Isle of Wight Council

Overbrook

Inspection report

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26 August 2017

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Overbrook is a local authority run care home registered to provide accommodation for up to four people living with a learning disability. At the time of our inspection there were four people living in the home. The inspection was unannounced and was carried out on 22, 24 and 26 August 2017.

There was a registered manager in place at the home. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run.

The provider was not fully engaged in the running of the home. They did not have an effective system in place to monitor the quality and safety of the home; the records relating to people's care were not always accurate and up to date.

There was not enough staff available at the home to safely meet people's needs. The registered manager had not always fully assessed the risks associated with people's care and support.

People medicines were not always managed safely and they did not always receive their medicine in the correct way. Staff did not always protect people from the risk of infection.

People's ability to make decisions was not assessed and staff did not follow legislation designed to protect people's rights.

People did not always receive support from staff who had received the appropriate training to meet their needs.

Staff were task focused and did not always treat people with dignity and respect; or respect people's choices and their privacy.

People's records of care were not always personalised and staff were not always responsive to people's needs.

People were not able to engage in individual activities and access the community on an individual basis. They did not receive appropriate mental and physical stimulation.

People were supported to have enough to eat and drink; however, mealtimes were not always a social experience for people.

People's families and staff had the opportunity to become involved in developing the service, however the provider did not always respond to feedback provided. The provider had a process in place to deal with any

complaints or concerns, although the process was not always followed. People's families were involved in discussions about their care.

Staff received an appropriate induction into their role and were aware of their responsibilities to safeguard people from abuse. Recruiting practices ensured that all appropriate checks had been completed.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

During our inspection, we identified five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken 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?

Inadequate

The service was not safe.

There was not enough staff to meet people's needs

The risks associated with people's care and support were not always assessed and safely managed.

People's medicines were not always managed safely and staff did not always follow guidance to prevent the spread of infection.

Staff were aware of their responsibilities to safeguard people; and recruiting practices ensured that all appropriate checks had been completed before staff started working at the service.

Is the service effective?

Requires Improvement

The service was not always effective.

People's ability to make decisions was not assessed and staff did not follow legislation designed to protect people's rights.

People did not always receive support from staff who had received the appropriate training to meet their needs.

People were supported to have enough to eat and drink; however, mealtimes were not always a social experience for the person.

People had access to health professionals and other specialists if they needed them and received support from staff who had received an appropriate induction into their role.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always treat people with dignity and respect.

Staff did not always respect people's choices and their privacy.

People's families were involved in discussions about the care of their relatives.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not always personalised and staff were not always responsive to people's needs.

People were not able to engage in individual activities and did not receive appropriate mental and physical stimulation.

The provider had a process in place to deal with any complaints or concerns, although this was not always followed.

Is the service well-led?

Inadequate

The service was not well-led.

The provider did not have an effective system in place to monitor the quality and safety of the home.

The records relating to people's care were not always accurate and up to date.

People's families and staff had the opportunity to become involved in developing the service, however the provider did not always respond to feedback provided.

Overbrook

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 checked whether the provider was 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.

The inspection was unannounced and was carried out on 22, 24, and 26 August 2017 by one inspector.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events, which the service is required to send us by law.

People living at the home were not able to communicate with us verbally. We observed care and support being delivered in communal areas of the home. 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 spoke with the families of two people.

We spoke with two members of the staff, a senior care staff member and the registered manager. We also spoke with the Service Manager - ASC Short Term and Learning Disability Services, who was the provider's representative. We looked at care plans and associated records for all four people living at the home, staff duty records and other records related to the running of the service, including recruitment files, records of complaints, accidents and incidents, policies and procedures and quality assurance records.

This home was previously inspected in July 2015 and was rated good.

Inadequate

Is the service safe?

Our findings

People did not always receive appropriate care and treatment because there was not always sufficient staff available to meet their needs. A family member told us, "I do have a concern that there is not enough staff. [My relative] doesn't go out as much as in the past." They also said, "I definitely feel [my relative] is safe; even with the staffing issue I don't feel [my relative] is unsafe." They added, "Staffing is my only concern but I am really grateful that [my relative] is where she is." Another family member said that some staff had been off sick, "This has put them [other staff] under real pressure. I suspect there is a problem [with staffing] the strain tells [on the staff] especially when covering sickness."

The registered manager told us they found it difficult to manage the home because they are "only allowed to work three shifts a week and 50% of that time is spent supporting staff to provide care." They said the staffing regime for the home was two staff on during the day and one member of staff doing a waking night shift. They also stated that the home was regularly using the provider's bank staff to cover staff shortages, including the wakeful night shift on their own. They had also recently started to use agency staff to cover day shifts with a regular member of staff.

