Healthcare Homes Group Limited

Overbury House Nursing and Residential Home

Inspection report

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Ratings

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**

Summary of findings

Overall summary

This inspection took place on 18 and 19 April 2018, it was unannounced.

Overbury House Nursing and Residential Home provides residential and nursing care to a maximum of 61 older people, some of whom may be living with dementia. At the time of our inspection there were 32 people living in the home, 14 receiving nursing care.

Overbury House Nursing and Residential Home is a 'care home' with nursing. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager appointed in June 2017; they were in the process of completing their registration with 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 was run.

We last inspected this service on 4 and 7 September 2017 and found the provider was in breach of six regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a requirement notice in respect of a breach of regulation relating to the need for consent.

We imposed positive conditions on the provider's registration at this location in respect of a breach of regulations relating to person-centred care, dignity and respect, safe care and treatment, meeting nutritional and hydration needs and good governance.

The overall rating for this service as an outcome of the inspection completed 4 and 7 September 2017 was 'Inadequate' and the service was therefore placed in 'Special Measures'. Services in special measures are 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.

Following our inspection in September 2017, the provider sent us an action plan to tell us about the actions they were going to take to meet these regulations. The action plan was reviewed with the manager and regional director during this inspection.

From this inspection, 18 and 19 April 2018 we identified areas of concern in relation to safe management of medicines, cleanliness of the environment and infection prevention control impacting on the care people received. This has resulted in the service continuing to be in breach of the conditions imposed as an outcome of the last inspection, with the service remaining rated as Inadequate and therefore continuing to

be placed in special measures.

The service did not have robust governance processes in place for monitoring standards and quality of care provided. Findings from clinical audits in areas such as medicines management and environmental condition did not reflect our findings during the inspection.

Staff did not consistently recognise the need to report safeguarding concerns to the local authority or to CQC.

Staff were not up to date with the provider's mandatory training or receiving annual performance appraisals.

However, we did find some areas of improvement at this inspection. We saw that staffing levels reflected the use of a dependency tool, with higher staffing levels in place in the morning, during meal times and early evening.

Staff treated people with care and compassion, and took pride in their caring roles. Staff approach and people's records demonstrated adherence to the Mental Capacity Act and Deprivation of Liberty Safeguards.

People had choice of food and fluids, with value placed on nutrition and food quality. People accessed activities in the local community and at the home, however, some people identified a need to improve access spiritual support to aid wellbeing.

People and their relatives knew how to make a complaint, and were encouraged to give feedback to the manager and provider.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks to people's wellbeing and safety were not always identified and actions to minimise risks were not consistently taken.

Medicines were not robustly audited, managed or stored safely.

The cleanliness of the home did not mitigate risk of the spread of infection by cross contamination.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were not up to date with the necessary training for their roles and for nurses, this linked to reviews of clinical competency.

Staff did not receive annual performance based appraisals.

Staff assessed people's mental capacity, with best interests decisions documented. However, we found inconsistent recording of consultation with relatives and healthcare professionals.

Value was placed on the importance of people having choice of food and drink to meet their nutrition and hydration needs.

Is the service caring?

Requires Improvement

The service was not always caring.

The condition of the care environment was not conducive to provision of high quality care.

People were treated with kindness, respect, dignity and compassion.

We received consistently positive feedback from people and their relatives about their care and treatment, the staff team and the service that they received.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans did not consistently link to risk assessments, with guidance for staff to follow in relation to the management of clinical risks such as choking and emergency evacuation plans.

People engaged with activities onsite and in the community.

Is the service well-led?

Inadequate

The service was not well-led.

There remained a lack of managerial oversight and quality audits in relation to areas such the condition of the care environment, administration of medicines, consistent completion of people's daily written records.

Not all staff recognised their professional and clinical accountability in relation to areas such as keeping people safe and administering medicines.

No staff had up to date performance appraisals.

Not all staff followed provider policies in relation to the health monitoring and management of people after falling.

Overbury House Nursing and Residential Home

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 was 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.

On the first day of the inspection the team consisted of two adult social care inspectors, a medicines inspector, a specialist advisor in relation to nursing and one expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the second day of the inspection the team consisted of one adult social care inspector.

During the inspection we spoke with six people who lived in the home. Due to the healthcare conditions that people were living with, some people were unable to tell us about their care. We observed care and support being delivered in communal areas including at meal times. We spoke with the relatives of five people and twelve members of care staff and the manager, regional director and group safeguarding lead.

We spoke with a visiting healthcare professional, attended the morning shift handover and the daily, midmorning staff meeting on the second day of the inspection visit.

We reviewed thirteen people's care plans in detail and looked at fifteen people's medicine administration records and the medicine management procedures in place.

We looked at three staff recruitment files as well as training, induction, supervision and appraisal records. We also viewed a range of monitoring reports and audits undertaken by the management team and other senior members of staff.

