Overton House Limited

Overton House

Inspection report

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03 September 2018
04 September 2018

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Please be advised Overton House has now closed.

The inspection took place on 03 September 2018 and was unannounced. This meant the service did not know we would be visiting. We carried out a further announced visit on 04 September 2018 to complete the inspection.

Overton House was a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

Overton House was registered with CQC to accommodate a maximum of 19 people. At the time of this inspection 14 people were accommodated and two people were in hospital. The majority of people who used the service at Overton House were living with enduring mental health issues and were extremely vulnerable.

We last inspected Overton House in 2016 when the service was owned and operated by a different provider and at that time we rated the service 'Good.' However, in 2017 the business was sold to a new provider and in August 2017 Overton House was re-registered with CQC, as is the legal requirement.

At this inspection we found widespread systemic failures and multiple breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014 concerning safe care and treatment, premises and equipment, staffing, the need for consent, dignity and respect and good governance. In the days immediately following our inspection visit, due to the seriousness of the issues we found, we informed the provider that we proposed to take urgent action to ensure the health, safety and well-being of people who used the service. We also informed Manchester Health and Care Commissioning (MHCC) of our intentions.

In response to the serious concerns raised by CQC, the provider informed us they had decided to close Overton House. On receipt of this information CQC liaised extensively with MHCC who took steps to ensure the immediate needs of people were being met. Two people who used the service were also identified as being out of area placements funded by Trafford Council, therefore Trafford local authority also provided additional support. By Monday 10 September 2018 all the residents had been found alternative accommodation.

Whilst the provider made a business decision to close Overton House, CQC has taken enforcement action to remove the providers registration in respect of the carrying on of a regulated activity at Overton House. Details of this are contained at the back of this report.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are registered persons'.

Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

On the first day of our inspection we conducted a tour of the premises at Overton House. The tour included the basement, communal areas and resident's private bedrooms'. During the tour we found significant areas of concern relating to the prevention and control of infection and found systemic poor practice which placed residents at a serious risk of harm.

We found the outside space to the rear and side of Overton House to be exceptionally unsafe. The concreate floor was uneven and posed a serious falls risk, hazardous materials associated with building maintenance had been discarded, there were loose bricks and rubble present which posed a risk of injury and steep concrete steps leading down to the basement area posed a serious falls risks.

Throughout the premises we found window restrictors were non-compliant with Health and Safety Executive (HSE) guidance or were missing entirely. We also found that whilst a care call alarm system was situ there were no pull cords available that would assist a resident to raise an alarm when they found themselves in difficulty or in the event of an emergency.

We looked at induction and training staff received to ensure they were skilled and competent to fulfil their roles. We found that a programme of unsupported training was in place delivered solely via online E-learning. We found no assessments of competency had been completed which meant there was no assurance that staff were sufficiently skilled and competent to provide care safely.

We looked at the mealtime experience and found this to be poor. In the dining room no menus were displayed. We asked the cook about this and were shown an example of weekly menus that had been stored in a cupboard in the kitchen. However, upon further investigation, we found the actual produce and ingredients that were available on the premises was not reflective of the menus, including an insufficient quantity of available ingredients. This meant it was impossible the daily menus shown to us were reflective of current practice.

The majority of care staff were well intentioned but it was evident, through talking to staff and from our own observations, that management and staff had been become completely disengaged from the service and there was an apathy across all aspects of the home . This had a detrimental impact on the quality of care being provided at Overton House. At provider level, there was a distinct lack of care and compassion shown towards the people who used the service. As evidenced by the conditions in which people were living.

The systemic issues found during this inspection meant there was a disregard for the human rights of people who used the service and there was no consideration given to any aspect of equality and diversity and to those people who may be from diverse backgrounds.

In all the care records we reviewed, we found an unacceptable level of variation. Some people had comprehensive care plans reflecting their support needs, likes, dislikes and personal preferences, whilst others distinctly lacked meaningful information that would enable staff to provide a responsive, person-centred level of care.