We found that the lack of staff was impacting on the care people received. One person required two members of staff to help them to mobilise. The senior care staff member told us, "It takes all morning to get everyone up and ready. We were lucky today as [the person who needed two staff to support them] went back to sleep but when [the person] doesn't, [the person] just has to lay there until we can get to [the person]." Another member of staff said, "We prioritise [the person who needed two staff to support them] if [the person] is wet otherwise [the person] has to wait." We observed that when the staff were supporting this person to get up and have their personal care in the morning they were absent from the other three people for over 30 minutes. This placed people at risk and meant that those people who were unable to mobilise independently may not be able to access support when they needed it. For example if they required a drink or needed access to the toilet.

The pressure sore management plan for this person, which was reviewed on 21 March 2017, stated they should be repositioned when in bed every two to four hours. The registered manager confirmed that the person was not repositioned during the night in compliance with their pressure sore management plan because there was not enough staff. The pressure sore management plan also stated the person should be repositioned every hour when sitting in a chair. During our inspection, we observed that this did not take place; at one point they sat in the same position for in excess of four hours. We raised this with the senior member of staff on duty and they said, "I know but we just don't have the staff to do that."

The independence plan for a different person, dated 12 April 2017, stated they should attend a day centre every Friday and should go swimming every other Saturday. We looked at the records of care for this person for July and August 2017 and found this was not occurring. We raised this with the registered manager who confirmed the person had not been able to attend these activities due to a lack of staff. We observed that staff were task focused and did not have time to interact with or provide stimulation to people in the home. For example one person who is blind was sat in front of the television, which was switched on for most of the

first and second days of the inspection. We raised the lack of interaction and stimulation with the registered manager who stated that it was because they did not have enough staff. A member of staff told us, "As soon as I walk in at 7.30am you are on the go full time." They added, "We never get time to sit with them [people]; you just can't do it." Another member of staff said, "I don't think we have enough staff. We have two clients who need a lot of care so we don't have time to do activities. We need three staff if we are going out so one can stay here with [named person]. We are always rushed all the time moving from job to job. It would be nice to have time to spend with people." A third member of staff told us, "I am concerned regarding staffing levels. We can't take them [people] out like I would like."

The failure to deploy sufficient numbers of suitably qualified staff available to meet people's needs is a breach of regulation 18 of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

Following our inspection, we wrote to the provider in respect of our concerns regarding staffing levels within the home and they took immediate action by providing an additional member of staff during the day and an addition sleeping night staff member.

The registered manager had not always assessed and safely managed the risks associated with providing care and support to people. One person's care plan stated 'Food must be chopped up small or there is a very real risk of choking'. There was no risk assessment in place to help staff understand this risk, how to mitigate the risk (apart from cutting the food up) or the action to take if the person started to choke. The same person was diabetic and required their blood glucose level to be taken twice a week. However, their care plan did not contain sufficient information to help staff understand how to help the person manage their diabetes safely. Staff were unaware of what was a high or low blood glucose reading for the person. Some staff told us it was between three and 20 millimoles per litre (mmol/L), others said that it was between three and 12 mmol/L. The registered manager said she could not remember. The person's diabetic nurse was contacted and identified that staff should seek medical advice if the person's reading was above 8.5 mmol/L. The records of the person's blood glucose results for between 26/06/2017and 22/08/2017 identified that there were 15 occasions when the person's blood sugar reading was higher than 8.5 mmol/L, with a maximum reading of 15.7 mmol/L. Staff confirmed that no action had been taken in any of these instances. This put the person at risk of harm. As a result of our intervention the registered manager updated the person's care record to show the action staff should take if the person's blood glucose read exceeded 8.5 mmol/L.

The care records for a different person did not contain a hot weather/ sun protection risk assessment. The daily records of care for this person identified that in July 2017 they had suffered severe sunburn and required pain relief and addition fluids. The same person who was epileptic, which was being managed through their medicine, did not have a risk assessment or epilepsy care plan to help staff understand the nature of their seizures and the action to take should one occur.

The failure to identify, assess and mitigate the risks to people's health and safety is a breach of regulation 12 of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

Following our inspection we wrote to the provider in respect of our concerns regarding a lack of appropriate risk assessments and the lack of an epilepsy care plan and they took immediate action to ensure all risk assessments were completed.

People's medicines were not always managed safely and they did not always receive them at the right time. The National Institute for Health and Care Excellence (NICE) guidelines state: Care home providers should ensure that a new, hand-written medicines administration record is produced only in exceptional

circumstances and is created by a member of care home staff with the training and skills for managing medicines and designated responsibility for medicines in the care home. The new record should be checked for accuracy and signed by a second trained and skilled member of staff before it is first used. During our inspection we found that the medicine administration record (MAR) for one person had two separate hand-written entries for medicines; and two other people had one hand-written entry for a medicine on their MAR charts. None of these entries had a second signature to confirm that they had been checked by another member of staff. This posed a risk that the entries might not have been accurately transcribed, leading to people receiving incorrect doses of medicine.

