment for one person indicated they were unable to understand using the call bell and were at high risk but there was no mitigation indicated to show how their safety would be maintained if they could not use the bell to summon help.
• We identified a number of hazardous items and substances which were not stored securely and could be accessed by people around the home. We found items including razors and scissors accessible in bathrooms, nail varnish remover in an unlocked cupboard and bottles of alcohol stored in a fridge and in the sideboard in the dining room. The provider had not identified possible risks with the way these items had been stored.
• The provider had not ensured all possible actions had been taken to reduce the risk of injury caused by people's environment. The building and fire procedures did not always comply with fire regulations. Therefore, they had not ensured people were living in a safe environment.
• The provider had an external contractor carry out an audit of the fire safety procedures and equipment in March 2021. The contractor identified a number of compliance issues in relation to the fire safety procedures. In addition, the London Fire Brigade conducted an inspection and issued an enforcement notice in August 2021 for a number of compliance issues.
• During our inspection we also identified a number of issues in relation to fire safety which could have been resolved. Access to some fire escapes was blocked by equipment and furniture including the access to one fire escape which was through a person's bedroom but as there was furniture and the person's belonging in the room, access was restricted.
• Emergency evacuation equipment was not accessible and was not placed around the home. At the time of the inspection the provider had evacuation equipment stored in a locked office and there was one evacuation chair located on the first floor of the main building with two further evacuation mats delivered during the inspection. The provider could not demonstrate that the staff had been trained in the use of evacuation equipment.
• We noted there was combustible decorating equipment including paint and a tin of stain block as well as dust sheets stored in the lobby next to the front door which was a fire escape route for people in the main building.
• The fire alarm system was not checked regularly to ensure they were working appropriately. During the inspection the fire alarm was triggered, and we observed that the staff congregated in the main reception area and they left the people seated in the lounge without any support. The external door in the dining room which led to the garden had been opened which meant people who were in the lounge could access the garden without support during this time.
• Personal emergency evacuation plans had not always been developed for people living at the home. The care plans for the majority of people we looked at did not include a PEEP and where one had been developed it did not include appropriate information to support how the person during an emergency evacuation.

The provider did not ensure that risks were identified, monitored and mitigated. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● The provider had not always taken the necessary steps to prevent and control infection. Since the start of the COVID-19 pandemic staff in care settings have been required to wear masks to help prevent the virus spreading. Throughout the inspection, we observed some staff including members of the senior staff and management team were not wearing masks in a safe manner, some wore loose fitting masks which slipped below their noses and some wore masks hanging around their ears or below their chins.

●We discussed this with the management team. We were assured the staff had received infection control training and the safe wearing and disposal of PPE training. Staff had been provided with the information needed but there was no oversight to ensure they put into practice what they had learnt. The management team had failed to monitor and enforce safe practice, and this presented a risk of the spread of infection.
• Care workers were not always disposing of clinical waste such as gloves in the appropriate clinical waste bins for example we found used gloves had been placed in a general waste bin in one bathroom.
• Food stored in fridges were not always appropriately labelled with the date food items were opened to ensure they were used within the use by date. As such care workers could not be sure if food was safe for people to eat. Records of temperature monitoring for the fridges in the dining room and small lounge were not always completed to demonstrate the temperature had been checked to ensure it was within the correct range for safe food storage.
• Whilst most of the home was kept to a good standard of maintenance, one chair in the main lounge had heavily stained fabric and frayed material which could not be kept clean to maintain good infection control and limit cross infection.
• The provider did not have robust risk assessments and management plans for people and staff because these had not considered all the risk factors associated with COVID-19 such as ethnicity and age. Therefore, appropriate measures had not been identified to mitigate risks associated with COVIID-19.

The provider did not ensure that infection control processes were always robust. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Although we found the above the main parts of the home were kept clean and was well ventilated and without malodours. Housekeeping and laundry staff took pride in their work and demonstrated they understood the importance of good infection control measures.
● The provider had introduced updated procedures during the pandemic, these included regular testing for people using the service, staff and visitors. They had made arrangements so visitors could safely meet their family members. Relatives comments included, "Going in we give evidence of Lateral flow tests on our phone which they ask to see, it's efficiently done; they go through the correct process", and "It's been good, you make an appointment to go and do a test, it's very efficient. I do a lateral flow test. I am happy with the infection control," and "They have been brilliant at keeping COVID out."

