Optima Care Limited

Gate House

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Gate House is a residential care home providing accommodation and personal care to four people with a learning disability at the time of the inspection. The service can support up to seven people.

People's experience of using this service and what we found
People were not protected from harm and were at risk of abuse from other people and staff. People had been unlawfully restrained by staff. Staff did not have the skills or competencies to support people when they were distressed or to support them proactively to manage their behaviours. Incidents were not reported to the relevant professional stakeholders. The provider had failed to introduce additional measures to reduce repeated incidents or learn lessons. The registered manager and provider had poor oversight of incidents and had allowed people to be harmed by one another and staff.
There was a poor culture within the service which was not person centred. People were restricted in their home, for example they were not allowed in certain areas of their home and could only have snacks at specific times of the day. Staff, the registered manager and provider were not open, honest or transparent when things went wrong. The registered manager and nominated individual failed to meet their regulatory requirements.
People's views had not been sought since they moved into the service, they were not encouraged to plan their care or make decisions about the service. The providers systems for overseeing the service were ineffective and not robust.

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

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the guidance CQC follows to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The service was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.

Right support:
The model of care setting did not maximise people's choice, control and Independence.

Right care:
Care was not person-centred and did not promote people's dignity, privacy and human Rights.

Right culture:

Ethos, values, attitudes and behaviours of leaders and care staff did not ensure people using services could lead confident, inclusive and empowered lives.

This meant people were placed at harm; had unnecessary restrictions placed on them and did not receive person centred care. The provider had not acted or taken any measures to mitigate the risk of harm to people or support people to live with choice or independence.

Following this inspection we worked closely with Local Authorities to ensure people were safeguarded from on-going harm. Three people were supported to move out of Gate House. There is currently no one living at Gate House.

Immediately following this inspection the nominated individual of this service changed.

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 13 December 2019).

Why we inspected
We received concerns in relation to incidents and allegations of abuse. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from Good to Inadequate. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the safe 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 Gate House on our website at www.cqc.org.uk.

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 coronavirus and other infection outbreaks effectively.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment, safeguarding, staffing, good governance, and notifications of other incidents at this inspection.

Following the inspection, we took immediate action to restrict admissions to the service. We took action against the provider and cancelled their registration at Gate House. Everyone moved out of the service and Gate House is now closed.

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 safe.	**Inadequate**
Is the service well-led? The service was not well-led.	**Inadequate**

Gate 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 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 carried out by two inspectors.

Service and service type
Gate House 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 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. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this

report. We used all of this information to plan our inspection.

During the inspection
We spoke with seven members of staff including the nominated individual, registered manager, operations manager, senior care workers and care workers. We reviewed a range of records. This included two people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People were not protected from abuse or the risk of abuse. Staff did not recognise when abuse occurred or follow safeguarding processes when allegations of abuse occurred. When incidents of abuse occurred, staff did not report these leading to further abuse.
- When abuse occurred, the registered manager did not take the necessary action to ensure incidents did not re-occur. The registered manager did not understand their responsibilities in respect of reporting all incidents of abuse to the local authority or Care Quality Commission (CQC).
- Incidents between people had not been reported to the local authority safeguarding team when they occurred. The registered manager told us they had assessed that no harm had come to people, which is why they did not report it. Most people living at the service had limited vocabulary and were unable to raise concerns when they had been harmed. They relied on staff to support them to stay safe.
- The provider failed to ensure there were robust procedures and policies in place to prevent people being abused. The providers auditing systems and oversight of abuse was not robust.
- One person was subject to physical, psychological and verbal abuse. Following this incident there were no welfare checks completed to ensure there were no lasting affects to the person.

The failure to protect people from abuse and improper treatment is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- People had behaviours that could be challenging to themselves and others. Some people had been subject to unlawful restraint and control which placed them at risk of harm. Where restraint had been used there was no clear, agreed plan to support them in the least restrictive way. One person had been physically restrained by up to five staff at one time. They had been unlawfully restrained for long periods of time. Records of these incidents of restraint were poor.
- The management of the service failed to identify that people had been restrained and placed at harm on at least five occasions from August 2020 to January 2021. They had not reported these incidents to CQC or the local authority.
- Risk management and assessment was poor. Staff were not skilled to support people with their complex communication and associated behavioural needs.
- Staff were often the trigger to incidents. For example, asking someone to change or clean their clothes, when this was known to distress and trigger anxieties. Restraint was used as the only form of management of incidents; this had a serious impact on people. Staff did not take proactive steps to de-escalate incidents which were harmful to people and others around them.

● People were at risk of physical harm from one another and little action had been taken to minimise this. Not all incidents were recorded. For example, on at least two occasions there were incidents between people living at the service. These were not documented on incident forms. The registered manager told us that people did not display behaviours that could be challenging towards each other, but we found this was not the case.
● People were being harmed and placed at risk of harm because incident management and oversight was poor. The registered manager and senior managers failed to read, review or analyse incident forms. There was no evidence of learning from incidents. There had been two incidents in a short period of time where staff had allegedly physically abused people. There had been no learning or improvements implemented as a result of the incidents.
● Environmental safety risks had not been assessed and mitigated. For example, the electric installation certificate needed to be renewed in October 2020. We discussed this with the registered manager who confirmed this had not occurred. The gas safety certificate dated December 2020 said work was needed to ensure an oven was safe to use. This had not been acted on.

Preventing and controlling infection
● We were not assured that the provider was meeting shielding and social distancing rules. Staff were being used across two sites to provide support and care to people. This was not following the government guidance to reduce the risk of spreading infection. The registered manager said there was no reason for movement of staff apart from staff preferring to have 'variety' by working with different people.
● The provider had not identified this had been happening as part of their audits. They told us this would be immediately stopped.
● Staffing had not been increased to support more frequent cleaning of the service including frequently touched areas.