NICE guidelines also state: Commissioners and providers of health or social care services should ensure that the following information is available for medicines reconciliation on the day that a resident transfers into or from a care home: known allergies and reactions to medicines or ingredients, and the type of reaction experienced. The MAR charts for two people in the home identified that they were allergic to particular types of medicines. However, there was no information on the MAR chart or in their care records as to the type of reaction they would experience or the action staff should take if the person suffered a reaction.

NICE guidelines in respect of 'when required' (PRN) medicine states: Care home providers should ensure that a process for administering 'when required' medicines is included in the care home medicines policy. The following information should be included: the reasons for giving the 'when required' medicine, how much to give if a variable dose has been prescribed, what the medicine is expected to do, the minimum time between doses if the first dose has not worked, offering the medicine when needed and not just during 'medication rounds' and when to check with the prescriber any confusion about which medicines or doses are to be given recording 'when required' medicines in the resident's care plan. All of the people at the home had been prescribed PRN medicines; however, there was no PRN guidance available to staff to allow them to understand when the medicine should be given, the expected effect, the frequency of doses or the action to take if the medicine was not effective.

One person was prescribed a medicine, which is subject to additional controls by law and required two signatures in the drugs book when administered or when new medicines were booked in. We looked at the drugs book and saw that there were two entries since June 2017 where only one member of staff had signed the book. This person required their medicine to be administered every 72 hours. However, we found there were two occasions since May 2017 when it was administered after 89 hours and 85 hours respectively. They were also prescribed a pain relief topical cream, which should be administered 3 times a day. However, between the 26 July 2017 and the 23 August 2017, the records showed the cream was only administered twice a day. There was no information on the person's MAR chart as to the reason it had not been given as prescribed. We raised this with a member of staff on duty who said, "I wasn't aware it was three times a day."

Another person had been prescribed two different anti-psychotic drugs at the same time and had a risk assessment in place because they were given the medicine on the instruction of the person's health professional but contrary to NICE guidelines. However, the risk assessment did not specify which specific anti-psychotic drugs it related to. The risk assessment stated the regime should continue as there were no 'ill effects'. In addition, the person's MAR chart identified that they had also been prescribed a medicine to negate the side effects of anti-psychotic medicines. However, the risk assessment or their care records did not provide any information to staff as to what 'ill effects' the person might experience, when they may need to take action or the action they should take.

All of the people in the home were living with severe learning disabilities and were not able to communicate verbally when they were in pain. Recognised good practice in homes supporting people living with a

learning disability is for staff to use a recognised pain assessment tool to help them understand when people are in pain, required PRN medicines and whether that medicine had been effective. The home did not use any pain assessment tool, therefore PRN pain relief medicines may not always be given appropriately or consistently. For example, one person's MAR chart recorded the following reasons for giving PRN pain relief medicine: 'paracetamol given PRN pain?', 'suspected pain', 'didn't want to get out of bed. Not eaten' and 'tearful'.

The systems in place to ensure the safe storage and disposal of medicines were not effective. The MAR chart for one person stated they had spat two different tablets out on the 11 August 2017. However, these were not logged in the returns book nor were they in the medicines cupboard. The senior member of staff on duty was not able to account for the missing tablets. We found that there were medicines and creams retained in the medicines cupboard, some since April 2017, which should have been disposed of, even though other medicines had been returned and disposed of since that date. This meant that there was a risk that staff could administer medicines, which should have been disposed of, to people.

The failure to ensure safe and proper management of medicines is a breach of regulation 12 of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

Following our inspection we wrote to the provider in respect of our concerns regarding the management of medicines and they took immediate action to ensure people were safe.

People were not always protected from the risk of infections because staff did not always follow the correct infection control guidance. One member of staff was wearing their personal protective equipment, gloves and apron, while supporting a person with their personal care in their bedroom. They then left this person and, still wearing the same gloves and apron, walked through the lounge of the home and spoke with another person touching, them on the shoulder. They returned to the first person and continued providing their personal care. The member of staff then came back into the lounge area with the hoist, still wearing the same gloves. We raised our concerns with the staff member who said, "Yes I know [the senior] told me about it."

We also saw the same member of staff supporting a person with their medicines. The person spat one of their tablets out into the hand of the member of staff, who was not wearing gloves. The member of staff then gave the same tablet back to the person and then carried on providing care and support to people without washing their hands. This posed a risk of cross-infection. We raised this with the staff member who agreed it was bad practice.