Using medicines safely
At our last inspection the provider had failed to ensure the appropriate management of medicines which put people at risk. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

• The provider did not always ensure people's medicines were administered as prescribed and in a safe and appropriate manner.
• People had been prescribed medicines with directions to be taken before or after food, but these were not always given as directed. We saw the medicines administration record (MAR) for one person indicated they had been prescribed a medicine which should the administered before food and a second medicine which should be given after food. The MAR chart showed these two medicines had been administered at 8.30am and the senior care worker confirmed the medicines were given at the same time. This meant the medicines were not being administered as directed to ensure they work effectively.
• Where medicines were required to be administered at a specific time, we saw this was not happening. The

MAR for one person indicated that a time sensitive medicine should be administered at midnight, but we found that it was regularly administered at 9.30pm. We identified that the dosage of one of the person's medicine had been altered and the senior care worker explained that this was at the request of the person's Power of Attorney. There was no record of this being discussed with the healthcare professional that prescribed the medicine to ensure the dosage was appropriate and safe.
• The MAR for one person included directions to crush their medicines where necessary, but the senior care worker confirmed this was a historic instruction and the medicines were no longer crushed. This meant the guidance provided did not reflect how the person's medicines should be administered.
• The temperature of the medicine's fridge was not recorded constantly to ensure it was at the correct setting for the safe storage of temperature sensitive medicines.
• The provider did not ensure medicines records were always accurate to demonstrate the stock of medicines held by the home. We noted the medicines records indicated a balance of 20 tablets of Lorazepam were in stock but the person these had been prescribed for had left the home. We were informed by the senior care worker the medicines had been transferred with the person, but the records did not reflect this and showed these were still in stock.

We found no evidence that people had been harmed however, the provider did not ensure people's medicines were always administered as prescribed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
• The provider had a processes for recording safeguarding concerns and incidents and accidents, but these were not robust enough as they did not always identify any lessons learnt and what remedial actions were required to prevent reoccurrence.
• Two accident records identified the same person had experienced falls within four weeks. The incident forms included information about the accidents but there were no records of any actions taken to reduce the risk of further falls occurring. The falls risk assessment and their care plan had not been updated to reflect the recent falls and review how care workers could support the person to reduce any risks.
• An incident form for one person indicated they had experienced a skin tear when receiving support. The form included actions about how care should be provided to reduce the risk of reoccurrence, but this information had not been added to the person's care plan to ensure care workers had appropriate guidance. We noted that the lessons learned from safeguarding concerns had not been identified so that actions could be taken to mitigate risk. We raised this with the acting deputy manager who noted that this information had not been recorded.

The provider did not ensure actions to mitigate possible risks were identified with care plans and risk assessments being updated appropriately when things go wrong. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
• The provider did not always ensure appropriate levels of care workers were on duty to provide people with the support they required. We were given the staffing rotas covering the period from 26 July 2021 to 5 September 2021. We reviewed the staffing levels between 26 July 2021 and 1 September 2021 which was the final day of the onsite inspection. We were informed by the nominated individual that there should be a senior care worker, as medicines could only be administered by a trained senior, and two care workers on duty at night. From the rotas we have reviewed we found this was not always the case.
• We found on 15 occasions there was no senior care worker on duty which included two nights with only

one care worker on duty alone, nine shifts where there were only two care workers on duty and five nights when there were only three care workers working. This meant that on 15 occasions where there was no senior care worker allocated on the rota any medicines required to be administered when required for example pain relief could not administered. Only senior care workers had completed training for the administration of medicines. A senior care worker confirmed they usually stayed after the end of their shift at 8pm to administer medicines at 9.30pm which was confirmed by MAR charts. We also identified that on two nights the senior care worker was the only member of staff on duty which meant they were responsible to providing care for all the people living at the home without additional support. This meant that the provider had not always deployed the required level of staff to ensure they could provide appropriate and safe care.
• During our observations we saw staff promptly supported people who required support and answered call bells quickly. However, one person described sometimes other people increasing support needs meant staff had to concentrate on those people if there was a problem. The person told us when we asked if there were enough staff, "No because we are missing some [staff] and we are affected by the increase in dementia patients."

The provider did not ensure there was always sufficient skilled and experienced care workers deployed to meet people's support needs. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• We reviewed the recruitment records for six staff who had been recently employed by the service which included care and support staff. The provider's recruitment procedure had been followed and checks had been carried out which included at least two references and a criminal records check.

Systems and processes to safeguard people from the risk of abuse
At our last inspection the provider had failed to investigate, and report allegations which meant people were at risk of abuse. 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.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 13.

