Optima Care Limited

Eastry Villa's

Inspection report

High Street
Eastry
Sandwich
Kent
CT13 0HE

Tel: 01304619976
Website: www.optimacare.co.uk

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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

Eastry Villa's is a 'care home' for up to 11 people with learning disabilities and mental health conditions. People in care homes receive accommodation and personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. At the time of the inspection, there were eight people living at the service. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

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

People had been unlawfully restrained by staff and were at risk of harm. There had been numerous incidents which were not reported to the relevant professional stakeholders. Staff did not have the skills or competencies to support people when they were distressed or to support them proactively to manage their behaviours. People's human rights were not upheld. People were told to 'be good' and punished for behaviour staff did not agree with. People had been unnecessarily restricted and were not supported to be independent or make their own choices. The registered manager and provider had poor oversight of incidents and had allowed people to be harmed by staff. The registered manager was involved in incidents of unlawful restraint. The provider had failed to introduce measures to reduce repeated incidents or learn lessons.
Medicines were not managed safely or in line with best practice guidance. There were not sufficient numbers of suitably qualified staff to meet people's needs. We were not assured that the provider was protecting people from the risk of infection.

There was a closed culture in the service which was not person centred. There was a lack of oversight and leadership at the service. Staff did not understand their responsibilities, as a result people were harmed. The provider did not learn lessons or implement improvements leaving people at risk. 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 told us they were not asked for their views or supported to make decisions about the service.

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 and 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.

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

Following this inspection, we worked closely with local authorities to ensure people were safeguarded from ongoing harm. Eight people were supported to move out of Eastry Villas, there is currently nobody living at Eastry Villas.

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 27 December 2018).

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 Eastry Villas 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 Eastry Villa's. We took action against the provider and cancelled their registration at Eastry Villa's. Everyone moved out of the service and Eastry Villa's 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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Eastry Villa's

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 on the first day and one inspector on the second day.

Service and service type
Eastry Villas 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 and received some feedback. 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 10 members of staff including the, operations manager, two consultants, a team leader, support workers and agency staff. We spoke with three people living at the service, some people were not able to verbally communicate so we made observations of staff interacting with people in the communal areas. We reviewed a range of records. This included four 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 did not receive all of the information we had requested.

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 the risk of abuse and as a result had suffered harm. People told us they had witnessed staff restraining people, and it had caused them distress. One person told us, "They end up doing restraint like a policeman would, I don't agree with it and I go upstairs and cry. I wish I had the power to pull them off." People told us they had expressed concerns to the registered manager but had 'given up' as they had not listened or taken any action.
- Staff did not have a good understanding around their responsibilities in respect of safeguarding, as a result people had been harmed. One person raised concerns about a historic incident of abuse that had occurred. Staff documented this, but it was not reported to the Local Authority safeguarding team or the Care Quality Commission (CQC). Staff told us they understood the principles of safeguarding, but we found they failed to report serious concerns when identified.
- People had been unlawfully restrained on a frequent basis. One staff member told us, "Now I think, yeah restraining someone I see it was a safeguarding. I wasn't aware there was paperwork and stuff needed with it." Incidents of restraint had not been reported to external agencies such as the local authority. After the inspection the provider's consultant told us 64 incidents should have been reported to the local authority safeguarding team and CQC.
- Where people had been physically harmed and the cause was unknown no investigation took place. One person had eight instances of unexplained bruising recorded on body maps from 15 December 2020 to 6 January 2021. Although these had been documented by staff, no analysis or reporting of the unexplained bruising had been completed by the registered manager or nominated individual.

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 people in the least restrictive way. One person was restrained on 10 occasions between 6 January 2020 and 16 November 2020 with up to six staff involved. Incident forms showed these incidents were not the least restrictive approach. The person did not have guidance or agreement in place that they could be restrained by staff. There had been no best interest meeting to agree on this action.
- Another person had been subjected to seven incidents of restraint during January 2021 where they were held on the floor by up to five staff for up to twenty minutes. The registered manager was involved in incidents of unlawful restraint. People were restrained by staff using techniques that would purposely cause

pain.
● People were being harmed and placed at risk of harm because incident management and oversight was poor. Piles of unread incidents reports were stored in carboard boxes and missed important information such as full names of staff involved. Senior managers failed to read, review or analyse incident forms. There was no evidence of learning from incidents.
● Risks to people's health had not been managed, and as a result people were harmed. One person had lost a significant amount of weight from March 2020 to February 2021. Staff had only raised concerns with the GP in January 2021.
● People were at risk of constipation and were not supported to manage this safely. On nine of 14 documented days, one person did not have a bowel movement, and on five of 14 occasions pass urine for the whole day. Staff did not seek medical advice from the GP as outlined in the person's care plan. On one occasion the person's daily notes said they were 'sat on the toilet crying then rolled and cried on the floor for 20 minutes. Sat back on the toilet and passed urine.'

Preventing and controlling infection
● We were not assured that the provider was protecting people from the risk of infection.
● One person told us staff did not always wear their mask or wear their mask correctly. Staff told us they struggled to enforce staff wearing their mask correctly, when senior managers were observed not to be wearing a mask. We observed staff to be wearing their masks under their nose, not in line with government guidance.
● Staff worked across two of the providers locations. We were told us this was to give staff variety of where they worked. This increased the risk of the spread of COVID-19 and is not in line with government guidance. 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.

