Care Worldwide (Bradford) Limited

Owlett Hall

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 13 and 16 November 2018. At our last inspection in June 2018, the service was rated over all good.

We carried out an unannounced comprehensive inspection of this service on 6 June 2018. After that inspection we received concerns in relation to the safety of people living in the home and concerns about the leadership of the service. As a result, we undertook a focused inspection looking at safe and well led to look into those concerns. This report only covers our findings in relation to these topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Owlett Hall on our website at www.cqc.org.uk.

Owlett Hall is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Owlett Hall is registered to provide accommodation for up to 50 people who require nursing or personal care. The home is on three levels with lift access and has a garden area and car parking to the front of the building. At the time of this inspection, 46 people were using the service and all were receiving nursing care.

The service had a registered manager in post. 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.

We found shortfalls in the recording relating to medicines. Poor documentation meant we were unable to determine if all medicines had been given. We also found some medicines which had not been stored and monitored correctly but this was addressed promptly by the manager.

We found a lack of completed and accurate records to show when care had been given. Medicines administration records were not always completed, nutritional charts to document people's food intake had not always been recorded and some audits were not effective in identifying issues. This meant some issues had not been identified through the monitoring systems within the service so that they could be addressed to prevent re occurrence.

Staffing levels were sufficient. However, improvements were required to ensure the deployment of staff around the home was effective so people's needs could be met at all times. We have made a recommendation about the deployment of staff.

People told us they felt safe living at Owlett Hall. Staff were aware of how to keep people safe from possible harm or abuse. Safeguarding concerns had been investigated and actions taken to prevent future risks.

Most risk assessments were carried out and regularly updated to reflect people's needs. However, we found one risk assessment which had not been followed. The registered manager had ensured the person's needs were being met during the inspection. Accidents and incidents were managed effectively and actions taken to prevent future risk.

The home was clean, spacious and suitable for the people who used the service. Health and safety checks were carried out on the premises to ensure people's safety.

Following the last inspection, the manager had implemented changes to drive improvement within the home. This included training some senior staff to become unit managers to develop their leadership skills and to provider further oversight for each unit.

Annual surveys were carried out to gather people's views. We also found surveys had been sent to people, relatives and staff when concerns were raised. The regional manager said this was to ensure any concerns were resolved.

People, relatives, staff and health professionals all told us the registered manager was approachable and they felt confident to raise any concerns.

We identified one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, namely Regulation 17 (Good governance). You can see what action we told the provider to take at the back of the full version of this report.

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

This service was not always safe.

We found shortfalls in recording relating to the management of medicines.

We found staffing levels were sufficient. However, the deployment of staff needed improving to ensure people's needs could be consistently met.

People told us they felt safe. Staff received training in how to protect people from abuse and how to respond if they suspected abuse was taking, or had taken place.

Risk assessments were in place for people who needed them and were specific to people's needs and their home environment.

Is the service well-led?

Requires Improvement

This service was not always well-led.

We found a lack of completed and accurate records. Not all audits were effective in identifying issues within the service.

Regular surveys were carried out to gather people's views and regular meetings were held with staff.

People, relatives, staff and health professionals told us the registered manager was approachable and that they felt concerns would be managed immediately.

Owlett Hall

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

We carried out an unannounced comprehensive inspection of this service on 6 June 2018. After that inspection we received concerns in relation to the safety of people living in the home and concerns about the leadership of the service. As a result, we undertook a focused inspection on 13 and 16 November 2018 looking at the 'safe' and 'well led' domains to look into those concerns. This report only covers our findings in relation to these topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Owlett Hall on our website at www.cqc.org.uk.

No risks, concerns or significant improvements were identified in the remaining key questions through our ongoing monitoring or during our inspection activity so we did not inspect them. The ratings from the previous comprehensive inspection for these key questions were included in calculating the overall rating in this inspection

The inspection was carried out by one adult social care inspector and one bank inspector.

We reviewed other information we held about the service, such as notifications we had received from the provider, including those in connection with deaths, safeguarding concerns and serious injuries. We also contacted the local safeguarding team and local authority commissioning teams to gather information they held about the service.

We spoke with six people living in the home, three relatives, five staff, one domestic staff member, maintenance staff, the administrator, the registered manager and the regional manager. We observed how staff interacted with people and looked at a range of records which included the care records of four people and medication records of people living in the home. Records relating to the management of the service were also reviewed.

Requires Improvement

Is the service safe?

Our findings

We carried out this focused inspection following concerns raised about the safety of people living in the home and concerns about the leadership of the service.