People's social needs were not being met which exposed them to an unacceptable risk of social isolation. Throughout the inspection we did not observe any meaningful activities taking place and we found no evidence that the home had historically attempted to engage people in activities that were non-care related.

Since the new provider took over Overton House in August 2017, the home had not been well-led. Every aspect of the service had been allowed to deteriorate which meant fundamental standards of quality and safety could not be met.

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.

The environment was unsafe.

Poor practice for the prevention and control of infection exposed people to a risk of harm.

Is the service effective?

Inadequate

The service was not effective.

The mealtime experience was poor.

The principles of the Mental Capacity Act 2005 had not been adhered to.

Is the service caring?

Inadequate

The service was not caring.

Care and support was not provided in a dignified or respectful way.

There was a poor approach to equality and diversity and people's human rights were not protected.

Is the service responsive?

Inadequate

The service was not effective.

People were at risk of social isolation.

Information contained in care plans was inconsistent and not always of a good quality.

Is the service well-led?

Inadequate

The service was not well-led.

Every aspect of the service was poorly operated and managed.

Systems and processes for audit, quality assurance and

questioning of practice were poor.

Overton House

Detailed findings

Background to this inspection

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

The inspection took place on 03 September 2018 and was unannounced. This meant the service did not know we would be visiting. We carried out a further announced visit on 04 September 2018 to complete the inspection.

During the course of the inspection, the inspection team comprised of three adult social care inspectors and an inspection manager from the Care Quality Commission.

Before the inspection the service had not 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 improvements they plan to make. However, we reviewed information we held in the form of statutory notifications received from the service, including those related to safeguarding incidents and injuries. Ahead of the inspection we also liaised with the local authority.

During this inspection we spoke with five people who used the service. However, due to the nature of the service provided at Overton House, we also completed a 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 also spoke with seven members of staff including the provider, registered manager, deputy manager, senior carers, care assistants, the cook and one visiting professional. Throughout the period of our inspection visit no relatives or friends visited people who used the service.

We looked in detail at six care plans and associated documentation; four staff files including recruitment and selection records; training and development records; audit and quality assurance; policies and procedures and records relating to the safety of the building, premises and equipment.

Inadequate

Is the service safe?

Our findings

On the first day of our inspection we conducted a tour of the premises at Overton House. The tour included the basement, communal areas and resident's private bedrooms'. During the tour we found significant areas of concern relating to the prevention and control of infection and found systemic poor practice which placed residents at a serious risk of harm.

In the laundry basement area we found conditions to be insanitary and visibly dirty. Soiled items of clothing and bedding had been thrown on the laundry floor, two washing machines full of laundry and several baskets of laundry had not been attended to and there was a strong odour of urine. Soiled and contaminated laundry was stored in plastic shopping bags and had not been placed in dedicated water soluble 'red bags' and therefore posed a serious risk of cross contamination. There was no laundry assistant on duty during the first day of inspection and staff said this was a regular occurrence with soiled and contaminated laundry items often left unwashed for several days. This meant there was frequently a shortage of essential items such as bedsheets, quilts and blankets. We corroborated this by viewing the linen store and we found there to be insufficient bedsheets to meet the needs of residents, in particularl, because one resident was had diarrhoea at the time of our inspection.

We found Overton House to have a serious and widespread problem relating to the control of rodents. Bate traps were located throughout the home, including in resident's bedrooms. We viewed an external out-house to the rear of the premises and found perishable food items were being stored unsafely. For example, potatoes were stored on the floor in a container without a lid, carrots were stored on a shelf in a container with an ill-fitting lid, and butternut squash was stored in an open cardboard box, underneath a tool kit. Furthermore, located next to the food storage area, we found highly volatile paint tins, paint thinners, paint brushes and other decorating/maintenance materials. The environmental conditions within the out-house were filthy and wholly inappropriate for the storage of perishable food items.

