Olympus Care Services Limited

Southfields House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced inspection took place on 6 & 7 April 2016. This residential care home is registered to provide accommodation and personal care for up to 46 older people. At the time of our inspection there were 34 people living at the home.

There was not a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. There was a manager in post and they had submitted their application to the CQC promptly once appointed.

Improvements were required to the staffing levels within the home to ensure people received timely and person centred care at all times. Improvements were also required to ensure that people's care plans reflected their current needs and levels of support.

People felt safe in the home. Staff understood the need to protect people from harm and abuse and knew what action they should take if they had any concerns. There were sufficient recruitment procedures in place to protect people from receiving unsafe care from care staff unsuited to the job.

People received care from staff that were supported to carry out their roles to meet the assessed needs of people living at the home. Staff received training in areas that enabled them to understand and meet the care needs of each person.

Risk assessments were in place to protect people from identified risks and they helped to keep people safe. People were supported to take their medicines as prescribed. Medicines were obtained, stored, administered and disposed of safely. People were supported to maintain good health and had access to healthcare services when needed.

People were actively involved in decisions about their care and support needs. There were formal systems in place to assess people's capacity for decision making under the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

Care plans were written in a person centred manner and focussed on ensuring people had choice and person centred care. They detailed how people wished to be supported and people were fully involved in making decisions about their care. People were able to choose where they spent their time and what they did.

Quality assurance systems were in place to monitor the care and support people received was in line with their requirements. People and staff reacted positively to the manager and the culture within the home focussed upon supporting people to receive the care they required in a nurturing environment. Systems

were in place for the home to receive and act on feedback and policies and procedures were available which reflected the care provided at the home.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Staffing levels did not always reflect the high dependency needs of people to ensure people received their care in a timely way.

People felt safe and comfortable in the home and staff were clear on their roles and responsibilities to safeguard them.

Risk assessments were in place and were managed in a way which enabled people to be as independent as possible and receive safe support.

There were systems in place to manage medicines in a safe way and people were supported to take their prescribed medicines.

Is the service effective?

Good

The service was effective.

People were actively involved in decisions about their care and support needs and how they spent their day. Staff demonstrated their understanding of the Mental Capacity Act, 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

People received personalised support. Staff received training which ensured they had the skills and knowledge to support people appropriately and in the way that they preferred.

Peoples physical health needs were kept under regular review. People were supported by a range of relevant health care professionals to ensure they received the support that they needed in a timely way.

Is the service caring?

Good

The service was caring.

People were encouraged to make decisions about how their support was provided and their privacy and dignity were protected and promoted.

There were positive interactions between people living at the home and staff. People were happy with the support they received from the staff.

Staff had a good understanding of people's needs and preferences and these were respected and accommodated by staff.

Staff promoted peoples independence in a supportive and collaborative way.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care plans were not reviewed or updated when people's needs had changed.

People were not always supported to have interaction or supported to complete activities on a regular basis.

Pre admission assessments were carried out to ensure the home was able to meet people's needs.

There was a transparent complaints system in place.

Is the service well-led?

Good

The service was well-led.

A registered manager was not in post however the service had made every reasonable effort to promptly submit an application for a suitable candidate.

The manager was supportive and instilled confidence into the staffing team.

Quality assurance measures were in place to improve the quality of the service.

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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 inspection took place on 6 and 7 April 2016 and was unannounced. The inspection was completed by one inspector.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The provider returned the PIR and we took this into account when we made judgements in this report.

We reviewed the information we held about the service, including statutory notifications that the provider had sent us. A statutory notification is information about important events which the provider is required to send us by law. We also contacted health and social care commissioners who place and monitor the care of people living in the home.

During our inspection we spoke with five people who lived at the home, four relatives, two members of care staff, one member of kitchen staff and two members of the management team.

We looked at care plan documentation relating to four people, and three staff files. We also looked at other information related to the running of and the quality of the service. This included quality assurance audits, maintenance schedules, training information for care staff, meeting minutes and arrangements for managing complaints.

Requires Improvement

Is the service safe?