Inadequate

Is the service safe?

Our findings

At our previous inspection on 4 and 7 September 2017 we identified an ongoing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because risks were not always identified and action was not always taken to keep people safe. At this inspection on 18 and 19 April 2018 we found insufficient improvements and additional concerns were identified resulting in safe remaining rated as inadequate.

Staff completed detailed risk assessments identifying individual needs relating to people's health and wellbeing. Staff demonstrated clear understanding of how to support people to meet their daily care and treatment needs, and adhered to the guidance detailed in people's care plans. Some staff told us they did not have sufficient time to read people's care plans to enable them to keep fully updated on changing needs as these changes occurred.

Care plans included guidance on use of moving and handling equipment, administration of creams and skin care treatments, however we found examples of corresponding daily records for creams and skin treatments in people's rooms were inconsistently completed, we escalated this matter to the manager during the inspection. During the daily staff meeting on the second day of the inspection, the manager discussed administration of creams and skin treatments with the staff team, with reminders given in relation to documentation. Staff checked the condition of people's skin regularly and escalated any concerns identified to the nurse or senior carer on shift.

Where applicable, people's care plans contained information on the support they required with day and night time positioning and repositioning charts to reduce the risks of pressure ulcers developing.

The manager completed regular environmental safety audits, including for infection prevention control, however we identified concerns in relation to infection control and cleanliness throughout the home. This included waste bins overflowing, debris, and dirt on communal tables and seating, unclean commodes and equipment to assist people on and off the toilet. From reviewing cleaning records, we found gaps in recording, with records indicating some toilets and commodes had not been cleaned for up to 17 days, dining tables not cleaned for up to 13 days, dining chairs not cleaned for up to 11 days within the month of the inspection. Each communal bathroom and toilet had a daily check sheet on the back of the door; these also contained little or no record of daily condition and hygiene checks. Serving areas for staff to dish up meals were dirty with food debris and sticky floors and work surfaces. The lack of cleanliness risked cross contamination and spread of infection.

Radiators had covers on them, made from metal that conducted heat therefore increasing the risk of burns and scalds. Some ensuite bathrooms had radiators with metal covers close to the toilets, although these were switched off on the day of the visit. Metal covered radiators were in situ in communal areas near to where people sat, for example, to eat their meals, with some damaged covers. We escalated our concerns regarding the risks associated with the metal covers to the manager during the inspection visit. The management team told us they were aware of the damaged covers and potential risk of metal conducting

heat, but there were no planned environmental changes or risk assessments in place to manage this risk. Following on from the concerns identified during the inspection, the provider completed a comprehensive check of the temperature and condition of radiators and covers throughout the service and has provided feedback on their findings stating that they do not have risks of burns and scalds from the heaters in situ at Overbury House.

Each person had a personal emergency evacuation plan in place for use in the event of an incident such as a fire. However, we found examples of plans lacking key safety information. For example not all plans detailed that the person was living with dementia, therefore may find it difficult to follow instructions in an emergency situation. One person chose to have a safety gate at their bedroom door to prevent other people entering their bedroom without permission. The gate reduced the width of the bedroom door therefore would impact on ease of movement in the event of an emergency. The person's evacuation plan did not contain this information. We escalated this to the manager during the inspection.

Designated staff monitored the condition of equipment such as electric profiling beds, bed rails, hoists and slings, height adjustable baths, shower seating and the people carrying lift. External companies completed regular maintenance checks each year. Records indicated completion of checks of the condition of equipment to ensure that equipment used by people was well maintained and safe. However, we found examples of rusty bathing equipment and dirty height adjustable baths, rusty shower drains that staff signed off as in a good condition when completing their regular checks. We walked around the home with the manager to highlight areas of concern.

Bathrooms contained clinical waste bins that needed emptying and made bathrooms smell which would be unpleasant for people to use. Some people had baths in their bedrooms; staff said these people did not access these baths. Overbury House had a refurbishment plan in place to remove them. Water supply to the baths remained in place, therefore could pose a risk if accessed by people without staff supervision.

We observed part of the morning medicine round and noted staff followed safe procedures and had a caring approach towards people when giving them their medicines, however, we were later notified that at the time of inspection some members of staff had either not recently received training updates or had their competence assessed to ensure they handled people's medicines safely.

Records were in place for medicine administration with instructions. However, we found that medicine records were not always accurate to reflect delivery of new medicines. For people prescribed skin patches for example for pain management, there were additional records to show where staff applied patches to their bodies and to confirm removal before the next patch was applied. However, staff did not consistently complete these records and we found an example of a delay for one person in the replacement of their pain relief patch which could have led to them receiving inadequate pain relief. We found a container of a cardiovascular medicine in the medicine trolley available for administration to the person, supplied four days before the inspection visit. There was only one tablet removed and there were no records to explain the reason for the person missing their medicines. We escalated medicines concerns to the manager and nurses while on site, and requested completion of further investigation.

