HICA

Overton House - Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Overton House is a 'care home'. People in care homes receive accommodation and nursing or 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.

The service is registered to provide personal care and accommodation for up to 40 older people, including people who are living with dementia. The home is situated in Cottingham, in the East Riding of Yorkshire and close to the city of Kingston upon Hull. All accommodation is on the ground floor and there are enclosed courtyards where people can access the outdoors. At the time of our inspection 36 people were using the service.

At a previous inspection in September 2015 and we rated the service good overall but found one breach of legal requirements in respect of the need for people to consent to their care. We therefore inspected the service again in November 2016 to check that improvements had been made in this area, and to re-assess the rating for the key question: 'Is the service effective?' We found improvements had been made and the rating for this key question was upgraded to good. At this inspection we found the evidence continued to support the rating of good overall and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. However, one key question: 'Is the service well-led?' has been down-graded to the rating of requires improvement, due to some record keeping and quality assurance issues we identified. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

There were systems and processes in place to protect people from the risk of harm. Staff were able to tell us about different types of abuse and were aware of action they should take if abuse was suspected.

Medicines were stored, administered and recorded safely. The premises were clean and well maintained to keep people safe.

Risks to people were assessed and action taken to mitigate them. However, we found examples where information about risk and about contact with healthcare professionals was not always clearly recorded.

Staffing levels were sufficient to meet people's needs. Robust recruitment and selection procedures were followed and appropriate checks had been undertaken before staff began work. Staff received the support and training they needed to give them the skills and knowledge to meet people's needs.

People were supported with their nutritional and healthcare needs and had access to healthcare professionals when required.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Staff treated people with dignity and respect; they knew people well and could anticipate their needs. We observed positive, caring interactions between staff and people who used the service. The environment was stimulating and people were able to access a range of activities and entertainment.

The provider had a system in place for responding to people's concerns and complaints. People, relatives and visiting professionals were asked for their views in meetings and surveys.

Care plans were in place to give staff the information they needed to support people in line with their preferences and assessed needs. However, we found variation in the quality and amount of information in some files. Quality assurance systems in place had not been effective in identifying and addressing this. We have made a recommendation about this in our report.

Further information is in the detailed findings below.

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 remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service had deteriorated to Requires Improvement.	**Requires Improvement**

Overton House - Care Home

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.

This comprehensive inspection took place on 12 and 22 March 2018. The first day was unannounced. We told the provider we would be returning for the second day of the inspection.

The inspection was carried out on the first day by two adult social care inspectors and an expert-by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of service. The expert-by-experience who assisted with this inspection had knowledge and experience relating to older people. Day two of the inspection was carried out by one adult social care inspector.

Before our inspection, we looked at information we held about the service. The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the information we held about the service, such as notifications we had received from the registered manager. A notification is information about important events which the service is required to send us by law. We sought feedback from the local authority contract monitoring team prior to our visit. We planned the inspection using this information.

During the inspection we spoke with one person who used the service, four relatives and two visiting healthcare professionals. We spoke with the registered manager, deputy manager, regional manager, four care staff, a chef and an activities coordinator.

We looked at a range of documents and records related to people's care and the management of the service. We viewed five people's care records, three care staff recruitment and induction files, training records and a selection of records used to monitor the quality of the service. We also spent time in the communal areas of the home and made observations throughout our visits of how people were being

supported. We carried out observations using the short observational framework for inspections (SOFI). SOFI is a tool used to capture the experiences of people who use services who may not be able to express this for themselves.

Good

Is the service safe?

Our findings

People and relatives told us they or their family member felt safe at Overton House. Relative's comments included, "There is good security" and "Doors are locked. They (staff) are good to her, watch her."

There were safeguarding policies and procedures in place. We viewed records that showed concerns had been appropriately reported and investigated where required. Staff received safeguarding training and were confident of the action to take if they had any concerns or suspected any abuse was taking place.

