PAPER C1

Purpose: For Discussion

Committee report

Committee	**HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY BOARD**
Date	**23 OCTOBER 2017**
Title	**CQC INSPECTION REPORT AT OVERBROOK (RESIDENTIAL CARE HOME)**
Report of	**DR CAROL TOZER – DIRECTOR OF ADULT SOCIAL CARE AND COUNCILLOR CLARE MOSDELL – CABINET MEMBER FOR ADULT SOCIAL CARE and PUBLIC HEALTH**

EXECUTIVE SUMMARY

1. Overbrook is a Registered Care Home for Learning Disabilities that is run by the Isle of Wight Council. There are four residents.

2. The home was inspected on the 22nd, 23rd, and 24th August 2017 by The Care Quality Commission (CQC). On the 7 September, CQC wrote to the Responsible Individual setting out serious concerns and requiring a detailed response setting out the immediate actions to be taken by noon on the 11 September.

3. An action plan was developed by the Service Manager (Responsible Individual), Director and Assistant Director over the weekend of the 9 and 10 September and submitted to CQC. The Assistant Director and service Manager met with CQC representatives on the 20th September and discussed and agreed this action plan.

4. The CQC report was published by CQC on the 6th October. CQC rated the unit as “inadequate” and placed Overbrook into special measures.

5. This report shares the details of the CQC inspection report, the actions already taken and those improvements still underway.

OVERVIEW

Located in Wootton, Overbrook is a Residential Care Home for four adults with a Learning Disability and additional physical disabilities including Dementia. The

people living at Overbrook have been there for many years and a previous CQC inspection in July 2015 had rated the service as “good”. An unannounced inspection was carried out on the 22nd, 23rd and 24th August 2017 and subsequently CQC has rated the home as “inadequate”.

The inspection took place over three days and as part of this process the Inspector spoke to the Registered Manager, staff, people who live at the house and their families. The overall rating was inadequate with inadequate ratings for safe service and well-led. As a result, we were notified by CQC that the home was failing to comply with parts of Regulation 12, 17 and 18, good governance, of The Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. (Appendix 1 – Full inspection report)

The service, therefore, has been put into special measures. The Service Manager (Responsible Individual) received a Letter of Intent to serve a S31 Notice on the 7th September and an action plan was immediately drafted by the Service Manager, the Director of Adult Social Services and the Assistant Director of Integrated Service Delivery. The action plan was submitted to CQC on the 11th September in response to the S31 notice and this resulted in CQC Removing that S31 notice on the 14 September 2017.

On the 20th September the Service Manager (Nominated Individual) and the Assistant Director Integrated Service Delivery, attended a meeting with the CQC inspector and the CQC Area Manager where the action plan submitted to CQC on the 11th Sept was discussed in detail. This resulted in CQC positively referring to our prompt response in its draft report - which arrived on the 18 September. With only minor changes requested for factual accuracy process, the final report was published by CQC on the 6 October.

A new Group Manager covering all of the Department’s learning disability units was appointed in the week beginning 11 September. In addition, the Director has commissioned the services of an independent learning disability expert to work alongside the Group Manager and Service Manager in order to support the changes needed. Specifically, she is focussed on embedding “active support” principles, processes and practices throughout all of the units and will develop the detailed plans for transferring some of these units into supported living (in order to ensure that the residents living in these units can have greater control and choice over their care). The Group Manager, independent consultant and Service Manager have also refined the original action plan submitted to CQC in response to their inspection and requirements and recommendations. (Appendix 2 – Action plan).

Since the inspection we have carried out a number of urgent actions to ensure better compliance and safety of the people living in the home. The attached action plan provides members with full details of the actions taken. The main actions to date are:

- Interim Group Manager for the Learning Disability Services has been engaged to provide leadership to all Registered Managers.
- An additional staff resource has been rostered on each day in order to ensure all people are able to go out and about, and reduce the reliance on the manager to provide day to day support.

- Reviews of the needs of the four people living at Overbrook have been carried out by a social care practitioner.
- Refresher training on diabetes and medication has been undertaken by all staff.
- All risk assessments have been completed and updated.
- The Department's quality assurance team have undertaken unannounced audits of Overbrook and all the other in-house residential homes (including the two services for elders, Adelaide and the Gouldings).
- The Group Manager and Consultant have completed more detailed audits in line with the with the CQC 5 key lines of enquiry.
- We have made contact with all family members of the four residents about the CQC inspection and findings and are continuing to keep them informed of our progress.