Staff completed regular internal audits to check people's medicines, however, for one medicine, we noted a numerical discrepancy. Staff had not identified this discrepancy from the audit or reported it as an incident for further investigation. We noted there had recently been some medicines that had not been given to people because they were unavailable and not obtained in time to ensure their treatments were continuous. There were gaps in recording of medicines prescribed for external use such as creams and ointments. These records did not confirm staff applied the creams and ointments as intended. There had been no recent

medicine related incidents logged and investigated by the manager, therefore we could not seek assurances that staff recognised or acted on errors and incidents relating to medicines.

Some supporting information was available for staff to refer to when handling and giving people their medicines. Each record had photographic identification and information about known allergies and medicine sensitivities but a lack of person-centred information about how people preferred to take their medicines.

When people had medicines on a when required basis (PRN), including pain relief and sedative medicines, staff did not consistently have access to written information to show staff how and when to give this medicine to people. For people prescribed pain-relief medicines on a PRN basis and who were unable to tell staff about their pain there were pain assessment tools in place. However, people's records lacked consistent use of the assessment tool when giving people pain relief medicines.

For another person who had PRN medicine an item on their prescription was discontinued by the GP, but written information about its PRN use was still available which could have led to confusion and error.

For a person with diabetes and who needed regular blood sugar monitoring their care plan referred to once weekly blood testing whereas their record sheet inaccurately indicated daily monitoring was required each morning. This was unclear for staff, and resulted in unnecessary blood testing.

Oral medicines were stored securely for the protection of people who used the service and at correct temperatures. However, we noted areas of the home where external medicines such as prescribed creams and ointments were not stored securely and were accessible to people placing themselves at risk of accidental harm for example by ingesting the item. This was a significant risk at Overbury House as many of the people were living with dementia and could lack insight into such dangers. We escalated these concerns to the manager, and work commenced on the second day of the inspection to ensure each person had a risk assessment in place for items such as creams to be securely stored in their bedrooms. The manager reminded all staff at shift handover to lock bathroom cabinets and ensure keys were not left in the cabinet doors.

The visiting healthcare professional told us that staff implemented preventative measures such as changes to the environment and use of technology while the person was on the waiting list for an assessment, and staff followed any guidance when provided. Staff collected and analysed incident information in relation to areas of risk such as falls. This was an improvement on the findings from the 2017 inspection. However, we identified areas requiring further improvement in relation to falls management as post incident medical forms were not consistently completed or followed. We could not source assurances that staff routinely accessed medical support after a person experienced a fall. Staff were not consistently working in line with the provider's head injury and falls policies, particularly for those people receiving residential services.

The above information meant the provider continued to be in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care staff demonstrated an understanding of safeguarding practices and procedures, and recognising types of abuse. Staff told inspectors the processes they would follow to escalate their concerns. However, some staff were not up to date with safeguarding training. We reviewed a recent safeguarding notification submitted to CQC, giving examples of staff following the home's policies and procedures. However, during the inspection, we found examples of incidents relating to the administering and safe storage of medicines, and staff had not reported these incidents to the local authority safeguarding team or to CQC. Staff had not

taken action to sufficiently mitigate risks, and we were not assured that staff consistently followed procedures in relation to safeguarding people. We escalated these concerns to the management team during the inspection. The manager submitted retrospective safeguarding referrals to the local authority.

The above information meant the provider was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans and risk assessments for people experiencing behaviour that may challenge themselves or others contained detailed guidance techniques for staff to follow. We observed good use of activities and communication techniques to de-escalate behaviours and manage potential risks to other people, for example, in communal areas of the home. Staff consulted with external healthcare professionals and sourced specialist advice, with evidence of guidance implementation in people's records and from observations of staff interaction. Care plans examined did not consistently contain information on ways to support people with protected characteristics that could be important such as sexuality, gender or spirituality.

At our last inspection in September 2017 we found improvements were required regarding the management of wounds and pressure ulcers in the home. At this inspection in April 2018, we identified that care plans and risk assessments contained use of photographs to monitor changes to wounds and skin ulcer appearance. Equipment such as pressure mattresses and cushions were in use as recommended by healthcare professionals. Staff reviewed risk assessments in relation to the condition of people's skin each month, and more frequently if needed. However, we identified a person at potential risk of developing sore or damaged skin due to inconsistent use of footwear when walking in communal areas; we escalated this risk to the manager and staff completed a risk assessment immediately.

The service had up to date fire, gas and electrical safety certificates in place and they completed regular fire safety drills, however, we did identify that some staff had out of date fire safety training. The manager confirmed they had training dates booked. Window restrictors were in place to maintain people's safety while having the windows open in their bedrooms and in communal areas.

