Ealing Eventide Homes Limited

Ealing Eventide Homes Limited - Downhurst

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Ealing Eventide Homes Limited – Downhurst is a care home for up to 26 older people. At the time of our inspection, 23 people were living at the service. 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 always safe because the provider had not fully assessed, monitored or mitigated the risks within the environment and for the individual activities people undertook. We were so concerned about this that we wrote to the provider asking them to take immediate action to address these concerns. They provided us with assurances that they were addressing the most pressing safety risks.

People were not always treated with respect. Staff custom and practice did not always take account of people's individual needs or how they experienced interactions, and as a result they sometimes provided care which was inappropriate and disrespectful.

The staff had not always proactively planned to meet people's needs. This meant people did not always receive personalised support.

The provider had not always ensured allegations of abuse were properly reported and investigated.

The provider's systems for monitoring the quality of the service and assessing risk were not always operated effectively.

Most people using the service and their relatives who spoke with us felt they received a good service and named specific members of staff who they felt provided good care and support.

The provider had effective systems for preventing and controlling the spread of infection. They had updated these since the start of the COVID-19 pandemic.

The provider responded promptly to concerns we raised.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (Published 5 October 2017).

Why we inspected
The inspection was prompted in part due to concerns about safety, following a serious fall which resulted in

a person being admitted to hospital. This was investigated under the local authority safeguarding procedures and the provider was found to have neglected the safety of this person. A decision was made for us to inspect and make sure the provider had implemented the recommended actions to improve safety at the service.

As a result, we undertook a focused inspection to review the key questions of safe, responsive and well-led. During our inspection, we found there were also concerns with the way people were being treated so we widened the scope of the inspection to include the key question of caring as well.

We reviewed the information we held about the service. No areas of concern were identified in relation to the key question of effective. We therefore did not inspect this. Ratings from previous comprehensive inspections for this key question was used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

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

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

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 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 have identified breaches in relation to person-centred care, dignity and respect, safe care and treatment, safeguarding people from abuse and good governance at this inspection.

We wrote to the provider telling them we were considering urgent enforcement action in relation to our concerns about safety at the service. The provider responded with an action plan which gave us assurances they were addressing these concerns and minimising the risks to people's safety.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

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.

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.

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
This inspection was unannounced.

What we did before the inspection
We looked at all the information we held about the service, including notifications of significant events. We

also contacted the local authority for their feedback about the service.

During the inspection
We spoke with five people who used the service and a visiting friend of one person. We also observed how people were being cared for and supported. We spoke with the registered manager, deputy manager, care workers and senior care workers. We looked at the care records for four people, staff recruitment records for four members of staff, medicines management and other records used by the provider, such as records of accidents and incidents, meeting minutes and complaints. We conducted a partial tour of the environment and looked at risk assessments for the environment.

At the end of our site visit we gave feedback about our findings to the registered manager, deputy manager and nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

After the inspection
We wrote to the provider asking them to take urgent action to address health and safety concerns and we reviewed the information they sent us telling us what they had done.

We also spoke with the relatives of six people who used the service by telephone to ask for feedback about their experiences.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

● Risks to people's safety and well-being had not always been assessed, monitored, or managed. There were exposed hot water pipes in different parts of the building and an exposed radiator. These were extremely hot to touch and accessible to people using the service. They presented a risk of people sustaining a burn.

● There were different staircases throughout the service. Access to these was not restricted and the risks of people using these had not been assessed. There was an incident in 2020, when a person fell down one flight of stairs. The provider had not taken enough action to mitigate the risk of someone else falling.

● We told the provider they needed to take urgent action to address the risks associated with hot water pipes and stairs. They sent us an action plan telling us what they would do, and when they would do this, to make the required improvements. In the meantime, they told us they had increased staffing levels in order to monitor people who were independently mobile when they were near these risky areas within the home.