What these improvements have meant for the individuals living at Overbrook, is that they are enjoying life much more. For instance, at his request, one gentleman is having his breakfast out on regular basis, three residents have joined a local social group and one resident is now swimming regularly. The staff team are more motivated and report that they are making a positive difference to the people living there. A relative of one of the resident has fed back that she has noticed a great improvement in the atmosphere in the home and that she is pleased to see her sister going out more.

CONCLUSIONS

When Adult Social Care delivers services and support to those we serve, our ambition is to be nothing short of outstanding. We have failed the people living in Overbrook and that is completely unacceptable. We are determined to make sure effective progress so that by CQC's next inspection we will not be found wanting against their standards and, more importantly, that our residents receive safe care and are living their lives to the full. Our residents and their families expect no less of us.

APPENDICES ATTACHED

Appendix 1 – Overbrook CQC inspection report summary (Full report - Paper C)
Appendix 2 – Overbrook Action plan – 10/09/17

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APPENDIX 1

CQC is the independent regulator of all health and social care in England. We are given powers by the government to register, monitor and inspect all health and care services.

Isle of Wight Council

Overbrook

Inspection summary

CQC carried out an inspection of this care service on 22 August 2017, 24 August 2017 and 26 August 2017. This is a summary of what we found.

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

Overbrook is a local authority run care home registered to provide accommodation for up to four people living with a learning disability. At the time of our inspection there were four people living in the home. The inspection was unannounced and was carried out on 22, 24 and 26 August 2017.

There was a registered manager in place at the home. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run.

The provider was not fully engaged in the running of the home. They did not have an effective system in place to monitor the quality and safety of the home; the records relating to people's care were not always accurate and up to date.

There was not enough staff available at the home to safely meet people's needs. The registered manager had not always fully assessed the risks associated with people's care and support.

People medicines were not always managed safely and they did not always receive their medicine in the correct way. Staff did not always protect people from the risk of infection.

People's ability to make decisions was not assessed and staff did not follow legislation designed to

protect people's rights.

People did not always receive support from staff who had received the appropriate training to meet their needs.

Staff were task focused and did not always treat people with dignity and respect; or respect people's choices and their privacy.

People's records of care were not always personalised and staff were not always responsive to people's needs.

People were not able to engage in individual activities and access the community on an individual basis. They did not receive appropriate mental and physical stimulation.

People were supported to have enough to eat and drink; however, mealtimes were not always a social experience for people.

People's families and staff had the opportunity to become involved in developing the service, however the provider did not always respond to feedback provided. The provider had a process in place to deal with any complaints or concerns, although the process was not always followed. People's families were involved in discussions about their care.

Staff received an appropriate induction into their role and were aware of their responsibilities to safeguard people from abuse. Recruiting practices ensured that all appropriate checks had been completed.

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.

During our inspection, we identified five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken at the back of the full version of the report.

You can ask your care service for the full report, or find it on our website at **www.cqc.org.uk** or by telephoning **03000 616161**

APPENDIX 2

Finding	Risk	Action	Timeframe	
Lack of staffing to meet the needs of people using the service. There were not sufficient numbers of staff to support service user. The registered manager told us there were two staff on duty during the day shifts and one member of staff working a waking night. The two staff during the day shift are also responsible for all of the ancillary duties, such as housekeeping and cooking. When we arrived at the home on the first day of the inspection, there was only one member of staff present. They told us this was because the registered manager had gone to a meeting and the other member of staff had gone to out the local pharmacy. This meant that the member of staff was not able to support service user A to mobilise or access personal care if they needed to. The registered manager also	There is a risk that due to a lack of staffing service users' will or may be exposed to the risk of harm.	Additional staffing is being put in place. This will be in the form of: • an additional shift each day to ensure that there will be 3 staff on through the peak parts of the day 7 days per week, to provide support to clients and reduce the reliance on the managers to provide day to day care. • additional sleep-in at night to augment the wakeful staff member • additional hours for the manager each week • Group Manager for the Learning disability services has been engaged to support during managers absence and • Commissioning additional support to embed Active Support principles to follow up the training provided through May, June and July this year Due to the concerns raised and urgency this will initially be through existing staff	The action plan has been discussed with the Registered Manager on Friday 8th September who has been tasked with putting this in place as soon as is practicable. There is an expectation that cover for the additional staff requirements will be sought as a matter of urgency and we can confirm from our visit on 9th September that this is underway Completion date for interim cover arrangements: 15/09/2017 **Completed** Completion date for Manager additional hours: 11/09/2017 **Completed**	Overbrook has four individuals residing at the home. A waking night and sleep in has been implemented from the 11th September. Current staff shortages are being resolved and a recruitment day was undertaken on the 19th September. The manager has also discussed with her current members of staff if they can increase their contracted hours to prevent the need for bank staff. An extra 6 hours per day has been implemented to ensure that whilst a service user is receiving personal care x 2 staff members that another staff member is supporting the 3 other service users, during this time it will also allow service uses to access

