Podsmead Residential Care Limited

Overleat Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced focussed inspection took place on 19 February and 6 March 2018 following the receipt of concerns relating to the safety of people and the quality of leadership at the home. We last inspected this home on 23 May 2017 when it was rated as 'Good' overall and 'Requires Improvement' in Safe. Following our inspection in May 2017 we recommended the provider review their recruitment policy.

The team inspected Overleat against three of the five questions we ask about services: is the service safe, is the service effective, is the service well led? This is because we had received some concerns relating to these questions and we identified some concerns during our inspection. No risks, concerns or significant improvement were identified in the remaining Key Questions through our ongoing monitoring or during our inspection activity so we did not inspect them. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection.

Overleat Residential Care Home, referred to in this report as Overleat, is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Overleat is registered to accommodate up to 13 people in one adapted building. Nursing care is not provided by staff at Overleat. This is provided by the community nursing service. At the time of this inspection in February and March 2018 there were 12 people living in the home.

The home had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People living in Overleat were not always safe. Although we saw a number of good examples of risks to people being managed, we also identified instances where risks had been identified but management plans had not been put in place to protect people. For example, where one person had been identified as being at risk due to their having diabetes, staff had not been provided with any information relating to their acceptable blood sugar ranges, how to identify when the person's sugars may be too low or too high or what action to take. We also found a lack of management plans in relation to risks posed by people's behaviours.

We found people were at risk with regards to their environment. During our inspection we found a steep staircase unsecured on two occasions which could have posed a risk to the person whose bedroom was at the top of the stairs and who was mobile. We also found a radiator in the lounge which did not have a protective guard around it and could have placed people at risk of burns.
Although staff had received training in safeguarding adults and had access to relevant information, we found people were not always safeguarded from abuse. This was due to an allegation not having been properly investigated and recorded in line with the home's safeguarding policy and best practice.

The five principles of the MCA include that all individuals are presumed to have capacity; an action taken on behalf of a person must be in their best interests and regard must be had as to whether an act or decision is the least restrictive of a person's rights and freedoms. These principles had not always been followed with regards to people who may lack capacity to make certain decisions. For instance, the registered manager had applied for some people to have their liberties restricted under the Deprivation of Liberty Safeguards without first conducting an assessment to ensure those people were unable to make the decisions for themselves.

Staff did not receive regular supervision, appraisal or access to staff meetings. Staff views were not regularly sought in order to improve the service. People's views and relatives' views were not sought in ways that met their communication needs and therefore the registered manager was unaware of a number of issues people shared with us during our inspection.

The systems and processes in place to monitor the safety and quality of care had not been effective in identifying the concerns we found during this inspection.

We found people's social needs were not always being met as they did not have access to sufficient activities to meet their individual needs.

People spoke highly of the food served at Overleat and we observed people being supported to eat their meals in a caring and compassionate way.

There were sufficient staff to meet people's needs and during our inspection we observed staff responding to call bells quickly and meeting people's needs in an unhurried and pleasant manner.

We found the home operated safe medicine management practices and had thorough recruitment practices which ensured, as far as possible, that suitable staff were employed.

The provider and the registered manager were very receptive to our feedback and following the inspection they worked hard towards implementing improvements. They took a number of actions to improve the service and have sought further advice.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches related to people not always being protected from harm, people's rights under the MCA not being protected, people's care not always meeting their needs, staff not being supported and ineffective quality assurance processes. You can see what action we told the provider to take at the back of the full version of the report.

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.

People were not always protected from risks relating to the environment.

Risks to people were not always identified and responded to in order to mitigate risks.

People were supported by sufficient numbers of staff to meet their needs.

Is the service effective?

Requires Improvement

The service was not always effective.

The principles of the Mental Capacity Act 2005 had not always been followed in relation to best interest decisions and Deprivation of Liberty Safeguards applications.

The provider had not ensured staff received appropriate support that enabled them to share their views, review their performance and understand their responsibilities.

People's social needs were not always being met as there was a lack of activities for people to take part in.

Staff received regular training to enable them to undertake their role.

People spoke positively of the food served at the home.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The systems the provider had in place to assess and monitor the quality and safety of care had not identified the concerns we found during our inspection.

Feedback had not been sought regularly from people, relatives or staff in order to improve the service provided.

People gave positive feedback about the registered manager.

People's records were secure and well maintained.

Overleat Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 19 February and 6 March 2018, both days were unannounced. This responsive focused inspection was prompted by a number of concerns received by CQC relating to the safety of people and the quality of the leadership at the home. We wanted to see whether people were receiving safe, effective and well led care and support. Two adult social care inspectors carried out the inspection, one on each day of inspection, and an expert-by-experience took part in the first day of inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we reviewed the information we had about the home, including notifications of events the home is required by law to send us. We also reviewed the home's inspection reports and spoke with the local safeguarding team.