● The risk assessments staff had completed for people were not detailed enough. The staff used a scoring system to identify the level of risk for a person undertaking specific activities. However, they did not always complete a plan to manage this risk. For example, risks relating to falling, those associated with people's health and well-being and use of potentially dangerous items, such as kettles. It was positive that people were supported to be independent in these areas, but without fully assessing and planning for the risks, the staff were not able to ensure people were safe.

● A tub of powder had been decanted into a tub previously used for cheese, and still labelled as if it contained cheese. This was not labelled with details of the product and contained no warning signs. The registered manager told us this was powdered milk. People were at risk if they accidently ingested this or breathed it in.

Failure to assess, monitor and mitigate risks was a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● Medicines were not always safely stored. A prescribed thickener was stored on a sideboard in a dining room which was accessed throughout the day by people using the service. Misuse and ingestion of thickeners can be fatal and has been the subject of a National Patient Safety Alert meaning that staff should have been aware of the consequences of misuse of this and how to correctly store this product.

Inappropriate storage of medicines and prescribed thickeners put people at risk and was a further breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

● Except for the above, medicines were managed appropriately, and all other medicines were stored correctly. The staff undertook checks on the temperatures of medicines storage and had systems for stock control.
● Medicines administration records and records to show receipt and return of medicines were accurate, up to date and appropriately detailed. The staff had created protocols to describe when PRN (as required) medicines should be administered.
● The staff responsible for administering medicines had received relevant training and had their competencies assessed to make sure they knew how to do this safely.
● People were enabled to manage their own medicines if this is what they wanted. This was appropriately assessed and monitored to make sure this was safely done. There were also appropriate assessments in place where medicines were administered covertly (without the person's knowledge). These assessments had been made and agreed by multidisciplinary teams, including the prescribing doctors and pharmacists.

Systems and processes to safeguard people from the risk of abuse
● People were not always safeguarded from the risk of abuse. The care records for one person included an allegation they had made in 2020 that they had been hit by a member of staff. The provider had not reported this to the local safeguarding authority or CQC for these external agencies to make sure the allegation was appropriately investigated.
● The provider's own investigation focussed on the person's mental health condition and an unrelated fall the person had experienced around this time. There was not enough evidence to show the allegation of physical abuse was investigated or acted on, with the provider recording they felt the allegation was ''unlikely because [person] is constantly agitated and anxious.'' Three staff had been asked to write statements. However, it was not clear how these connected to the allegation and there was no record to show other investigations had taken place.

Failure to investigate and report allegations meant people were at risk of abuse. This was a breach of Regulation 13 (safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● The provider had not always learnt when things went wrong. For example, they had not taken adequate steps to improve safety following a fall in 2020 and the subsequent safeguarding investigation. However, they did have systems for ensuring people received immediate medical and first aid support following accidents, and that their health and well-being was monitored.
● Staff had recorded accidents and incidents and these records showed how they had supported people and any remedial action they felt was necessary.
● There were regular team meetings and handovers, where adverse events and changes in people's well-being were discussed. The registered manager told us they spoke with all staff following our inspection visit to help make sure they understood where practice needed to be improved.

Staffing and recruitment
● There were enough staff employed to care for people, and the provider increased staffing levels following our inspection visit, in order to help maintain safety. However, sometimes the staff were deployed in a way which was not appropriate. For example, when one member of staff was supporting two people to eat at the same time rather than giving time and attention to people individually. We discussed this with the registered manager.
● There were appropriate systems for recruiting staff to make sure they were suitable. These included

making checks on their suitability and employment history and inviting them to complete a range of training and assessments.

Preventing and controlling infection

● There were systems designed for preventing and controlling infection. These included thorough cleaning and regular audits of cleanliness. The procedures had been updated since the outbreak of the COVID-19 pandemic in line with national guidance and good practice recommendations.

● Staff, people who used the service and visitors were regularly tested for COVID-19 and there were appropriate procedures to be followed if a test indicated someone had COVID-19. Staff and people using the service had been supported to access COVID-19 and flu vaccinations.

● Staff and visitors were provided with suitable protective equipment (PPE) such as gloves and masks to help minimise the risk of spreading infections.

Requires Improvement

Is the service caring?