We found poor and unsafe practices related to infection control. For example, mops, buckets and cleaning cloths were not colour coded and the same items of equipment were used throughout the service, irrespective of the area being cleaned. Paper towel dispensers and liquid soap dispensers in communal toilets and bathrooms were empty which meant there was poor and unhygienic practices for hand hygiene. Throughout the service there was a lack of a personal protective equipment available at the point of care. This posed a risk of cross contamination as staff could not easily access disposable gloves or aprons when providing personal care.

In one bedroom that was occupied we found a serious malodour of urine and the carpet was damp in places due to urine contamination. In a second room we found another serious malodour of urine; this bedroom was a shared room, occupied by two residents, one of whom was reported to be doubly incontinent of both urine and faeces on a regular basis .

Throughout the home all carpets were visibly dirty, worn and in a state of disrepair. During the second day of inspection, in the carpeted dining area, an insect was seen to be crawling on the trouser leg of a CQC

inspector and a second insect was seen to be crawling along the carpet.

Due to the seriousness of the issues detailed above, on the first day of inspection we made an urgent referral the Community Infection Control Team and to Environmental Health at Manchester City Council. On the second day of inspection an Infection Prevention and Control Specialist Nurse attended Overton House and met with CQC inspectors. The specialist nurse agreed that residents were at 'high risk' due to inadequate and unsafe practices for the prevention and control of infection.

An Environmental Health Officer also attend Overton House and they provided a report to CQC which confirmed Overton House had a serious problem in the following key areas: Inhabitation of rats, the origin of which had been located above an exposed open drain above the basement area; poor environmental management of the building and premises, including a failure to carry out routine maintenance, which meant holes in wooden floors and skirting boards had not been adequately attended to, this left the home vulnerable to rodents; A failure of the provider to effectively manage the contractual relationship with the pest control company, including a failure to fully acknowledge the extent of the rodent problem and the actions that were required to rectify the problems. The Environmental Health Officer also confirmed the insects observed in the dining room were carpet beetles.

With regards to the risks associated with unsafe premises, we looked at a health and safety inspection report completed by an external company in April 2018. This report highlighted five areas that that were deemed 'high risk'. The definition of high risk as stated in the report was: 'contravention of statutory requirements that could lead to fatal or serious personal injury, ill health, issuing of an improvement notice and / or which may lead to legal proceedings by the enforcing authority indicating areas of non-compliance. These matters require a planned programmed of action to eliminate or control the risks identified.' The five areas of concern as stated in the report were: gas safety; risk assessments related to employee safety; asbestos; lifting equipment; and, water temperature

We asked the registered manager about the contents of report and were told they had no knowledge of the health and safety report or its contents. We then asked the registered manager for documentary evidence that each of the areas in the report deemed 'high risk' had been actioned and resolved and that the required health and safety certification was in place, but none could be provided.

We found the outside space to rear and side of Overton House to be exceptionally unsafe. The concrete floor was uneven and posed a serious falls risk, hazardous materials associated with building maintenance had been discarded, there were loose bricks and rubble present which posed a risk of injury and steep concrete steps leading down to the basement area posed a serious falls risks. Furthermore, despite this outside area being used regularly by residents who smoked on an unsupervised basis, we found no environmental or personal risk assessments had been completed.

During our tour of the premises we also found the basement area was used inappropriately to store rubbish and unused equipment. This posed both an environmental and fire hazard due to the nature of the materials stored in the basement area. For example, carboard boxes, plastic crates and refuse sacks full of rubbish. Due to the seriousness of these concerns on the first day of inspection we made an urgent referral to the Fire Safety Protection Team at Greater Manchester Fire and Rescue Service (GMFRS). On the second day of inspection, a fire officer from GMFRS attended Overton House and carried out an inspection of the premises. Whilst we found the provider had taken positive action in removing the hazardous items from the basement area, additional areas of concern were identified. It was found the linen room on the upper floor was not safe and needed to be replaced. This was because the strips and seals had been extensively painted over which meant the door was no longer fit for purpose. The linen room door was also unlocked and there

was no signage displayed to indicate the door should remain locked at all times. This is important in a mental health setting due to the elevated risk of residents who may cause fire. It was also found a ground floor fire escape door was faulty and needed to be urgently replaced. This fire door provided the only means of escape from that section of the building if the escape route via the main lounge was impassable.