Our findings

There was not always enough staff to meet people's needs in a timely way. People that were able to communicate with us told us that staff were available when they needed them. One person also explained that if they spent time in their bedrooms they had access to a bell which alerted staff that they required assistance. One person told us that staff came quickly whenever they pressed their bell. Another person told us, "The staff are always around [if I need them]." Staff told us that generally there was enough staff available but there were times when it was difficult to get to everyone in a timely way. We saw that staff worked together to meet people's needs and at key times of the day, for example at mealtimes, additional staff were deployed to ensure people could eat their meals with staff support. However, we also observed that when people required two members of staff support to get out of bed, there were not always enough staff to support people to get out of bed at the times they preferred. The staff confirmed that this had happened on occasions, particularly if people required additional support with their personal care and the manager was reviewing ways this could be improved.

People's care needs were well managed by staff and they had a good knowledge of the risks associated with each person. However we found that people's written risk assessments were not always reviewed at regular intervals, or updated when people's care needs had changed. People we spoke with told us that they felt the staff helped to keep them safe whilst living at the home. One person said, "I feel very safe here with all the staff. They know me well." Staff were able to clearly explain how they supported people with changing care needs to keep them safe, and recognised when people's health had improved and required less intervention. For example, staff recognised that one person was at risk of developing pressure damage to their skin and supported them to use a pressure cushion on the chair they liked to sit in, and this was moved if they changed chairs. We found that staff understood how people's care needs had changed following a period in hospital, however on their return, their risk assessments had not been reviewed or updated to reflect the new strategies that were in place to ensure they received safe care and support.

People were supported by staff that had been deemed suitable to work in the care industry. There were appropriate recruitment practices in place. Staff employment histories were checked and staff backgrounds were checked with the Disclosure and Barring Service (DBS) for criminal convictions before they were able to start work and provide care to people. This meant that people were safeguarded against the risk of being cared for by unsuitable staff.

People were supported by staff that knew how to recognise when people were at risk of harm and knew what action they should take to keep people safe. Staff received training to support them to identify signs of abuse and they understood how they could report their concerns. Staff understood the need to report any concerns or allegations of safeguarding immediately. One member of staff said, "If there were any concerns at all, I'd report it to the manager or go above them." The provider's safeguarding policy explained the procedures staff needed to follow if they had any concerns and the manager had a good knowledge of the procedure. We saw that appropriate safeguarding referrals had been made to the relevant authorities and full investigations had been completed when concerns were identified. Prompt and robust action had been taken following a safeguarding concern and the management team had changed procedures and

introduced new safety measures to ensure that people and their belongings were managed safely.

Accidents and incidents, including falls, were recorded by staff and reviewed by the manager. Staff discussed incidents during handover to identify if any immediate action needed to be taken to prevent future incidents. In addition, a monthly log was maintained and the registered manager reviewed this to identify if there were any trends or repeated incidents. Staff took appropriate action and gave consideration to the events that led up to the incident to reduce the risk of a repeated incident. Staff understood what could be potential triggers and there was a plan in place to reduce the possibility of a similar incident.

There were appropriate arrangements in place for the management of medicines. One person said, "I always get my medicines, and they ask me if I'm in any pain, or need any paracetamol. There's no concerns there." Staff that were trained to administer medicines were able to explain the procedures they followed which ensured people received the correct medication at the correct time. We observed that people received their medication from staff in a professional and encouraging way. People were told what their medicines were for and were given reassurance when they needed it. We heard staff giving instructions to people who required it about how to take their medicines safely; people that required pain relief where asked or assessed if they needed it. Staff had received training in the safe administration, storage and disposal of medicines and they were knowledgeable about how to safely administer medicines to people. We saw that medication administration records (MAR) were completed accurately after each person had received their medicine and people's medicines were kept locked securely at all times.

People lived in an environment that was safe. There was a system in place to ensure the safety of the premises as regular fire safety checks were made. People had emergency evacuation plans in place which ensured staff had access to people's support requirements in an emergency situation. We observed that the environment supported safe movement around the building and there were no obstructions for people who required support with their mobility.