Our findings

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

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

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

● People were not always well treated. We witnessed some interactions which did not respect people's dignity or feelings. For example, during lunch, a member of staff supported two people at the same time. They sat with their back to one person, turning around to give them a spoonful of food and then turning back again throughout the meal. They did not speak with this person and spoke only occasionally to the other person who they were supporting. Several time during the meal they stood up and walked away without warning to support a third person. At one point they gave one person someone else's food off the other person's spoon.

● Another member of staff started to take people's temperatures whilst they were eating and offered them medicines in the middle of their meal. This was unnecessary and showed a lack of respect for people to have uninterrupted mealtimes.

● We witnessed two different members of staff speaking with people in an instructional tone, stating their names and then telling them to do something. They did not enquire about these people's well-being or show an understanding of how their approach may have felt to the person.

● Throughout the day we saw one person regularly became distressed, voicing their anxiety and repeating feelings of bereavement and guilt about situations that had happened, or they were imagining had happened. Except for the registered manager and deputy manager, none of the staff offered this person comfort. Several different staff regularly entered the room whilst this was happening. None of these staff acknowledged the person or the person's distress. A member of staff who was designated to spend time in the same room as the person mostly ignored their distress, although at one point argued with them when the person said their relative had come to visit. The staff member then took the person out of the room to prove the person was wrong about their visitor.

Failure to treat people with dignity and respect was a breach of Regulation 10 (dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

● Notwithstanding the above, people using the service and most of the relatives/friends told us they were happy with the care people received. One person told us they felt as if there was a family atmosphere. A relative explained they though staff were kind and another relative told us there was ''warmth and empathy'' at the service.

● People were supported to be independent where they were able. For example, when people were able to do things for themselves, this was recorded in their care plans and they were supported to remain

independent.

Supporting people to express their views and be involved in making decisions about their care
● People's views about their care and their preferences were recorded in their care plans. One person told us, they were happy that the staff did not 'interfere' too much, and they were able to make choices about how they spent their time and what they could do for themselves. We saw care plans recorded when people were independent and encouraged staff to support people to make choices and be as independent as they wanted and could be.

Requires Improvement

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 good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People did not always receive personalised care which met their needs and preferences. For example, we saw people were left for long periods of time (most of our visit) with limited interactions and no activities to participate in. Some people slept for most of the day, except during mealtimes. We observed one person who sat with their forehead resting on a dining room table for over three hours. We discussed this concern with the registered manager.
- One person spent a large amount of time voicing distress. There were no proactive strategies to support the person or distract them from their negative thoughts. Their care plan and risk assessments focused on managing their mood when they became extremely distressed through medication and seeking further medical input, rather than planning care which might reduce their anxiety and distress.
- One relative told us they were concerned their relative's needs were not being monitored or met. They found their relative had a rash and swelling which staff had not noticed, recorded, or sought medical advice for. They told us staff explained they had not noticed this because they had not supported the person with personal care. Whilst, the relative accepted it was positive to encourage the person to be independent, they were concerned the condition had worsened without staff noticing this.
- There were limited structured activities for many of the people living at the service. On the day of the inspection, the only activity most people participated in was colouring. However, we noted many people ignored their colouring sheets which were placed in front of them and did not participate in the activity. Whilst there were resources available, such as games, books and toys, the care staff did not use these to engage with people or offer them opportunities to take part in other activities.

Failure to provide personalised care was a breach of Regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

- The provider employed an activities coordinator and we received a good amount of positive feedback about them and how they supported people. We saw them engaging with individual people and supporting them. One person told us there were some group activities such as quizzes, these were not always well attended, but they enjoyed them. Prior to the COVID-19 pandemic they had organised a lot of special events and these had been popular. Some people using the service and their visitors told us about these.
- People were supported to stay in touch with their friends and families. They had received visitors in the garden, and the provider was starting to organise indoor visits in line with changes in government guidance. Visitors also told us people were supported to use video calling to speak with them. We witnessed one person speaking with a relative via video call which the staff had linked up to the television to help the

person because it was a bigger screen.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● People's communication needs were recorded within their care plans, along with any specific requirements they had to help them understand information. Care plans included details about any sensory impairments and the aids people needed to help them overcome communication barriers.

