

Sutton And Cheam Elderly People's Housing Association

Eversfield House

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

Eversfield House is a residential care home providing personal care to up to 24 people. The service provides support to older adults. At the time of our inspection there were 24 people using the service.

People's experience of using this service and what we found

People were at risk of receiving unsafe care and support. There were insufficient care records that did not detail specific information about risks to people's safety and how they were to be supported. We observed staff supporting people safely and they had good knowledge of people's needs, but this information was not recorded.

The provider did not ensure the environment was always safe and people were protected from the risk of falling from height. Windows were not appropriately restricted and there were no barriers from the fire escape to prevent people from going onto part of the building with a flat roof.

Medicines were not managed safely. Staff did not maintain accurate records of administered medicines and staff were not observing people taking their medicines to ensure they were taken as prescribed. Medicines were dispensed into staff's hands prior to being given to people, increasing the risk of contamination.

There were insufficient systems in place to provide adequate oversight of the quality of the service. Audits and checks on the quality of care had not been completed in the months before our inspection. There were no clear improvements plans in place to ensure timely action was taken to address any concerns identified.

Despite the concerns raised about the systems and processes in place, staff were knowledgeable about people's needs and we observed them providing people with the level of support they required to ensure they had a good quality life, and they were supported in a safe way. Staff worked closely with the GP and staff from the local authority's care home support team to ensure any concerns about people's health or welfare was reviewed.

People enjoyed living at Eversfield House and told us they felt comfortable speaking with staff, and expressing their views and opinions. 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.

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 16 June 2021).

Why we inspected

This inspection was prompted by a review of the information we held about this service.

We undertook a focused inspection to review the key questions of safe and well-led only. 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 changed from good to requires improvement based on the findings of this inspection.

Enforcement

We have identified breaches in relation to safe care and treatment and good governance at this inspection.

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 from 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 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?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement ●

Eversfield House

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

This inspection was undertaken by one inspector.

Service and service type

Eversfield House 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. Eversfield House is a care home without 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 not a registered manager in post. A new manager was in post who had been working with the service for 7 weeks. They had plans to apply to become the registered manager.

Notice of inspection

This inspection was unannounced.

What we did before the inspection

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 6 people and 4 staff, including the manager, senior care worker and care workers. We reviewed 5 people's care records and records relating to staffing and the management of the service. We undertook observations of the environment and observed interactions between people and staff.

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 good. At this inspection the rating has changed 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

- The provider did not ensure a safe environment was provided. People were not protected from the risk of falling from height. We observed that some windows had a broken restrictor and other windows had the keys to override the restrictor in them, so windows could be opened wider than the recommended amount.
- Fire doors were not alarmed and the fire escape directed people from the first and second floor out onto the flat roof of another part of the building. There were no barriers in place to prevent people from going onto the flat roof or protect them from falling from height.
- There were not sufficiently detailed risk assessments in place to inform staff as to the risks to people's safety and how they were to be supported to minimise these, this left people at risk of receiving unsafe care.

Risks to people's safety had not been appropriately assessed and mitigated. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Despite the concerns identified above, we observed staff supporting people safely and they were knowledgeable about the individual risks to people living at the service. For example, in relation to moving and handling support needs.
- If there were any concerns regarding a person's health or welfare. Staff liaised with the GP or members of the local authority's care home support team, to ensure the person received the care and support they required. One person told us, "I'm well looked after."

Using medicines safely

- Safe medicines management was not in place.
- Medicine administration records (MAR) were not completed correctly. Staff signed MAR to indicate people had taken their medicines before giving these to them. There was a risk that the person would refuse their medicines and then an accurate record would not be maintained. Staff also signed some medicines as refused when actually not enough time had passed between doses for a person to taken them safely. This indicated a risk that such medicines would then not be administered at a safe time as they had been recorded already as refused.
- Medicines were being taken out of blister packs into staff's bare hands before being put into a medicine pot. There was a risk of contamination due to medicines being handled this way and is not in line with best practice.
- People's care records had not been updated to reflect people's needs regarding their medicines. For example, one person was diabetic and their care plan had not been clearly updated to state the staff were

now required to support the person with their insulin administration.