During the inspection we looked at the way people were being supported, looked at the way in which medicines were recorded, stored and administered, and the way in which meals were prepared and served. We looked in detail at the care provided to seven people, including looking at their care files and other records. We reviewed the recruitment and training files for three members of staff and other records relating to the operation of the home such as risk assessments, policies and procedures.

We spoke with eight people who lived in Overleat, two visiting relatives, six members of staff, the registered manager and the provider. We also spoke with and reviewed reports from the local safeguarding team relating to some of the concerns which had been raised.

During this inspection we did not conduct a short observational framework for inspection (SOFI) as a number of people were able to share their experiences with us. SOFI is a specific way of observing care to help us understand the experience of people who are unable to talk to us. We did, however, use the principles of SOFI when carrying out observations in the service.

Requires Improvement

Is the service safe?

Our findings

Following our previous inspection in May 2017 this domain had been rated as Requires Improvement. This is because we had identified some improvements were required with regards to the home's recruitment practices. At this inspection in February and March 2018 we found action had been taken to improve this.

The decision to undertake this inspection was made in response to a number of concerns received by CQC about the safety of people living in the home. During this inspection we found a number of concerns relating to risks to people were not being managed safely, and identified some improvements were needed to the environment in order to minimise risks to people.

During our inspection we found people who lived in Overleat were not always safe. Although we found a number of good examples of risks to people being identified and action being taken to respond to these and minimise risks, this was not always the case. We found that where some risks had been identified, management plans or risk assessments had not been put in place to ensure all staff understood how to protect people.

For example, one person who had lived in Overleat for a number of years had diet controlled type two diabetes. Staff did not know any specific details relating to this, such as the acceptable blood sugar ranges for the person, how the person presented if they suffered with blood sugars which were too high or too low, how they should act should this be the case or what controls their diet needed to have. Staff were restricting the person's access to foods in order to ensure they did not eat "too much sugar." However, nobody at the home was able to identify what "too much sugar" was for this person and had not sought information about this from the doctor, the person themselves or their relatives. This lack of knowledge could have placed this person at risks should their blood sugars fall outside of their personal acceptable range.

The registered manager told us this person had recently started throwing their hot drinks to the side of their chair when they were in the living room. They told us staff were aware of this and therefore provided them with cups that were less full. This new behaviour had not, however, been identified as a risk of scalds to this person or to others who may be walking past or sitting close by.

Another person displayed behaviours which had placed staff members at risk of physical assault. Although these behaviours had been identified, there was no plan in place or guidance for staff on how to protect themselves. Staff and the registered manager were able to explain how well they knew the person and what they would do should they be at risk of harm, however this person's potential risk to themselves, other people living in the home and visitors had not been identified.

Guidance had not been sought from professionals in relation to either of these people in relation to their behaviours, no risk assessment had been completed and staff had not been provided with any guidance on how to manage these behaviours.

These concerns were discussed with the registered manager and the provider who told us they would be

taking immediate action to seek guidance and put in place clear information for staff to follow in order to minimise any risks.

We identified that improvements were required with regards to the environment in order to keep people safe. At the rear of the home was a steep staircase which led up to people's bedrooms. At the top of this staircase was a wooden stair gate with a small brass bolt. During our first day of inspection, we found this gate had been left open on two occasions. We spoke about this with the registered manager and the provider who told us staff had acknowledged this error and they planned to put up a sign reminding staff to close it every time they used it. The registered manager told us that nobody who lived in the home used this staircase but that one person whosese bedroom was located at the top of the staircase, also accessed via a stair-lift at the end of the hall, could potentially be at risk of falls if the gate was left open.

During our first day of inspection we identified the radiator in the living room did not have a protective guard around it. This was identified to the provider. On our second day of inspection we found a cover had not yet been placed on this radiator although the provider was in the process of making one. Although this radiator was partially blocked from access by the television, there was still a potential risk of someone falling or leaning against it and scalding themselves.

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

People told us they felt safe living in Overleat with comments including "I feel safe here by day and night" and "I am safe living here". One relative said "I'd rather (my relative) was still at home, but that said, I know (my relative) is safe here".

Overleat had in place a policy and procedures to follow should staff suspect people were at risk of abuse or harm. Staff had undertaken training in safeguarding and were able to tell us what actions they would take if they had concerns.

There were sufficient staff available to meet people's needs. Although there had recently been some difficulties relating to staff cancelling shifts at short notice and extreme weather conditions stopping staff from being able to travel to the home, the registered manager had managed to ensure staffing levels remained safe. During our inspection we observed staff responding to call bells quickly and saw people's needs were met in an unhurried manner.