The failure to follow guidance in respect of the prevention and control of infection is a breach of regulation 12 of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

The provider had an infection control policy and the registered manager was the infection control lead for the home. The home was clean and a cleanliness audit had been completed in June 2017.

There were plans in place to deal with foreseeable emergencies. People had individual personal emergency evacuation plans (PEEP) which detailed their ability to respond in case of a fire and the support they would need if they had to be evacuated in an emergency. However, these were stored with people's care records and would not be easily accessible to staff in an emergency. We raised this with the registered manager who said they would arrange for an appropriately equipped 'grab bag', including the PEEPs to be available in an accessible place.

Family members told us they felt their relatives were safe at the home. One family member said, "[My relative] is completely safe at the home. They are very well looked after from a safety point of view." All of the staff and the registered manager had received appropriate training in safeguarding. Staff were able to explain the actions they would take if they had a concern about people's safety. They were aware of the provider's policy and the other organisations they could report concerns to, such as the local authority and the Care Quality Commission. One member of staff told us, "Safeguarding is all forms of abuse. Any danger and I would report to the manager or who I was on with." Another member of staff said if they had a safeguarding concern they would, "Go to the manager; if not, go to the senior or phone safeguarding or the police."

The provider had a service-wide recruitment process in place to help ensure that staff they recruited were suitable to work with the people they supported. This was managed by the provider's recruitment team in conjunction with the registered manager for the home. All of the appropriate pre-employment checks, such as references and Disclosure and Barring Service (DBS) checks were completed for all of the staff. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

Requires Improvement

Is the service effective?

Our findings

People's ability to make decisions was not always assessed in line with the Mental Capacity Act, 2005 (MCA). The 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 they lack mental capacity to make particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible.

Although staff and the registered manager had received training in respect of MCA and had an awareness of the principles of MCA, we found this training had not been refreshed in line with the provider's training policy. Staff did not always apply the principles of the MCA to the people they supported. All of the people at the home were living with a learning disability and had a limited capacity to understand particular decisions. However, no assessment of capacity had been completed to allow staff to understand what particular decisions each person was able to make for themselves and which decisions they needed help to make. For example, staff had made a decision to obtain a urine sample from one person to have it tested for a urinary tract infection. They had not completed an assessment of this person's capacity to decide whether they wanted to provide a sample or not; and no best interests decision had been completed. Two people's liberty was restricted by the use of bedrails and wheelchair lap restraints. These people were unable to consent to having their liberty restricted and staff had not followed the MCA by carrying out assessments of their capacity or completing best interest decisions. There were also no best interests decisions in respect of the provision of personal care for any of the people living at the home. Each person did have a best interests decision in respect of consenting to staff managing their medicines but these had not been preceded by assessments of people's capacity to make this decision. Therefore, the provider was unable to confirm that best interests decisions were necessary.

Staff did not always seek consent before providing care and support. Throughout the inspection we observed staff providing care without checking with people that they were happy before they did so. For example, before they supported a person to mobilise or wipe their face.

The failure to seek consent and act in accordance with the Mental Capacity Act 2005 is a breach of regulation 11 of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

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 MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA in respect of DoLS, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the provider and the registered manager were following the necessary requirements. Applications for DoLS authorisations had been made for all of the people at the home.

People did not always receive support from staff who had received the appropriate training to meet their needs. The provider had a service wide system to record the training that staff had completed and to

identify when training needed to be repeated. This included the provider's mandatory training, such as medicines training, safeguarding adults, fire safety and first aid. A member of staff told us, "I have done lots of training. I am all up to date, except for fire training which was cancelled and I am waiting for it to be re-booked". Another member of staff said, "We have regular training. I've done all of the mandatory training and just waiting for my fire and MCA training to be renewed".

Following the inspection, we requested a copy of the provider's training matrix which recorded the training staff had received. We were told that the matrix was correct as of 7 September 2017. The training matrix identified that staff were not receiving training to refresh their skills in line with the provider's policy. For example, all of the staff last received MCA training in June 2015. The training matrix identified that this should have been refreshed after a year. This had not occurred and during this inspection, we identified concerns with how staff supported people in line with the MCA.

All staff last received blood glucose and diabetes training on 2 July 2015. The training matrix identified that this should have been updated after two years. This had not occurred and during this inspection, we identified concerns with how staff supported a person to manage their diabetes and monitor their blood glucose levels. We also found that the training matrix identified that staff training had not been updated in respect of manual handling and positioning; and falls prevention.
The provider had not assured that staff received training to enable them to meet people's needs in a safe and effective way.