Throughout the premises we found window restrictors were non-compliant with Health and Safety Executive (HSE) guidance or were missing entirely. We also found that whilst a care call alarm system was situ there were no pull cords available for a resident to raise an alarm when they found themselves in difficulty or in the event of an emergency.

During the inspection we looked at four care files and found risk assessments to be inadequate. For example, in each of the care files we found risk assessments had been completed relating to risks associated with accessing the community, personal hygiene, mental health and mobility. However, each risk assessments failed to provide sufficient detail to demonstrate how the risk was mitigated and what actions staff should take to keep people safe.

We also found that risk assessments associated with maintaining health were not sufficiently robust or had not been completed. For example, one resident was under a Community Treatment Order (CTO) and we found no risk assessment had been considered to ensure this person's set conditions were appropriately captured and followed. A CTO is part of the Mental Health Act, this allows people to leave hospital and be treated safely in the community

We looked at systems in place for the storage and management of medicines. Due to the size of the home a dedicated medicines clinic room was not available. However, medicines were stored safely in line with legal requirements in a locked trolley and a separate controlled drugs cabinet was in place. Fridge temperatures were recorded daily, but we noted ambient room temperatures were not being recorded and the deputy manager confirmed to us thermometers were not in place. A maximum/minimum thermometer should be placed in all rooms where medicines are stored and the temperature of the room monitored on a daily basis to ensure medicines are stored within the recommended temperature limit and their effectiveness is not compromised.

There were appropriate arrangements in place for the management of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). At the time of our inspection no controlled drugs were being stored.

We looked at the medication and medicine records of seven residents and found their medicines had been stored and administered safely. PRN (as required) protocols were in place for people who only required medications to be administered when needed. However, we found two people's PRN for paracetamol was not in place .

Senior staff administered and managed people's medicines and they had their competency assessed in medicines management. However, we noted two senior staff had not yet received the appropriate training. The registered manager told us both staff members were shadowing and not directly administering medicines, however we were provided with no evidence to confirm this .

A list of senior staff responsible for administering medicines was not up to date and no sample signatures were available for reference. People had individual medication records that contained a photograph, however this record did not detail key information such as the person's date of birth and known medical conditions.

The evidence as outlined above demonstrates a serious systemic failure to provide safe care and treatment.

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

Inadequate

Is the service effective?

Our findings

We looked at induction and training staff received to ensure they were skilled and competent to carry out their roles effectively. This included a review of the training matrix, training records and certificates and through speaking to staff.

We looked at induction and training staff new to care received. We were told by registered manager that newly recruited staff with little or no experience in care would complete a number of modules aligned to the Care Certificate. The Care Certificate aims to ensure care workers have the same foundation skills, knowledge and behaviours to provide compassionate, safe and high-quality care. We asked the registered manager for evidence of this but they admitted to us no member of staff had fully completed the care certificate and that staff had not engaged well with online e-learning which meant many of the modules had not been completed. We were told by the registered manager they had planned to start using work books but we found this work had not yet started.

We found that a programme of unsupported training was in place delivered solely via online E-learning. The training matrix showed that 19 members of staff were required to complete training that was fundamental to their role and to ensure the regulated activity was delivered safely. However, from the training matrix, we noted a high number of training courses had not been undertaken by staff directly involved in providing care and support. For example, we found out of the 19 staff on the training matrix, only seven staff had completed training on safeguarding adults, two staff out of 19 had completed dementia awareness, six out of 19 had completed falls prevention, five out of 19 had completed mental health awareness and one out of 19 had completed moving and handling. Furthermore, we found no assessments of competency had been completed which meant there was no assurance that staff were sufficiently skilled and competent to provide care safely.

We also noted a resident would at times display behaviours that challenged others but we found no training in managing behaviours that challenge available to staff. This meant staff were not adequately equipped to ensure they could meet this person's needs.

