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

Summary of findings

Overall summary

This inspection took place on 18 September 2017 and was unannounced. The service provides accommodation for up to 46 older people who require support with their personal care. At the time of our inspection there were 40 people living at the service. We carried out this comprehensive inspection due to concerns we had received about the service in the two months prior to this inspection.

There was a registered manager in post at the time of our inspection. 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.

At this inspection we found breaches of four regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The breaches we identified were in relation to medicines management, risk assessing, nutritional monitoring and support, safeguarding people against abuse and in relation to how the service was being run. At our last inspection the service was rated as 'Requires Improvement.' You can see the action we have asked the provider to take at the end of this report.

People's risk assessments and care plans did not always reflect their current needs. Risks to people had not always been accurately calculated and this put people at risk of receiving unsafe care and support.

Medicines were not being safely managed, stored or administered at the service and although an action plan was in place to improve medicines and how they were being managed, some of the issues we identified had not been identified by the registered manager. There had been eight substantiated safeguarding investigations into people who had not received their medicines as required over the period of two months.

People were not being adequately supported with their nutritional needs and there was confusion within the service about how people's meals were fortified. This was not always happening as required. People had not always been referred to the dietitian where this may have been required. There was not an adequate number of staff to support people as they needed at mealtimes.

Staff felt supported and were trained to deliver safe care to people. This training was monitored and refreshed when needed. However, there was a training gap in relation to managing behaviour which may have been challenging for staff.

Although there were mental capacity assessments carried out at the service, there were no best interest meetings held or documented to consider decisions made in relation to how people were cared for. There was not adequate monitoring and oversight of Deprivation of Liberty Safeguards at the service.

Incidents and complaints had not always been appropriately recorded or responded to and some safeguarding incidents had not been recognised as such by the registered manager. We have made a

recommendation about the management of complaints. Some of the safeguarding concerns we looked at had not been responded to as they should have been in order to protect people from the risk of abuse.

There was a lack of management oversight across the service which meant that people's risks were not being monitored and improvements were not made as needed. Quality assurance systems were not effective as information was not being monitored by the registered manager.

People were cared for by kind and compassionate staff who knew people well. People's privacy was respected and their dignity maintained and care records detailed people's personal histories and their preferences in relation to their care.

People were encouraged to remain independent wherever possible and there were activities within the service that people could choose to get involved with.

Most staff felt supported by the registered manager and there were regular meetings held to obtain both the views of staff and the views of people who used the service.

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 safe.

People's risks were not always accurately assessed and planned for.

Medicines were not managed, stored or administered safely.

There were not sufficient numbers of staff to support people as needed at mealtimes.

Some safeguarding concerns had not been recognised as such or reported as needed. Incidents had not always been reported as they should have been.

Staff were safely recruited.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's dietary needs were not being met and people were not being supported to eat and drink as they required.

Staff had an induction into the service and training was delivered and refreshed. However, there was a training gap in relation to managing behaviour which may have been challenging for staff to manage.

People's mental capacity had been assessed when needed but no best interest meetings had been held to consider any restrictions placed on people or decisions relating to how they were being cared for.

Referrals to health professionals had not always been made when needed.

Consent was sought from people prior to them receiving care.

Is the service caring?

Good

The service was caring.

People were supported and cared for by staff who knew them well and who treated them in a caring and compassionate manner.

People's dignity was maintained and their privacy respected.

People were treated as individuals and were able to spend their time as they wished.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Complaints had not been managed well at the service or in line with the complaints policy in place.

Risk assessments were not always accurate and did not always reflect people's current needs.

People were not involved in on-going reviews of their care.

People were encouraged to remain independent wherever possible.

Is the service well-led?

Requires Improvement

The service was not well-led.

The registered manager did not have oversight across the service as a whole and was not aware of risks across the service.

The registered manager was not clear on the needs of people using the service and quality assurance systems were not being managed effectively.

Incidents and complaints had not always been managed well and reported as they should have been.

Staff felt supported in their roles and felt that these were clearly defined.

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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 was 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 18 September 2017 and was unannounced. The inspection team consisted of three inspectors, an expert by experience and a specialist advisor. Our advisor was a pharmacist. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to our inspection 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.

