Care Quality Commission

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Oliver House

Inspection report

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Ratings

Overall rating for this service	**Inadequate**
Is the service safe?	**Inadequate**
Is the service effective?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Inadequate**

Overall summary

This inspection was unannounced and took place on 15 October 2015. The service was registered to provide accommodation for up to 26 people. People who used the service had physical health needs and/or were living with dementia. Some of the people required nursing support. At the time of our inspection 25 people were using the service.

The service did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The provider had recruited a manager and they told us they were going to apply to register with us.

The service did not have sufficient staff to support the needs of the people at the home and to keep people safe. There was limited information in the care plans which meant people didn't always receive their care in accordance with their needs as it had not been documented or communicated to the staff. Risk to people's health and wellbeing were not consistently

Summary of findings

identified, managed and reviewed. This meant people's needs were not always met and the staff did not have the time to consistently treat people with dignity and compassion.

There was a limited choice of food; however there was not always the support available to encourage people's independence or to assist people with their meal. Records were not maintained and monitored to ensure people received the required amounts to maintain their food and drink requirements.

The provider had not followed their responsibility to comply with the requirements of the Mental Capacity Act 2005 (MCA) People had not received best interest assessments to ascertain if they are able to make their own decisions or if they required support. Deprivation of Liberty Safeguards (DoLS) assessment had not been requested from the local authority.

Some people required support from health professionals to maintain their health. However there were some incidents which had not been referred in a timely manner which may have prevented people receiving the support they required.

Staff had little time to interact with people due to the workload and staffing constraints. We observed some interactions which showed kindness and care.

The staff had not received appropriate training before they commence working in the care environment and ongoing training was not checked to ensure staff understood and felt competent to use the training to support the care they provided.

The care plans provided to support people's individual care were not centred around the person's needs and preferences. The service offered little stimulation to the people or the opportunity to engage in a chosen activity.

People felt able to complain, however the provider did not have a process for managing complaints.

The provider had not been notifying us of incidents in the home which had affected people's welfare and their potential safety.

The provider did not have systems in place to audit, monitor or manage the care provided at the home. Staff didn't always feel supported by the manager or provider. The home required repairs to be made to ensure the environment was comfortable and safe for care to be provided.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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 was not safe

Risks to people's health and wellbeing were not consistently identified, managed and reviewed. There were not sufficient staff to meet people's individual needs and to keep them safe.

People's medicines were not managed safely.

Inadequate

Is the service effective?
The service was not effective

Consent to care was not sought in line with legislation and guidance. This meant people could not be assured that decisions were being made in their best interest when they were unable to make decisions themselves.

Staff did not always receive the level of training before commencing their work in the care environment and on-going training was not supported with competency checks.

People did not always receive the support they required to eat and drink in accordance with their individual preferences.

Referrals to health professionals were not always completed to support people's health and wellbeing.

Requires improvement

Is the service caring?
The service was not consistently caring.

People were not always offered choices about their care.

Staff did not have the time to provide care that was individual, caring and compassionate.

People told us they felt their privacy and dignity was maintained.

Requires improvement

Is the service responsive?
The service was not responsive.

The care plans were not person centred and people had not been consulted on their care needs and preferences.

The home provided no activities to provide people with stimulation.

People and relatives told us they knew how to complain, however there were no formal process in place to support any complaints made.

Requires improvement

Is the service well-led?
The service was not well led.

Inadequate

Summary of findings

Effective systems were not in place to assess, monitor and improve quality of care. People were not engaged in sharing their opinions about the service.

Support to staff was not always provided.

The provider did not always comply with the requirement of their registration with CQC.

Oliver House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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. Our inspection team consisted of two inspectors.

This inspection was brought forward following the receipt of information of concern. We also checked the information we held about the service and the provider. This included notifications that the provider had sent to us about incidents at the service and information we had received from the public. We also spoke with the local authority who provided us with current monitoring information. We used this information to formulate our inspection plan.

We spoke with four people who used the service and five relatives. Some people were unable to tell us their experience of their life in the home, so we observed how the staff interacted with them in communal areas.

We also spoke with six members of care staff, the cook, domestic staff, the manager and the provider. We looked at care records of six people and other records relating to the management of the service.

On this occasion, we had not asked the provider to send us a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. However, we offered the provider the opportunity to share information they felt was relevant.

Inadequate

Is the service safe?