The failure to assess the risks to the health and safety of people, doing all that is reasonably practicable to mitigate risks. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● People were not supported by competent experienced staff to meet their needs. This had a significant impact on their safety.
● People were supported by high numbers of agency staff members. We asked the registered manager how they assured themselves agency staff had the relevant skills and experience, they told us this was detailed on the agency worker placement checklist. Two out of three agency worker placement checklists we reviewed did not evidence staff had been trained in restraint techniques. This included staff who had been involved in incidents of restraint.
● Staff lacked the skills and experience to support people in a positive way. The staff we spoke to could not give a clear description of what de-escalation techniques were or how they supported people in a positive way. Staff and the registered manager did not understand why unlawful restraint was inappropriate, or placed people at risk. The providers training matrix confirmed only five of 21 staff had current training in positive behaviour support.

The failure to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were supported by staff that had been recruited in line with the providers processes. Recruitment checks included full employment history for staff. Before staff worked with people, criminal record checks

with the Disclosure and Barring Service were completed.

Using medicines safely

● Medicines were managed using an online system. Only a few staff were trained to administer medicines using the system. Staff had to be called to administer medicines when they were not on shift or when they were working at one of the providers other services on site. There was a risk people may not receive their medicine on time or receive as and when medicines when required.

● Temperature checks were made to ensure medicines were stored safely to remain effective. There were five gaps in the temperature records over December 2020 and January 2021. The registered manager and provider had not identified this. Some of the temperatures recorded had significant differences from day to day. Further analysis had not been completed to identify if this would affect the safety of the medicines. This is an area that requires improvement.

● People received their medicines when required.

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.

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

- There was a closed culture which was not person centred. A closed culture means a poor culture that can lead to harm, which can include human rights breaches such as abuse. People had unnecessary restrictions placed on them. For example, the registered manager informed us that people were not allowed in the office. When we challenged this in relation to one person. We were told it was because they were able to read, and there was sensitive documentation in the office, such as the whistle blowing process.
- People's human rights were not upheld. For example, people had set meal and snack times, which did not support freedom of choice. Staff could not tell us why snack times were set, and why people could not have a snack when they wanted one.
- The culture did not support staff being open and honest. Staff we spoke with were guarded with the information they shared with us in relation to incidents at the service. Staff had failed to follow safeguarding processes and procedures.
- The registered manager and nominated individual had not been open and honest in line with their legal responsibilities. The registered manager and nominated individual were aware incidents of restraint had occurred and were not honest and open sharing this information with stakeholders.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The registered manager and nominated individual failed to meet their regulatory requirements. During inspection we identified at least five incidents which should have been reported to the local authority safeguarding team, and the Care Quality Commission (CQC) but had not. Following our inspection, the operations manager submitted eight notifications to the CQC.
- The registered manager and nominated individual failed to ensure that legislation was complied with. For example, mental capacity assessments and best interest decisions were not completed in relation to the use of restraint.
- The registered manager and nominated individual failed to assess and act on risk. For example, they had not identified the risk to people being unlawfully restrained or implemented processes or guidance to reduce the risk to people.

The failure to notify the CQC of safeguarding incidents is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Continuous learning and improving care

● The regulatory compliance officer completed a 360 audit on the service in November 2020. The actions of the audit were compiled onto a service improvement plan (SIP). The audit completed by the regulatory compliance officer had failed to identify and act on the incidents of restraint.

● The SIP did not detail who was responsible for the actions, a timescale to achieve the actions and who would review the completed actions. There was no evidence that any of the points had been actioned. For example, weekly fire checks had not taken place since October 2020. There was no evidence to suggest this was now in place.

● The SIP stated audits needed to be completed on activities and support plans. There was no evidence this had occurred, support plans were poor and people were involved in very little activities.

● The registered manager and nominated individual failed to identify the significant shortfalls highlighted within this inspection.

The failure to assess, monitor and mitigate risks to the quality and safety of the service and to individual people using the service is a breach of Regulation 17 of the Health & Social care Act 2008 (Regulated Activities) Regulations 2014.

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

● People's views had not been sought since they moved into the service. People had not been involved in creating their care plans, or feedback sought following them moving into the service.

● It was identified in the SIP in November 2020 that resident meetings had not taken place. We found this was not implemented by the time we inspected in February 2021.

● There was no evidence that the opinions of relatives had been sought and acted on.

● Staff meeting minutes emailed to staff on 1 December 2020 identified that staff were not following guidance in place to support people. There was no follow up to this information or confirmation of what guidance was not being followed.

● Staff meeting minutes emailed to staff on 1 December 2020 stated that 'safeguarding alerts had been raised' and 'action is being taken and the service remains in a safe place'. We found this was not the case.

Working in partnership with others

● The registered manager and nominated individual had not been open and honest with CQC and with stakeholders including, the police, the local authority safeguarding team and commissioners about events that occurred in the service.

● The registered manager and nominated individual had not sought support from external health care professionals in relation to behaviours which had challenged people and staff.

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 18 Registration Regulations 2009 Notifications of other incidents The provider failed to notify the CQC of safeguarding incidents.

The enforcement action we took:

NOP to cancel location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to assess the risks to the health and safety of people, doing all that is reasonably practicable to mitigate risks.

The enforcement action we took:

NOP to remove location

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 provider failed to protect people from abuse and improper treatment.

The enforcement action we took:

NOP to remove location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to assess, monitor and mitigate risks to the quality and safety of the service and to individual people using the service.

The enforcement action we took:

NOP to cancel location

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

The provider failed to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff is a breach.

The enforcement action we took:

NOP to remove location