Over the course of the inspection, we spoke with eight people who used the service, two relatives, the registered manager, the area manager, two team leaders, a shift leader and four care staff. We viewed eight records about people's care and treatment which included their daily care records, risk assessments and medicines records. We did this to ensure that they were accurate, clear and up-to-date. We made observations of the care being delivered to people and looked at people's care from planning through to delivery.

We looked at the systems the provider had in place to monitor the quality of service to ensure people received care that met their needs.

Requires Improvement

Is the service safe?

Our findings

We returned to the service to carry out this comprehensive inspection due to information of concern in relation to the safe management of medicines and how the service was being managed.

People were not always having their medicines administered to them safely. For example, one person was having their medicine mixed into yoghurt or tea. This medicine should not be mixed with this type of food and drink as it would reduce the effectiveness of the medication. We advised the registered manager of this during the inspection who had been unaware that this was the case. This person was also reported to be having their medicines covertly (without their knowledge). When we raised this with the registered manager they told us that there was some confusion in the service about what was meant by 'covert medication'. This was something that was planned to be addressed at the time of our inspection as several people within the service were described as having their medicines covertly. However, when we looked into this, some people knew the medicines were being given to them and so the administration was not covert.

Medicines were not being safely stored. We found very high temperatures in rooms where medicines were being stored and some fridge temperatures which had been taken and recorded indicated that medicines had not been stored safely. We found several days where room and fridge temperatures had not been taken or recorded. When we asked what action had been taken as a result of the high temperature readings recorded, we were told that no action had been taken. We found two people's medicines were not being kept at a safe temperature at the time of our inspection. There were not adequate systems in place to store medicines safely.

People were not always administered their medicines safely. We looked at the Medicines Administration Records (MARs) and found that one person had been given their Warfarin medication at different doses on different days. There was no explanation as to why this had happened and the dose had not been given as prescribed. We observed another person being asked to take two tablets at the same time. This was visibly difficult for this person who had to make several attempts before they were able to swallow both tablets which were given to them on a spoon.

People's risks were not always accurately assessed at the service to ensure they received safe care which met their needs. For example, two people deemed to be at nutritional risk did not have an accurate Body Mass Index (BMI) calculated. These risk assessments were incomplete and did not accurately reflect their nutritional risk. Another person had a falls risk assessment in place which had not been accurately calculated based on the person's current needs. Their risk assessment stated that they were low risk of falls but did not take into account how they mobilised around the service.

People's weight was monitored on an individual basis, however, there was no tracking of people's weight loss across the service. The registered manager relied on the team leaders to collate this information and was not able to tell us about people's weight loss or their nutritional risk and needs. Four people we looked at had lost a significant amount of weight since April 2017 but only two of them had been referred to a dietitian. This put these people at risk.

The above evidence indicates a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

Some of the staff we spoke with during our inspection told us that, although it was busy within the service, there were enough staff to safely meet people's needs. One staff member said, "It's very good at the minute. It's definitely improved." Another staff member told us, "Things are changing. We're getting a lot more help. The emphasis is on working as a team." Some staff members expressed with us that it could be very busy working at the service and that, at times; this could impact on people who used the service. One staff member said, "It can be very hard work with the numbers of staff we've got. Some staff aren't willing to help as much." Our observations during the inspection found that meal times were not adequately staffed across the service and that this meant some people were not supported as they needed to be with their food and drink. We observed two people asleep during mealtimes who were not supported to eat their meals. These meals were subsequently cleared away without these two people having anything to eat.

Staff were trained in safeguarding people from abuse and safeguarding referrals had been made when incidents had been recognised as safeguarding. However, we did find some incidents of unexplained bruising which had not been appropriately referred by the service. Although these bruises had been recorded within people's care records, as they were unexplained, they had not been reported as safeguarding concerns. When we asked the registered manager why this had not been done they were not able to tell us. We found that one complaint, which consisted of safeguarding concerns about a member of staff and their behaviour towards a person who used the service, had not been recognised as a possible allegation of abuse and had not been referred to safeguarding. This complaint alleged that the person had been a victim of abuse and yet no referral had been made to the local authority or to CQC about this allegation. There were not always adequate processes in place to protect people from abuse.

The above evidence indicates a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding service users from abuse and improper treatment.

Staff we spoke with could name different types of abuse and were able to tell us how they would report any allegations of abuse should they need to. People using the service told us they felt safe. One person told us, "I feel very safe here; you don't have to worry about that." Another person said, "I feel safe because I like the staff."