Good

Is the service effective?

Our findings

People received support from staff that had received training which enabled them to understand the needs of the people they were supporting. New staff were supported in their role to understand and learn about the people they were supporting and they were required to 'shadow' a variety of shifts to observe how people's needs were met at different times of the day. New staff were also required to complete the Care Certificate which supported staff to provide compassionate and safe care to 15 required standards. Staff told us they felt the training was good and prepared them to perform their role well. One member of staff said, "The training we get here is really good. There's a variety." Staff also had additional training specifically relevant to the people that lived at the home which included dementia awareness. Staff told us this had been helpful to understand how dementia may affect people and the kind of support they might need. A program was in place to ensure experienced staff regularly refreshed their knowledge and skills training and knowledge about current practices including safeguarding and supporting people to move safely.

Staff had the guidance and support when they needed it. Staff were confident in the manager and were satisfied with the level of support and supervision they received. One member of staff told us, "I get really good support and regular supervisions, usually monthly." Supervisions and appraisals were used to discuss performance issues and training requirements and to support staff in their role. The manager had recently implemented a system to ensure that all members of staff received regular supervision sessions to help drive improvement and aid communication. The manager maintained an open and accessible approach and encouraged staff to speak to her if there were any concerns they needed support with.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). We checked whether the service was working within the principles of the MCA and we saw that they were. 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 MCA 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.

The management team and staff were aware of their responsibilities under the MCA. We found that staff received relevant training and when staff had identified that people's mental capacity may be limited, staff understood they had a responsibility to request further support for people. We saw that staff had completed mental capacity assessments when it had been felt that people who lived at the home were unable to make their own decisions without assistance. We also saw that where appropriate, staff had applied for the appropriate Deprivation of Liberty Safeguard (DoLS). Staff carefully considered whether people had the capacity to make specific decisions or provide consent in their daily lives and where they were unable to, decisions were made in their best interests.

People were supported to maintain a balanced diet and eat well. One person told us, "There's always plenty to eat. I certainly don't starve." Another person's relative told us, "The staff are good at encouraging people to eat, and helping them if they need it – but they don't take over." We saw that people were supported to

eat meals they enjoyed, and to eat them as independently as possible. Staff provided good support and encouragement to people who required it, so people could eat in a timely way. People were not rushed to hurry their meals and were supported at their own pace.

People's nutritional needs were assessed and regularly monitored. For example, people's weights were monitored to ensure that people remained within a healthy range, and when concerns were identified further action was taken to monitor and improve this. People were supported with their nutrition with referrals to dietitians or speech and language therapists when necessary. One person's relative told us, "They [the staff] noticed when [name] was having problems swallowing her food and they got the dietitian involved so now she has special food." We checked that staff were aware of when changes had been made to people's diets, and people were receiving the correct food to meet their needs. A member of the kitchen staff explained they had access to people's food and nutritional preferences and ensured the food met with people's requirements. For example, a range of diabetes friendly snacks were available for people that had diabetes.

People's healthcare needs were monitored by knowledgeable and consistent staff, and staff understood how care should be delivered effectively. One person said, "They must look after me alright because they keep me healthy." Staff were aware of people's health needs and could recognise when people were unwell. One person's relative said, "If [name] is poorly they do their best to get a doctor out. They're very good at picking up if she's not well." We also saw that staff were vigilant to people's changing health needs, for example when one person's condition had improved following a hospital stay, staff worked with the district nurse to review the level of support the person required. People who lived at the home had annual healthcare checks and care records showed that people had access to specialist nurses and their local doctors when they needed extra support. Management staff were working with professionals and the local authority to identify if the number of GP surgeries involved in supporting the home could be reduced to ensure a streamlined approach to the service people received.

Good

Is the service caring?

Our findings

People appeared relaxed and comfortable in the company of staff. People told us that the staff treated them well and we could see staff built caring relationships with the people who lived at the home. One person said, "The staff treat me well, we have a bit of a laugh together." Another person told us, "The staff are lovely." And one person said, "They make me laugh and keep me going."