The failure to ensure staff received appropriate training to meet the needs of the people they were supporting is a breach of regulation 18 of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

People were supported by staff who had received an effective induction into their role. Each member of staff had undertaken an induction programme, which included a period of shadowing another member of staff. All of the permanent staff at the home had been in post for at least two and a half years. The registered manager told us that a member of staff who was new to care would have to complete an induction which followed the principles of the Care Certificate. The Care Certificate is a set of standards that health and social care workers adhere to in their daily working life.

Staff told us they felt supported by the registered manager; there was an open door policy and they could raise any concerns with them. They said they had regular supervisions. Supervision is an opportunity for management to meet with staff, feedback on their performance, identify any concerns, offer support, assurances and identify learning opportunities to help them develop. A member of staff said, "We have one to one meetings [supervision] but they did suffer when [the registered manager] was off." Another member of staff told us, "[The senior staff member] usually does mine. They are roughly every six months and an appraisal once a year."

People's families told us they felt staff understood their relative's needs and had the skills and training to look after them. One family member said the home was, "Somewhere where [my relative] is comfortable, safe, and staff know what [my relative] is like". They added, "Staff understand [my relative]. They know [my relative] better than I do". Another family member told us, "Staff have a very good understanding of [my relative] and their needs. [My relative] has been with them for such a long time they are like surrogate parents. They know what [my relative] likes and what [my relative] doesn't like."

People were supported to maintain good health and had access to appropriate healthcare services. Their records showed they had regular appointments with health professionals, such as chiropodists, opticians,

dentists and GPs. However, the records did not always reflect the outcome of those appointments. For example, an entry in the medical visits section of a person's care record stated 'urine sample taken to DR's to be checked [for a urinary tract infection]. No results yet'. There was no information as to whether staff had made follow up enquires in respect of the results. We raised this with the registered manager who told us they were sure it was done but not recorded.

People were supported to eat their meals in line with their care plans. However, mealtimes were task orientated and not always a social event for the person being supported. Staff providing support to people with their food did not always engage with them and frequently carried on a conversation with other members of staff, who were sometime in a different room. Staff who prepared people's food were aware of their likes and dislikes, allergies and preferences. A member of staff told us the menu was based on what they knew people liked.

Requires Improvement

Is the service caring?

Our findings

Family members told us they felt their relatives were treated with respect and dignity. One family member said, "Yes. They treat [my relative] with dignity. I haven't seen anything that isn't." They added, "Staff have got tasks to do but are interacting with residents all the time. They may be feeding [one person] but they will talk to the others as well." Another family member told us, "They treat them all with enormous dignity and respect. Not easy to maintain that dignity and respect with people who are so disabled."

However, our observations showed that people were not always cared for with dignity and respect. People's care plans indicated they were 'None verbal but do have a high level of understanding'. However, staff did not engage with the people they were supporting. At lunchtime, a member of staff supported a person, who was blind, with their meal. The member of staff did not introduce themself or engage the person in conversation while they were supporting them with their meal. Instead, they carried on a conversation with another member of staff about that member of staff's health. The member of staff supported the person in line with their care plan by placing their hand on top of the person's hand and guiding it to their mouth. The member of staff did not explain what was happening, what the meal was or what the person was about to eat. The only engagement with the person was task focused comments, such as, "Have you swallowed it?", "You have spilt some" and "Do you need to cough?" On a different occasion another member of staff was supporting the same person with their drink. The member of staff did not engage with the person but carried on a conversation with another member of staff about their private lives. At one point the member of staff said, "[Named person] is not drinking it; [the person] is playing up."

On a separate occasion, another person, who was blind, was sat at the dining table after eating their breakfast. Two members of staff sat at the table with the person during their break. They did not introduce themselves or engage with the person; they then carried on a conversation between themselves about different books they had read. They did not include or engage with the person who was sat passively at the table.

Staff were directive towards people and did not involve them in their care. For example, one person was sat at the table having finished their breakfast. A member of staff who was in the kitchen said in a loud voice to another member of staff who was in the lounge, where the person was sat "[Named person] can go and sit in his chair now, is that okay." The member of staff then entered the lounge and said "[Named person] stand up please." They then supported the person to their chair. They did not ask the person whether they wanted to move or where they would prefer to go or sit.

Another person, who was blind, required their food pureed. Staff told us they pureed the food altogether into one mixture, which meant the person was unable to fully enjoy the different flavours of their meal or understand what they were eating.

Other examples of where staff failed to treat people with dignity and respect included: Staff moaning about other members of staff and their failure to do their jobs properly in the presence and hearing of people; staff talking at people rather than engaging with them. A member of staff walking though the lounge and said in a

loud voice "[Named person's] grinning; [named person] likes this one", referring to a song playing on the TV; and staff approaching people, who were blind and moving their chair or undoing their aprons without saying who they were and warning them something was about to happen.