The evidence outlined above demonstrates a failure to ensure suitably qualified, competent, skilled and experienced staff were deployed to meet the needs of residents. The overreliance on E-learning as a sole means of training placed the health, safety and well-being of residents at risk. In particular, in respect of a lack of practical moving and handling training and a failure to test the competency and skills of staff before care was delivered.

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

We looked at what consideration the service gave to 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 take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

In respect of DOLS applications made to the local authority, we noted a 'tracker' was in place which indicated when the registered manager had submitted a DOLS application. However, we found no mental capacity assessments had been completed to support the DOLS applications or to evidence how the registered managed had concluded a person lacked the mental capacity to keep themselves safe. we asked the registered manager about this and confirmed they did not complete any form of assessment that was in line with MCA.

We looked at how the service gained people's consent to care and treatment in line with the MCA. We noted one person who lacked capacity to make decisions for their care and treatment had signed a consent form called 'care and treatment' within their care plan to agree they consented to their care being provided by the home. However, as stated, this person was deemed to lack mental capacity therefore, we could not be certain they fully understood what they were signing.

With regard to specific training, we found only eight out of the 19 staff had received training on the MCA and DOLS and through talking to staff, we found they had a limited understanding of the MCA and the DOLS process.

By failing to comply with the principles of Mental Capacity Act (2005) there was a risk that people were being deprived of their liberty without proper lawful authority and that consent to care was not sought in a lawful way that respected people's human rights.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Need for consent.

We looked at the mealtime experience for residents at Overton House and found this to be poor. In the dining room no menus were displayed so we asked the cook what daily choices residents were offered at mealtimes and we were then shown a sample of daily menus that had been stored in the kitchen. However, upon further investigation, we found the actual produce and ingredients that were available on the premises was not reflective of the menus; this included an insufficient quantity of available ingredients. This meant it was impossible the daily menus shown to us were reflective of current practice. As previously described in this report, we found the dining area to be visibly dirty and carpet beetles were present. Whilst we found staff provided assistance at mealtimes to those who required it, the overall mealtime service and the environment in which meals were served was unacceptable.

The provider of Overton House had installed a closed circuit television surveillance system (CCTV). Whilst this was not in use in residents private bedrooms, the CCTV system was installed and operational in all communal areas and in the manager's office. However, the provider was unable to provide any documentary evidence to demonstrate they had taken into account guidance issued by CQC on the use of surveillance in a care setting. We also asked the registered manager whether or not residents, or their lawful representatives, had been consulted before the CCTV had been installed and we were told they had not.

We also established the CCTV was monitored remotely offsite from Overton House at another business premises belonging to the provider. This meant the registered manager at Overton House had no ability to view or playback any CCTV recordings in the event an urgent situation. For example, if a resident had fallen in a communal area but the fall was unwitnessed. Furthermore, during our inspection of Overton House, it became apparent to members of the inspection team that they were under surveillance by the provider, from their offsite location. We were informed by the registered manager that on several occasions the provider had telephoned the registered manager at Overton House to enquire what we were doing. For example, the provider telephoned the registered manager to object to an inspector taking evidential photographs in and around Overton House.

The evidence outlined above demonstrates a failure to ensure the installation and operation of a CCTV system at Overton House was in the best interest of residents and a failure to take account of guidance published by CQC on the use of surveillance in a care setting.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regard to premises and equipment.

Inadequate

Is the service caring?

Our findings

Throughout this inspection we found the majority of care staff to be well intentioned but it was strikingly obvious through talking to staff and from our own observations, that management and staff had been become completely disengaged from the service and there was an apathy across all aspects of the home . This inevitably had a detrimental impact on the quality of care being provided at Overton House. At provider level, there was a distinct lack of care and compassion shown towards the people who used the service. The conditions alone in which people were living demonstrated this.

During our inspection we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We completed two SOFI observations during day two of inspection. One SOFI took place in a communal lounge whilst the other was completed in the dining room where a number of people remained after lunch time service.