Our findings

People who used the service told us there was not enough staff. One person said, "There is not enough staff, I want to go to the bathroom and there is no one to support me." Another person said, "It's no wonder my breakfast is late they need more carers." We observed people waiting to be supported by staff and long periods when there were no staff available for people to ask for support. For example one person was sat at the table and waited 35 minutes for their breakfast. Other people who remained in their bedrooms had to wait to receive their personal care support; some people waited until 11.00 and were unable to call for assistance. Staff confirmed some people had been waiting up to two and a half hours and that several of the people had no means of calling for help to support their care needs to be met.

We saw that some people were up and dressed, before the morning staff arrived. People were unable to tell us if this was their preference. However one person did complain to their relative that staff had got them up at 6.30 and that's why they were tired. One relative told us, "They are very short of staff." Several staff confirmed there was not enough staff. One staff member said, "There is not enough staff in relation to the number of people and their needs." We observed staff had no system to ensure people had received their meals, care and any additional support in line with their individual requirements. This demonstrated there were not always enough staff to meet people's needs in a timely manner.

We saw that staff had not been inducted in a way that supported people safely. For example one staff member confirmed they had not received any moving and handling training and we observed this staff member support people to transfer with equipment. This staff member was still undergoing an induction period; however they had been included in the staff numbers for that shift. This meant that people cared for by the staff had not been trained to an appropriate standard before working in a caring environment.

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

The risk of harm to people who used the service was not consistently identified and managed to promote their safety. There were no individual risk assessment plans for people who had specific needs. For example some people presented with behaviour which challenged their safety and the safety of other people at the home. These people had no specific management plans in place to provide staff with guidance on how to manage the behaviours. Records confirmed a behavioural diary had been completed, which identified on-going incidents and risks to staff and other people; however no action had been taken to reduce the risks.

Some people, who had identified health needs, did not have a risk assessment to consider the safe way to support their needs. For example one person received oxygen daily; there was no risk management plan in place in relation to the safe use of the oxygen and its storage. This meant this person was not consistently protected from potential risks associated with oxygen therapy.

The medicines were not always ordered and recorded safely. For example two people had not received their medicine because the provider had not obtained them in sufficient time. Other medicine had been received but there was no administration sheet to record when the person had taken the medicine. In addition we saw and staff confirmed two people did not receive their medicine until two hours after the prescribed time. The medicines for both people had been prescribed and the delay in administering the medicine could have an impact on maintaining their health condition.

We observed the medicine cabinet was left open and unattended when the nurse was administering medicines to people. Some medicines had been dispensed from their original packaging, transferred into medicine pots and then taken to the person. We observed that the nurse did not wait with the person until they had safely taken the medicine. This meant there was a risk that people did not take their medication and medicines were accessible to other people within the home.

There was no auditing process to check the stock of the medicines. For example we observed the nurse having to order medicines which were required for that day. There was no system to ensure the correct amount of medicine were available to meet people's prescribed levels.

This is a breach Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not always feel safe. One person said, "I do feel safe, however sometimes a person wanders into my room."

Inadequate

Is the service safe?

Staff referred to these people as the 'wanderers' and they had no individualised approach on how to support people living with dementia. There was no evidence in the care plans to demonstrate how to support people with specific needs. Staff we spoke with told us they would recognise and report abuse. One staff member said, "We need to make sure people are safe and keep them out of danger. We need to watch for hazards." Staff had received training in safeguarding, however we found safeguarding incidents had not been reported to the local authority in accordance with guidance. This meant that the provider was not taking the appropriate action to ensure people's safety.

The provider had an on-going recruitment programme. One staff member had commenced employment whilst awaiting the confirmation of an updated disclosure and barring service check (DBS). A DBS provides a check relating to any previous criminal records. The provider did not complete risk assessments to safeguard people during this period.

Requires improvement

Is the service effective?

Our findings

The provider had not followed the legal requirements in relation to the Mental Capacity Act 2005 (MCA). Care plans did not show how people were supported to make decisions when they lacked capacity. Where people were unable to consent, mental capacity assessments and best interest decisions had not been completed with consideration to the person's level of capacity. Staff told us they had received training in MCA, however not all of them were able to demonstrate an understanding of the requirements under this legislation. For example one staff member had an understanding that everyone should be treated the same.