All the people who lived in the home required support from staff to take their medicines. Staff told us they were confident people received their medicines as prescribed by their doctor. The registered manager told us staff had been trained to administer medicines safely and had their competencies checked. Only staff who had received this training were able to administer medicines to people. Staff administering medicines carried out daily medicine checks to ensure people had received their medicines and any errors were picked up without delay. The registered manager completed thorough medicine audits monthly.

Recruitment practices ensured, as far as possible, that only suitable staff were employed at the home. Staff files showed the relevant checks had been completed to ensure staff employed were suitable to work with people who are vulnerable. This included a disclosure and barring service check (police record check). Proof of identity and references were obtained as well as full employment histories; this protected people from the risks associated with employing unsuitable staff.

There were arrangements in place to deal with foreseeable emergencies and each person had a personal emergency evacuation plan in place. We found these had recently been reviewed and updated with any changes. They detailed how people needed to be supported in the event of an emergency evacuation from the home. Regular checks were undertaken in relation to the safety of equipment and emergency fire procedures. The home had fire extinguishers, fire protection equipment and clearly signposted fire exits to assist people in the event of a fire. Records showed that safety checks had been undertaken of the electrical and gas installations.

Accidents and incidents were recorded, however there was no system for keeping track of the number of incidents each person had had. For example, staff and the registered manager did not have a clear overview of how many falls one person had experienced in the last few weeks and it was necessary to go through each entry in the accidents and incidents book to ascertain this.

The home was clean with no unpleasant odours. Staff were aware of infection control procedures, and had access to personal protective equipment (PPE) to reduce the risk of cross contamination and the spread of infection. Training records showed that staff had received training in infection control.

Requires Improvement

Is the service effective?

Our findings

Following our inspection in May 2017 we rated this question 'Good'. The decision was made to inspect against this question following some concerns we identified during this inspection in February and March 2018. We identified some concerns relating to the Mental Capacity Act 2005 which could have resulted in people potentially having their rights restricted.

The people who lived in Overleat had a variety of needs, with some people living with forms of cognitive impairments, such as dementia, which could affect their ability to make decisions. We therefore checked whether Overleat was working within the principles of The Mental Capacity Act 2005 (MCA). 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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We found there was confusion on behalf of the registered manager, the provider and staff in relation to the MCA and the five statutory principles of the MCA. The five principles of the MCA include that all individuals are presumed to have capacity; an action taken on behalf of a person must be in their best interests and regard must be had as to whether an act or decision is the least restrictive of a person's rights and freedoms. These principles had not always been followed with regards to people who may lack capacity to make certain decisions.

For example, one person's care plan stated they were able to make day to day decisions for themselves but were unable to make other decisions, such as leaving the home on their own. No assessment had been completed in order to determine this. Staff had installed bed rails on this person's bed but had not asked them for permission or assessed whether they were unable to make the decision for themselves. No best interest discussion or meeting had taken place and there was no documentation relating to how this decision was made.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). In order for a service to apply to deprive someone of their liberty under DoLS, it must first be established that the person is not capable of making certain decisions for themselves. We found the registered manager had completed a number of applications for people without first completing a mental capacity assessment. This could have led to some restrictions on people being inappropriate. The registered manager agreed to seek some advice in relation to this and review people's DoLS applications.

This was a breach of regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The systems in place for ensuring staff received sufficient support, supervision and appraisal were inadequate. Staff did not have regular meetings, supervision or appraisal. This meant the provider and registered manager did not have a clear overview of staff issues, staff dynamics, concerns and gaps in training and knowledge. Supervisions and appraisals are an opportunity for staff to discuss concerns, their work performance or training and development needs. The registered manager told us they had identified this issue and were planning to implement new systems in order to ensure staff were provided with the support and supervision necessary for them to undertake their role.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements were required in order to ensure people's care was effective in meeting all their needs. People spoke highly of the staff and how they were supported, with comments including "They really are gorgeous here", "I feel well cared for in general" and "My room is always kept lovely and clear and so yes, I feel I'm well cared for". We found, however, that some of people's needs were not being met. For example, one person had been diagnosed with depression and although their care plan referred to this, no research had been done into how this may present itself and what staff could do to support this person with this. Staff did not know how to support this person to avoid becoming depressed, identify when they may be becoming depressed or how to help them during times when they were depressed. This did not ensure all this person's needs were met.

People's social needs were not being met. Although some people's care plans detailed what their interests were and what activities they enjoyed, these were very basic. People's records showed they had not taken part in many activities and the majority of the ones they did take part in revolved around watching television. The registered manager told us the home had access to a number of activities but agreed improvements could be made in this area. They told us they were looking into potentially appointing an activities coordinator role and expanding on how they met people's social needs.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff undertook a number of mandatory training courses, some of which were online and some in person. The mandatory training staff undertook included safeguarding, health and safety, infection control, manual handling, The Mental Capacity Act 2005 and first aid. Although there was a system in place to ensure staff attended this training, there was no system in place to ensure staff had understood it or put it into practice. We spoke about this with the provider and registered manager and they told us they would be creating a more robust monitoring system in relation to this and incorporate it into their new supervision system.