We found some shortfalls with medicines management. Staff had not always recorded when prescribed creams had been administered. We found one topical MAR which had not recorded that a person's cream had been administered on 15 occasions within a four week period. We checked this with the person who said they received their creams daily. However, staff had not recorded this on the MAR which meant the provider's medication policy had not been followed.

Room temperature charts were in place because creams were stored in locked cupboards in people's bedrooms. We found these had not always been recorded. For example, for the month of September we found only three daily records had been completed for one person. We found incomplete entries of room temperatures in four rooms that we looked in. We could not be assured that temperatures were being taken in line with best practice guidance.

We found some people were prescribed 'as required' medicines. We found some protocols lacked detail to instruct staff on when these should be administered. For example, one person had a prescribed cream. There were no details recorded for how this should be applied and the body chart to instruct staff on where to apply this had not been filled out.

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

One person told us, "I don't get my creams every day." We found the person was prescribed a cream which should have been administered daily but records of this had not been completed on eight days in a four-week period. All other people we spoke with told us they received all of their medicines as prescribed.

Medicines had been left out in people's rooms and not stored in a locked cupboard. We found two prescribed creams which had been left out in people's rooms which did not follow the provider's medicines policy. We discussed this with the registered manager who ensured these medicines were stored correctly during our visit.

We discussed medicines management with the registered manager. They said staff checks were carried out annually to ensure staff were competent in medicine administration. The registered manager told us there were a lot of new staff and following our discussion about medicines management particularly related to creams, they had arranged a meeting with staff to address these concerns.

We found medicines that were given on a regular basis had been ordered, stored and administered following the providers policy. Most medicines were in dossett boxes and other medicines in individual boxes. Dossett boxes contain designated sealed compartments, or spaces for medicines to be taken at

particular times of the day. They can help people to keep track of their medicines. We found staff had recorded the date for when boxes of medicines had been opened and included the person's name to ensure the medicine was not given to the wrong person. Medicines administration records (MARs) had been completed by staff and recorded when people received their medicines.

People and their relatives provided mixed views about the staffing levels. Comments included, "They (staff) don't come often. Maybe they are busy with someone else. You don't get the help from staff. We need more staff. We don't see anybody for ages. It feels lonely. Staff do their best", "There is enough staff" and "I think they are shorthanded, there's not always staff around."

One health care professional said, "They just seem really, really busy, and the care could be better with more staff, but no one is at risk of harm with the staffing I see, any shortfalls in quality of life are never for the want of the staff trying, they know people well."

We looked at staffing rota's which showed the manager had over staffed on most days in accordance with the dependency tools used to determine staffing levels. The registered manager used a dependency tool and the 24-hour checks that staff carried out to determine staffing levels. We found staff deployment could be improved. Staff and the manager said should support be needed on a different unit this was done on an as needed basis. We found this ineffective. For example, we observed a person who was in 15-minute observations entering a person's room and attempted to climb into their bed. The inspector pressed the call bell as there were no staff on the floor at this time. It was not until staff came back from another area in the home that the person was supported. We discussed this with the registered manager who implemented 1-1 support for the person so the risk was reduced. The registered manager said they would look at the deployment of staff to ensure people's needs were being met.

We recommend the provider ensures staff deployment is effective to keep people safe within the home.

We looked at staff recruitment records which showed sufficient checks were undertaken by the provider before staff began work. These checks included a Disclosure and Barring Service (DBS) check. These checks identify if prospective staff have a criminal record or are barred from working with children or adults at risk. The provider also had a matrix to show checks on professional registrations, such as the Nursing and Midwifery Council (NMC) register, and carried out and were free from restrictions.

People and their relatives told us they or their relatives were safe living at Owlett hall. Comments included, "It's alright, I feel safe" and "Very pleased with it here. [Name] is safe and well looked after, never had any concerns all the staff are wonderful and they know what they are doing." In the most recent relatives survey all but one relative said they felt satisfied, very satisfied or extremely satisfied that their relative was safe. One relative said, "I am absolutely sure of my relative's security at Owlett Hall."

Staff were aware of how to keep people safe from possible harm or abuse. One staff member told us they would always report any concerns to the registered manager. We saw staff had reported concerns and actions had been taken. For example, one person at high risk of falls had been found with an unexplained bruise. This was recorded as a safeguarding and actions taken including a sensor mat put in their room to prevent future injuries and to alert staff of their movements. There was a safeguarding and whistleblowing policy which staff followed. The registered manager told us how they would manage these which included referrals and notifications to relevant external stakeholders.

Risk assessments were carried out and regularly updated when people's needs changed. However, we found one risk assessment which had not been followed. One person at high risk of falls was on 15-minute

observations to ensure their safety. During the inspection we asked to see these observations however, there was no record of this. We discussed this with the registered manager during our inspection who told us checks had been carried out but the records of these could not be found. New record observation sheets had been put in place during the inspection.

