Barchester Healthcare Homes Limited

Ottley House

Inspection report

Corporation Lane
Cotton Hill
Shrewsbury
Shropshire
SY1 2PA

Tel: 01743364863
Website: www.barchester.com

Date of inspection visit:
29 January 2018
30 January 2018

Date of publication:
14 March 2018

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 29 and 30 January 2018 and was unannounced.

Ottley House 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. Ottley House provides accommodation with nursing care for up to 72 people. The home is purpose built and all accommodation is on ground floor level. Bedrooms are for single occupancy and have en-suite facilities. The home consists of two separate units; The Ann Carter unit provides general nursing care and the Memory Lane unit provides care for people who are living with dementia.

At the time of the inspection there were 67 people living at the home.

At the last inspection in June 2016, the service was rated Good

At this inspection we found the service remained Good overall with Requires Improvement for the Effective key question.

People were supported by adequate numbers of staff who had the skills and knowledge to meet their needs. Staff knew how to protect people from the risk of harm and abuse. There were systems in place to identify and manage risks and to protect people from harm or abuse. People received their medicines when they needed them and medicines were stored and managed in a safe way.

Most people continued to receive effective care. However due to recent incidents, improvement was required in this area to ensure people's health care needs were monitored and met. People were supported by staff who were well trained. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People were cared for by staff who were kind and considerate. There was a cheerful atmosphere in the home and people were supported in a relaxed and unhurried manner.

People continued to receive a service which was responsive to their needs and preferences. Staff knew what was important to the people they supported and people were involved in planning and reviewing the care they received. There was a varied programme of activities for people if they wanted to join in. Complaints were taken seriously.

Staff told us the management within the home were open and approachable. The registered manager and provider continually monitored the quality of the service and made improvements where needed.

Further information is in the detailed findings below

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service remains Good

Is the service effective?

Requires Improvement

The rating has changed from Good to Requires Improvement

Most people continued to receive effective care. However due to recent incidents, improvement was required in this area to ensure people's health care needs were monitored and met.

People made decisions about their day to day lives and were cared for in line with their preferences and choices.

Staff received on-going training to make sure they had the skills and knowledge to provide effective care to people.

Is the service caring?

Good

The service remains Good

Is the service responsive?

Good

The service remains Good

Is the service well-led?

Good

The service remains Good

Ottley House

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 was a comprehensive inspection carried out by two adult social care inspectors and a specialist advisor. The specialist advisor was a registered nurse who specialised in tissue viability, pressure care and infection control. The inspection took place on the 29 & 30 January 2018 and was unannounced.

This inspection was partly prompted by an incident which had a serious impact on two people using the service and this indicated potential concerns about the management of risk in the service. While we did not look at the circumstances of the specific incident, we did look at associated risks.

At our last inspection of the service in July 2016 we did not identify any breaches in our regulations.

The provider was not requested to submit a Provider Information Record (PIR) before the inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. We looked at notifications sent in by the service. A notification is information about important events which the service is required to tell us about by law. We looked at previous inspection reports and other information we held about the service before we visited. We used this information to plan the inspection.

During our visits we spoke with 15 people who used the service, 12 relatives and one visitor. We met with the registered manager and one of the provider's regional managers and also spoke with 21 other staff members.

Some of the people we met with were unable to tell us about their experiences so we used the Short

Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at a sample of records relating to the running of the home and the care of individuals. These included the care records of 19 people who lived at the home. We also looked at records related to the management and administration of people's medicines, health and safety, quality assurance and staff recruitment.

Good

Our findings

People continued to receive safe care.

People looked relaxed and comfortable in their surroundings and with the staff who supported them. One person told us "I do feel safe living here, the staff couldn't be better." Another person said "I do feel safe here. The staff are very good, well-trained and seem very capable." A relative told us "I can't tell you how happy the whole family are. It's such a relief knowing my [relative] is now safe and well cared for." Another relative said "They [relative] are safe. When we leave we are confident they are in safe hands."

People were protected from abuse through the providers' processes and practices. These included a recruitment process which made sure only people suitable to work with the people who lived at the home were employed. Staff told us they had not been able to commence work in the home until all checks had been carried out. Records seen confirmed this.

The provider also made sure all staff knew how to recognise and report any suspicions of abuse All staff we spoke with said they would not hesitate to raise any concerns and all were confident that action would be taken to keep people safe. A member of staff said "If I thought someone was being abused I wouldn't hesitate in reporting it, even if it involved a work colleague. Our role is to protect people." Where allegations had been made the registered manager had worked in partnership with appropriate authorities to make sure issues were fully investigated.

Where things went wrong the provider learned from these mistakes and took action to make sure improvements were made and people were safe. Before this inspection we were made aware of two serious incidents which had occurred. These incidents were subject to an external investigation so we did not focus on this during our inspection however we continue to consider this information. We were able to see that the provider had taken action to mitigate further risks to the people who used the service.