We found that incidents and accidents were logged within the service and that these were reviewed and collated centrally to analyse them for any patterns and trends. However, some incidents had not always been appropriately reported.

Staff were recruited using safe recruitment procedures. Pre-employment checks were carried out to ensure prospective new staff were fit and of good character. These checks included disclosure and barring service (DBS) checks for staff. DBS checks are made against the police national computer database to see if there are any convictions, cautions, warnings or reprimands listed for the applicant. This meant that the manager could be sure that staff were of good character and fit to work with vulnerable people.

Requires Improvement

Is the service effective?

Our findings

People were not adequately supported with their nutritional needs. We found people who required staff to assist them with eating were not being assisted due to staffing levels at the service during meal times. People's dietary needs were not clearly identified and there was confusion within the service about who was responsible for fortifying meals for people who were at nutritional risk. We raised this with the registered manager who was not clear on the processes and how they worked.

One person required fortified foods to enhance their dietary intake, however, this was not being done as there was some confusion within the service about whether the kitchen staff did this or the staff that provided the person care. When we addressed this with the registered manager, they told us that the kitchen staff fortified the meals, however, staff told us that the unit leaders would do this. We found that some people's meals were not being fortified as required and that these people were not receiving the nutritional input they needed, putting them at risk of malnutrition.

People waited for long periods to be served their meals and one person had to wait to be assisted with their meal. They waited for 20 minutes. The person became upset as their meal had gone cold by this time and the person's meal had to be taken away. They were served a yoghurt rather than a hot meal.

We found that four people had lost significant amounts of weight at the service. Two people had lost five kilograms between April 2017 and September 2017. No action had been taken as a result of this weight loss and no referrals made to healthcare professionals for further support. We found two other people who had lost a similar amount of weight who had been referred to a dietitian. We raised this with the registered manager who did not know why two of the four people had not been referred due to their weight loss and who told us that they would look into this following our inspection to ensure that people got the nutritional support they required.

Staff were not clear on people's dietary needs and the level of support they required. People were not always cared for by staff that knew them as they chose to eat in different areas of the home, this caused confusion as the staff in these areas didn't know them well. We observed that people were not always supported in the way they needed to eat and some of those people did not get the food and drink they required as a result.

The above evidence indicates a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Meeting nutritional and hydration needs.

We found that drinks were readily available for people should they want them and people were given a choice in what they had to eat and drink. One person told us, "We have a choice at meal times the staff tell us what there is." Another person said, "I like the food, we get enough and there is a choice." The relative of someone who used the service told us that meals were not always well planned and that they had to raise issues about their relative having their breakfast and lunch very close together. They told us that they had raised this with the service and that it had been resolved.

Staff had an induction when they began working at the service which covered key areas in the safe and effective delivery of care. We saw that staff received training during the course of their employment with the provider and that this training was monitored and refreshed when needed. There were areas of training in relation to medicines management that staff needed further training on and this had been recognised and planned for at the service. During our inspection we found that some of the people using the service could display behaviour that, at times, may have been challenging for staff to manage. When we asked the registered manager about this they told us this was not the case, however, we found evidence in care records that people had been challenging towards staff and we saw one person hit out at a staff member during our inspection. Staff we spoke with told us that they had not received any training in relation to managing behaviour that challenges. Records and discussions with the registered manager confirmed this. Staff did not have adequate training to keep people and themselves safe in relation to behaviours that challenge.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack capacity to do so for themselves. The Act requires that as far as possible people make their own decision 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. Capacity assessments had been carried out on people when required and in line with legal requirements. However, we saw that decisions had been made for people who lacked capacity, such as them being given their medicines covertly, without any best interest decision being documented. One person had bed rails in place and although they had been deemed to lack capacity, no best interest decision process had been implemented to make the decision about this restriction.

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 MCA. We checked that the service was working within the principles of the MCA 2005. We saw that applications had been made when people may have been deprived of their liberty. We found that these applications were not being monitored and that one of them went back to 2015. The registered manager had not followed up on this application and was not clear about who had an application in place or pending. There was not adequate oversight in relation to the deprivation of people's liberty within the service.

People's consent was sought by staff. People told us that staff always asked permission from them before they carried out any task or personal care and we saw this was the case during the course of our inspection.