We looked at the arrangements in place to manage risk so people were protected and their freedom supported and respected. Risks to people's safety had been assessed by staff and regularly reviewed. However, we did find some inconsistencies in how the response to risk was recorded. For example, one person had had falls from bed, and although we found measures had been put in place to respond to this, it was not clear from documentation what other risk reduction options had been considered. The registered manager agreed to address this.

The provider recorded accidents, incidents and safeguarding issues on a database, which enabled them to monitor any patterns and make improvements where required. The information was also reviewed at monthly health and safety scrutiny meetings. The regional manager gave us an example to show how they had made changes to an area of staff training as the result of learning from an incident.

Staff were appropriately vetted prior to their employment, to ensure they were suitable to work with vulnerable people. This included seeking references from previous employers and a Disclosure and Barring Service (DBS) check.

There were sufficient staff to meet people's needs. On the first day of our inspection we noted occasions where people were unattended in the dining area, which meant staff were not able to hear and intervene when there were incidents between people in this area. However, generally there were sufficient staff available to respond promptly to people's needs and requests, and staff had time to chat to people. Staff, people and relatives we spoke with confirmed they felt there were enough staff. The provider had recently reviewed staffing levels and rota patterns, and was in the process of recruiting additional night staff to reflect this change.

We looked at records which confirmed checks of the building and equipment were carried out to ensure the environment and equipment was maintained safely. These included checks on the fire alarm, electrical wiring and gas safety. Arrangements were in place to prevent and control the risk of infections and the building was generally clean and hygienically maintained.

Medicines were appropriately managed, stored, recorded and administered. People were supported to take their medicines by staff who were trained and had their competency assessed. We noted from medicine records that one person had not always received one of their daily medicines due to being asleep, and the registered manager agreed to look into changing the arrangements for their medicines. We saw the

registered manager had taken action to address issues identified in monthly medication audits, including working with their pharmacy supplier.

Good

Is the service effective?

Our findings

People and relatives we spoke with confirmed that they felt staff had the right skills to care for people effectively.

Staff received a range of training, such as health and safety, food hygiene, infection control, dementia, challenging behaviour and pressure area care. A staff member told us, "The training is good and you can ask for any extra that you want." Staff also confirmed, and we saw records which showed, that staff received regular supervision, team meetings and an annual appraisal.

Arrangements were in place to assess people's needs and choices in line with legislation and best practice. The provider also demonstrated knowledge of best practice in relation to dementia care and dementia friendly environments. We found the environment was adapted and decorated with consideration of people's needs. The home was spacious and there were colour contrasting wall and door frames to aid vision and orientation. There were lots of interesting items for people to pick up and look at, to encourage stimulation and engagement. There was also an area of the home that was decorated as a train carriage, with a visual screen (in the shape of a carriage window) showing a film of the countryside passing by, creating the impression of being on a train journey. This was aimed at stimulating discussion and memories.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The procedure 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. We found that DoLS authorisations were in place, or had been applied for, for people who required them. We saw evidence of mental capacity assessments and best interests decisions. In some cases these records would benefit from more detail and we brought this to the attention of the registered manager. Where people had a Lasting Power of Attorney (LPA) for health and welfare decisions or for finances the provider retained evidence of this, to help ensure that relatives were only asked to sign to consent to decisions for which they had legal authority.

People were supported to maintain a balanced diet. We observed mealtimes were relaxed and people's dietary needs were catered for. Staff were available to support those who required assistance and people appeared to enjoy the food available. Relatives commented positively about the meals. We saw food and fluid charts were completed and people's weights were monitored.

People's received support with their healthcare needs and the service had good links with a range of healthcare services. Care records showed people had access to a dentist and optician. The healthcare professionals we spoke with told us, "They (staff) call us out appropriately and follow our advice" and "I only have positive things to say about Overton House." We noted however that one care file we viewed lacked detail about the support someone required in relation to care of their stoma. On the first day our inspection we also found that medical attention had been requested for someone in relation to a concern about their

feet, but details of this had not been recorded in their care file, which led to confusion and could have resulted in duplication of the request for an appointment. We have addressed these record keeping issues further in the 'well-led' section of the report.