• The provider had reported safeguarding concerns to the local authority. Although there had been a delay in reporting due in part to the disruption to the management team, we saw three safeguarding adult referral forms had been completed with information on the specific concern. An investigation and progress sheet had been completed for one safeguarding referral which identified actions. For example, a care worker informed the manager of a concern relating to a person's skin integrity and identified when a district nurse visited to undertake a pressure ulcer assessment.
• Staff told us how they would recognise abuse, one care worker told us, "If they are not eating or in a corner by themself, or they don't want to change their clothes or a change of behaviour. I would try to talk to them and maybe I would need to speak to a manager. If there was something wrong, I would need to see a manager."
• People told us they felt safe and staff were "Good". One person told us, "Safe yes here… It's been fine here." Relatives comments included, "Yes, [Person] safe. They have a good relationship with the staff, they laugh," and "Person is happy there. It feels like a family there. We wouldn't want that to change."

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience
• The provider could not demonstrate new care workers were provided with an induction when they started work at the care home. Also care workers did not have their competency assessed in relation to moving and handling and medicines administration to enable them to provide safe and appropriate care which met people's support needs.
• We reviewed the recruitment records for five care workers who had been recruited recently. There were no records to indicate they had completed an induction or any shadowing of experienced care workers so they could develop an understanding of the home and the people's support needs. There was no assessment of the new care workers skills and knowledge to ensure they could provide appropriate care and to identify if any additional training was required.
• The provider was unable to demonstrate that care workers had their competency assessed in relation to moving and handling to identify they had the appropriate skills when supporting a person to move safely. Senior care workers were responsible for administering medicines, but the provider could not demonstrate that they had undertaken an assessment of the senior care workers' competency when administering medicines.

The provider was unable to demonstrate that new staff members received regular support within their role. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• We reviewed the training records for all the staff, and they indicated that the majority of staff had completed the training courses identified as necessary for their role by the provider. These training courses included basic life support, health and safety, safeguarding adults and equality and diversity.
• Staff told us, they had received recent training and found it helpful. Their comments included, "A lot of PPE training, online training, moving and handling and health and safety and food hygiene," and "Now is better than before, I'm very happy with the e-learning, very happy."

Adapting service, design, decoration to meet people's needs
• The environment of the home did not always meet people's individual needs and the provider did not ensure the environment was always safe or suitable.
• The Department of Health guidance "Health Building Note 08-02 Dementia Friendly Health and Social Care Environment' identified guidance on signage including the 'Use personal items to identify personal or private space (e.g. on doors to bedrooms).' It also provided guidance on safe environments which stated

there should be 'slip-resistant, matt finished flooring with no patterns and shadows, contrasting texture and/or colours at the beginning and ends of stairs, contrasting leading edges on stairs, and appropriate technology and sensors) to reduce the risk of slips, trips, and falls'
• The bedroom doors in the home had either a small picture of the person or just a room number with all the doors having a small metal name plate with the person's name. Bedroom doors along the same corridor were all the same colour which meant they were not distinctive enough to support a person with dementia to identify where they were in the corridor and locate their room. Signage around the home was not always clear and corridors were painted in a pale colour which made them appear longer and did not include reference points so people could identify where they were in the home and support them to get to where they want to be. There was tiled flooring in the corridors of a pale colour which were highly reflective and were not made from a non- slip material. The stairs in the main hallway did not clearly differentiate where the floor of the landing areas ended, and the steps began which meant a person living with a spatial awareness issue or visual impairment was at increased risk of falls.
• People could access the garden, but we noted that the path and grass areas were uneven and there was a number of trip hazards, which meant people were at risk of falls
• The home had installed a CCTV system in the communal and office areas. The provider's policy on the use of CCTV stated that 'If any equipment is installed in any part of the premises there will be clear signs to indicate that it is there and could be recording people who are in that location.' During the inspection we noted that there was no signage in the communal areas of the home to indicate that CCTV for both visual pictures and sound was in use.

The provider did not ensure the environment of the home was always appropriate and safe to meet people's care and support needs. This was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The 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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

• The provider did not ensure people's care was provided in the least restrictive manner and according to the MCA principles.
• When a mental capacity assessment had been carried out it was not in relation to a specific aspect of the care being provided for example the administration of medicines or personal care. Where a person was identified as lacking capacity to make a decision on that specific aspect of their care best interest decisions were not in place to confirm what action the provider had taken to meet that care need.
• The provider had introduced the use of door sensors which were placed on people's bedrooms doors to alert care workers at night when the bedroom door was opened. Sensors were also installed on stairwells to alert care workers if people attempted to use the stairs without support during the night. As the door sensors

could be seen as limiting an individual's free movement, the provider could not demonstrate that they had sought consent from people to use these door sensors and where people could not consent that they had carried out best interests decisions.

