HICA

Overton House - Care Home

Inspection report

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Ratings

Overall rating for this service	Good
Is the service effective?	Good

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 24 September 2015 and we found a breach of legal requirements in respect of the need for people to consent to their care. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to this breach. We undertook this focused inspection to check that they had followed their plan and to check that they now met legal requirements. This report covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Overton House on our website at www.cqc.org.uk

The home is registered to provide accommodation and care for up to 40 older people, including people who are living with dementia. The home is situated in Cottingham, in the East Riding of Yorkshire and also close to the city of Kingston upon Hull. All accommodation is on the ground floor and there are enclosed courtyards where people can access the outdoors safely. People have single bedrooms with en-suite facilities, and there are also communal bathing and showering facilities.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager who was registered with the Care Quality Commission (CQC). 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 service was working within the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). We saw that people's capacity to make decisions had been assessed and when people lacked the capacity to make decisions for themselves, best interest decisions had been made on their behalf and had been recorded.

Staff had received the training they needed to carry out their roles effectively, and they received support from a senior manager in supervision and appraisal meetings.

People's nutritional needs were assessed and their special diets were catered for. People received support from health care professionals when required and we found that staff followed any advice and guidance they were given.

The premises continued to provide suitable accommodation for people who were living with dementia, including signage to help people find their way around the premises.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service effective?

Good

The service was effective.

Staff received the training and support they required to fulfil their roles and meet people's needs

The service was meeting the requirements of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

People's nutritional needs had been assessed and their special diets were being catered for.

People's healthcare needs were assessed and people had access to a range of health professionals.

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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 registered provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 24 November 2016 and was unannounced. This inspection was done to check that improvements to meet legal requirements planned by the registered provider after our September 2015 inspection had been made. We inspected the service against one of the five questions we ask about services: Is the service safe? Is the service effective? Is the service caring? Is the service responsive to people's needs? Is the service well-led? This is because the service was not meeting one legal requirement. At this inspection we checked: Is the service effective? The inspection was carried out by one Adult Social Care (ASC) inspector.

Before this inspection we reviewed the information we held about the home, such as information we had received from the local authority who commissioned a service from the registered provider and notifications we had received from the registered provider. Notifications are documents that the registered provider submits to the Care Quality Commission (CQC) to inform us of important events that happen in the service. The registered provider was not asked to submit a provider information return (PIR) before this focused inspection. The PIR is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

On the day of the inspection we spoke with the registered manager and chatted with staff and people who lived at the home. We also spent time looking at records, which included the care records for three people who lived at the home, training records, staff supervision records and records in respect of people's nutritional needs.

Good

Is the service effective?

Our findings

The Mental Capacity Act 2005 (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.

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw a chart in the registered manager's office that recorded the DoLS applications that had been authorised and the date the authorisation had to be re-applied for. Notifications had been submitted to CQC when applications had been authorised. People's care plans included copies of the application and the documentation to confirm the application had been authorised by the local authority.

We saw that staff had completed training on the MCA and DoLS. The registered manager told us that senior staff were currently completing further in-depth training on the MCA with the local authority.

At the last inspection we were told that the home had a 'no restraint' policy yet we saw that one person's care plan had been updated and indicated that minimal restraint could be used to ensure the person was able to receive the personal care they required. This person was not able to consent to this and there was no documentation in place to evidence that a decision had been made in the person's best interests.

At this inspection we saw the best interest documentation that recorded the details of the meeting that had taken place, the people who had been involved in the decision making and the specific decisions that had been made. The document recorded, 'For [name] to take medication to make them calm enough to have personal care……..this is needed so their personal care is not neglected'.

We saw the records that confirmed the GP had prescribed this medication to be taken 'as and when required' (PRN) and that it had only been used when other interventions had failed; on four occasions from 8 August to 4 September 2016 and on two occasions from 5 September to 2 October 2016. The registered manager told us that the frequency of administration of this medication was reducing and the records we saw confirmed this.

This person also had other best interest decisions recorded in their care plan and these evidenced that the correct procedures had been adhered to. In addition to this, we saw there was a review of this person's mental capacity, orientation, comprehension, response to care and memory as well as a specific care plan in respect of their cognition abilities.

We saw that staff continually asked people to consent to their care and support before it was provided. This

was in respect of food and drink, personal care and taking part in activities. Although we saw that staff gave people straightforward options to help them make a decision, agreement was frequently in the form of 'implied' consent.

The registered manager told us that staff attended the organisation's induction programme before they commenced work, and then started to work towards the Care Certificate. The Care Certificate was introduced by Skills for Care, and is a nationally recognised set of standards and training that staff new to working in care are expected to work towards. We checked the training records for a new member of staff and these confirmed that they had completed the induction programme.

Training considered to be essential by the organisation included Respect training, a programme of training on how to manage behaviour that could challenge the service. Training records showed that all staff, including ancillary staff, had completed this training. Other essential training consisted of safeguarding adults from abuse, person-centred care, privacy and dignity, capacity and DoLS, food hygiene, infection control, health and safety, first aid, equality and diversity, moving and handling and skin integrity / pressure care.

We reviewed the home's training matrix and saw that staff had continued to complete both induction and refresher training. The training matrix recorded whether the training needed to be completed annually, every two years, every three years or was discretionary. We also saw the supervision matrix and this showed that staff had taken part in a supervision meeting with a manager two or three times during the year.

We saw that the service continued to record any contact with health care professionals. For example, one person had been referred to the Falls team and re-referred to the dietician during November 2016. This person's care plan included a report from the dietician, which stated that the person should be provided with finger foods, could drink from a cup independently and had been prescribed food supplements. The registered manager showed us the special food and fluid charts that had been recommended for this person by the dietician. These recorded food and drink intake each hour throughout the day. We saw that these charts were being used effectively by staff, although fluid intake had not been totalled by staff each day to help them monitor the person's overall daily intake of fluid. The registered manager told us that they would address this with staff.

Some people who lived at the home chose not to sit at a table to eat their meals, and ate throughout the day rather than at set mealtimes. We saw that finger foods were always available so people could eat when they chose to.

The home continued to provide a choice of main meal and dessert at each mealtime. There was a daily menu on display but the home did not use a picture menu. The registered manager told us they had found it more effective to show people the two meals on offer so they could make a choice each mealtime.

The premises continued to provide suitable accommodation for people who were living with dementia. There was signage to help people find their way around the premises and colours had been used to help people identify areas such as handrails, bedroom doors and toilet facilities.