People were not offered choices about where they sat, what they wanted to do and what they wanted to eat. One person, who was blind, was being supported by a member of staff to mobilise from the dining table. They said "Shall we sit you in your chair?" and without waiting for a response led them to the sofa by the window. When they got there the member of staff changed their mind and turned the person around and said "No, let's put you on the other sofa; [named person who usually sits on that sofa] won't mind." There was no engagement with the person as to where they would prefer to sit or explanation as to why they were to sit on a different sofa.

The failure to respect people's choices and treat them with dignity and respect is a breach of regulation 10 of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

Staff did not always respect people's privacy. During the inspection we heard staff using a loud voice and sometimes from room to room to discuss personal issues such as "I am just taking [named person] to the toilet" and "Can you get a flannel to wipe [named person's] face." The daily staff shift handover took place in the lounge area in the presence and hearing of people. These handovers included discussions about people's care, other private information and personal details.

The failure to ensure the privacy of people is a breach of regulation 10 of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

People's families told us they thought staff had developed caring and positive relationships with their relatives. One family member told us, "Staff are devoted [to the people]; I know they do a lot in their own time. They visited [one person] in hospital and for [my relative's] birthday they came in especially for it even though they were off". Another family member said, "The service is excellent towards outstanding". They said the reason they felt this was because of "The care and commitment of staff above all else. So conscientious, committed and devoted".

We did see other occasions where staff interacted with people in a positive way. For example, one person liked to sit on the floor and we saw a member of staff sit on the floor to engage with them. On another occasion a person who was unable to mobilise by themselves, looked uncomfortable in their chair. A member of staff identified this and asked whether they would like a cushion. Although the person was unable to respond, the member of staff obtained a cushion and placed it under the person's arm. We could see from the person's face that they felt more comfortable.

People's families were involved in discussions about developing their care plans. One family member told us, "I do get involved in [my relative's] care review. I think we have had one this year". Another family member said, "I am involved in [my relative's] care to a certain extent; as much as I can be in [name of location where they reside]. I am removed from the day to day care. They tell me if there is anything serious".

Requires Improvement

Is the service responsive?

Our findings

People's families told us they were happy with how staff looked after their relatives. One family member said, "I usually visit once a week. If [my relative] doesn't feel well they [staff] tell me; she may go to her room; they give her paracetamol or something."

However, staff told us they did not feel they were able to effectively meet the needs of two people in the home. One member of staff told us "I don't think we can meet [named person's] needs. [The person] struggles to get upstairs so [the person] sleeps in the lounge on a 'Z' bed. We put a screen around [the person] for privacy." They added, "When I first came here we were able to do lots of things, but as people's needs have changed it is harder." Another member of staff told us, "It has got a lot harder because of [named person] and [named person]. We used to go out a lot but can't get out now because we haven't got the staff." They told us they were aware of a person's pressure sore management and the need to reposition them in bed night. They said, "You have to just roll [the person] because you are on your own."

People did not always receive care and treatment that was personalised and met their needs. One person suffered from a hay fever allergy; however, there was no information in their care records to help staff understand how the hay fever affected them and the action staff should take to support them. The person did have some hay fever medicine to take on an 'as required' PRN basis but there was no guidance for staff as to when this medicine should be administered.

Another person had a history of urinary tract infections (UTI), however there was no UTI care plan available to help staff understand what preventative action they could take, how a UTI would affect the person and the action they should take if a UTI was suspected or identified.

People's care records were not individualised in a way that helped staff understand how to support them in line with their individual needs. The records identified that two people had medicine related allergies however they did not identify how those allergies would affect the person and the action they should take to support them if they had a reaction. We have referred to this in detail in the safe section of this report.

We did see other examples of where people had a plan that was personalised to them. For example one person who occasionally behaved in a way that staff or other people using the service may find distressing, had a plan in place to help staff understand how to manage that behaviour. Another person who was at risk of pressure sore injuries had a pressure sore management plan in place to help staff understand how to support the person safely. However, staff did not always follow this plan. We have referred to this in detail in the safe section of this report.

People were not provided with appropriate mental and physical stimulation. People spent their time sat passively or sleeping in the lounge area with very limited interaction with staff. One person who was more mobile than the others did instigate interactions with staff but this was mostly as a means of drawing their attention to something they wanted, such a drink. As a result of staffing levels people did not have the opportunity to access the community on an individual basis, although three of them did have limited

opportunity to go out collectively, once or twice a month. People also received a visit from an aromatherapist at the home who spent time with each of them on an individual basis.

We raised these concerns with the registered manager who accepted they were an area that needed improvement but were related to the lack of staff which we have referred to in detail in the safe section of this report.