This is a breach Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the time of our inspection, no one had a Deprivation of Liberty Safeguards (DoLS). This relates to legislation which requires a DoLS assessment to be completed by the local authority were people are supported in the home for their own safety. There were no authorisations in place and no DoLS referrals had been made to the local authority. The home had locks on all exits which restricted people's movements. Several people exhibited behaviours relating to either attempting to leave the home or by verbally expressing that wish. People could go to their bedrooms, however many of the people required constant support and people in these circumstances had not been referred to the local authority for a DoLS assessment. One staff member had expressed concerns to the management that some people at the service should receive an assessment. The manager told us there was no one who met the criteria and therefore no referrals had been made.

This is a breach Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People felt there were limited choices and variety. One person said, "The foods not up to scratch, it could do with improvement." The cook was aware of people's preferences and dietary needs, however felt restricted by the menus established by the provider. We observed the lunchtime meal. The meal was plated up by the care staff from an unheated trolley. The process took 15 minutes; this meant that the temperature of the meals presented to people who received their meal at the end of this time was not at an appropriate temperature and resulted in the food being cold and some people not eating their food.

Some people who could eat independently were not prompted or supported. For example one person ate their meal using a knife, the fork was hidden under the plate and there were no staff available to offer support to correct this and make the mealtime a more pleasurable experience.

Some people required the monitoring of their fluid and food intake and some records had not been maintained. For example one person had declined food on 41 occasions over a five week period and some entries had not been completed. No action had been taken to investigate the reasons for the decline, or to provide a plan of support to ensure the person received their meals as required.

Staff told us they had received training through a 'workbook' approach. This involved the staff reading information on a subject and completing questions and answers to clarify their understanding. Staff told us they needed more training. One staff member said, "What's needed is training with a trainer, I desperately need training in dementia care and managing behaviours." Staff felt that they were unable to support people with challenging behaviours. One staff member said, "I am putting myself at risk as well as others." This meant that staff were not appropriately trained to support people's needs.

We saw that contact had been made with health professionals including opticians, GP's and other health professionals. However there were some incidents which had not been progressed which may have prevented the maintenance of people's health. For example one person who had declined food on several occasions and who exhibited behaviours that challenged had not been referred to a health professional in relation to their diet or the behaviour.

Relatives we spoke with told us they were informed following any appointments or health concerns in relation to their relative. One relative said, "My relative had a fall a few days ago and they kept me informed on their progress and they got a different cushion to make [name] more comfortable." The home was undergoing training to join

Requires improvement

Is the service effective?

the new interactive the 'Tele med' system. This system links with the GP practice and a specialist nurse enabling a video call to be made to the practice to speak to a nurse. They will then provide direct advice or offer to visit.

Requires improvement

Is the service caring?

Our findings

People had mixed views about the care they received. One person said, “There is a mixed bag of carers.” We observed that when staff had the time to interact with people this was done with kindness and care. For example one person required staff to help with putting on stockings. The staff member took time to explain their actions in a calm and caring manner. Once completed giving reassurance, “I have finished now, you can rest.” We saw this practice was undertaken in the lounge area and not in the privacy of the person’s bedroom.

Staff did not always have the time to support people. For example we observed different staff members supporting the same person with their lunch. This person was left between the staff changes and the person was not given an apology for the disruption. Other people were asked to wait when they requested personal care support. A staff member said, “You will have to wait, I have to do the medicines and run the floor.”

Relatives could visit whenever they wished. One relative said, “The staff are lovely and the care [name] has received has been excellent.” There were no separate spaces for relatives to be with the person, other than the communal lounge or the person’s bedroom. Some relatives told us they would like to visit their relative in a private space.

People and relatives told us they had not been consulted in the development and reviews of their care plans. The plans we looked at confirmed this as they contained no information about the person’s history or their preferences for how they wished their care to be provided. Staff we spoke with were unable to tell us about the person only the tasks that they had to complete in supporting the persons care needs. One staff member said, “I feel I don’t know people’s history, there is no information.”

People told us they were treated with dignity. One person said, “Staff always knock my door, and respect my privacy in the bathroom.” One staff member told us, “I try to give choices as much as possible, it can be stressful.” Another staff member said, “I put myself in their position.” We observed some positive interactions; one staff member took a person to their room as they were upset and sat with them until they felt more settled. However workload and time restraints limited the opportunities for this to happen consistently.

Requires improvement

Is the service responsive?