Staff demonstrated a good knowledge and understanding about the people they cared for. The staff showed a good understanding of people's needs and they were able to tell us about each person's individual choices and preferences. For example, staff could tell us people who liked to stay in bed, or have their meals in a certain place. People had developed positive relationships with staff and they were able to share jokes and banter with each other. For example, one person joked with staff about the way they made coffee and another person was praised and encouraged for attempting to stand independently but with staff nearby.

People were involved in personalising their own bedrooms so that they had items around them that they treasured and had meaning to them. People showed us their bedrooms and we saw that people were enabled to have pictures and photographs on display. Staff used their knowledge of people to talk about their interests or family to enable people to have meaningful conversations. For example one member of staff reminded one person of their swimming and athletics background and they enjoyed reminiscing about their past.

People were encouraged to express their views and to make their own choices in a number of ways. People told us they felt listened to and staff responded to people effectively and with warmth and affection. We saw staff gave choices to people in everything they did, including what they would like to eat, where they would like to sit, who they would like to sit with. Staff explained that if people were unable to verbally communicate they presented them with the physical options to support them to make their choices, for example, by showing people different clothes options, or responding to people's body language to help them make a choice.

Staff understood the need to respect people's confidentiality and understood not to discuss issues in public or disclose information to people who did not need to know. Any information that needed to be passed on about people was placed in a confidential document or discussed at staff handovers which were conducted in private. Staff respected people's privacy and ensured that all personal care was supported discreetly and with the doors closed. Staff supported people to maintain their dignity and offered support to people to adjust their clothing when this was compromised. For example when one lady wearing a skirt used the hoist to change chairs, staff ensured her dignity was maintained by placing a blanket over her legs. Staff communicated what they were doing, and offered reassuring explanations.

People received personalised care which supported their individual requirements. Staff were encouraging and attentive. We observed one person liked to have a high level of staff interaction and staff made efforts to engage with the person at every request. Staff understood when people showed signs of distress or anxiety and responded quickly to this. We also saw that people who had items or toys of comfort were enabled to

have these items close to them to provide the comfort and reassurance they enjoyed. Each person had an identified senior member of staff who was responsible for ensuring people had access to resources and support they required and we saw that people had good relationships not just with this person but with all members of staff.

There was information on advocacy services which was available for people and their relatives to view on the noticeboard. The management team were aware of when advocacy services could be used for people, particularly for people who did not have any involvement or support from family or friends. However the manager confirmed that there was nobody currently at the home that required the support of an advocate. Visitors, such as relatives and people's friends, were encouraged at the home and made to feel welcome. One relative said, "We tend to come at the same time each week but we know we can come whenever we like. Everyone knows [name]. We couldn't wish for better for her." We saw that people were able to support people at mealtimes if they wished and were involved in understanding the care that their relative received.

Requires Improvement

Is the service responsive?

Our findings

People were limited with the level of engagement and interaction they had in their day. People told us there was not always much time for staff to be able to talk to them beyond providing their care and people had limited access to any meaningful activities. Staff told us they were encouraged to provide activities or tasks people enjoyed however this was often not possible due to the high level of support people required on a daily basis and the limited number of staff that were available to support people. We observed that beyond the television, there was little opportunity for engagement. We saw that staff made efforts to engage with people wherever possible however these opportunities were limited.

People had detailed care plans in place which explained people's care needs and the support they required. However these were not always updated or reviewed when people's care needs changed. For example, one person's care plan did not accurately reflect the diet the person required, and the support another person required with their mobility. We spoke with different members of staff, including the management team and all the staff had a good understanding of people's current needs and supported them with this. The management team had made a commitment prior to the inspection to review all the care plans to ensure they were current and up to date and this was in motion to commence immediately after the inspection.

People's care and support needs were assessed before they came to live at the home to determine if the home could meet their needs. People and their relatives were encouraged to visit the home and discuss the support they would require before a decision was made about whether the home was right for them. Staff gathered as much information as possible about each person during the pre-admission procedure from people themselves if they were able to communicate, and from relatives, advocates and professionals already involved in supporting each person. This ensured as smooth a transition as possible into the home if the person decided they would like to move in.