The onsite maintenance and housekeeping team completed regular legionella water safety checks and an external company completed regular testing. We saw the safety certificate during the inspection. The maintenance team kept a log of hot and cold water temperature checks, flushing of the water system and descaling items such as shower heads. Water supplies accessed by people living in the home had thermostatic mixer valves (TMV) installed in bedroom wash basins and communal bathrooms to ensure that water temperatures were within a safe level to help safeguard people from scalding. This was an improvement from the September 2017 inspection.

Staff worked in three teams for each shift to meet the daily support needs of people. Use of a dependency tool recognised greater support needs in the morning to assist people with washing and dressing, during meal times, and early evenings. The service had additional staff supporting people during meal times and a twilight shift, although some twilight shifts were unfilled. The three staff teams cared for people receiving nursing care and those receiving residential. This ensured even weighting of staff workload. The manager and regional director identified that the dependency tool was not sensitive enough to reflect the complexity of the people living at Overbury House or aspects of the care environment, and were clear the tool was not the only method used to make decisions regarding safe staffing levels.

From staffing rotas examined, there were sufficient staff on shift to meet people's needs and inbuilt flexibility to respond to changes in people's conditions or supporting with attendance at appointments. Two people

had a member of staff assigned to them each day to offer one to one support and this was consistently built into overall staffing numbers. A sheet used at shift handovers gave timings for staff breaks to ensure sufficient staff availability and prevented breaks at busy times during a shift such as meal times. The home operated a policy of involvement of all staff in supporting people with tasks such as meals. Housekeeping and administration staff completed training to the same level as care staff to give them skills and confidence to assist people. Staff told us they worked as a team, with the manager, senior staff and nurses working as care staff to cover gaps in a shift, and ensuring people consistently received the same standard of care.

The service reported to have not used agency staff in the six months prior to the inspection, instead covering shifts with their own staff team. This ensured consistency and familiarity for staff and people receiving care. This was an improvement since the last inspection in September 2017.

People told us staff responded to their needs in a timely manner. One person said, "In the last six months I would say the numbers of staff have increased. Since the new manager has been here, it's definitely better." Another person said, "I think the numbers of staff here are good, there always seems to be carers about so if you need help, you don't have long to wait."

Employment records examined contained references, copies of proof of identity documents. Disclosure and Barring Service (DBS) checks (which helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups) undertaken before new staff started work. This helped to ensure people's safety by employing staff who were suitable to work in the care sector. The home had improved arrangements for the recording of proof of identity documents since the last inspection in September 2017.

Most people told us they felt safe living at Overbury House. One person said, "Well of course I do, they look after me don't they." Another person said, "Mostly I do but sometimes people come into my room at night. If they do I might ask them to leave or I will press my bell. As soon as a member of staff comes, they understand and take the person away."

Technology such as pressure mats were used to assist with keeping people safe, especially during the night to alert staff in the event a person had a fall. We spoke with a community healthcare professional visiting to support a person with the management of their falls. The healthcare professional told us the staff made appropriate onward referrals to the community team to access assessments for falls prevention and the management of other health risks.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection on 4 and 7 September 2017 we identified repeated breaches of Regulations 9, 11 and 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people did not always receive the right level of support to eat or have sufficient fluids the service did not fully adhere to the Mental Capacity Act 2005 (MCA) in relation to people's rights to provide consent. At this inspection on 18 and 19 April 2018 we found some improvements had been made but areas were still needing improvement, resulting in effective being rated as requires improvement.

Our previous inspection had identified concerns that actions were not taken to manage the risk to people from not eating enough. At this inspection we found that staff had identified people at risk from malnutrition and recorded actions required to mitigate and monitor this risk. Staff recorded people's weights monthly or more frequently if required, with changes in weight monitored closely and linking to the Malnutrition Universal Screening Tool (MUST), used to identify people, who were at risk of not maintaining a healthy weight. We did find some examples of inconsistent recording for people requiring weekly weight checks.

The chefs worked with staff to manage people's nutritional needs, including adding supplements and increased calories to people's diets. We observed discussions around meal choice and methods for increasing calories during the daily staff meeting we attended.

We observed the lunchtime meal on the first day of the inspection. Staff demonstrated awareness of their roles and responsibilities during the meal time, with staff assigned to people to support and encourage them to eat. The meal was three courses, offering people choice. If a person was unsure what they wished to eat, staff brought out food on plates to show people what the food looked and smelt like to aid decision making and maintaining choice. If a person did not want to eat the food available, the chef offered alternative options as needed and the home ran an all-day breakfast menu to encourage people to consume snacks and smaller meals to increase calorie intake across the day. One person helped staff before meals getting tables ready and folding napkins which they felt gave them a meaningful task to complete.

People gave positive feedback regarding the choice and standard of food. One person said, "Sometimes I like what's on offer and sometimes I don't. There's always a choice but it isn't always for me but if I say I don't fancy it they'll offer to make me up an egg omelette or something."