Safe medicines management practices were not in place. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People we spoke to told us they received their medicines and this was given to them regularly by the staff.

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. People had the capacity to consent to their care and were involved in decision making.

Staffing and recruitment

- There were sufficient numbers of staff on duty to meet people's needs. One person told us, "Staff are great. There certainly is enough staff for me." Another person said, "The staff are alright. They come and have a chat sometimes."
- Safe recruitment practices were in place to ensure suitable staff were employed to support people. This included undertaking criminal records checks, getting references from previous employers, checking people's identity and their eligibility to work in the UK.

Preventing and controlling infection

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

Visiting in care homes

- There were no visiting restrictions in place and friends and family were welcome to visit the service.

Systems and processes to safeguard people from the risk of abuse

- People were kept safe from avoidable harm because staff knew them well and understood how to protect them from abuse. The service worked well with other agencies to do so.
- Staff had training on how to recognise and report abuse and they knew how to apply it.

- Staff knew people well, including their personal preferences and beliefs. We observed people being treated kindly and free from discrimination.

Learning lessons when things go wrong

- The service managed incidents affecting people's safety well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned.
- When things went wrong, staff apologised and gave people honest information and suitable support.

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 good. At this inspection the rating has changed to 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; Continuous learning and improving care

- There were not effective systems in place to have sufficient oversight of the quality of care delivery.
- There was a programme of audits, however, these had not been completed in the months prior to our inspection. This included audits on the quality and safety of care records, infection control procedures, and effective audits on medicines management.
- There were no systems in place to identify the concerns we found during inspection, and there was no clear programme for making improvements. The manager told us they were aware that care records needed updating but they did not have clear plans in place as to when or how these improvements were going to be made.
- Clear, accurate and complete records were not maintained about people's care. Care records did not contain detailed information about people's support needs, risks to their safety or how they were to be supported. There was a risk that people would not receive the care they required due to the lack of records maintained.
- There were also ineffective systems in place to monitor staff's compliance with mandatory training. Whilst staff confirmed they had received training on key topics. Accurate management records were not maintained to enable the manager to have oversight of who had completed their training and when they were due refresher courses.

Effective systems were not in place to ensure a regular review of quality of the service and ensure up to date and accurate care records were maintained. 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.

Working in partnership with others

- The service worked closely with other health and social care professionals in order to meet the needs of the people living there. This included close working with their allocated GP and the local authority's care home support team.
- The manager also told us they found the local authority supportive and had begun to engage in forums and training provided by them.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering

their equality characteristics

- There were regular meetings with people and staff to obtain their views and experiences of the service. A staff member told us, "Very happy working here. [The manager] is doing well and is really nice. They're very approachable with the staff and the residents. He listens to any feedback or suggestions. We have a staff meeting tomorrow. The first one with [the new manager] and then we will agree frequency."
- People and staff told us they felt comfortable approaching the manager and having open conversations with them. They felt they were listened to and action was taken to address any concerns raised. One person told us, "The new manager – he's very nice. I don't feel at the moment that I have any concerns but feel I could speak with him if I needed to. Nothing that I want changed. It all seems ok."
- The manager was aware of people's communication needs so they were able to provide meaningful engagement with them. For example, one person did not communicate verbally and preferred to communicate via written text.

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 service apologised to people, and those important to them, when things went wrong.
- Staff gave honest information and suitable support, and applied duty of candour where appropriate.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured people received safe care. A safe environment was not provided and medicines were not managed safely. Regulation 12 (1) (2) (a) (b) (d) (g).
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured there were effective systems in place to review and improve the quality of care. They had not ensured complete and accurate care records and staff records were maintained. Regulation 17 (1) (2) (a) (b) (c) (d).