People's care and treatment was planned and delivered in line with people's individual preferences and choices. For example, people that enjoyed a bath were supported to have one on a regular basis, and people that preferred to have a body wash were supported with this. Care plans also contained information about people's past history, where they had previously lived and what interested them. Staff used this information to talk to people about places and people they cared for, and to support people to have person centred care. We saw that one person preferred to have their breakfast in bed before their personal care and this was respected by staff.

People's changing needs were understood and maintained by staff. Staff met with people and their relatives if they wished on a quarterly basis to discuss the care people received and whether any changes needed to be made. Staff were knowledgeable about what people's current care needs were, and when they had been subject to change. For example, one person sometimes required additional support and reassurance from staff to sit down independently. Staff offered encouragement and physical support if required, dependent on the person's health and confidence.

A complaints procedure was in place which explained what people or their relatives could do if they were

unhappy about any aspect of the home. Staff were responsive and aware of their responsibility to identify if people were unhappy with anything within the home and understood how they could support people to make a complaint. We saw that no complaints had been raised recently however the manager was aware of the procedures to follow in the event of a complaint.

Good

Is the service well-led?

Our findings

The home did not have a registered manager in place however, when the last registered manager left the provider took swift action to recruit a suitable candidate and this manager submitted an application immediately to the CQC. People at the home reacted positively to the manager. People who were able to communicate with us knew who the manager was and told us that the manager "…often popped in [to the unit]". Staff commented that they felt the home was well led and they had confidence in the management team. Staff felt confident to speak with a member of the management team if they had suggestions for improvement or concerns. One member of staff said, "The manager seems to get most things resolved quite quickly if we raise them." Another member of staff spoke positively when they had requested more cups and told us this had been resolved very quickly.

The culture within the home focused upon providing a nurturing environment for people to live and enjoy their life. One member of staff told us, "I love working here – I like making it great for everybody that lives here." All of the staff we spoke with were committed to providing a high standard of personalised care and support. Staff were focussed on the outcomes for the people who lived at the home and spoke passionately about providing the care people needed. Staff worked well together and as a team, they were focused on ensuring that each person's needs were met, for example, at mealtimes staff worked as a team to ensure everybody had their meals in a timely way with the support they required. Staff clearly enjoyed their work and told us that they received regular support from their manager.

Systems were in place for people, visitors and staff to provide feedback about the home and the quality of care people received. People were invited to attend meetings with their keyworker and people were supported to consider what was and wasn't working well for them. Staff took time to observe people's reactions and body language to gain feedback from people about what they enjoyed or were unhappy about. Regular staff meetings took place at different times to ensure that all staff could attend and minutes were available for staff that were unable to attend. Minutes showed that there were opportunities for staff to raise ideas and become involved in decisions about changes and improvements within the home.

The home had policies and procedures in place which covered all aspects relevant to operating a care home which included safeguarding and recruitment procedures. The policies and procedures were detailed and provided guidance for staff. Staff had access to the policies and procedures whenever they were required and staff were expected to read and understand them as part of their role. The registered manager had submitted appropriate notifications to the CQC when required, for example, as a result of safeguarding concerns.

The home had a good quality assurance system in place to monitor the quality of the service provided by the home. This included regular audits completed by the manager and the provider. When areas for improvement had been identified these were targeted and improvements were monitored. For example, there had been a frequency of medication errors and the management team worked with staff to drive improvements through practical demonstrations and actions for staff to follow. This had improved staff understanding and improved how medications were handled and recorded.

The management team recognised areas that required improvement and worked to address these. For example, each senior member of staff had taken responsibility for areas of improvement including falls management and end of life care. The seniors worked with outside agencies, and internal colleagues with experience in their field to identify best practice and this had been implemented with success. We saw that one person's family who had been supported to have a beautiful and dignified death had sent a heartfelt thank you card recognising the efforts, love and support they were all provided with.