There were adequate numbers of staff to keep people safe and meet their physical needs. During the inspection we observed people received support promptly when they requested it. People had call bells in their rooms to enable them to summon help when they needed it. We did not hear call bells ringing for long periods of time which indicated people received support in a timely manner when they requested it. One person said "The staff are wonderful. When I ring my bell they come quickly." People who were being cared for in bed were regularly visited by staff to make sure they were comfortable.

People's medicines were safely managed and administered by staff who received regular training and monitoring of their practice to ensure it remained safe. When staff were administering people's medicines they wore a red tabard which indicated they should not be disturbed. This meant the staff member was not distracted and helped to reduce the risk of errors. Some people were prescribed medicines, such as pain relief, on an 'as required' basis. During the inspection we saw these medicines being offered to people. One person who lived at the home said "I have pain killers and I always get them when I need them." Medication administration records showed medicines entering the home from the pharmacy were recorded when received and when administered or refused. This gave a clear audit trail and enabled the staff to know what medicines were on the premises.

People were protected from the risk of the spread of infection because staff had received training in infection control and there were systems in place to minimise this risk. The home was kept clean by a dedicated team of domestic staff and all staff had access to personal protective equipment such as disposable gloves and aprons. Sanitising hand gel and hand washing facilities were available throughout the building.

Risks to people were reduced because there were systems in place to identify and manage risks. These included reducing the risk of falls, assisting people to mobilise and reducing risks to people who were at high risk of malnutrition and pressure damage to their skin. A plan of care had been developed to minimise risks and these were understood and followed by staff. Where there was an assessed need, people had specialised mattresses on their bed and pressure relieving cushions on their chair. People who had been assessed as being at high risk of malnutrition received enriched diets and were regularly monitored.

Systems were in place to safely evacuate people from the home in the event of an emergency. Each person had a personal emergency evacuation plan. This gave details about how to evacuate each person with minimal risks to people and staff. Fire grab bags were situated at fire exits so they could be quickly accessed in the event of an emergency. These contained a fire risk assessment, evacuation plan and list of people using the service.

The premises were well maintained. Maintenance staff were employed and regular checks were carried out to make sure the environment and equipment remained safe. Records showed that repairs had been completed without delay.

Requires Improvement

Our findings

The rating for this key question has changed from Good to Requires Improvement. Most people continued to receive effective care however prior to our inspection visit we were made aware of two serious incidents that had occurred which highlighted the need for some improvements in how people's health care needs were monitored and met.

Prior to this inspection we were made aware of an incident which had occurred. Concerns related to the monitoring and management of pressure sores which had resulted in a significant deterioration in one person's wound. These concerns were subject to an on-going external investigation and we did not focus on this at our inspection. However we found the provider had implemented systems to mitigate risks to the people who lived at the home. We read the care plans for three people who were being treated for a pressure sore. Care plans provided clear information about the size and status of the wound, the prescribed treatment and frequency of the treatment. Running records completed by the registered nurses demonstrated they were following the plan of care. The effectiveness of the treatment had been regularly reviewed and we saw photographs were used to monitor the status of the wound. We were able to see that staff had requested the input from other professionals such as tissue viability nurses, where there were concerns about the status of a wound. People who were assessed as being at high risk of pressure damage to their skin were provided with suitable equipment such as pressure relieving mattresses and cushions.

Prior to the inspection we received serious concerns about the management of people who had been assessed as being at high risk of dehydration and malnutrition. Although the provider had systems in place to monitor people's intake these were not always followed by staff. Records did not demonstrate that people received the desired amount of food and drink which had been specified in their plan of care. Concerns about people's intake were not always communicated to all staff or other professionals. These concerns were subject to an on-going external investigation so we did not focus on this at our inspection. However we found the provider had taken action to improve practice and mitigate risks to the people who lived at the home. At this inspection we found where people required their food and fluid intake to be monitored, this had been recorded. Registered nurses regularly checked people's intake charts to ensure they received enough to eat and drink. We saw that any concerns about a person's intake were communicated to the registered nurse who then contacted the person's GP. We heard a registered nurse on the telephone to a person's GP discussing concern's about the person's weight loss. The registered nurse told us that the GP would make a referral for a dietetic assessment.

