Bethesda Healthcare Ltd

Otterbourne Grange Residential Care Home

Inspection report

Grange Drive
Otterbourne
Winchester
Hampshire
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Tel: 02380253519

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05 November 2019

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Otterbourne Grange Residential Care Home is a residential care home providing personal care to up to 25 people who may be living with dementia. There were 19 people living in the home at the time of the inspection.

People's experience of using this service and what we found
People's health and mental health care risks had been assessed and care plans gave clear information for staff to follow, for example, how to support people living with diabetes. Senior staff had received training to support people living with diabetes and epilepsy.

Risks around the safety of the building had been identified and action taken to reduce the risks.

Rating at last inspection and update
The last rating for this service was requires improvement (published 24 August 2019).

Following our last inspection, we served a warning notice on the provider and the registered manager. We required them to be compliant with Regulation 12 (Safe care and treatment) by 16 August 2019. The registered manager and the provider had not ensured risks for people were appropriately assessed, or plans developed to mitigate the risks and professional guidance were followed.

Why we inspected
This was a targeted inspection based on the warning notice we sent to the provider and the registered manager following our last inspection. The Care Quality Commission are conducting trials of targeted inspections to measure their effectiveness in services where we served a warning notice.

We undertook this targeted inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to aspects of the safety of the service. The overall rating for the service has not changed following this targeted inspection and remains requires improvement. This is because we have not assessed all areas of the key questions.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 always safe.
Details are in our safe findings below.

Otterbourne Grange Residential Care Home

Detailed findings

Background to this inspection

The inspection
We previously carried out an inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014. This inspection was a targeted inspection. CQC are conducting trials of this type of inspection to follow up services where CQC have issued a warning notice.

Inspection team
The inspection was carried out by one inspector and one assistant inspector.

Service and service type
Otterbourne Grange Residential Care Home 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.

The service had a manager registered with CQC. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. However, the registered manager had left the service the day before the inspection took place. The provider had recruited a new manager who had started work on the day of the inspection.

Since the last inspection, the provider had put in place another level of management, which included a quality assurance manager and an operations manager. Their role was to ensure improvements were made to the quality of care provided at Otterbourne Grange.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we held about the service, such as the previous inspection report, the warning notice and the action plan. The law requires providers to notify us of certain events that happen during the running of a service. We reviewed notifications received since the last inspection.

We used all of this information to plan our inspection.

During the inspection
We spoke with three members of the management team: the new manager, the quality assurance manager and the operations manager, as well as three care staff. We looked at specific care records for two people and a range of records relating to the safety of the building.

After the inspection
We continued to communicate with the provider's representative to confirm the ongoing action being taken by them to ensure they completely met the requirements of the warning notice.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. We have not changed the rating as we have not assessed all of this key question area. We will assess all of the key question at the next comprehensive inspection of the service.

The purpose of this inspection was to check if the provider had met the requirements of the warning notice. Enough timely action had been taken and the provider was no longer in breach of Regulation 12, (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regard to assessing and mitigating risks to people.

Assessing risk, safety monitoring and management

- At the last inspection people were not always protected against risks associated with their care and support because risks had not been effectively assessed and plans implemented to reduce risks to people.
- At this inspection we saw people's health and mental health care risks had been assessed and care plans gave clear information for staff to follow, for example, how to support people living with diabetes. Senior staff had received training to support people living with diabetes and epilepsy.
- Legionnaires' disease is a potentially fatal form of pneumonia caused by Legionella bacteria which is commonly found in water. At our previous inspection there was not an adequate risk assessment or written scheme in place to ensure the risk of Legionella were identified and mitigated. During this inspection we found action had been taken to ensure records were kept regarding flushing of water outlets, for example, however, a comprehensive risk assessment had not been carried out. Following discussion with the management team, they immediately commissioned an external company who visited the home the next day to identify the risks. The full risk assessment will be given to the provider as a matter of urgency.
- At the last inspection an item of clothing had been placed over a fire door which would have prevented the door closing properly. During this inspection we saw that there were no restrictions on the fire doors. However, we found that some fire doors did not fully close when released from their magnetic closure device. We raised this with the provider's management team who immediately took action and the fire doors were working appropriately by the end of the inspection.
- We previously found a small window on the first floor did not have a restrictor fitted or a risk assessment in place. During this inspection we saw there was a restrictor fitted which meant the window could not open far enough to be a risk to people.