People and their relatives felt that people's well-being was adequately monitored, however, we found that improvements were needed in order to ensure people's health and well-being, particularly in relation to their nutritional needs.

Staff felt supported in their roles and were able to describe having regular meetings to discuss their roles and any issues they may need to raise. Most of the staff we spoke with felt that they could approach their line manager should they need to. One staff member told us, "Communication is good. The team work is good." Many staff described being part of an effective team who worked well together and supported one another.

Good

Is the service caring?

Our findings

During our inspection we observed positive interactions between staff and people who used the service. One person who used the service told us, "Staff treat me well, they seem to care." Another person said, "The staff on the unit are really nice." People's relatives were equally positive about staff working at the service and described how they worked to ensure their relative was happy and comfortable.

Staff knew the people they cared for well and understood how to deliver care which maintained people's dignity and respected their privacy. We observed staff treat people with respect and consult with people prior to delivering care to them. Staff were focussed on care being centred around people's individual needs and preferences and were able to describe this as being the new approach within the service. One staff member told us, "It wasn't very customer focussed but it is now." Another staff member said, "We genuinely care." We observed staff to be kind and caring in their approach to people.

Care records for people described how people liked their care to be delivered to them. The care plans were written to reflect people as individuals, describing their life histories and providing information to staff about who the person was. They were written respectfully and reflected how the person would want their care to be delivered and why. The care records encouraged people to remain independent where possible, for example, one person's care plan stated, "[Person] is a private and independent man who likes to do as much as he can for himself." This illustrated how the service worked to maintain people's dignity and treated them with respect.

People were able to access a garden area at the service whenever they wished to and there were private spaces so that people could meet with friends and family without being disturbed should they want to. This had been arranged in order to provide people with privacy. People had access to their rooms whenever they wanted and were able to access all areas of the home as and when they wished.

There were systems in place to allow people to feedback on the care delivered at the service and we saw that this feedback was collated and reviewed to ensure that people were getting what they wanted. We found that people felt comfortable to raise any issues and concerns they had with staff working at the service.

Requires Improvement

Is the service responsive?

Our findings

People could not be assured that their concerns and issues would be adequately addressed at the service as complaints were not being fully responded to. Appropriate action was not always taken in response to complaints received. For example, we found a written complaint which had been sent to the service. When we looked into the actions taken in relation to the concerns raised we found that steps had been taken to address the issues outlined. However, we found that no written response had been sent to the person who had made the complaint outlining what the service had done in response to the concerns raised. This was not in line with the complaints policy in place at the service.

There was no clear oversight of the complaints process to ensure that these were responded to appropriately and in line with the policy in place at the service. The policy we were provided with stated that complaints should have been recorded onto a central system to ensure that the provider had oversight into complaints received. We found that this was not the case when looking at complaints and how these were managed and responded to at the service. We found two complaints that had not been centrally logged as required.

We recommend that the service seek advice and guidance from a reputable source, about the management of and learning from complaints.

People we spoke with were clear about how to complain. One person said, "I know how to make a complaint – I think I'd go into the office." Another person who used the service told us, "I talk to the team leaders on the unit if I am concerned about anything."

People had their needs assessed prior to coming to the service and these assessments considered people's individual care needs and preferences to ensure that the service was able to meet these. Once people were admitted to the service, we found that care plans and risk assessments were devised to ensure people got the care and support they needed and to ensure that people were safe. However, we did find that some of these assessments were not always accurate and that they did not always reflect people's current requirements. This put people at risk and these assessments would not have enabled staff to deliver the care and support that people may have needed.

People were not sure that they had been involved in the planning of their care and relatives spoke with raised similar issues. One relative told us, "I don't know anything about my wife's care plan if she has one, I think social services deal with all that." Another relative said, "I don't have any input into my mother's care plan." Although care plans reflected the person they concerned and had been written initially involving the person who used the service, there was little evidence that people and their relatives had been involved in on-going reviews of their care and support.

We found that people were encouraged to be independent wherever possible and that the service supported them in this. For example, one person with limited mobility was encouraged and supported to move around the service in the way they chose to prevent them from being socially isolated. Activities were

provided to people at the service and people moved around the home so that they were able to chat with other people who used the service and to provide them with a change of scenery should they want one.

Requires Improvement

Is the service well-led?