Staff monitored each person's fluid intake, with exact levels discussed at shift handovers to prevent risk of dehydration. Staff understood use of thickening agents added to drinks to prevent risk of choking and aspiration. From care records we looked at we saw examples of staff sourcing specialist advice from speech and language therapists, and following guidance put in place resulting from specialist assessments, or management of risks while awaiting an assessment. Overall, the management of people's nutrition and fluid intake had improved since the 2017 inspection visit.

Staff served drinks from a trolley at regular intervals during the day supporting people to maintain required fluid levels. We did note that people did not have access to drinks between trolley rounds and not all people

would be able to ask for a drink but may have been thirsty. The environment was hot on the day of the inspection.

Staff provided snacks between meals for people needing to increase their calorie intake; however, we found examples of incomplete records of people receiving snacks. We escalated this to the manager who addressed this with staff directly.

Care plans provided guidance for staff on supporting people with their personal care, eating and drinking to prevent risks of choking and aspiration. However, we found one example of a person at high risk of choking associated with falling asleep during meals. The care plan did not contain clear guidance for staff to follow in the event they thought the person had food in their mouth, or the timescales for responding to and escalating potential risks. We brought this matter to the attention of the manager during the inspection, assurances were given that the care plan would be amended. Management of risks associated with choking was identified during the September 2017 inspection visit.

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 Act 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 in their best interests and legally authorised under the MCA. The application procedures for this in care home and hospitals are called 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 was being met.

People's records contained mental capacity assessments in relation to consent for areas such as having their photograph taken to be stored with their medication records. Where people were unable to give their consent, staff consulted with relatives who had legal authorisation in place to give consent on the person's behalf. This was an improvement on the September 2017 inspection findings.

Staff submitted DoLS applications to the local authority and demonstrated clear awareness of working to least restrictive practices while maintaining people's rights to choice. Staff completed and recorded decision specific mental capacity assessments, and best interest decisions, however records did not consistently demonstrate consultation with people's relatives and other professionals involved in their care. For a person whose medicines was administered to them in food (covertly), a mental capacity assessment and best interest decisions were on record, but the assessments did not include consultation with the GP and pharmacist. This would be best practice to ensure medicines would be suitable to give covertly, and to check compatibility with foods.

People's records included when relatives had legal authority to give consent on people's behalf in relation to their finances or healthcare. This was an improvement on the 2017 inspection findings.

Shift handover records identified if people had Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders in place. Ten people did not have an indication of whether a DNACPR order was in place or not which made it unclear for staff to ensure they made the correct decision. Three people on the handover record indicated for staff to consult with relatives for a decision, this would cause delays in the event CPR needed to start and again was unclear for staff.

The provider held a training matrix listing their mandatory training requirements. From reviewing training data, completion rates varied, particularly with training areas such as medicines management, safeguarding adults and children, dementia awareness, infection control and mental capacity assessment. We could not be assured that staff had all necessary training and skills required to fulfil the requirements of their job role. The manager provided dates for staff due to complete fire safety and moving and handling training courses. Staff told us there was a plan for refresher training to be arranged, and nurses told us they felt the training they received supported them with the revalidation process, linked to the maintenance of their registration with the Nursing and Midwifery Council.

New staff completed an induction programme including spending time with experienced staff shadowing shifts and completing a corporate induction programme. Overbury House had started to offer apprenticeships, and had their first apprentice in post.

No staff had up to date annual performance appraisals in place, although the manager identified that dates for later in the year were planned. Staff performance was not regularly reviewed or robustly monitored, particularly in relation to nursing staff competencies. There was a supervision structure in place. Supervision offered staff the opportunity to discuss their work, receive feedback on their practice and identify training and development needs. Nurses received clinical supervision from the regional director as a qualified nurse. However, we identified areas of performance improvement linked to clinical competency for nursing staff. This including medicines management by nursing staff.

Staff used aids such as picture books for communication and to reduce people's frustration. Staff demonstrated awareness of people's non-verbal communication and body language to understand their support needs. For example a person regularly moved around and held the front of their clothes when needing encouragement to access the toilet.

People's we spoke with discussed access to healthcare professionals. One said, ""I have seen the optician since I came here and I am going to see a dentist, they arrange it all." Another person said, "I know if you are ill, they do whatever is needed so if you need a doctor or a nurse or they even call for an ambulance, they will make the necessary phone calls."

Requires Improvement

Is the service caring?

Our findings

At our last inspection on 4 and 7 September 2017 we found the provider was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people were not always treated with dignity and respect. At this inspection on 18 and 19 April 2018 we found sufficient improvements had been made and the provider was no longer in breach of this regulation. However, the condition of the care environment was not conducive to high quality care resulting in caring being rated as requires improvement. A lack of clear risk assessments and guidance for people regarding choking and personal emergency evacuation plans showed a lack of a caring service.

Two people shared a bedroom. A curtain that did not reach the floor or the width of the bedroom separated their beds. This impacted on each person's privacy and dignity. Care plans did not indicate that either person had chosen to share a bedroom or if this was in their best interests.