We found some people did not have a call bell in their room. The registered manager told us some people who lacked capacity were unable to use the call bell therefore regular checks were carried out. Other people had sensor mats in place to alert staff of when they may require assistance.

We found accidents and incidents were managed effectively with actions taken to reduce risk. For example, one person had a fall and cut their head. An ambulance was immediately called and actions taken to prevent future risk. This included a sensor mat being put in place and the persons bed lowered to reduce impact if they were to fall again. We also saw a care plan was put in place to promote healing of the cut.

The home was clean, spacious and suitable for the people who used the service. The provider had procedures in place for managing the maintenance of the premises. Appropriate personal protective equipment (PPE) and hand washing facilities were available. Staff had completed infection control training. There were arrangements in place for keeping people safe in the event of an emergency. Appropriate health and safety checks were carried out and the records for portable appliance testing and gas safety were up to date.

Requires Improvement

Is the service well-led?

Our findings

We carried out this focused inspection following concerns raised about the safety of people living in the home and concerns about the leadership of the service.

We found a lack of completed and accurate records. Some people required air pressure mattresses to prevent pressure sores. We found the charts to record the air pressure had not always been completed. For example, one person's chart did not state what the air pressure should be and what the person weighed. This meant staff would not have been aware of what levels of pressure relief would be needed to prevent sores and protect the person's skin integrity.

We found medicine audits were carried out monthly on 10% of MARs within the home. We found no actions were required on any of these audits. However, we found several medications recording issues during our inspection. The audit did not highlight which MARs had been looked at which meant not everyone would be involved in the audit process because there was no record to see which people's MARs had been previously looked at. We discussed this with the registered manager who agreed to include people's names to ensure all MARs were audited so that any issues were identified.

Staff had not always recorded when prescribed creams had been administered. Room temperatures had not always been recorded in people rooms where medicines were stored. We found some people were prescribed 'as required' medicines but some protocols related to the administration of these medicines lacked detail to instruct staff on when these should be given.

We found some nutritional monitoring charts had not been completed. We found one chart which had not been filled out for an entire day to show what the person had eaten so this could be monitored. Again, on two other occasions at dinner time there was no record of what the person had been offered to eat.

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

Although we found recording issues this did not impact on the care people received. Most of the people we spoke with said they received their medicines and were offered food. The registered manager told us they always made sure lessons were learnt to follow any errors made within the service. For example, following our findings on the two days of inspection the registered manager immediately put in place an action plan to address matters and ensure the safety of the home.

We found other audits had been carried out to monitor the service. Some of these included infection control, health and safety, call bells, catering and medicines. These were carried out either monthly, quarterly or annually. We found these audits had been effective when identifying concerns within the home and taking actions to address these. For example, following our last inspection call bell audits were put in place to monitor how often quickly staff attended to people's needs. We found that since this had been implemented there had been a reduction in the time taken for staff to attend to people's needs. The

registered manager said if a call bell had been left unanswered for a period of time this would be investigated and actions taken to ensure this did not happen again.

Annual surveys were sent to relatives. These had just been received by the provider and 13 had been completed. 11 relatives said the level of support and care that people received was satisfactory, very satisfied or extremely satisfied. One person did not answer and two relatives said they thought the care and support was fair.

We spoke with the regional manager who said following concerns raised by a whistleblower a survey was sent out to gather their views. We found 13 staff had completed the survey. All but one person said they felt the registered manager was approachable. All staff said the care people received within the home was either good or excellent. The regional manager was also planning to send surveys to relatives to obtain feedback following concerns raised with the local authority to ensure people could provide honest and open feedback to the provider. This meant action was being taken to gather feedback and to drive improvement within the home.

People, relatives, staff and health professionals told us the registered manager was approachable and felt concerns would be managed immediately. Comments included, "When things go wrong I speak to [Registered manager] and [Name] puts things right every time", [Name], the manager, is really approachable – can always speak to them and they will put things right. I've no concerns there."

Since the last inspection the registered manager told us they had implemented some changes to drive improvement. The registered manager said they wanted to "empower" staff in their job roles and developed the role of unit manager on each floor to support staff to develop their leadership skills and to improve the oversight of each floor.

The registered manager told us they had positive community links. Some of these included working with district nurses, tissue viability nurses and social workers to ensure effective care was being provided. One health care professional said, "The manager, is really approachable – can always speak to her and she will put things right." The registered manager said they involved all health professionals when reviewing care.

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 17 HSCA RA Regulations 2014 Good governance There was a failure to maintain contemporaneous, accurate and complete records about people's care. Some audits were also not robust as they did not always identify shortfalls.