Otterburn Health Care Limited

Otterburn

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 4,5 and 18 October 2015. During that inspection we identified breaches of two legal requirements. This was because people were not consistently receiving safe care and because adequate numbers of staff were not always available to meet people's support needs. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breach. We also met with them to discuss our concerns and to hear about the improvements they planned to make.

We undertook a focused inspection on the 18 May 2015 to check that they were following their plan, and continuing to make improvements to ensure they would meet people's needs and the requirements of the law. We also focussed on following up on issues that had been raised indicating that aspects of the premises were not safe and could present a risk to people using the service.

CQC receives information about people's experience of care from a wide range of sources. We received information about incidents that occurred at Otterburn that suggested people had come to harm, and that potentially this could have been avoided. During this focussed visit we looked at the risk to people who were at a high risk of falling to determine if the registered manager had done all that was reasonably practicable to manage these risks, to determine if there were any on-going risks, and to decide whether any enforcement action should arise from any breach of Regulations identified.

This report only covers our findings in relation to the key question, 'Safe'. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Otterburn' on our website at www.cqc.org.uk'

Otterburn provides accommodation for up to 30 people who require nursing care and support with their personal care. The home supports people who are living with a wide range of neurological disorders. There were 29 people living at the home at the time of our inspection.

The home had a registered manager. They were present throughout the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

People told us, or indicated with gestures that they felt safe. Staff we spoke with confirmed this, and were able to describe a range of developments that had occurred across the service recently, which in their opinion improved people's safety even further.

People who were at a high risk of falls could not be certain their care would always be planned or provided in ways that would reduce as far as possible the likelihood of them falling and sustaining a injury.

The provider had identified prior to our visit that action was required to ensure the environment and equipment provided was in good order, and that repairs took place swiftly when things broke. We found some improvements had been made, but that further work on this was required.

We found that the number of staff had increased and that the number of staff on duty now reflected the assessed needs of people more accurately. Staff had received additional training, and we observed staff working safely, and demonstrating greater, more in depth knowledge about people's needs.

Work had been undertaken to improve the management of medicines. Nursing staff had received training about medicines. An external audit undertaken by a pharmacist working for the Clinical Commissioning Group (CCG) shortly before our visit provided evidence that the required improvements had taken place.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Evidence that the environment and equipment had been well maintained was not consistently available.

Risks people faced, including falls were not always well managed.

People were supported by adequate numbers of staff who had been trained in safe working techniques.

People could be certain they would get their medicines as prescribed by the Doctor.

Otterburn

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 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.

This inspection took place on 18 May 2016 and was unannounced.

We looked at the information we already had about this provider. Providers are required to notify the Care Quality Commission about specific events and incidents that occur including serious injuries to people receiving care and any safeguarding matters. These help us to plan our inspection.

During the inspection we spoke with five people who use the service and three members of staff. We spoke with the Registered Manager and the Operations Manager. We looked in detail at two people's care files. We looked at a medicine audit undertaken by an external NHS pharmacist, and the providers own records about staff training, health and safety records such as falls and accidents, maintenance and servicing records and the staffing rota.

Requires Improvement

Is the service safe?

Our findings

We undertook a comprehensive inspection in October 2015. At that inspection we found that the provider was not meeting people's needs or the requirements of the law, as there were not enough staff to meet people's needs and people were not consistently receiving safe care and treatment. At this focussed inspection we looked at the work the provider had undertaken to address and improve these issues.

CQC receives information about people's experiences of care from a variety of sources. We had recently received information that suggested people at a high risk of falling were not being well supported, and that falls had occurred which could have been avoided. From the home's own records we identified some of the people who had fallen frequently in recent months. We looked at the work staff had undertaken to identify and assess the risk of falling. We found that each person had a falls risk assessment that did reflect the extreme risk they faced. We did however find that the risk assessments had not been effectively reviewed following each fall. Sometimes people had experienced a cluster of falls that were of a similar type. There was not always evidence that these had been swiftly identified and that a review had been undertaken. When a review of the person's care had occurred it was not always apparent that this had been effective. Members of the multi disciplinary team had not been consulted to consider possible ways of reducing the risk or impact of the falls.

