Central England Healthcare (Wolverhampton) Limited

Eversleigh Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Eversleigh Care Centre is a residential care home providing personal and nursing care to up to 84 people. The service provides support to older people, some of whom are living with dementia, or have a physical disability. At the time of our inspection there were 49 people using the service.

Eversleigh Care Centre accommodates people in 3 separate units, each of which has separate adapted facilities. Only 2 units were in use at the time of the inspection.

People's experience of using this service and what we found
Systems and processes in place to monitor people's care delivery were not effective in ensuring actions were taken when there were gaps in records.

People did not always have their medicines administration documented. People's care records did not always show how and when their planned care had been delivered.
Staff understood how to support people to manage risks to their safety and could recognise any signs of abuse and taken action to protect people.

Staff were recruited safely and there were enough staff to meet people's needs. The service was clean, hygienic and infection prevention control procedures were followed. When incidents occurred, these were reviewed, and actions taken to prevent them from happening again.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

People were supported to be engaged in the home. There was support for staff in their role and regular updates about learning when things went wrong. There were relationships with other health professionals where required to support people with their care needs. The provider had systems in place to ensure they met their responsibilities for duty of candour.

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 (6 April 2023).

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 improvements had been made and the provider was no longer in breach of

some regulations, but others remained in breach.

Why we inspected
We carried out an unannounced focussed inspection of this service on 7 February 2023. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment, staffing and governance.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has remained requires improvement. This is based on the findings at this inspection.

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

Enforcement and Recommendations
We have identified breaches in relation to governance arrangements 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Eversleigh Care Centre

Detailed findings

Background to this inspection

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

Inspection team
The inspection was conducted by 2 inspectors, a specialist nurse advisor and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Eversleigh Care Centre is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Eversleigh Care Centre is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a manager in post, who planned to register.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback

from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 10 people who used the service and 3 visitors about their experience of the care provided. 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 also spoke with 8 staff, including the manager, deputy manager, operations manager, care staff and nurses and the nominated individual. We looked at a range of records including staff recruitment files, policies and minutes of meetings.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained 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; Using medicines safely

At our last inspection the provider had failed to have systems in place which robustly managed risks to people's safety and ensure effective medicines administration. This was a breach of regulation 12 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 12 but further improvements were needed.

- Improvements were needed to how staff documented when people's care needs had been met in line with their risk assessments and care plans. We found where people required repositioning due to the risk of sore skin or required their fluid intake monitoring was not always documented correctly. The provider could not be sure people had received their care as required.
- Medicines administration records (MAR) were not consistently completed to show when people had their medicines. For example, we found medicines which were not accounted for in people's stock counts. We found people's MAR charts had times and dates which did not have a signature on to show medicines had been administered. This meant there were no record of these medicines being administered and the provider could not be confident people had had their prescribed medicines.
- People had risks to their safety assessed and plans put in place to minimise them, and staff and people confirmed to us these needs were met.
- Medicines were stored safely, and staff had received training and had their competency assessed.
- People told us they felt their needs were met. One person told us, "The nurses give me my tablets, they have never missed." Another person told us, "I have an air pressure bed as I get sore heels, the staff check it every day."

Systems and processes to safeguard people from the risk of abuse

- People and relatives told us the home felt safe. One person said, "I feel safe here, look at all the staff here." A relative told us, "I have peace of mind when I leave knowing [person's name] is in safe hands when I go home."
- There were systems in place to ensure safeguarding incidents were reported to the appropriate body. Where incidents had occurred, these were also notified to CQC as required by law.
- Staff understood how to identify concerns for people's safety and recognise possible signs of abuse.
- Incidents were monitored to ensure any outcomes from investigations were appropriately actioned.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

Staffing and recruitment

At our last inspection the provider had failed to ensure there were sufficient suitably qualified staff deployed to meet people's needs. This was a breach of regulation 18 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 18.

● People and their relatives told us there was enough staff to offer support when people needed it. One person told us, "There are plenty of staff, I never have to wait for help."
● Staff were observed supporting people when they needed help and the atmosphere was relaxed and calm. Staff told us things had improved since the last inspection and they had enough staff now to meet people's needs in a timely way. Our observations supported this as people did not have to wait for their support.
● Staff were recruited safely. The provider had checks in place to ensure staff were suitable to work with people including carrying out a Disclosure and Barring Service (DBS) check which provides information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes

People were able to receive visitors to the home without restrictions.

Learning lessons when things go wrong

●Accidents and incidents were monitored. The manager used the electronic system to review any incidents and ensure follow up actions were taken. For example, where 1person had a fall, we saw actions had been taken to prevent a reoccurrence and individual risk assessments and care plans were updated.

● Lessons learned were identified and shared with the staff team for example, using the handover processes in place and regular meetings and supervision.

Requires Improvement

Is the service well-led?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has remained requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

At our last inspection the provider had failed to establish systems to assess, monitor and improve the quality and safety of the service provided. This was a breach of regulation 17 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 17.

- The systems in place to ensure accurate records of the care people received had failed to ensure action was taken when gaps were identified. The electronic system created an alert when care was not documented, however there was no evidence of actions taken when these alerts were noted. This meant the governance systems were not preventing people from being exposed to the risk of harm.
- The provider had failed to ensure action was taken when quality assurance systems identified people had not received their required care to maintain their skin integrity. For example, when people had not been repositioned in line with their care plan the system had identified this, but no actions were taken to address this leaving the person at risk of harm.
- The quality assurance system to ensure actions were taken when people's care records had not been fully completed for nutrition and hydration needs For example, one person was at risk of malnutrition, and we could not be sure why, on some occasions, the person had no food intake recorded, leaving the person at risk of harm.
- Medicines quality assurance processes had failed to ensure action was taken when there were gaps identified in people's medicines administration records. This meant we could not be assured people had received their medicine as prescribed and people were exposed to the risk of harm.

Systems to assess, monitor and mitigate risks had not ensured actions were taken when people had not received their care and support as required. This placed people at risk of harm. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They confirmed they had made

changes to their systems to ensure actions were taken and the manager was now checking to ensure these were complete and documenting the outcome.
● The registered manager had developed an open culture in the home and staff felt able to share any concerns.
● People received person centred care. Staff knew people well and had spent time getting to know and understand people's preferences for their care.

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 provider understood their responsibilities when things went wrong. When incidents occurred, they notified the appropriate people and ensured their regulatory requirements were met for submitting notifications to the CQC.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● There were surveys undertaken with people living at the home and this was used to develop an action plan and make improvements. For example, changes had been made to menus following feedback and initiated work with other agencies to improve transfers of care.
● People and their relatives were happy with the service. One relative told us, "I visit every day, it has a good atmosphere, they keep me informed of any changes to [person's name], they say they are happy here and that is all that matters to me."
● People and their relatives told us the service was well managed. One relative told us, "The home is well run, and the manager is available if we need to talk to them, I think it is a happy place."
● Staff were actively involved in the service and had opportunities to discuss how things were going and seek advice. We saw staff had identified some areas of development with the electronic recording system and this led to actions taken to offer advice and guidance.
● We saw the provider had systems in place to work with other agencies involved in people's care. For example, one person had support from an external health professional to give guidance and advice on managing their health condition.

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
Treatment of disease, disorder or injury	The provider had failed to take actions when systems identified areas of concern with care delivery and medicines. The systems in place to ensure accurate records of the care people received had failed to ensure action was taken when gaps were identified.

The enforcement action we took:

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