People had lived at the home for a long time and were supported by staff who knew their needs because they had worked with them for a number of years. Staff were able to describe the care and support required by individual people. For example, one member of staff was able to describe the support a person required when they were eating their meals. This corresponded to information within the person's care plan. We saw them supporting the person in line with their care plan. Handover meetings were held at the start of every shift and provided the opportunity for staff to be made aware of any relevant information about risks, concerns and changes to the needs of the people they were supporting. This was supported by a correspondence book, which provided written information about people and their care, for those staff who were not working at that time.

Each person had an allocated keyworker, whose role was to be the focal point for that person and maintain contact with the important people in the person's circle of support. Each of the key workers carried out a monthly review of any activities they had engaged with and their health needs. A copy of this review was then sent to their family as an update and to seek their views. The families we spoke with confirmed they received these reports and found them helpful. However, one family member said, "They don't seem to send the monthly reports out as often as they did. They do come but not for some time."

The provider had a policy and arrangements in place to deal with complaints. They provided detailed information on the action people could take if they were not satisfied with the service being provided. Both of the family members we spoke with told us they knew how to complain but did not have any complaints. One said, "I have not had anything to complain about but I would speak to [the registered manager] if I had a complaint." The other family member told us, "If I was concerned I would raise it with [the registered manager] or a member of staff." The registered manager told us they had received one complaint over the previous year. They dealt with this complaint but had not recorded it in line with the provider's policy.

Inadequate

Is the service well-led?

Our findings

The provider did not have a system or process in place to ensure that records related to people's care and treatment were accurate and up to date. The registered manager explained that each person had two files in respect of their care, one which contained day to day information and some updated aspects of their care plan and a second file which contained the remainder of their care records.

We checked both care files for one person and found their moving and handling assessment had not been updated since 2013, when it stated they required minimal assistance to mobilise. Their daytime personal care plan had not been updated since 25 January 2016 and stated 'Two staff will need to support me to walk anywhere even short distances as I am becoming frail and unsteady on my feet'. Staff informed us that this person had been unable to walk for over a year and could only mobilise with a hoist and wheelchair. The same person's nutritional care plan, which was dated 9 January 2016, stated 'I need to be offered a drink every 15 minutes. Due to dementia I forget. Drinking is vitally important'. During the inspection we observed this was not happening. We raised this with the senior member of staff on duty and they told us "This was no longer relevant as they were monitoring [the person] and she was drinking plenty of fluids." We looked at this person's care records and there was no updated nutritional care plan to reflect this change. They also had a letter in their care records from the Speech and Language Team (SALT) dated 12 May 2017 confirming that the person needed stage 1 thickener in their fluids. However, a risk assessment, from before the SALT letter, dated 9 January 2017 stated 'Drinks are now to be thickened to stage 2/3'. When we raised this with the registered manager they confirmed they adjust the amount of thickener on a day to day basis on the advice of a GP, although there was no documentation to support this.

We looked at the care records for another person who is diabetic; they stated 'If I appear overly sleepy or lethargic or you are concerned about my levels please ensure my blood sugars are tested by a support worker'. During the inspection, we observed that the person remained asleep on the sofa for over three hours despite staff's attempt to rouse them. We raised this with a member of staff who told us the entry was no longer relevant as this was now normal behaviour for the person since they had come out of hospital in April 2017. The person's care record had not been updated to reflect this.

Although, the same person's manual handling assessment had been reviewed following their discharge for hospital in April 2017, it did not reflect changes to their mobility since their discharge. The person was no longer always able to mobilise upstairs to their bedroom; and they displayed behaviour where, while being supported to mobilise, they would just drop to the floor and not move. In addition, an entry in the communication book for 13/08/2017 stated the person was taking medicines which may affect their mobility.

There were other examples of records not being accurate or out of date, these included; two people who each had three separate documents within their care records regarding the medicines they were taking. Each document was different and not properly cross referenced. One person's hospital passport, (which the registered manager told us was used as a 'grab sheet' for when they need to attend hospital in an emergency), was last updated in 2015 and was out of date. Their health action plan within their care records

had also not been updated since 2013.

A member of staff told us, "I only look at the daily records [of care] to find out what's been happening as I know some of the other stuff is out of date."
The absence of a robust governance system to ensure records were analysed and completed accurately by staff exposed people to risks of unsafe or inappropriate care or treatment.

The failure to operate effective systems or processes to ensure people's records were accurate and up to date is a breach of regulation 17 of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

The provider did not have an effective system in place to monitor the quality and safety of the service provided at Overbrook. There was a lack of strategic oversight in respect of the running of the home and the robustness of the registered manager's internal quality assurance processes. The registered manager had undertaken some audits, which included a health and safety inspection, cleanliness audit, a bedroom check, an equipment audit and a medication audit. However, their approach to quality assurance was not effective and had not identified the concerns, resulting in five breaches of regulation that we found during the inspection. These breaches were with regard to, the lack of risk assessments, inaccurate and out of date records, poor infection control, unsafe medicines management, out of date staff training and a failure to treat people with dignity and respect.