The provider did not always ensure people were supported to make decisions about their care in line with the principles of the MCA. This was a breach of regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's care and support needs had been assessed before they moved into the home to ensure their identified needs could be met. We saw there was an initial needs assessment had been completed on the electronic care plan system for some of the people whose records we reviewed.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
• People were supported to access healthcare services and support from other agencies when required.
• People's care plan folder included copies of letters from a range of healthcare professionals and confirmed they were appropriately referred and supported by the provider with their healthcare needs. We saw there were copies of discharge summaries from the NHS with records of optician and dentist visits.
• Two relatives told us their family member's health had improved since living at the home. One of them said, "Definitely, their needs are met, [Person] looks healthier than they've done in years."

Supporting people to eat and drink enough to maintain a balanced diet
• People were supported to have a healthy diet which included food and drinks they enjoyed. People spoke positively about the meals they received. They told us they had received their choice of meal and felt the food was "good."
• Relatives we spoke with gave positive feedback on the meals and drinks provided for their family member. One relative commented "They are flexible about [family member] choosing breakfast in their room at 9.30am although lunch at 12pm seems a bit early. [My family member] says the food is good," another relative told us, "The cooking is good."
• The record of the care provided each day which were completed by the care worker included when the person ate a meal or was offered a drink.

Inspected but not rated

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as requires improvement. We have not changed the rating of this key question, as we have only looked at the part of the key question, we have specific concerns about.

The purpose of this inspection was to check if the provider had met the requirements of the breach of regulation following the inspection in March 2021. We will assess all of the key question at the next comprehensive inspection of the service.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

At our last inspection the provider had failed to ensure people were treated with respect and dignity and had failed to respond in a caring manner when people had become distressed which put people at risk. This was a breach of regulation 10 (dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found this breach had been addressed and the provider is no longer in breach of this regulation.

●Care was being provided in a caring, polite and respectful manner. Care workers promoted people's dignity and responded when people required assistance in a timely and unrushed way.
●During our last inspection care workers inappropriately supported people who required help to eat their meal. During this inspection we observed staff were working appropriately. One care worker supported each person throughout their meal. Support was provided in a sensitive manner. The care workers sat beside the person, told them about the meal, spoke gently and made the mealtime experience a pleasurable event.
●We observed when one person became agitated the care worker was able to interact well with them. They gave the person a little time and physical space and then returned to calmly provide the person with reassurances and supported them to sit at the dining table for their meal.
●People told us they liked the care workers. One person told us they attended religious services and showed us the programme for visiting clergy and their faith representatives which was displayed on the notice board. Another person told us, "The [care workers] manage [people] well, both [friend who also lived at the home] and I feel they are good… I wouldn't hear a word against the staff…they are very good"
● Care workers we spoke with felt they were working with people in a caring manner. One care worker told us, "I show respect, respect is important to me. I support them to be clean, I try and give them food they like, plenty of fluids, this is important for them. I talk to them and I can see from their expression and body language what they like. It is important because I can see they can refuse, so I will try and explain again."
• Notwithstanding these improvements, we have identified the service was still not always caring as we had

noted a number of issues during the March 2021 inspection and we found these had not been addressed by the provider at this inspection to ensure people always receive safe care. For example, people were not always well treated and respected, in that the provider had not ensured people received their medicines safely and as prescribed; risks they faced while using the service and those associated with the premises were identified and appropriately managed; their rights to make decisions were always upheld or their care provided in the least restrictive way, were upheld; and their care plans always addressed their needs in a person centred way.

Inspected but not rated

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as requires improvement. We have not changed the rating of this key question, as we have only looked at the part of the key question, we have specific concerns about.

The purpose of this inspection was to check if the provider had met the requirements of the breach of regulations following the inspection in March 2021. We will assess all of the key question at the next comprehensive inspection of the service.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support

At our last inspection the provider had failed to provide personalised care. This was a breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 9.