End of life care and support
● No one was being cared for at the end of their lives at the time of the inspection. However, the provider worked closely with other healthcare professionals and families to enable people to be able to remain at the home when they were dying, if this was their wish.
● They had cared for people at the end of their lives in the past. The staff knew they needed to support people to be comfortable and pain free. There were no restrictions on visitors to people at the end of their lives, and visiting palliative care teams provided the medical support they needed.

Improving care quality in response to complaints or concerns
● There were suitable systems for responding to complaints. People using the service and visitors told us they knew who they would speak with if they had a concern and felt confident this would be dealt with.
● The registered manager kept a log of all complaints, which showed how these had been investigated and any changes made as a result of the complaint.

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 good. 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.

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

- The provider's systems for continuous learning and improving care were not being operated effectively. We identified breaches of regulations relating to safety, treating people with respect, personalised care and safeguarding adults from abuse.

The provider's systems had not identified these failures and therefore they had not taken action to address them.

- There were significant health and safety failings which put people at increased risk of harm. Whilst the provider acted to address these when we asked them to, they had not taken any action before this, despite a serious incident in 2020 when someone had fallen down a staircase.
- We observed poor interactions which were disrespectful. Some of these interactions were witnessed by other staff, including senior staff and managers. Their failure to address these concerns indicated a culture where people were not always treated with respect, and at times were treated unkindly.
- The widespread shortfalls meant there was no assurances of high quality care and people were at risk of receiving unsafe or inappropriate care.

Failure to monitor and improve quality, as well as failing to identify, monitor and manage risk was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following our visit, we wrote to the provider to tell them they must address the health and safety concerns immediately. They responded with an action plan which described what they would do and how they would minimise the risk of harm.
- Notwithstanding our findings, people and their visitors spoke positively about their experiences. One relative told us, ''I couldn't think of anywhere better.''

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Some relatives we spoke with told us they felt there was not always good communication from the staff. They explained there had been delays in them receiving information about people's needs, despite requesting this. They also told us they were not given regular updates about people, which they had expected during the pandemic when they were less able to visit or see people. One relative said they had not been asked to share information they had about a person's needs when they first moved in. They said this had led to confusion. Following receipt of the draft inspection report, the registered manager told us they

always made sure they had as much information as possible about people when they moved to the service.
● There were regular meetings for staff and people using the service where they were able to discuss the service. They were also invited to complete surveys about their experiences annually.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; 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
● People using the service and most visitors spoke positively about the registered manager, deputy manager and provider. They explained they could approach them with concerns and felt they were listened to. Staff also confirmed this.
● The registered manager was experienced and had worked at the service for many years. They knew people well and had a good rapport with them. The registered manager spoke positively about the way the staff had worked hard throughout the period of the pandemic.
● Relatives told us they found the registered manager was open and had apologised when things had gone wrong.

Working in partnership with others
● The provider worked in partnership with others. The registered manager attended local authority forums and liaised with other care home managers. They also worked closely with healthcare professionals to make sure people's needs were being met.
● A representative from the local authority told us the service was responsive to their requests and the registered manager was open and transparent.

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 9 HSCA RA Regulations 2014 Person-centred care The registered person had not always ensured care and treatment was appropriate, met service users' needs or reflected their preferences. Regulation 9

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered person did not ensure that service users were always treated with dignity and respect. Regulation 10

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not always ensure the safe care and treatment of service users. Regulation 12

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 The registered person did not always ensure

service users were protected from abuse and improper treatment.

Regulation 13

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 17 HSCA RA Regulations 2014 Good governance The registered provider did not always effectively operate systems and processes for monitoring and improving the quality of the service or assessing, monitoring and mitigating risks. Regulation 17

The enforcement action we took:

We have issued a warning notice telling the registered person they must make the required improvements by 30 June 2021.