We found that a lack of attention to some people's continence needs had placed people in situations which compromised their dignity. We found some people's rooms had a strong unpleasant odour that was also apparent in the corridor to people passing by potentially impacting on their dignity. However, staff reported to complete regular deep cleans and replacements of soft furnishings to try to manage this. This was some improvement on the 2017 inspection findings.

From observations of staff interaction with people, staff treated people with dignity, care and respect and were familiar with each person's care and support needs and preferences. We observed staff knocking on bedroom doors before entering rooms. Staff hung signs on people's bedroom doors 'dignity in care' posters, to alert others personal care was in progress to protect people's dignity. The service had policies in place to support staff with the management of people's dignity in relation to protected characteristics including disability and sexuality, however, this was not reflected in each person's care and support plans.

People gave feedback on the care they received. One person told us, "They are lovely, they are kind, nothing is too much trouble, and I love it here." Another person said, "I have been here about two months, on my birthday they bought me flowers, wasn't that nice." One relative said "[relative] can be difficult, [relative] hits out sometimes and has refused food and drink. They (carers) are brilliant with [relative], they do not react."

We saw staff position themselves to be at eye level with people when speaking with them. Staff called people by their preferred name. Staff adapted their communication techniques and approaches to accommodate people with communication and sensory difficulties such as hearing loss and those living with dementia. Staff gave reassurance and emotional support to people when they showed signs of distress or feeling unwell through appropriate levels of physical contact such as holding people's hands.

Staff encouraged people to maintain contact with their relatives with telephone calls used when relatives did not live locally. The provider and staff team demonstrated familiarity with each person and their relatives, and sourced feedback on their experiences of using the service, and suggested areas of improvement. The provider sourced feedback through relative meetings. We saw copies of relative meeting

minutes, these demonstrated open and honest dialogues between relatives and the manager. Minutes contained clear action points for the manager to complete after the meetings.

People had personal effects in their bedrooms and choice over what to watch on television or what music they wished to listen to. People were encouraged to maintain personal hobbies and interests such as gardening and going out in the community with relatives. We did receive feedback from some people wishing to maintain their religious wellbeing through attending church services or spiritual visits on site.

One person told us, "I am very happy here but I would like to see a priest now and then." Another person told us, "There used to be services once a month, the vicar used to come in but they stopped coming, I do not know why. We do record [name of a religious television programme] and show that and have a bit of a sing song."

People used walking aids and mobility equipment such as wheelchairs and specialist seating. Staff hoisted people in the privacy of their bedrooms, and people sat at the dining tables in their wheelchairs or specialist seating to maintain their dignity in communal areas if unable to transfer independently. Staff positioned seating close to the dining tables or used height adjustable tables to maintain people's comfort while eating.

Staff supported people to maintain their personal appearance and presentation, and encouraged people to make their own clothing choices. A hairdresser visited regularly.

Care plans indicated people's individual preferences for showers or baths, and staff placed value on completion of regular personal hygiene for people's comfort and dignity particularly where people experienced difficulties with continence management.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection on 4 and 7 September 2017 we found the provider was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the service did not provide person centred care. At this inspection on 18 and 19 April 2018 we found some improvements had been made but areas still needing improvement, resulting in responsive being rated as requires improvement

Staff provided end of life care services, particularly for those people receiving nursing care. People had end of life care plans, incorporating decisions, wishes and preferences made by some people ahead of needing the decision in place or in consultation with relatives. Staff did not complete training in provision of end of life care, and Overbury House did not hold an associated accreditation. The manager and regional director recognised the need for staff to complete end of life care training, and this was reportedly a plan for the future. No timescales for completion were in place at the time of the inspection.

Care plans did not consistently link to risk assessments, with guidance for staff to follow in relation to the management of clinical risks such as choking and emergency evacuation plans. However, care plans did demonstrate detailed guidance on clinical risks such as falls and diabetes care. Staff wrote care plans collaboratively with people and their relatives.

Behavioural management plans incorporated triggers and approaches for staff to follow. We found good examples of plans incorporating detailed life history documents. These offered staff topics of conversation for people to talk about. The documents demonstrated involvement from people and their relatives to incorporate their personal preferences. This was an improvement on the 2017 inspection findings.

Overbury House worked closely with local schools and the library service to bring community projects such as poetry and literature reading into the home. One staff member brought their dog into the home to spend time with certain people who were finding engagement with staff and living in a care home unsettling. Access to animals had a calming effect on people and offered a topic of conversation.

People spoke positively about accessing the local community. One person said, "I know the area very well and to be honest I love it. I like to have a change of scene so going out, even if it is just to go to a café or the shops means a lot to me." One person told us, "Four of us in wheelchairs, with four carers go for a walk and maybe a coffee or something."