• The provider did not always ensure that people's care plans reflected their current care needs and care plans did not describe people's wishes as to how they wanted their care provided. The provider had recently introduced an electronic care planning system, replacing paper care plans, which enabled care workers to access care plans and record the support they have provided using handheld devices. We reviewed the electronic care plans for people living at the home and found the information on the system did not always describe people's care in a person-centred manner.
• The paper versions of the care plans were stored in an office, but the acting deputy manager explained these were no longer accessed or updated by care workers. The information from these documents had not been transferred to the new electronic system. This meant that care workers were unable to access detailed information on people's choices and preferences for their care. We noted that the paper care plans, and risk assessments had not been updated since April 2021.
• For example, the personal care section of the electronic care plan for one person stated 'I need support when having a wash or shower' with the action the care workers should take being 'Carer to assist with personal care. Carer to guide me throughout with a step by step guidance.' There was no information in the electronic care plan describing how the support should be provided and if the person had any preferences for their care.
• People's wishes in relation to how they wanted their care provided when receiving support at the end of their life were not always recorded as part of their care plan. In the death and dying section of the electronic care plan for a number of people we saw the only information related to if they had a, 'Do not attempt cardiopulmonary resuscitation' (DNACPR) in place. There was no information in relation to their wishes and any support needs relating to their cultural and religious preferences.

• The electronic care plan for one person did not reflect guidance from the dietitian in relation to their nutritional requirements. The care plan folder for this person included a letter from a dietitian indicating the person should be on a fortified, high protein diet with good fluid intake including nourishing drinks, such as milkshakes and juice, throughout the day. The electronic care plan, used by care workers, did not include any guidance on the use of fortified meals and supporting good levels of fluid intake. We noted that the care plan stated care worker should encourage the person to eat and drink as well as ensuring all food and fluid charts were completed.
• The electronic care plan sections for this person relating to maintaining a safe environment and skin integrity indicated the person was at risk of developing a pressure ulcer. While a care plan was in place, this did not address the care the individual needed to help prevent a pressure ulcer from developing. For example, the care plan did not state the person should be repositioned and how often this should be done. Therefore, the care plan did not provide appropriate guidance on the action care workers should take to meet the person's support needs.
• The care plan for another person indicated they were prone to urinary tract infections and their care plan stated that care workers should encourage the intake of fluid and record it on the fluid chart. We noted that the fluid intake records for the three days before the inspection indicated the person had been offered less that 500ml per day and the records showed their intake was around 200ml on two days and showed no fluid intake on the third day. We asked a senior care worker about the person's fluid intake and they explained the person's fluid intake was not always recorded. This meant that care workers did not always monitor the person's fluid intake as directed in their care plan to ensure they received appropriate support to prevent possible infections.
• Care plans did not demonstrate that people were always involved in the development of their care plan and had agreed to the care plan. There was no record of the person or their representative being involved in the discussions about their care needs and when the review was carried out the person's involvement was not recorded. This meant the provider could not always ensure the care plans were based upon people's wishes and preferences.

The provider had not always ensured the care being provided was person-centred. This was a continued breach of regulation 9 (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

At our last inspection the provider had failed to have robust processes and systems to monitor, assess and improve the quality 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 at this inspection the breach continued not to be met.

• At this inspection we found that the provider still did not have a robust quality assurance process in place which would enable them to assess, monitor and improve the quality and safety of the service. They had not made the necessary changes to their service to enable them to identify shortfalls and make improvements. We found repeated and additional breaches of the regulations. .
• The provider is charitable organisation managed by a board of trustees. At the time of the inspection the provider was not operating the service safely and did not have an effective management team and robust oversight of the quality of the service provided to ensure people received safe care and were protected from the risk of avoidable harm. For example, the provider had not always ensured the number of staff on duty always met the minimum staffing levels which were identified by the provider. This meant that people may not have received the level of care and support they needed in a safe and appropriate manner.
• Issues had been identified in relation to the home's environment which was not always suitable or safe to meet people's needs. There were associated risks and health and safety failings which had not been identified and addressed. For example, a number of failings relating to fire safety had been identified by a consultant and the London Fire Brigade during 2021. While the provider had sought the services of a consultant to implement the different actions required, they had failed to make simple remedial improvements to make the environment safer for people living at the home. For instance, they had not removed items impeding fire exits, which could have easily been done. Therefore, the provider had not taken immediate action to ensure people were living in a safe environment.
• The provider did not have robust risk management processes and systems. They did not always ensure they carried out effective risk assessments to identify risks in relation to people's health and wellbeing and where risks were identified they had not ensured risk management plans were in place and implemented to mitigate risks. We identified a range of concerns in relation to the management of risks which put people using the service at risk of unsafe care.