Good

Is the service caring?

Our findings

Throughout our inspection we observed people were treated with kindness, respect and compassion. One person we spoke with confirmed staff were caring and relatives told us staff were, "Very friendly, helpful," "Okay" and "Excellent. If you ask them they do anything for you. So caring." A visiting healthcare professional commented on the positive approach staff had with people and told us they had just visited someone who had been saying how happy they were living at the home.

We saw many examples where staff responded and offered reassurance when people were confused or distressed. For example, when one person said they were lost and confused staff chatted with them, provided information reassuringly then offered them the opportunity to do some baking. The person agreed to this and appeared much calmer. On another occasion a person was distressed and trying to get outside so the registered manager organised for a member of staff to take them out for a walk. This calmed the person as it appeared to enable them to move on from feeling restricted.

People were involved in their care and encouraged to make decisions where they were able to. This included what they wanted to eat and how they wanted to spend their time. One person we spoke with confirmed they were able to make their own decisions and gave their bedtime routine as an example. Some relatives we spoke with said that their loved ones were unable to make many decisions due to their needs, but confirmed staff offered choices. One told us, "I have seen them show him plates of food and ask him to choose."

Systems were in place to keep people and their relatives informed about what was happening at the service. There was a newsletter and 'relatives and clients' meetings took place. Information about the local advocacy service was available, so people could access independent support to express their wishes. We were advised one person had an advocate. The provider was aware of the Accessible Information Standard and we discussed the accessibility of some of the information available to people and plans the service had to improve this, such as introducing pictorial menus. By the second day of our inspection the registered manager had produced these menus.

We observed staff encouraged people to do things for themselves where they were able to, in order to maintain their independence in so far as possible. This included engaging people in familiar daily living activities, such as folding and sorting smaller laundry items, cooking and baking.

People's privacy and dignity was respected and promoted. Staff knocked on people's bedroom doors before entering and told us they ensured doors were closed when supporting people with personal care to give them privacy. Staff also provided us with other examples to illustrate how they maintained people's dignity.

Staff completed equality and diversity training as part of their induction and information about people's diversity needs was recorded in care files. People's faiths were respected. For instance, one person had regular visits from a vicar.

Care files and information related to people who used the service were stored securely and accessible to staff when needed. This meant people's confidential information was protected appropriately in accordance with data protection guidelines.

Good

Is the service responsive?

Our findings

The provider conducted an assessment of people's needs prior to them moving to the home, to ensure the service could meet their needs. Care plans were then developed for each person, to give staff the information and guidance they needed to support people. Care records contained a one page profile of each person including things which were important to them, things which upset them, their dietary preferences, mobility and personal care support needs. The amount of detail in these varied; some gave clear information about the person and how they should be supported, whilst others were brief and required more detail in some areas. For instance, one required more detail about the person's continence care needs. When we spoke with staff, they had a good understanding of people's needs and how to care for them.

We observed staff responding to people's needs and it was apparent that staff knew people well. For example, staff knew which activities people may like to take part in and offered options appropriate to people's interests and skills. We saw staff responding to people when they were distressed or needed assistance.

The atmosphere at home was pleasant and calm, yet there were periods where it was lively with activity. We saw people singing and dancing, making bread and baking. There was also a film afternoon and staff used this to promote discussion about people's favourite films, books and actors. The provider employed two activities coordinators, to provide support with activities over seven days a week. We meet one of the activities coordinators and they spoke enthusiastically about their role and the activities people took part in. This included exercise classes, arts and crafts, quizzes, carpet bowls, music days, gardening and trips out in the service minibus. The registered manager told us they had also been working to try and increase the amount of activities that appealed to the males living at the home. They had worked with a local group 'Men in Sheds' and one person had painted garden furniture in the outdoor courtyard, for people to sit out and enjoy.