There was an activity co-ordinator in place, who actively encouraged people to participate in activities in groups and on a one to one basis. On the first day of the inspection, people played games in the garden and spent time talking with staff while enjoying ice creams. The activity co-ordinator and staff engaged with people and their relatives to find out about their hobbies and interests. Staff discussed activities at the daily staff meeting.

People told us they chose whether to participate in daily activities or not. One person said, "It is up to me

whether I join in with what is going on in the home or not, sometimes I do but often I am happier staying in my room. If they (carers) ask me if I want a shower, I can say I would like it later, or I might decide to have it then, they do not mind."

The home had multiple lounges offering quiet rooms for people to use if finding noise or large numbers of people unsettling. We observed staff relocating people to quiet lounges before people became distressed. Care plans contained guidance for staff to monitor, with examples of behaviours and body language a person may display when feeling distressed or upset.

Rooms had large written and pictorial signs on the doors, including for communal bathrooms. However, these bathrooms were locked manually at the top of the door, and were used as storage rooms for equipment such as hoists, boxes of gloves and shampoo. For people living with dementia, having the signs in place but making the rooms inaccessible could cause confusion.

We looked at the home's complaints records and saw that the provider had investigated and appropriately responded to concerns they had received. Written responses offered apologies from the manager and demonstrated duty of candour in relation to the management of incidents.

People told us they felt comfortable to raise concerns with staff. One person said, "They are easy to talk to, I could talk to any of them if I had a problem and I am sure they would be able to sort it out for me."

We saw examples of compliments from relatives in relation to the care and support provided to people. Some relatives completed online feedback published on the internet.

We observed staff responding in a timely manner to people's needs and requests for example if they asked to access the toilet.

The service had a staff picture board to assist with identification and aid familiarity with faces. However, this information was separate from areas of the home accessed by people living there as it was based in the main reception. Having staff picture boards in communal areas of the home would aid people's familiarity with staff.

Inadequate

Is the service well-led?

Our findings

At our last inspection in 4 and 7 September 2017 we found the provider remained in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had failed to implement effective systems to assess, monitor and improve the quality and safety of the service. This had resulted in some people experiencing poor care and support. They had also failed to maintain an accurate and complete record in respect of each person who used the service. This resulted in the rating of Inadequate.
At this inspection on 18 and 19 April 2018 we found insufficient improvements and additional concerns were identified resulting in well-led remaining rated as Inadequate.

As an outcome of the September 2017 inspection, we imposed conditions on the providers registration that required them to provide monthly data on incidents including falls, the monitoring of people's weights, with reports on the analysis of incidents.

This had raised overall standards of management overview and evaluation of incidents. The manager shared their findings with the regional director further increasing clinical nursing and managerial oversight.

Our findings during this inspection showed that the provider had failed to address concerns identified from the September 2017 inspection to meet the regulations for safe care and treatment, and good governance. The provider had consistently failed to sustain and make improvements where non-compliance and breaches of regulations had been identified during the previous two inspections. This has resulted in the service continuing to be in breach of the conditions imposed, with the service remaining rated as Inadequate and therefore continuing to be placed in special measures.

Whilst there were some systems in place in the home to monitor the quality of the service provided through audits on areas such as health and safety, infection control, medicines, and care plans, these were not effective at identifying the areas of concern that we found during this inspection.

The manager told us they completed regular audits and walk arounds of the home, these looked at areas including cleanliness and infection prevention control, and monitoring of staff training completion. However, we identified significant concerns in these areas during this inspection, we could not be assured that audits and walk around checking processes were robust. Since the last inspection, these areas of improvement were incorporated into the provider's action plan linked to the September 2017 inspection. As a result of our findings on this inspection, we were concerned that there was a lack of oversight of the identified and required actions that needed to be taken to make sustainable improvements in the home.

We found significant gaps in cleaning records, which did not demonstrate that the manager was monitoring staff completion of these tasks or auditing their paperwork or standards of work. The manager was responsive to addressing these concerns when identified during the inspection.

We identified areas requiring further improvement in relation to falls management as the forms used to

monitor people's medical needs following falls were not consistently completed or followed. Staff were not working in line with the provider's head injury and falls policies, particularly for those people receiving residential services.

The qualified nurses needed to take more of a lead with clinical tasks linked to their role and responsibilities. We found areas of concern in medicines management and administration linked to people receiving nursing services. We concluded there was a lack of clinical accountability and ownership by the nurses. Examples of this include, where we identified concerns relating to people's medicines, we needed to request submission of safeguarding referrals and completion of medicines stock checks.

We identified that the manager lacked confidence to delegate responsibilities and tasks to staff. This had resulted in the manager not taking annual leave, and finding it difficult to relinquish responsibilities to colleagues. This was not a sustainable situation for the manager and we shared our concerns with the manager, regional director and group safeguarding lead.

The manager had identified areas of performance improvement for the nurses and a management plan was in place by the manager and regional director to address these concerns.