We looked to see if the strategies detailed in people's risk assessments were being used, and if they were being reviewed. Doing this would help staff identify if the plan was being effective, or if other strategies needed to be considered. Records did not show the risk reducing strategies were always being used as planned.

Otterburn is a purpose built nursing home, and contains many environmental aids to promote people's independence and safety. We looked at the systems in place to ensure that the building and equipment were well maintained, and that repairs which could impact on people were attended to promptly. We were informed about two recent changes that had taken place. One change was in respect of the maintenance staff team, and the other change was to the systems for reporting and requesting repairs. We viewed four maintenance books, one of these showed that most repairs were undertaken promptly, often on the same day or the day following a report. However the remaining three books did not show that maintenance issues had all been attended to, or provide evidence that the repair had been undertaken swiftly. Some of these repairs included work on people's wheelchairs, beds and call alarms. We looked to see how the increased risks people might be exposed to without these aids or equipment were managed. Care records did not show this had been planned for or considered. We did not find evidence that repairs that would impact on people's safety or mobility were always undertaken promptly, or that people were supplied with interim equipment until their own equipment was repaired and returned to them.

The records of maintenance and service held at Otterburn, showed that all routine servicing, and repairs that were identified through service, were undertaken by suitable qualified experts. This ensured specific specialist equipment such as hoists and slings were maintained in as good order as possible.

We spoke with three of the people who lived at Otterburn. We asked them if they felt safe. People told us they did, and two people gave us positive gestures, including a 'thumbs up', indicating that they felt safe. We asked staff if they had any concerns about people's safety. They shared examples of how they felt the service had become safer in recent months. Their feedback included, "I feel confident now that people are safe" and "I have no concerns. I feel people here are safe." Staff described new checks and audits that had been completed to monitor safety, and the additional numbers of staff as some of the ways safety had improved.

We talked with people using the service and members of staff about the number of staff available. Feedback from everyone was that this area had improved, and that more staff, and staff who were familiar with people's needs were now provided. Comments we received included, "There are certainly more staff now, and we have received a lot of helpful training" and "There are a lot more staff. The team is more stable, we have some regular agency staff to help us when people are on training or off sick." The rota showed that the number of staff on duty better reflected the assessed needs of people and the number of people who required the support of a dedicated member of staff. Staff we spoke with went on to describe the positive impact this on had on people using the service, which included with the additional staff provided being able to undertake more interesting activities and having their needs met in a more timely way.

At our comprehensive inspection in October 2015 we identified that emergency equipment was not always ready and available for use. This inspection identified that systems to ensure this equipment was available and ready to use had been developed and were being used. We observed that the equipment was in place in all of the three units of the home we visited.

We had previously observed people being supported to move. The staff involved had not consistently used safe techniques. We spoke with staff about manual handling. They were all able to describe the update and refresher training they had been provided with. Records showed that staff had been provided with recent training to ensure their skills were up to date. We observed some manual handling manoeuvres while in the home. We observed people being supported to mobilise and being transferred using hoists. Staff used safe techniques and reassured people while providing this support.

At our last inspection we identified that some improvements were required to the management of medicines. We did not inspect medicines management at this visit, but we looked at the training that had been provided to nurses, and at an audit taken in the past two weeks by a NHS pharmacist. The report identified that improvements had occurred in medicines management. Specific shortfalls we observed and reported on in October 2015 had been reviewed during the audit were found to have improved. This meant people could be more confident they would receive their medicines as prescribed.

At our inspection in October 2015 we looked at the systems the provider had in place to ensure safe recruitment of staff. At that visit we found that a range of robust checks were made to ensure the people recruited were suitable to work in Adult Social Care. We had received no information to suggest that this situation had changed, so we did not look at staff recruitment at this focussed inspection.