There was a varied menu which provided choices for every meal. Catering staff were employed and were led

by a head chef who had an excellent knowledge of people's needs and preferences. They explained they met with people and their relatives when they moved to the home to discuss their preferences. The head chef explained how they fortified foods and drinks for people who were assessed as high risk of malnutrition. Throughout the day we observed people were provided with fortified milkshakes, smoothies and snacks which included fruit, cakes and biscuits. The head chef met with the registered manager at least monthly to review each person's nutritional needs and weights. This meant any concerns about weight loss could be addressed promptly. The home provided specialist diets for people who required it. For example some care plans stated that people needed their food to be served at a specific consistency and at lunch time we saw people received an appropriate meal. Some people also required their fluids to be thickened to minimise the risk of them choking and again we saw these people received drinks in accordance with the recommendations which had been made by relevant professionals such as speech and language therapists

Staff told us they received the required training to meet the needs of the people they supported. In addition to a range of health and safety topics, staff completed additional training to meet more specific needs. This included caring for people who were living with dementia, diabetes, tissue viability and caring for people nearing the end of their lives. We observed staff were confident and competent when they assisted people with a task. There were always trained nurses on duty to monitor people's health and respond appropriately. Trained nurses were able to access training which kept their clinical skills up to date and enabled them to remain registered as nurses.

One person who lived at the home said "The staff are great. They know how to look after me." A relative told us "We have confidence in the staff and they know what they are doing. I would say they are well trained and competent."

Staff knew the importance of seeking people's consent before they assisted or supported them. One member of staff said "You can't force people to do anything. That would be wrong. If a resident [person who lived at the home] didn't want to be helped to get up and dressed I would respect that and try again later." A person who lived at the home told us "If I say don't do something, they [staff] respect my wishes and always listen to me." A relative said "Staff do ask for consent from our relative all the time before doing anything and we are confident with the care they receive." The people who were living with dementia were not able to tell us about their experiences. However; we observed staff seeking people's consent before assisting them with a task.

Staff had received training about the Mental Capacity Act 2005 (MCA). The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant.

Staff spoken with were aware of the need to assess people's capacity to make specific decisions. Where appropriate they had involved family and professional representatives to ensure decisions made were in people's best interests. Care plans contained assessments of people's capacity to make certain decisions. These included the management of medicines, consent to healthcare treatment and the use of bedrails and pressure mats to help reduce the risk of falls. This made sure people's legal rights were protected.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager had an understanding of the mental capacity act and worked in partnership with relevant authorities to make sure people's rights were protected.

The home was purpose built and all accommodation was at ground floor level and there were doors leading out on to accessible garden areas. All bedrooms were for single occupancy and people were able to personalise their rooms in accordance with their tastes and needs. The home was divided into two units one of which provided a service to people who were living with dementia. We asked the registered manager if there were plans to further enhance this environment as we found the corridors looked sparse and did not contain any items of interest or anything for people to interact with. We also observed there were no orientation boards which could help people to orientate themselves to such things as the day, date, season and what activities were planned. Following the inspection the registered manager confirmed they had taken steps to address this and that one of the provider's dementia specialists would be visiting the home to look at how to further improve the environment for people.

Good

Our findings

People continued to receive a caring service.

People were supported by staff who were kind, caring and respectful. People were not rushed and staff took time to find out what a person wanted to do. From our discussions with staff it was apparent they cared about the people they supported a great deal. A person who lived at the home said "The staff are lovely. Very kind indeed." Another person said "It's excellent here. They [staff] do what you tell them. I have no complaints. They [staff] are all very kind." People's relatives were also positive about the staff; one relative said "It's a very happy place with a nice cheerful atmosphere. The staff are very flexible and accommodating." Another relative said "My [relative] is settled and content living here. The staff are friendly and welcoming and I can't speak highly enough of them."

Not everyone was able to tell us about their experiences because they were living with dementia. During our observations on the dementia unit we observed staff interacted with people in a very kind and patient manner. There was a cheerful atmosphere and people responded positively when staff interacted with them. For example one person kissed the hand of a staff member when they spoke to them. Another person smiled when a staff member handed them their cuddly toy.

We observed a member responded very quickly when they noticed a person may be experiencing pain. The person was living with dementia and was unable to fully express what they were feeling. The person started to cry and the staff member immediately went to them, got down to their level, took their hand and quietly asked them if they were in pain. When the person nodded, the member of staff immediately informed the registered nurse who administered pain relief. We observed the person later in the day and they appeared more relaxed.

All the staff we met with had a good knowledge and understanding about people's needs, preferences, social history and what was important to the people they supported. We heard staff chatting with people about their family, pets, hobbies and jobs they had during their lives. Care plans contained a document called 'my memories.' This provided staff with important information about the person's social and life history, preferences and family members and enabled staff to engage in meaningful conversations with people.

People's privacy and dignity was respected and people told us staff were respectful when they assisted them with personal care. One person said "When I'm having a wash I'm never made to feel embarrassed by

staff. They are very good." Another person told us "The staff are very respectful and they always knock on my door before they come in." On the dementia unit we heard staff offering people assistance with personal care in a discreet and caring manner. When staff assisted people, they did so in the privacy of the person's bedroom.