In the communal lounge we observed eight people to be seated with one member of staff present who was chatting with several people. However, the majority of people sat in the lounge were not engaged and spent the period of time sat in silence with a television on in the background. During this period of formal observation, the member of staff who was in the lounge left to attend to other duties leaving all the residents unsupervised in the lounge area and no interaction taking place. This demonstrated to us that staff did not have enough time to dedicate to sit and talk with people in a meaningful and caring way.

In the dining room, we observed two people to be seated long after lunch time service had finished. One person was seated adjacent to the wall and a fixed radiator and we saw how they were continually falling asleep against the wall and radiator (the radiator was switched off). During this time the person also asked a member of staff on several occasions to be taken to the toilet but the carer stated they were busy and would be back "in a minute." However, when the carer did not return, a member of the inspection team intervened and asked staff to tend to this person's care needs, including ensuring they were made more comfortable in a seating area of their choice.

We viewed the shared rooms at Overton House and found no privacy screens were available for use when personal care was being provided. This meant people's privacy and dignity could not be protected and care was not delivered in a respectful way.

We found the registered persons failed to ensure care and support was provided to people in a dignified and respectful way.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Dignity and respect.

The systemic issues found during this inspection meant there was a disregard for the human rights of people who used the service and there was no consideration given to any aspect of equality and diversity to those people who may be from diverse backgrounds.

No evidence was made available to us to support that people had access to independent advocacy services or that information had been made available regarding this .

Inadequate

Is the service responsive?

Our findings

The Accessible Information Standard (AIS) was introduced by the government in 2016 to make sure that people with a disability or sensory loss are provided with information in an accessible format. During this inspection we found the needs of people living with a disability and sensory loss had not been met by the service.

During the inspection we overserved one person to be non-verbal in communication. We therefore looked at their care records and found this was associated with sensory loss and long term mental health issues. However, this person's care plan lacked sufficient detail to enable staff to provide a responsive level of care and to fully understand how best to meet this person's needs. We found no attempt had been made to ensure their care plan was in a format that was accessible to them and easy to read. This meant this person could not have been involved planning and agreeing their care. Furthermore, we found no evidence to support that consideration had been given to making a referral to a relevant health care professional. For example, a referral to speech and language therapy for an assessment of need with a view to exploring alternative methods of communication or the use of assistive technology.

We found the registered persons failed to treat people who used the service with dignity and respect and that insufficient consideration had been given to people with a protected characteristic. The registered persons also failed to take account of the Accessible Information Standard by failing to ensure people with a disability or sensory loss were given information in a format accessible to them.

This was a further breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Dignity and respect

In all of the care records we reviewed, we found an unacceptable level of variation. Some people had comprehensive care plans reflecting their support needs, likes, dislikes and personal preferences, whilst others distinctly lacked any kind of meaningful information that would enable staff to provide a responsive, person-centred level of care.

Due to the nature of the service provided at Overton House, some people who used the service were far more independent than others. However, we found no evidence to support whether or not it had been explored with these people the possibility of increasing their independence with a view to moving on from Overton House into accommodation that may have better suited to their needs. For example, two people who used the service told us staff did not provide any additional support or encouragement to improve skills, such as managing their own medicines, accessing the community, finances or cooking skills. We did not see evidence of how the service assessed people's daily living skills to determine their level of ability to manage activities of daily living themselves, such as getting dressed, taking a shower or preparing their own meals.

People's social needs were not being met which exposed them to an unacceptable risk of social isolation. Throughout the inspection we did not observe any meaningful activities taking place and we found no evidence that the home had historically attempted to engage people in activities that were non-care related. Whilst a very small number of people were able to access the wider community and leave Overton House on a daily basis, the vast majority of people either remained in one of two lounges all day or simply slept in their bedroom.

At the time of our inspection, Overton House was not an accredited provider of end of life care but in any case, staff lacked the skills and experience to provide end of life care safely. However, during our inspection the registered manager told us one person was in hospital nearing the end of their life and they had planned to bring this person back to Overton House. We raised our serious concerns about this but events regarding the homes closure meant an alternative placement was found for this person anyway.

Inadequate

Is the service well-led?

