Optima Care Limited

Optima Care Limited - 37 Spenser Road

Inspection report

37 Spenser Road
Herne Bay
Kent
CT6 5QP

Tel: 01227741114
Website: www.optimacare.co.uk

Date of inspection visit:
24 August 2020

Date of publication:
27 October 2021

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
37 Spenser Road is a residential care home providing personal care to 11 people the time of the inspection. The service can support up to 13 people in two buildings.

Services for people with learning disabilities and or autism are supported
The service was registered to provide support to up to 13 people and there were 11 people using the service at the time of our inspection. The service is larger than recommended by best practice guidance. The service was not person centred, and people were not supported to maximise their independence.

People's experience of using this service and what we found
There had been very little improvement since our last inspection in May 2019. There remained serious short-falls within the service which exposed people to risk.

Risk assessments were not in place to support people living with health conditions including constipation, and epilepsy. Manual handling guidelines were not in place for a person who required support moving and transferring. Most of the staff team did not have in date manual handling training.

Environmental risks had not been assessed, as there was a bath hoist that had not been serviced. Provider audits did not identify this issue.

Staff lacked the training guidance and support to fulfil their roles. For example, staff had not received training in key areas such as positive behaviour support. The provider did not recruit staff in a safe way to ensure people were suitable to work with vulnerable adults.

Risks relating to covid-19 had not been identified by the provider. For example, staff were not using the appropriate personal protective equipment in line with government guidelines.

There was a lack of oversight and learning in relation to incidents and accidents. Improvements had not been implemented and embedded and as a result incidents re-occurred.

The culture of the service was not positive. The changes in management had left staff morale low. There had not been a registered manager at the service since July 2018. This had impacted on the quality of the service, and outcomes for people.

Checks and audits had been ineffective. Issues identified at our last inspection remained and we identified further concerns. There was a lack of leadership, consistency and oversight at the service. Regulatory responsibilities had not been met.

The service didn't always (consistently) apply the principles and values of Registering the Right Support and

other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence. The outcomes for people did not fully reflect the principles and values of Registering the Right Support for the following reasons; lack of choice and control, limited independence, limited inclusion for example, people were not engaged in meaningful activities.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection (and update)
The last rating for this service was Requires Improvement (published 3 July 2019) and there were two breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
We received concerns in relation to staffing, risks to people, lack of management oversight. 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 Requires Improvement 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 key question 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 37 Spenser Road on our website at www.cqc.org.uk.

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 risks to people not being mitigated, people being at risk of abuse, staff not being recruited safely, notifications not being submitted and checks and audits being ineffective at this inspection.

We imposed positive conditions on the providers registration.

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**

Optima Care Limited - 37 Spenser Road

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 as part of our Thematic Review of infection control and prevention in care homes.

Inspection team
The inspection was carried out by two inspectors.

Service and service type
37 Spenser Road 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 did not have a manager registered with the Care Quality Commission. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was announced. We gave the provider less than 24 hours' notice of the inspection. This was to check if any staff or people at the service had tested positive or had symptoms of COVID-19 and to discuss arrangements for the inspection and PPE required.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used all of this information to plan our inspection.

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.

During the inspection-
We spoke with two people who used the service about their experience of the care provided. We spoke with ten members of staff including the provider, manager of another of the providers services, senior care workers, care worker.

We reviewed a range of records. This included nine 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. We spoke with two professionals who have visited the service.

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 Requires Improvement. At this inspection this key question has deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Preventing and controlling infection

- At our last inspection we identified risks to people had not been identified and action taken to mitigate them. At this inspection we found no improvements.
- Risks to people's health had not been identified or mitigated. For example, three people were at risk of constipation. There were no risk assessments or care plans in place to inform staff of action to take should someone become constipated. Bowel movement charts were in place for staff to monitor people's bowel movement. However, on four different occasions over one month one person was noted as having no movement for between three and nine days. The provider was unable to evidence action taken, for example a referral to the GP. This placed people at significant risk.
- Personal Emergency Evacuation Plans (PEEP) were in place to inform staff how best to support people in the event of a fire. However, they were very basic, did not always detail the support people would need. Other risks had not been considered, for example some people used emollient creams which were highly flammable. This was not detailed on the person's PEEP and the PEEP lacked guidance for staff to reduce the risk such as regular washing of clothing.
- At our last inspection we found a lack of guidance for staff on how to support people who used a hoist. At this inspection we found no improvements. Information in care plans was not detailed enough and referenced guidance on the person's bedroom which was not in place. Staff did not have in-date manual handling training.
- At our last inspection, we found one person lived with epilepsy did not have a care plan in place. At this inspection we found one person living with epilepsy who had regular seizures did not have a care plan in place to advise staff how best to support the person. During the inspection staff wrote the care plan, and we were sent copies of this following the inspection.
- One person had behaviours which could challenge others. The provider had implemented a 'risk and management plan' which detailed how to support the person and included a section for physical intervention. There was no documentation to evidence a best interest meeting had been held to agree to the use of physical intervention.
- Not all staff followed the guidance on appropriate PPE (personal protective equipment) in line with Public Health England's 'Personal protective equipment (PPE) – resource for care workers working in care homes during sustained covid-19 transmission in England' July 2020. Staff were observed wearing fabric face masks, and one staff member often had their mask resting under their nose. This placed people at higher risk of covid-19.
- Staff had not received any training on the risks of covid-19, or how to apply and take off their PPE to reduce the risk of cross infection.
- Thickening powder was not stored in line with guidance. During the inspection we observed thickening