told us they were contracted to work three shifts a week and 50% of that time was spent working on the floor supporting staff and providing care. They told us this meant they were unable to run the home effectively. The registered manager explained that service user A and service user B's needs had increased over the previous two years and that they had raised concerns over the staffing required to meet those increased needs at previous managers meetings. They told us that no action had been taken. Shortfalls in care staff hours were covered by care staff or by the use of your bank staff and agency staff. The There is a risk that due to a lack of staffing service users' will or may be exposed to the risk of harm. Registered manager explained that due to sickness problems there has been a heavy reliance on the use of bank staff, including bank staff working on		where possible but will be augmented with bank staff. Bank staff are comprised of staff dedicated to the service but who have a zero hour contract as well as those who currently work in other internally run services and where possible we will continue to prioritise that regularly do so and know those who use the services needs well. As we have made it clear previously, we will only use outside agency staff as a last resort and always in conjunction with other experienced staff. During this period we will also be urgently reviewing the needs of those people using the service to ascertain the current needs and review the viability of the service being able to meet the need of those who use the service in the future. There is no embargo on recruiting to posts nor is there any expectation that front line services will make any contribution to savings through vacancy management. As a provider the local Authority has significantly streamlined the recruitment process in relation to front line services by removing much of the bureaucracy and continue to provide administrative support to manager in relation to this ensure this	Completion date for Group Manager Role: 11/09/2017 **Completed** Completion date for initial review of those that use the service: 15/09/2017 **Completed** Completion date for ongoing Active Support development recruitment: 31/10/2017	the community, interacting during the day and a activities plan has been implemented. Full time staff member now back from sick leave. Registered manager now working 30 hours per week.

their own during the night shift. The service had also recently started to use agency staff during the day. This meant that service users' were being supported by staff who may not have a detailed knowledge of their care needs and risks. The registered manager also told us they had recently had an extended period of time off sick. They explained that when they were not there, there was no manager to provide cover; the senior care staff member is expected to step in and cover alongside their normal duties, with access to an on-call manager for emergencies. This meant they were unable to effective manage the home on a day to day basis. The registered manager and all of the staff we spoke with and a relative expressed concerns as to as to the level of staff within the home and the impact that this was having on the service users.		process is expedited. PACS Active Support training has been provided through May June and July this year across the Learning Disability support homes in relation to developing more person centred and less task and time focused approach to care. This training included, and had, a significant focus on Overbrook. This is to be extended as ongoing work as we have commissioned Jayne Kilgallen to continue the work with our services on an ongoing basis to support the transformation of services and service delivery Jayne starts with the authority on 02/10/2017 for a period of 9 months and is a senior manager who has a demonstrable record of leading and delivering this work across multiple organisations.		

Service user A required two to one care. This meant that when staff were supporting this service user in their room with personal care, the three remaining service users were left without support. We observed that on 24 August 2017 this took staff 32 minutes. Staff told us they were not able to meet service user A needs as detailed in their care plan because they did not have time. Staff also said they were unable to respond to this person in a person centred way due to a lack of staff. Staff were task focused, they did not spend time interacting with service users in a way that provided one to one stimulation during the day. Staff were unable to take people out on an individual basis to activities within the community. Service user D's independence plan dated 12 April 2017 stated they attend a day centre every Friday and go swimming every other Saturday. We looked at service user D's daily records for July				Support plans have been updated and now sectioned into relevant domains, and all old records have been archived and now located in one relevant folder. All previous monthly reviews have been archived. All fluid charts are totalled daily and this as evidenced. Weight charts are in place and this has been raised with the manager to ensure these are completed monthly. Water flow pressure sore risk assessment has been completed by district nurse and in place. A swallowing risk assessment is in place for WT. Vanessa Porter – Continence team visiting 06/10/17 to review WT & EH.