Our findings

People's care plans were not centred around the person and people we spoke with had not been involved in their care planning. The plans provided limited information about the care required and people's preferences. For example one person told us they had a structured daily routine. This was not documented and we saw staff did not support the person to meet these needs. Staff confirmed that they had not read at the care plans. One staff member said, "I have not looked at the care plan, other staff have told me what to do, however it is just the task not about the person." Another staff member said, "I have not had time to look, the one I have looked at didn't give me much information." There was no evidence to demonstrate that the care plans had been reviewed. This meant people were at risk of receiving inconsistent care and support.

Some people told us they had not received a bath in accordance with their care needs. One person said, "It's been four weeks since I have had a bath and five weeks for [name]." Staff confirmed that these people had not received a bath as they had not had enough time to provide this support. We observed people sat for long periods without any support, one staff member said, "I cannot get round everyone, so many people need continuous support." This demonstrated the provider was not responsive to the individual care and support needs of people.

People who used the service told us that staff did not have the time to encourage or enable people to engage in their preferred activities. One staff member said, "We are not doing what people need, there is not enough time." Another staff member said, "It's all task led, there is no time for interaction." The manager told us that the activities coordinator had left and they had recruited another person who was due to start in the next month. During our inspection we observed no activities with people to support them to pursue their hobbies and interests.

This is a breach Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People we spoke with said if they had any complaints they would report them to the staff.

The provider had a copy of the complaints policy on display, however there were no complaints records or systems in place. The manager was aware of this and had discussed with the provider the need to establish a record and audit process in the future. This meant people could not be sure their complaint would be dealt with in line with procedures.

Inadequate

Is the service well-led?

Our findings

The provider's legal responsibilities had not been met regarding statutory notifications that are required in accordance with the regulations. We identified that the provider had not notified us when referrals were made to the supervisory body for authority to deprive a person of their liberty and the outcome of referrals. For example one person had fallen, sustaining a serious injury we had not been informed of this incident. This demonstrated the provider and manager did not understand their responsibilities of the registration with us.

This is a breach of Regulation 18 (2) and 18 (4A) and (4B) of the Care Quality Commission (Registration) Regulations 2009

The provider did not have a system in place for auditing the risks to people through accidents and incidents. For example entries in the behaviour diary had not been recorded as incidents. There was audit process or evidence that the provider had taken any action to reduce the risk to the person who used the service, staff or other people.

The provider did not audit and monitor the quality of the care being provided. For example there had not been any opportunity made available to obtain people's opinion of the service. There were no records to show people or relatives had been invited to meetings to gain their views and experiences.

The Provider did not have a procedure for dealing with complaints and therefore did not have a system to address concerns and drive improvement.

The provider did not have an induction programme which supported new staff. The manager and records confirmed that staff did not receive training before they commenced work. We saw the new staff on duty had been included on the staffing numbers.

Some staff told us they did not feel competent following training. There were no records to demonstrate the provider complete competency checks to establish the level of understanding following training the staff had completed.

Staff confirmed they had not had formal supervision. The manager had held a team meeting, however a staff member said, "The minutes of the meeting do not reflect the meeting content." Staff we spoke with were not clear on the expectations required of them to support people.

Some of the staff felt the provider was not approachable and that this had an impact on the development of the home. One staff member said, "The provider is not supportive, it's all about keeping costs down." For example a person using the service requested some items to enhance their stay in the home, these had not been not provided. The manager confirmed they had met with the provider to discuss the manager's role and the service developments. However there were no records to clarify any agreed actions or developments for the home.

We saw the home had areas of disrepair. For example the bath panel in one of the bathrooms was broken; the bath hoist fixing was rusty and the tiles on the window ledge were broken. There were other areas of the home which were dirty including a commode which had not been emptied or cleaned. This meant the areas used for personal care where not appropriate to support people safely and people were at risk.

The service did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The provider had recruited a manager and they told us they were going to apply to register with us.

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

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **There were not sufficient staff to meet people's individual needs and to keep them safe.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Risks to people's health and wellbeing were not consistently identified, managed and reviewed.People's medicines were not managed safely.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Consent to care was not sought in line with legislation and guidance. This meant people could not be assured that decisions were being made in their best interest when they were unable to make decisions themselves.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **People were not supported to ensure their own safety and assessments had not been requested from the local authority under the Deprivation of Liberty Safeguards.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

This section is primarily information for the provider

Enforcement actions

The care plans were not person centred and people had not been consulted on their care needs and preferences.

The home provided no activities to provide people with stimulation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Effective systems were not in place to assess, monitor and improve quality of care. People were not engaged in sharing their opinions about the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The provider's legal responsibilities had not been met regarding statutory notifications that are required in accordance with the regulations.