The home ensured that people enjoyed a relaxed and sociable mealtime experience. We observed lunch being served on both units. Tables were attractively laid with tablecloths, napkins, condiments and flowers. A selection of drinks were offered including wine and there were three choices for the main meal. On the unit for people living with dementia, staff showed people plated meals which enabled them to make an informed choice. On both units there was a happy and sociable atmosphere with people engaging in conversations with each other and with the staff who were supporting them. People's relatives were also able to join them for meals. One relative said "We are very happy. I always have lunch with my [relative]." Another relative said "It's so nice that I can have lunch with my [relative] whenever I want to."

Good

Our findings

People continued to receive a responsive service.

The people who lived at the home and their representatives were involved in planning and reviewing the care and support they received. This helped to ensure that people received the care they needed in the way they wanted. A relative told us "We've been involved in reviews of the care plan. They [staff] responded to the issues we raised and made suitable changes." Another relative said "We have had reviews in the past to review the care my [relative] receives. The staff give us plenty of options to discuss the care plan."

People received care and support which was personalised to their needs and preferences. Care plans provided information about people's needs and how these should be met by staff. Care plans contained information about what was important to the person, their family, and friends and how they liked to spend their day. This helped staff to support people in a way that met their needs and respected the person's wishes.

On both days of our visits we heard pleasant conversations which showed staff knew people and the things that were important to them. For example, we heard one member of staff reminiscing with a person about their previous job. Another member of staff was talking to a person about a pet they used to have.

People were supported to follow their interests and take part in social activities. Designated activity staff were employed and people were provided with opportunities to take part in a varied activity programme within the home and in the local community. There were visiting entertainers, animal therapy, trips out to places of interest as well as in house activities such as gentle exercise, arts and crafts and sing-a-longs. A person who lived at the home said "There are lots of activities here. There is always something going on and the two [activities coordinators] are excellent." Another person said "I've been on a canal boat and to the flower show. They do lots of activities." A relative told us "There are a lot of activities and our [relative] occasionally chooses to get involved. They have regular trips out and my [relative] enjoyed a trip to the flower show. They are never excluded from anything."

The provider had a complaints procedure which was displayed in the home. People and their relatives told us they would feel comfortable in raising concerns if they had any. One person said "I don't have any worries. If I did I would report them. I know it would be sorted." A relative said "When I have had concerns they are dealt with straight away. I know how to make a formal complaint if needed." Records of complaints showed that all complaints expressed verbally or in writing were responded to in a timely manner. We saw

complaints had been fully investigated and action was taken to address people's concerns.

The registered manager told us there was nobody receiving end of life care. We saw care plans contained information about people's preferences during their final days and following death. This meant staff had the information needed to ensure people's wishes were respected.

Good

Our findings

The service continued to be well-led.

There was 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.

The registered manager provided clear leadership to other members of staff. They led by example and were well respected by staff and people who lived at the home. A member of staff said "[Name of registered manager] has an open door policy and is very approachable." Another member of staff told us "The management here is good. The registered manager is very supportive and they know how to make us feel valued."

There was a staffing structure in the home which provided clear lines of accountability and responsibility. In addition to the registered manager and deputy manager there were unit managers, who were registered nurses, who were supported by a team of care staff. The skill mix of staff meant experienced staff were available to support less experienced staff. Staff were clear about their role and of the responsibilities which came with that. Catering, domestic, administrative and maintenance and activity staff were also employed. Each had a head of department who met with the registered manager and nursing staff each day to share pertinent issues affecting the care of the people who lived at the home.

The registered manager and provider promoted an ethos of honesty, learned from mistakes and admitted when things had gone wrong. This reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment. For example following a significant incident at the home, the registered manager had worked in partnership with other authorities and had implemented systems to reduce the risk of the incident happening again. Areas for improvement were identified and shared with staff and additional training had been arranged.

Regular meetings were held for people who lived at the home and their relatives/representatives. Meetings provided an opportunity to inform people of any changes or events which had been planned. The minutes of a recent meeting showed that people's views were encouraged and responded to. For example, following a vote people had chosen to change the entertainment provided and their request for an alternative was responded to. A relative said "I have been to a residents meeting where they discussed activities and asked

what people wanted to do." Another relative told us "There are regular meetings and I have also filled in questionnaires and made suggestions. We asked for a sensory room and have been told there is going to be a sensory garden. They also intend to buy some sensory equipment as a result of our suggestions."

There were quality assurance systems in place to monitor care and plan on going improvements. There were audits and checks in place to monitor safety and quality of care. We saw that where shortfalls in the service had been identified action had been taken to improve practice. The registered manager also carried out regular unannounced out of hours visits to monitor practice. All accidents and incidents which occurred in the home were recorded and analysed and action taken to learn from them. This demonstrated the home had a culture of continuous improvement in the quality of care provided.

In accordance with their legal responsibilities, the provider had conspicuously displayed their previous inspection rating both in the home and on their website and had informed us of significant events.