and August 2017 and found this was not happening. The registered manager told us this was due to a lack of staff. The registered manager told us they could only take three of the service users out together when they had three staff. Service user D did not go out as per their recorded needs. They also told us they had not been able to take the service users away for a holiday, due to staffing levels, since they have been with this provider.				
Staff training We received a copy of your training matrix on 07 September 2017, which detailed the training for staff at Overbrook. It confirmed that they last received training in diabetes and blood glucose in July 2015. Service user B is diabetic and requires their blood glucose to be taken four times a day, twice a week. Staff were unable to tell us what was a high or low blood sugar reading for service user B. They contacted the local surgery and the diabetic nurse confirmed	There was a risk of staff not being sufficiently skilled to enable them to carry out their roles safely or effectively which exposes service users to a risk of harm because they may not have the appropriate skill to respond safely to service users who are diabetic.	The guidance in the support plan has been updated and staff made aware of current tolerances and actions required when blood glucose levels fall outside that. Service user B has a diabetes review on Thursday 14th September. This will ensure that the blood glucose parameters and actions are up to date. Urgent refresher training for staff in relation to Diabetes is currently being sourced	Completion date for update of support plan: 08/09/2017 **Completed** Completion date for service user B diabetes review : 14/09/2107 **Completed** Completion date for refresher diabetes training for staff: 30/09/2017. **Completed**	19/09/17 – staff attended medication training. 03/10/17 – staff attended diabetes training. Guidelines and support plans updated and all staff are aware of actions required when blood glucose levels fall outside.

that high was 8.5 and staff should seek medical advice, if the reading goes higher than this. Between 26 June 2017 and 22 August 2017 there were 15 occasions when service user B's blood sugars were recorded as higher than 8.5, with a maximum reading of 15.7. Staff confirmed that no action had been taken on any of these occasions.				
Medicines are not managed safely. Staff are not following NICE guideline in respect of: handwritten MAR chart entries being checked for accuracy and signed by a second trained and skilled member of staff before it is first used; the recording of the type of reaction service users' have to known allergies; and guidance in respect of 'when required' PRN medicines. There is not an effective system in place to ensure service users' pain is managed effectively. Service user C required pain relief in the form of a transdermal patch and via a cream. They did not always	safely exposes service users to a risk of receiving their medicines inappropriately and exposes them to a risk of harm	We are seeking an urgent medicines management update training and will liaise with the Medicines Management Team. This will also include seeking clinical advice on pain management tools to find one that best fits the clients who live at Overbrook. In relation to the concerns raised around service user D being prescribed two anti-psychotic drugs at the same time it is our understanding that this medication regime has been in effect significant amount of time including the use of Kemedrin and that the risk assessment pertained to other effects other than those being managed by the Kemedrin. It is also our understanding that attempts in the past to alter the current medication regime has had	Completion date for Medicines management update training and clinical support of identifying the most appropriate pain management tool: 30/09/2017 **Completed** Completion date for Client D anti-psychotic clinical medication review: 30/10/2017 – (TBC as this is dependent upon the Psychiatrists availably)	Medication training undertaken on the 19th September. All medication files have been updated and divided into each service users section, their picture, Mar sheet, PRN protocols, medication profile, medication policy and a staff read and sign. In regards to service user D being prescribed two anti-psychotic drugs; we have requested on the 12/09/17 that her psychiatrist undertakes a review.

receive this pain relief in a timely way or at the frequency prescribed. None of the service users' are able to communicate verbally. The staff told us they did not use any pain assessment tool to help them understand when a service user was in pain. There was no PRN guidance in place to assist staff in understanding when PRN pain relief should be given. The PRN records for service user D stated the reasons for PRN paracetamol being given were – 'pain?', 'suspected pain', 'didn't want to get out of bed. Not eaten' and 'tearful'. This is not appropriate because this may lead to the service user receiving pain relief inappropriately and demonstrates that the lack of a coherent approach to pain management. The risks relating to service users' medicines were not always detailed or focused on the individual. Service user D was prescribed to take two anti-psychotic drugs the same time. Although this was contrary to NICE guidelines it		significant negative impact on the individual's wellbeing and quality of life as a result. However, in light of the concerns you raise we are arranging a review with D's Physiatrist and will forward on your concerns regarding their medication regime for a clinical review.		All PRN guidelines have been implemented. A new support plan has been implemented for medication administration and disposal.

was on the instruction of the service users' psychiatrist. The risk assessment stated the regime should continue, as there were no 'ill effects'. The risk assessment did not specify which anti-psychotic drugs it related to or the action staff should take if these were changed. It did not identify what 'ill effects' meant so staff would know when to take action. The service users' current MAR chart shows that they are also taking Kemadrin, which has been identified by our pharmacy team as a medication to negate the side effects of anti-psychotic medicines. This demonstrates that that the service user is suffering side effects from the anti-psychotic medicines. The return of unused medicine was not managed effectively. The MAR chart for service user D identified that they had spat out two tablets. However, these were not logged in the returns book nor were they in the medicines cupboard. The senior on duty was unable to account for the missing tablets.				