Our findings

At the time of this inspection there was a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Since the new provider took over Overton House in August 2017, the home had not been well-led. Every aspect of the service had been allowed to deteriorate which meant fundamental standards of quality and safety could not be met. The multiple breaches identified in this report demonstrates widespread systemic failures by the registered persons in providing safe and effective care. Whilst the provider made a business decision to close Overton House in the days following CQC's inspection, we have taken enforcement action to remove the providers registration in respect of the carrying on of a regulated activity at Overton House.

We looked at what systems and processes were in place by means of audit, quality assurance and questioning of practice to ensure the safety and quality of services being provided and to demonstrate good governance and compliance with regulations.

We viewed an audit file that contained audits for infection control and safeguarding but no other audits or quality assurance documentation was present. In respect of the audits for infection control, these were not fit for purpose and failed to recognise and address the areas of serious concern, as detailed in this report. The audit file also contained documentation related to audits that for safeguarding. However, the information contained within the 'audit' was of a very poor quality and it was not clear what the audit sought to achieve.

We also looked at the management of accidents and incidents and viewed a file which contained a record of any incidents within the service such as falls. Whilst we found an overview of key information such as the time incident occurred, the type of event, location and level of intervention was recorded, we found no analysis had been completed to ascertain whether there were any similar themes or trends that required action to reduce the likelihood of a reoccurrence.

Throughout the inspection we asked for evidence that demonstrated how the provider, in addition to the registered manager, maintained oversight of the service by means of audit, quality assurance and questioning of practice but none could be provided.

We asked for a variety of records and documentation to be made available to the inspection team. All too frequently this information was not provided in a timely manner and when presented, was incomplete. This delayed the inspection process and demonstrated poor management and governance. Furthermore, whilst reviewing documentation related to staff rotas, we found a number of discrepancies which lead us to believe records had been falsified. We asked the registered manager about this and they admitted this had taken place.

We found the registered persons had failed to have systems and processes, to assess, monitor and improve the quality and safety of the service. Furthermore, there was a failure to have effective systems which sought to assess, monitor and mitigate the risks relating to the health, safety and welfare of people who used the service and others who may be at risk which arise from the carrying on of the regulated activity.

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

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 10 HSCA RA Regulations 2014 Dignity and respect The registered persons failed to treat service users with dignity and respect. The registered persons failed take account of the Accessible Information Standard 2016 by failing to ensure service users with a disability or sensory loss were given information in a format accessible to them.

The enforcement action we took:

Cancel Registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered persons failed to comply with the principles of Mental Capacity Act (2005) which meant there was a risk that people were being deprived of their liberty without proper lawful authority. Consent to care was not sought in a lawful way that respected people's human rights.

The enforcement action we took:

Cancel Registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered persons had failed to assess the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated. This meant service users were not being protected from receiving unsafe care and support and that service users were or

may have been be exposed to the risk of harm.

The registered persons had failed to ensure the premises used by you as a service provider and in connection with a regulated activity were not safe to use for their intended purpose and used in a safe way.

The registered persons had failed to adequately assess the risk to the health and safety of service users and failed to do all that is reasonable practicable to mitigate any such risks.

The enforcement action we took:

Cancel Registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The registered persons had failed to ensure the installation and operation of a CCTV system was in the best interest of service users. The registered persons had failed to take account of guidance published by the Commission on the use of surveillance in a care setting.

The enforcement action we took:

Cancel Registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered persons had failed to have systems and processes, such as regular audits of the service provided, which sought to assess, monitor and improve the quality and safety of the service. The registered persons had failed to have effective systems which sought to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.

The enforcement action we took:

Cancel Registration.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

The registered persons had failed to ensure suitably qualified, competent, skilled and experienced staff were deployed to meet the needs of service users.

The overreliance on E-learning as a sole means of training placed the health, safety and well-being of service users at risk. In particular, in respect of a lack of practical moving and handling training and a failure to test the competency and skills of staff before care is delivered to service users.

The enforcement action we took:

Cancel Registration.