The provider had trialled getting some soft toy dogs and animals to have around the home. They found that many people responded really well to these, so the registered manager had purchased a number of additional ones. We noted throughout our inspection that many people who used the service picked up, carried, talked to and cuddled these dogs which appeared to give them much comfort and reassurance.

The provider had a complaints policy and procedure. This contained details about how complaints or concerns were managed. Records showed that complaints had been investigated and responded to in line with the provider's policy. People and their relatives told us they felt confident to raise any concerns with staff or management. A relative told us they had raised a recent issue in relation to the heating in one area of the home and we found the registered manager was taking action to address this.

We read a number of compliments and thank you cards received by the service. This included cards from relatives about the support their loved ones had received at the end of their lives. Senior care staff had received care of the dying training and the provider had an end of life care policy and procedure.

Requires Improvement

Is the service well-led?

Our findings

The service had a registered manager who had been registered as the manager with CQC since 2013. Relatives told us they thought the home was well-managed. Visiting healthcare professionals said the registered manager was "Approachable" and staff spoke positively about the registered manager and the support they received. Staff said the registered manager treated everyone fairly and equally and that they would address any issues with staff when required. They also commented, "The service users are the priority." Another staff member told us, "I love it here…I love the job." Comments from staff indicated a positive and open culture. The registered manager encouraged communication between staff and themselves.

There were policies in place to prevent discrimination and promote equality in the workplace. The registered manager understood and had carried out their responsibilities with regards to submitting statutory notifications, as required by law, for incidents that occurred at the service.

The provider worked in partnership with other organisations, to enrich the opportunities available to people and to ensure people had access to services and community facilities. For instance, the service had taken part in a Hull City of Culture Storybox initiative, where people went to various places in the city and worked together to create a story. There were links with local pubs, including plans to help host a dementia afternoon. People and staff had also taken part in fundraising events, such as a sponsored walk. The provider built positive relationships with healthcare professionals.

Relatives, people who used the service, visiting professionals and staff were invited to complete an annual survey in order to give feedback on the service. 'Relatives and clients' meetings also took place, as a further opportunity to seek people's views and share information. People had requested a larger television to watch films, so the provider had purchased a large projector screen. Examples like this showed the service listened to ideas and took action to improve the service provided.

The provider had a quality assurance system and regular audits were completed to monitor the care provided. This included audits in relation to infection control, catering and medication, plus accident and incident monitoring and health and safety committee meetings. There were also monthly visits by the provider to assess a range of areas of practice. Actions identified in audits were collated on to a database, so that progress on these actions could be monitored. We saw examples to show us that these processes were used to improve aspects of practice. For example, reminders were issued to staff about medication practices and action had been taken to rectify some issues in relation to inappropriate storage as a result of an infection control audit. However, throughout our inspection we identified a number of record keeping issues in care files, and the quality assurance systems in place had not been effective in identifying and effectively addressing these issues. For example, some care files lacked comprehensive information about referrals to other healthcare professionals and the outcome of this, such as a file we viewed where the outcome of a referral to the falls team was not recorded. The amount of care plan audits (known as care programme audits) completed in the three months prior to our inspection had not been in line with the provider's expectations. More frequent and thorough checks on care plans could have helped to identify the variance

we saw in quality between care plans written by different staff members.

We also noted that an issue we identified at our last comprehensive inspection in September 2015, about the lack of detail in some care files about the positive support interventions staff should use when people were displaying behaviour which was challenging, had recurred. Whilst we found no evidence that these record keeping issues had impacted on the care people received, collectively they showed that improvement was required to the systems in place to ensure the quality of care documentation.

We recommend the provider reviews quality assurance processes and takes action to ensure that records retained in respect of each person are more consistently and fully maintained.

The provider started taking action to address these issues after the first day of our inspection.