We identified gaps in the recording of topical medicines such as creams and ointments. This identified a lack of management oversight of these records. This did not provide assurance of consistent monitoring of people's skin care and treatment.

At the time of this inspection, and the last inspection, the manager was in post but had not completed the registration process with CQC. We sought assurance from the manager that they planned to complete the registration process in a timely manner.

The above information meant the provider continued to be in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements were found since the last inspection in relation to the management of people's nutritional and hydration needs, dignity and care, consent and person-centred care.

We received positive feedback from a visiting community healthcare professional during the inspection, and saw examples in people's records of staff following advice from healthcare professionals. This was an improvement on the 2017 inspection findings.

The manager took a hands-on approach to their role and was familiar with each person's care and support needs. The manager had written many of the care and support plans, and led the daily shift handover and daily staff monitoring meetings. They encouraged staff and gave positive feedback and praise where it was due.

Care staff were clear and confident of their roles, and demonstrated extensive skills working with the people living at the home.

At the last inspection, September 2017, we identified concerns in relation to the quality of people's care records, with a lack of up to date and detailed information. At this inspection, significant improvements had been made in the content of people's care and support records, with regular reviews completed. Each person was allocated as a 'resident of the month'; to ensure all care plans and risk assessments were fully reviewed and updated a minimum of monthly. However, gaps and inconsistencies in records identified

during the inspection had not been picked up during these monthly reviews. We did identify that some documents were difficult to read due to illegible handwriting. This could impact on easily accessing information for staff. This also posed a potential risk in relation to people's hospital passports as the information contained in these documents was shared on admission to hospital.

When we attended shift handover, we noted the improved level of detail discussed and recorded to support staff to work effectively with people. Staff were clear of their allocated roles for the shift and which people they were working with. Paperwork planned staff breaks to ensure even staff coverage across the shift whilst ensuring staff accessed regular breaks. Staff offering one to one support to people knew this was their allocated role at the start of each shift. Staff worked cohesively as three teams, but also supported each other across the teams as needed. Staff demonstrated strong team work, and good morale. Staff wanted to offer people a consistently high standard of care and treatment. This linked to a reduction in use of agency staff, and improvements in recruitment and retention.

People gave feedback on staff and standards of care, they told us, "I think higher numbers of carers means they have a little more time to chat and get their work done, they seem happier too." A relative told us, "I think there were more agency staff before and a higher staff turnover, things have improved."

Staff were aware of the provider's whistleblowing procedures, and reported to feel comfortable to raise concerns with the manager if needed. There were no whistleblowing concerns under investigation at the time of the inspection.

Some staff identified increased workload for example with more paperwork to complete.

The manager held regular meetings with staff and relatives. Staff meeting minutes did not contain action points to complete before the next meeting. This did not demonstrate that management listened to staff feedback or acted on.

Relatives provided feedback on the meetings held with the manager and management of complaints. One person said, "There are regular relative meetings, every month and they are good. They cover all sorts of things, the way the home is run, future plans, all sorts. If you have a complaint or a worry you can raise it at the meeting, and I feel it is taken seriously." Another person told us, "Since [manager] has been here I think [manager] made a difference and [manager] always seems busy but I know if I wanted to talk to [manager] they would listen."

The provider worked closely with other healthcare professionals and sourced specialist support for people in a timely way. This was an improvement from the September 2017 inspection.

Staff and people spoke positively of the manager's hands on approach and open door policy. People told us, "It has changed, the new manager has made quite a few changes and it has definitely improved since [name] started." Another person spoke about the manager and said, "Oh yes, I see [name] almost every day, [name] comes and says hello and is very approachable."

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The care provider did not meet people's needs in relation to safe management of medicines, and associated reporting processes when medication errors occurred. The care provider did not manage or identify risks relating to the condition and cleanliness of the care environment. The care provided did not effectively identify concerns relating to people's fire safety and emergency evacuation risks. The care provider did not consistently ensure completion of post-falls healthcare monitoring. The care provider did not ensure staff completed mandatory training to meet the requirements of their job roles. The care provider did not ensure staff had annual, performance appraisals in place. Regulation 12 (1) (2) (a) (b) (c) (d) (g) (h)

The enforcement action we took:

A notice of decision to impose conditions on the provider's registration at this location remained imposed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The care provider had not implemented effective quality auditing processes and spot checks, or identified gaps in cleaning records. The care provider had not effectively managed concerns relating to the role, responsibility and clinical accountability of the registered nurses working at the service. The care provider did not have good monitoring processes in place to ensure safeguarding incidents were notified to the local authority and to CQC. This resulted in a breach of regulation 13, and relates to the breach of regulation 17 in relation governance monitoring

and oversight of incidents and adherence to safeguarding procedures.

Regulation 17 (1) (2) (a) (b) (c) (f)

The enforcement action we took:

A notice of decision to impose conditions on the provider's registration at this location remained imposed.