Our findings

We found a number of concerns within the service which had not been picked up by the registered manager at the time of our inspection. There was an action plan in place to address the issues surrounding the management of medicines at the service following eight substantiated safeguarding enquiries. People had not been receiving their medicines safely and there were several areas in which the service needed to improve in order to address this. The local authority was working with the service in order to ensure these improvements were made. However, during this inspection we found a number of concerns in relation to medicines management which had not been identified by the registered manager or the provider. These were in relation to how medicines were being administered and stored. Although medicines management formed part of a wider "service improvement plan", this plan had not identified some the failings we picked up during our inspection and neither had the auditing processes in place.

The registered manager was unable to tell us about people's current needs as they were not involved in reviewing the care records at the service. When we asked about people who had their medicines covertly, the registered manager was not able to tell us who had their medication this way as they did not have oversight of people's current care needs. They told us that the information was within the folders on each unit. When we asked to see a record of people's weights and any weight loss across the service, the registered manager was unable to give us this information as they relied on the unit leaders tracking this on each of the units. This meant that there was no oversight of risk across the service and that quality assurance systems were not effective in assessing quality over the service as a whole.

We had concerns about confusion within the service about people having their meals fortified as advised by a dietitian. We observed that this was not happening during our inspection and raised this with the registered manager. The registered manager told us that the meals should be fortified by the kitchen, however, staff told us that the meals were fortified on the individual units once they came across from the kitchen. People were not getting their dietary needs met during our inspection and the registered manager did not have oversight of this process. There was no quality assurance process in place to monitor people's nutritional intake and needs. The "service improvement plan" in place had not identified this as an area which needed improvement.

We asked the registered manager whether anyone was cared for in bed at the start of our inspection. We were told that nobody stayed in bed at the service. However, during the course of our inspection we identified someone who was being cared for in bed. This person had lost a significant amount of weight since April 2017 and yet no referral had been made to a dietitian. When we raised this with the registered manager they were not aware that this person was cared for in bed nor were they aware of the weight loss. There was no adequate oversight of people's needs across the service to ensure their safety.

Incidents were logged on a central system to allow for these to be monitored by the provider to look for any patterns and trends. However, we found records relating to people who had suffered unexplained bruising. When we raised this with the registered manager, they advised that these had not been logged as incidents or as safeguarding concerns. These incidents were not being adequately monitored within the service to

keep people safe.

Complaints received by the registered manager had not been processed as they should have been to ensure people got the response they required. We were shown complaints which were kept in the registered manager's desk drawer which did not form part of the complaints record and which had not been responded to in line with the policy in place at the service.

The above evidence indicates breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

We found that notifications of incidents were made to the relevant authorities when incidents were recognised as notifiable. However, we had concerns that some of the incidents we reviewed had not been recognised, logged and notified as they should have been. We raised this with the registered manager who told us that they would review this going forward.

People and their relatives were not clear about who the manager was at the home and felt that they would benefit from staff being more identifiable. We saw during our inspection that people were not always clear about who was staff. One relative told us, "I think the manager's name is Carol or Karen, it would help if staff wore name badges not just for the residents but for the visitors." There wasn't a clear management presence within the service and people were not sure who to approach should they need to. One person using the service said, "I don't know the managers name."

Most of the staff we spoke with felt supported in their roles and described some positive changes being implemented at the service by the registered manager. One staff member said, "I feel more supported than I used to. We were all over the place before." Another staff member told us, "It's very good at the minute. It's definitely improved." Generally, the staff we spoke with felt they worked well as a team and that there were systems in place to support them should they need it. Most of the staff felt that the registered manager was approachable and that their roles were clearly defined.

People were able to feedback about their care through meetings held with people who used the service and their relatives. We saw evidence of regular meetings for people living at the service. Regular meetings were also held with staff to discuss any concerns or issues they may have.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not being safely managed and risks associated with people's care delivery had not been adequately assessed and planned for.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Incidents had not been recognised as possible safeguarding incidents and had not been reported to protect people from the risk of abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs People were not receiving the nutritional support and input they required. There was a lack of staff to support people as they required during meal times and people were not always getting the nutritional input they needed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a lack of effective quality assurance systems in place at the service and the registered manager and provider lacked oversight of people's care needs and any risks

associated with the delivery of their care.