powder to be on the kitchen side, within easy access of people. Staff told us thickening powders were stored in two cupboards within the service. One cupboard was open with the keys in the lock, and the second cupboard did not have a lock. Thickening powder is used to make fluids thicker so that people with swallowing difficulties can drink safely. If the thickening powder is swallowed without fluid, it can form an obstruction and people would be at risk of choking.

● Environmental risks had not always been well managed. For example, we identified that the bath chair within the service was due to be serviced in July 2020. There was confusion from the provider about when the chair was due to be serviced. Despite hoists being serviced in July 2020 the operations manager told us they had been unable to have the bath chair serviced due to covid-19.

Learning lessons when things go wrong

● The provider informed us that accident and incident forms were completed and details of these were logged on a central report. However, when the provider reviewed this report, the last entry of an incident was February 2020. Following the inspection, the provider sent us a revised accidents and incident log but this did not detail all incidents reported to us.

● The providers response to reviewing and investigating incidents was insufficient. There was no evidence of learning from incidents, and we found necessary improvements were not always made. For example, when one person displayed behaviours which could be challenging to them and others, we found their care plan had not been reviewed. There was no positive behaviour support (PBS) support plan and support plans in place did not have guidance for staff on how best to support that individual. Positive behaviour support (PBS) is 'a person-centred framework for providing long-term support to people with a learning disability, and/or autism, including those with mental health conditions, who have, or may be at risk of developing, behaviours that challenge. Incidents involving this person had re-occurred.

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.

Systems and processes to safeguard people from the risk of abuse

● The provider had not always protected people from the risk of abuse. We identified an incident between two people at the service which had not been reported to the local safeguarding authority.

● An incident report between two people detailed that a person had been 'held back' by a staff member. The person involved was not assessed as needing to be restrained, and staff had not received training in restraint. The provider had failed to identify the potential unauthorised use of restraint and investigate accordingly.

● As a result of incidents between people, one person spent their time at the annex within the grounds of the service. There was no risk assessment or best interest documentation in place to support the decision making to seclude the person.

● Staff told us they understood how to raise concerns about people. However, the majority of staff had not completed safeguarding training.

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.

Staffing and recruitment

● There were insufficient numbers of suitably qualified, competent, skilled and experienced staff to meet people's needs. This had a significant impact on people's safety and their care and treatment.

● The provider had not used a dependency tool to determine the number of staff needed to meet people's

needs. People had a range of complex needs, some of which had increased during the pandemic. The provider had failed to re-assess people's needs and increase staffing to keep people safe.

● There were six staff members deployed in the morning, with one person being supported on a one to one basis. One person needed two staff to support with personal care and to transfer safely. Staff were also responsible for the cleaning, food preparation, cooking and laundry at the service.

● The provider failed to organise alternative activities during the pandemic, when people were unable to take part in the activities they would have previously. Staff told us as a result of there being more people in the service, not engaging in activities incidents between people had increased. For example, one person had increased behaviours that challenged with resulted in re-occurring incidents between them and others living at the service.

● Some people could display behaviours that could challenge others. We found that only a quarter of the staff had been trained in positive behaviour support (PBS). Positive Behaviour Support is a person-centred approach to supporting people with a learning disability who may be at risk of displaying behaviours that could challenge. When people displayed behaviours that challenged staff did not respond appropriately, and incidents between people reoccurred staffing levels were not re-assessed or amended placing people at risk.

● No staff had received training in Therapeutic Management of Violence & Aggression (TMVA), despite physical intervention being written into a person's care plan. Some people were at risk of choking, but staff had not received any training in this area.

● Some people needed support to transfer with a hoist. Staff we spoke with told us they regularly supported the person, despite not having in date moving and handling training. This placed the person at risk of receiving unsafe care.

The failure 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 not protected by robust recruitment procedures. This left people at risk of harm because the provider had not made all the appropriate checks to ensure staff were suitable for their role.

● All three staff recruitment files viewed had missing checks and information. One staff member had left the service and returned several month later. A new Disclosure and Barring Service (DBS) check was not obtained. (DBS checks identified if prospective staff had a criminal record or were barred from working with adults). Checks had not been made or references obtained for the period of time the staff member had left the service.

● Another staff member references had not ensured they were suitable and of good character and gaps in employment had not been fully explored. The third recruitment file viewed recorded one reference had been received after the staff member had begun employment and the other reference was a personal reference so the provider could not be assured the staff member was suitable for the role. Their identification had not been verified and there were gaps in the employment history.