A number of discontinued, creams, tablets and enemas dating from April 2017 were still retained in the medicines cupboard, when other medicines had been returned to the pharmacy since that date. This demonstrated that medicines were not managed safely and there was a risk that staff could administer out of date or inappropriate medicines in error.				
Risk assessments. Risk assessments were not completed effectively citing a plan to meet the actual risk. For example, there was no risk assessment in place for service user B who was at risk of choking. Service user A requires their drinks to be thickened. A telephone SALT review which took place on 12 May 2017 stated service user A required stage 1 thickener in their drinks. A risk assessment dated 09 January 2017, before the telephone review by SALT, stated 'Drinks are now to be thickened to stage 2/3'. We	Failure to have risk assessments in place to manage these specific conditions exposes service users to a risk of harm.	All risk assessments are currently being completed and updated. Additional support in the form of the Group Manager will be providing dedicated additional support over the week commencing 11/09/2017 In relation to the concern raised regarding the change to the thickening of drinks, as confirmed by the Registered Manager this was on the instruction of the GP. The GP is providing written confirmation of this. The Registered Manager and staff have been instructed to ensure that changes of instruction by GP or other clinicians are appropriately recorded, risk assessments reviewed and followed up in writing asap following, that change as soon as is practicable. In addition the registered	Completion and update of risk assessments for all of those who use the service: 15/09/2017 **Completed** Registered Manager and staff instructed to ensure any changes are immediately updated on risk assessments and appropriately	All risk assessments have been updated and placed in one folder, we have contacted service user B's GP and requested protocols for her thick and easy; this has now been received in writing by her GP that clearly states stage 2/3 consistency.

raised this with the registered manager and they confirmed they adjust the amount of thickener in service user A's drinks dependent on whether they started to cough or choke. She said this was on the advice of a GP. There is no documentation to support this. Service user D is epileptic and service user B is diabetic; there was not sufficiently detailed documentation in place to allow staff to understand how epilepsy and diabetes affect these service users and how to support them safely, mitigate the risk and the action to take if the risk occurred. There was no sun protection risk assessment for service user D who had recently suffered severe sunburn while out of the home. There was a failure to mitigate any further risk by ensuring there was a risk assessment in place to prevent this from happening again.		manager and staff have been instructed to ensure any changes are shared with other clinicians involved to ensure that there is no confusion relating to contrary instructions.	recorded: 09/09/2017 **Completed**	
Provider level quality assurance The provider did not have an effective system in place to	Service users were exposed to the risk of harm because the provider was not	The current Local Authority regulated activities and services had all been scheduled this year for Quality Assurance reviews from the Local Authority Quality Assurance Team – however in light of the	Completion date for Quality Assurance reviews: 30/09/2017 **Completed**	

assess, monitor and improve the quality and safety of the services provided. The registered manager was not able to provide any evidence of provider level audits or quality assurance processes for the service. They told us that the current nominated individual, who is their line manager, had not visited the home since they took over that role in February 2017 and the previous line manager had only visited twice. The provider did not have a structured approach to quality assurance and the governance of the service. This meant that there were no effective systems in place to help identify areas of concern or risk within the service to allow early intervention and action to be taken.	able to assure themselves of the quality of the service provided.	concerns you have raised these reviews have been brought forward and all are due to be complete by the end of September. Please note that the template QA documentation can be made available at your request We have, with immediate effect, reinstated the group manager role for the Learning Disability services to ensure there is sufficient capacity within the organisation to deliver a more robust assurance programme. Jo Parry will be taking on this role from 11th September. Jo has been seconded as an independent from the current service provision, holds a Level 5 in leadership and management in care settings, has a demonstrable track record as a Registered Manager and Quality and Compliance lead of multiple residential care home services. This role will take line management of the Registered Managers for Local Authority provided Learning Disability services, report direct to the Service Manager and Nominated Individual and has delegated authority to effect required changes. We have commissioned support from Jane Kilgallen who delivered the Active Support training and is an experienced senior	Completion date for Group Manager Role: 11/09/2017 **Completed** Completion date for ongoing Active Support development, modelling and transformation of services: 31/10/2017	

		manager with a demonstrable track record of leading and delivering this work across multiple mainland organisations. Jayne will work directly with the Registered Mangers, Group Manager and Service Manager to deliver the future person centred modelling and transformation of the services. We will be meeting with families of those who use the service to update them of the concerns raised during the inspection and share details of our action plan	Contact to be made with families of those who use the service: 15/09/2017 **Completed**	