Using medicines safely
● Medicines were not managed safely or in line with best practice guidance. Medicine's had not been counted when new cycles started; there was no documentation to confirm the number of medicines there should have been in place. Staff told us daily and weekly counts stopped when new systems were implemented in December 2020.
● Stock checks completed during the inspection suggested people had up to two weeks' worth of surplus medicines. Due to the lack of oversight of medicines stock, staff could not be assured that people had been given their medicines as prescribed.
● Some people were prescribed medicines on an 'as and when' basis. Guidance around this was not clear, and did not detail the maximum dose people could have in a 24-hour period. Where people were prescribed medicines to support them to open their bowels on an 'as and when' basis, these were not always administered when required, placing them at risk of harm.
● There were not sufficient numbers of competent staff to administer medicines. Staff from the providers other services would attend to give people their medicines. Staff's lack of knowledge of people and the lack of guidance increased the risk of people not receiving their medicines as prescribed.
● Medicines administration records (MAR) were not completed accurately resulting in gaps in recording. We could not be assured people received their medicines as prescribed.

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

Staffing and recruitment

● There were not sufficient numbers of suitably qualified staff to meet people's needs. People could display behaviours which could be challenging to manage. Staff lacked the knowledge, skill and competency to support people in a positive way. For example, staff did not understand the principles of positive behaviour support (PBS). Instead of supporting people positively punishments were used when people behaved in a way staff did not agree with, such as ending activities. We observed staff stand and watch people who became anxious, they did not understand how to de-escalate situations or offer positive support.

● Not all staff had training in physical restraint and did not know how to undertake restraint safely. Staff were not competent to manage behaviours that were challenging. One person told us, "Some of the agency use pressure, they use their elbows with so much force. I would be surprised if the [people] didn't get hurt," and "The staff get puffed out that's how hard they are holding them, they have to swap around."

● There was a high volume of agency staff deployed. The registered manager and nominated individual did not complete checks to assure themselves that agency staff had the skills and knowledge to support people.

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 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.

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.

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

●The registered manager, nominated individual and regulatory compliance manager failed to identify there was a lack of guidance and risk assessments for staff to follow. This placed people at significant risk of harm, and people were subjected to unlawful restraint on numerous occasions.

● There was a lack of oversight and leadership at the service. Staff did not understand their responsibilities. As a result people were harmed. We identified widespread and significant shortfalls in the management of risk and delivery of care. These had not been identified by registered manager, operations manager, or nominated individual.

● The registered manager was aware and had been involved in incidents of unlawful restraint. These incidents had not been notified to the Care Quality Commission (CQC) or the Local Authority Safeguarding team.

● 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 always completed in relation to the use of restraint. Some people had authorised Deprivation of Liberty safeguard (DoLS) to agree certain restrictions. The registered manager did not ensure conditions attached to the DoLS were complied with. Some DoLS had expired and people continued to be restricted.

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

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 in the service 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, not being able to go into the kitchen or being allowed certain food.

● People's human rights were not upheld. People were told to 'be good' and punished for behaviour staff did not agree with. For example, following an incident a person was told that 'their actions were unacceptable and told to sit on the bean bag for 10 minutes'. Another person had an incident which resulted in them being restrained by four staff. One of the triggers identified as being the cause of the incident was the person being told the night before that their behaviour had made the team leader

'disappointed' in them.
● The duty of candour is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. 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 in sharing this information with stakeholders.

Continuous learning and improving care
● The provider did not learn lessons or implement improvements leaving people at risk. Medicine audits had not been completed since September 2020. A new medication system had been implemented in December 2020. No checks had been completed on the effectiveness of the new system. The registered manager and nominated individual failed to identify any significant shortfalls identified during inspection of the management of medicines.
● There had been no oversight or scrutiny of incident records. There had been no learning to prevent repeated incidents from occurring.
● After the inspection the provider sent us an audit which was completed in October 2020 by the regulatory compliance manager. This was ineffective and failed to identify the wide range of concerns we identified. For example, incident forms were reviewed, but there was a failure to identify the significant risks to people who had been unlawfully restrained, or that there was a lack of guidance and documentation. The provider told us after the inspection there were significant shortfalls in their auditing systems, and they were unaware of the significant risks and harm people had been subjected to.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People told us they were not asked for their views or supported to make decisions about the service, people did not have any resident meetings. One person had identified that another person was triggered by the environment and had shared their concerns with the registered manager, but no action had been taken. People were not asked about how they wanted the service decorated or have any choice around their meals.
● Some people spoke multiple languages. There were no details in the care plans about how to communicate with people in different languages. Staff told us they had not learnt any words in other languages. Some people did not communicate verbally. Not all staff were trained in the use of Makaton, which caused incidents with people. For example, one incident report said an incident had occurred because people were frustrated staff could not understand them.
● There was no evidence that the opinions of relatives had been sought and acted on.

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. Some care managers were in regular contact with the service but were not informed of the significant risks to people.
● 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.

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.

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

The enforcement action we took:

NOP to remove location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The failure to assess the risks to the health and safety of people, doing all that is reasonably practicable to mitigate risks is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 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.

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 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.

The enforcement action we took:

NOP to remove location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing 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.

The enforcement action we took:

NOP to remove location