The failure to ensure that persons employed were of good character and to ensure recruitment procedures were operated effectively. This is a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014

Using medicines safely

● Medicines were managed safely however there was no specific guidance around how people preferred to take their medicines. For example, some people preferred to take their medicine from specific coloured medicine pots and beakers. One person would sometime refuse their medicines. Although staff described the action they took if this happened. There was no recorded information for staff to follow who may not

know the person as well or to ensure the approach to managing this was consistent.

● Self-medication assessments had been completed when people first moved into the service. However, people had not been re-assessed. The provider had not demonstrated people had been continually assessed to try and support them to become more independent around this. This is an area for improvement.

● Temperatures had been taken to ensure medicines maintained their efficiency, and action had been taken when temperatures increased.

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 Requires Improvement. 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.

At our last inspection the provider had failed to assess, monitor and improve the quality and safety of the service. This was a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

At this inspection, improvements had not been made and the provider was still in breach of Regulation 17.

Continuous learning and improving care

- We identified wide spread and significant shortfalls in the management of risk and delivery of care during our inspection.
- Quality assurance processes were not effective and did not address issues identified in our previous inspection. For example, during our last inspection it was identified care plans were not sufficiently detailed. The provider told us they were in the process of re-writing them however during this inspection we found no improvements.
- At our last inspection, risks to people had not been prioritised when re-writing care plans, and we found the same during this inspection. Some information missing during our last inspection was still not in place, for example manual handling guidelines and risk assessments to reduce the risks to people's health.
- At our last inspection, we identified people were not engaged in meaningful activities. At this inspection we found no improvement. The provider had not implemented new activity time tables for people or identified people's activities would need reviewing as they were not able to do previous activities due to covid-19.
- There was a service improvement plan (SIP) in place to implement improvements within the service. This had been ineffective and was inaccurate. For example, the SIP detailed notifications had been completed and was 100% complete. However, this had not been reviewed, and we identified notification had not been submitted. Some actions had been marked as completed in December 2020 which was incorrect.
- The SIP detailed resident meetings were occurring, however the recording of these were poor and no actions or outcomes were documented making them ineffective.
- The SIP detailed that accidents and incidents reports needed to be signed off by a manager with outcome analysed and recorded. The SIP identified that these actions should have been completed by March 2020, however there was no detail to confirm this had been completed. Incident forms had not always been reviewed by management.
- An incident report reviewed noted that one person had been 'held back.' The provider had failed to identify this or conduct an investigation into the potential use of unauthorised restraint.
- Quality assurance processes did not identify gaps identified with training for staff. For example, people

were supported by staff who did not all have in date training for manual handling.

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 not a positive culture within the service. Staff felt frustrated at the lack of leadership and changes in management.

● People had not been supported to achieve positive outcomes. For example, providing support to people had not progressed since our last inspection, and people told us they wanted to take part in more activities which had not been facilitated.

● Documentation reviewed was not always person centred and in line with current guidance on how to support people. For example, an incident form reviewed noted someone was 'sent' to the kitchen.

● During our inspection we observed positive interactions between people and staff.

● The provider had not been open and honest. For example, staff told us following an incident between two people, the provider had failed to inform the people's relatives about the incident. Staff told us the person was informed by their loved one.

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

● Resident meetings had taken place but were not meaningful. For example, there was no details of outcomes of meetings or actions taken as a response to the meeting.

● Quality assurance questionnaires had been sent to family members but were in the process of being collated by the provider. Two of the three questionnaires detailed relatives did not feel 'kept up to date with changes in the home.' We will review action taken as a result of feedback during our next inspection.

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

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

● At the time of our inspection, there was no registered manager in post. This is a condition of the provider's registration with the CQC. The registered manager had left the service in June 2018. Since then a number of managers had managed the service. A manager had been appointed and had applied to be registered with the CQC, however this application is now on hold as the manager is not currently at the service.

● Governance systems were not effective, and roles and responsibilities were unclear. The provider had not been open and transparent about incidents that had occurred at the service.

● Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. This enables us to check that appropriate action had been taken. The provider had failed to inform the CQC of a safeguarding incident.

● Incident documentation was not collated and complete, therefore we could not be sure that other incidents had not been notified to the CQC.

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

Working in partnership with others

● The provider had not always been open and transparent with external stakeholders and agencies. For example, when incidents occurred the provider had failed to inform CQC, the Local authority safeguarding

team, and people's relatives.
● Staff worked with healthcare professionals to support people to access care needed, for example the reflexologist and chiropodist.

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 You failed to notify the CQC of safeguarding incidents.

The enforcement action we took:

Impose a condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment You 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:

Impose a condition

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 You failed to protect people from abuse and improper treatment.

The enforcement action we took:

Impose a condition

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

The enforcement action we took:

Impose a condition

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed You failed to ensure that persons employed were of good character and to ensure recruitment procedures were operated effectively.

The enforcement action we took:

Impose a condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing You failed to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff.

The enforcement action we took:

Impose a condition