There were two cooks who worked at the home and catered to people's individual tastes and preferences. People told us they enjoyed the food at the home, with comments including "The food here is wonderful. The quality is good and the choice is varied", "The food here is wonderful. There's a daily choice and if it's not to your taste, you can order something alternative" and "I can't complain about the food. The quality is very good and I'm never hungry." During our inspection we observed people eating their breakfast and lunchtime meal. Some people chose to eat in the dining room whereas others chose to eat in their bedrooms. One person said "I sometimes stay here in my room rather than go along to the dining room". People's meals looked appetizing and where people needed staff to help them eat we saw this was done in a caring and compassionate way. Throughout the day people were provided with a selection of hot drinks and snacks.

Care records showed that if people's needs had changed, staff obtained guidance or advice from the person's doctor or other healthcare professionals. Outcomes of people's visits to healthcare professionals were recorded in their care records. People were provided with specialist equipment such as sensor mats, wheelchairs, walking frames, hoists or specialist beds to assist and support people overcome everyday difficulties caused by their disability or illness.

Requires Improvement

Is the service well-led?

Our findings

Following our inspection in May 2017 we rated this question as 'Good'. We inspected it during this inspection in February and March 2018 due to concerns being raised about the quality of the leadership and governance. The leadership at Overleat consisted of senior carers, a registered manager and the provider who was regularly on site.

During this inspection we identified some concerns relating to the leadership of the home and the effectiveness of the quality monitoring systems. The registered manager and provider were very enthusiastic about wanting to improve and started taking action to respond to the concerns raised as soon as possible following our inspection.

The systems and processes in place to monitor the safety and quality of care had not been effective in identifying the concerns we found during our inspection. Although people's care plans were being checked monthly by the registered manager and completed by senior carers, we found some risk assessments and information missing. Therefore, the registered manager was not aware of risks to people not being identified or acted on until our inspection. These risks included risks relating to people's behaviours, diabetes management or the environment. The registered manager told us that although senior staff were responsible for completing and checking people's care plans, they accepted they had not given staff clear guidance on their responsibilities and how best to complete these.

The home was not working within the principles of The Mental Capacity Act 2005 (MCA) as the systems in place had not identified that the home was not always taking appropriate action to protect people's rights.

Accidents and incidents were recorded, however the provider did not have a systematic approach to ensure this information was collated and analysed to look for any trends or identified measures minimise the risk of further occurrences.

People's views had not regularly been sought in ways that met their communication needs about ways in which the service could be improved. Although the registered manager told us they spoke with people every day and it was clear they and staff knew people well, there was no clear process to ensure people's views were obtained. The result of this was that when we spoke with people about certain aspects of their care they shared some complaints with us. We then shared these with the registered manager who were not always aware of these issues.

Recent concerns had been raised by staff members about the quality of the leadership and the support they received. We spoke with the registered manager and the provider about these concerns and they told us that although they operated an 'open door' policy, this had not resulted in staff sharing their concerns with them and therefore new systems were required to ensure any issues were identified sooner.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People praised the registered manager but shared some unhappy views about the provider. These related to the provider's manner and attitude. We shared these with the provider who was surprised at the comments but told us they would be asking the registered manager to speak to people to find out more. They told us they cared deeply about people feeling comfortable and supported and therefore were open to make any changes needed.

People's personal confidential information was held securely and only staff had access to records and personal information relating to people living at the home and staff. People's records were well maintained.

Following our inspection the registered manager worked hard to implement new systems and act on our feedback without delay. They created new behaviour plans for people where these were required, new risk assessments, spoke to people who had shared concerns with us and put out questionnaires to people and their relatives in order to gain their feedback. They told us they planned to ask staff to complete questionnaires also and act on any comments where necessary. They had started completing and reviewing mental capacity assessments for people and had put together a new staff handbook which would serve to encourage staff to work towards Overleat's ethos and remind them of their responsibilities.

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 provider did not always meet people's individual needs. Regulation 9 (1)(b)(2)(3)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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. Regulation 11(1) of the Health and Social Care Act 2005 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Some risks to people's safety had not been identified or mitigated. Regulation 12 (1)(2)(a)(b)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance

There were ineffective systems and processes in place to assess and monitor the service provided.

Regulation 17 (1)(2)(a)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not have access to regular staff meetings, supervisions or appraisals to support them to carry out their role. Regulation 18 (2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014