The failure to have effective systems and processes to assess, monitor and improve the quality of the service is a breach of regulation 17 of the Health and Social Care Act 2008 (regulated activities) regulations 2014.

The registered manager did not always take appropriate action when incidents occurred within the home. For example, the daily records of care for one person identified that they had suffered severe sunburn, requiring pain relief and additional support; however, they did not identify this as an incident that should be notified to the appropriate authority, such as the local adult safeguarding team.

There was a clear management structure, which consisted of the Service Manager - ASC Short Term and Learning Disability Services, who was the provider's representative; the registered manager; and the senior care staff member. However, the provider was not fully engaged with the running of the home and had not demonstrated good leadership in respect of the support provided to the registered manager. During the inspection we found that the registered manager had not received adequate support from the provider. The registered manager was contracted to work three shifts a week; whilst on duty the registered manager also assisted care staff to deliver care as the current staffing levels were not meeting people's needs. This meant that the registered manager had little protected time to undertake all of their responsibilities in relation to monitoring the quality and safety of the service. The registered manager told us they had previously raised their concerns with their line managers "But they have not listened." They told us that although they felt better supported by their current line manager, who had been in post since February 2017, they felt it was "More of a remote support; so we just plod along and do the best we can." They told us the provider's Service Manager had not previously visited the home until the day of our inspection. We found that the provider had failed to provide sufficient time and structured support to enable the registered manager to undertake their role effectively and to a good standard.

The registered manager did attend a monthly managers meeting, which was attended by the managers of the provider's other services and the Service Manager. They said "I have raised the issue of staffing in the past many times but not with [the current Service Manager]". The registered manager told us they had been off work for a period of time and now they felt like they were "Chasing their tail". They said, "When I am off,

no-one covers. We have an on call [manager] for emergencies and my senior has to cope but she is on shift". A member of staff told us, "[The registered manager] can only work three shifts, so sometimes things are in a bit of a muddle and she has been off for some time as well."

Regular staff meetings provided the opportunity for the registered manager to engage with staff who spoke positively about the registered manager. One member of staff said, "We have regular staff meetings, about every six weeks. I like to think they listen [when we raise things]; sometimes things change." They added, "[The registered manager] is open and approachable." Another member of staff told us, "[The registered manager] is part time; she does three shifts a week and will come in if needed. She has an open door policy and if she can sort it out she will sort it out."

Although they worked part time, the registered manager made sure they were available for people and encouraged open communication with families and staff. People's families all said they were happy with the service provided.

People had access to advocates who were available to support them if they had concerns about the service provided. The registered manager sought feedback from people's families on an informal basis when they met with them at the home or during telephone contact. They also used the keyworker review, which was sent to people's families as an opportunity to obtain feedback. One family member told us, "I do give feedback, usually at the bottom of the monthly reports. I write something about how I found [my relative] or feedback on the service. We do have a dialogue". The registered manager also sent out a questionnaire seeking the views of people's families, and professionals. We looked at the results from questionnaires sent out in 2017 and saw these were primarily positive. However, respondents did make comments about staffing levels, such as 'More staff needed' and 'To say they are short staffed they do a wonderful job'. Another family member commented the home 'needs improvement' and raised concerns about their relative sleeping on the sofa. A professional commented that they felt the home was 'exceptional' and 'Overbrook is a flag ship home for the council. Should be proud'.

The home had a whistle-blowing policy, which provided details of external organisations where staff could raise concerns if they felt unable to raise them internally. Staff were aware of different organisations they could contact to raise concerns. For example, care staff told us they could approach the local authority or the Care Quality Commission if they felt it was necessary.

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 10 HSCA RA Regulations 2014 Dignity and respect The provider had failed to ensure that staff respected people's choices and treat them with dignity and respect

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure staff sought consent from people and act in accordance with the Mental Capacity Act 2005

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure medicines were managed safely; risks to the health and safety of service users are assessed and mitigated consistently; and that staff followed infection control guidance in respect of the prevention and control of infection.

The enforcement action we took:

Warning notice issued

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure that service users' records were accurate and up to date; and they failed to ensure that you have effective systems and processes in place to assess, monitor and improve the quality of the service.

The enforcement action we took:

Warning notice issued

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure that sufficient numbers of suitably qualified, competent, skilled and experienced staff were deployed to meet people's needs.

The enforcement action we took:

Warning notice issued