• The provider did not reflect on or analyse investigation findings following incidents, accidents or safeguarding concerns. Therefore, they did not learn from what had taken place and share the lessons learned with the staff team. They had not reviewed and changed people's care plans and risk assessments to reflect those lessons learnt and implemented them to prevent a reoccurrence.
• The provider was carrying out audits of medicines management however these did not identify all the issues identified during the inspection. We found medicines management within the home was not underpinned by effective staff training and competency assessments or a robust governance framework.
• Lack of oversight was also evident when during the inspection a repair to the office door was not risk assessed or appropriately overseen by management. The drilling caused a very high volume of dust which triggered the fire alarms. The area was not cordoned off for the safety of people and the dust settling on the floor made the tiled surface slippery as no dust sheets had been laid down. The person doing the repair was instructed to wear a respirator mask after the alarms had gone off and the air was filled with dust. There was no oversight or co-ordination of what was taking place.
• The provider did not have appropriate oversight of their information systems. The provider was unable to access to the main office computer which meant the management team were unable to access, check and update relevant documents. The provider had completed a COVID-19 risk assessment for the home which considered possible risks across the service, who was at risk and further actions. The audit was not dated, and the date of the next review was not recorded. The risk assessment did not indicate if any of the actions had been monitored and had been completed. Also, the assessment did not indicate if these actions were successful in mitigating the risk or if other action needed to be considered.
• Relatives we spoke with provided a wide range of feedback both with positive feedback and four relatives expressed concerns regarding the current management of service. Four relatives told us they were concerned a number of familiar staff had left and there had been recent changes of staff in the service and the possible impact on the way care was provided.
● The provider used a CCTV system in the communal areas of the home but they could not demonstrate its use met national guidance and that they had appropriate oversight in relation to the use of the CCTV system, to ensure the privacy of people, visitors, staff and others. The provider's policy in relation to 'Computers, Internet CCTV and Social Networking' did not clearly identity how the footage including sound would be stored to ensure it was kept securely, who would have access to it and how long it would be retained for.
• Following our inspection visit and calls to relatives we received concerns from relatives, one of which was about communication and how the provider engaged and involved them in the provision of the service and in caring for their family members. In particular they felt there was a lack of support to speak with staff and family members at the weekend and in the late afternoon and evenings. One relative said, "Appreciating that there have been several changes of staff, but it continues to be hard to get responses to emails or to know who to contact or get a response from about relative's care."
● There had been a recent meeting to give people and their relatives an opportunity to meet and to ask questions about the service. Two relatives told us they were unhappy at the way the meeting had been conducted, because they said it was arranged to speak out about the previous management team rather than to have a constructive meeting about the future and development of the service. Two relatives commented about staff turnover whilst feeling happy with the service provided.

Due to the extensive number of both repeated and new shortfalls that have been identified at this inspection we found there was no assurance that people would receive high quality, safe and appropriate care. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Relatives however, in general were happy with the care their family member received and felt they were well looked after. Some relative did say that they had little or no recent experience of visiting the home due

to the pandemic restrictions.
● Some staff told us they felt the team was not, "stable" at the moment. One staff member said "[Nominated individual] is here every day to make sure it is ok…[Acting deputy] is helping also until we get a manager, we are doing our best. A lot of improvements, we are working on it."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● People we spoke with were happy with the care they received. There had been 'Residents' meetings where concerns were raised, and they felt the management had responded. A person we spoke with confirmed they could and had raised concerns, they felt the nominated individual would listen and act on their wishes. They described how the [previous] registered manager had acted and resolved a concern in a way they felt was reassuring and facilitated a way forward. Their comments included, "[Previous deputy] was very nice, [Previous registered manager] led the way, a good meeting it cleared the air. They are very good here"
● People were observed to be well looked after by staff, they were smartly dressed and well kept. They understood the service was their home and walked about freely. However, the processes to keep people safe from harm as described throughout this report were not robustly in place to keep people safe.

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 nominated individual described they were open and transparent in their dealings with people. They gave examples of the recent relatives meeting, "Many relatives were there." They said they were honest about the home and the previous CQC report and was always prepared to discuss with relatives and people what was happening in the home. They described they were recruiting a manager and would expect a manager to be open and transparent in their dealings with all parties.

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 11 HSCA RA Regulations 2014 Need for consent The provider did not act in accordance with the Mental Capacity Act 2005 as they did not ensure service users' mental capacity was assessed and recorded where they were unable to give consent. Regulation 11 (3)