Barchester Healthcare Homes Limited

Ottley House

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Requires Improvement
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

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, and to provide a rating for the service under the Care Act 2014.

This inspection was unannounced and we visited the home over two days.

Ottley House is registered to provide accommodation and nursing or personal care for 72 people. People were cared for in two units Ann Carter and Memory Lane. The service was meeting the requirements of the Health and Social Care Act 2008 prior to this inspection. There were no enforcement actions being taken against this provider. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

Summary of findings

We found the provider needed to make improvements to ensure people's needs were met and they were safe. We saw a person requiring one to one support left unsupervised and staff unclear about their role in supervising this person, placing that person and others at risk. Staff had not followed the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards; this meant that some people were potentially unlawfully having their movements restricted. We saw one example where a person was potentially being deprived of their liberty. Staff did know how to spot the signs of abuse and knew who to refer these concerns to when they happened.

We saw that staffing levels were suitable but the way in which the leadership team had deployed staff meant there was no effective way of making sure people had continuity of care. Recent changes to the rota system meant that staff were now clear about when they should come to work.

The support and training that staff received needed to be improved. Despite the provider having training resources and supervision procedures in place they had not been followed by the registered manager. As a result staff told us they felt unsupported and lacked direction.

We found that people's experience of meal time varied considerably on each unit and improvements were needed to make sure that meals and drinks were served for people in a respectful and dignified manner. Improvements had been made to the way the staff assessed and recorded the risk to people when not being able to eat and drink a balanced diet.

We found that people were not always treated with respect, dignity or consideration. This was particularly evidenced in Memory Lane unit where people's care needs were not consistently being met. Most of the relatives and people who used the service told us they thought the care was good but staff were rushed at times.

People we spoke with told us they did not have confidence in the registered manager when dealing with complaints. They did however acknowledge the provider had a system in place to deal with complaints and if complaints were escalated to senior managers in the organisation they were addressed.

This service was under internal scrutiny by the provider because they had identified that it was failing to meet their required standards. We found breaches of regulations during this inspection that meant the service was not meeting the required standards of the law. The service lacked effective leadership.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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 always safe.

People told us they felt safe living in this home but we found there were improvements needed to make sure that all of the people who lived there were safe and free from harm.

There were systems in place that should make sure that people were not deprived of their liberty, however we found that not all deprivations had been identified and managed. This meant people were potentially being deprived of their liberty without permission.

Staffing levels were assessed and suitable based upon people's needs but the way in which staff were deployed meant that people did not always get the care and supported they needed.

Is the service effective?

Inadequate 

The service was not always effective.

Staff we spoke with did not have the supervision and training they needed to help them deliver effective care and support for people. Improvements were needed despite the provider having a system for supporting its staff in place.

Improvements had been made to the way in which the service assessed people's individual risk in relation to eating and drinking a balanced diet. The quality of the dining experience varied considerably for those people who used the service and were living with dementia.

Is the service caring?

Requires Improvement 

The service was not always caring

We saw some good examples of care during our visit but we also saw some examples of care that meant people were not treated with consideration or dignity. The provider needs to improve the way in which it supported people who used the service.

People we spoke with told us that staff talked to them about the care and supported they needed. For those people who lived with dementia we found improvements were needed so that people would be included in the planning and decision making in their care.

Is the service responsive?

Inadequate 

The service was not always responsive.

Summary of findings

We spoke with people about how the staff responded to their care needs. Most of the people we spoke with said they were happy but some people said that they would like staff to respond more quickly, take account of their individual needs and provide them with more stimulation and activity.

People told us they knew how to make a complaint, however not all the people we spoke with were confident their complaints would be listened to by the management team in the home. People told us that only when senior managers within the provider's organisation became involved that changes happened.

Is the service well-led?

Inadequate

The service was not well-led.

People who used the service, their relatives and staff told us the service lacked effective leadership. This was a home under 'focus' from the provider because their own internal systems had already recognised the failings in the service. The improvements had yet to take place.

Staff told us that the leadership and support from the registered manager was not good. They told us they lacked focus and direction and they found working in that environment demoralising.

Ottley House

Detailed findings

Background to this inspection

The inspection team consisted of two inspection managers and one expert by experience. An expert by experience is a person who has personal experience of using or caring for some someone who uses this type of care service. Our expert had particular experience caring for a person who had dementia.

The last inspection of this service took place July 2013. At that time the provider was meeting the requirements of the law.

We looked at the information we held about the service prior to the inspection. This included statutory notifications; information about how the service managed allegations of abuse and the provider information return (PIR). This document was requested from the provider and gave us their interpretation and evidence about how they feel they are meeting the five questions.

At the time of this inspection the service had been identified as a 'focus home' by the provider. This meant that prior to our inspection, they had identified the service was not meeting the standards they expected. Extra resources had been provided to help the registered manager make the necessary improvement and this included support from another manager. In the report we refer to both the registered manager and support manager to reflect this.

We spent time during the visit speaking with the registered manager and a supporting manager, the divisional manager, regional manager and the provider's regulation manager. We also spoke with eight care staff and three nurses, four friends and relatives of people who used the service and ten people who used the service. We also spoke with commissioners of the service after our visit.

We reviewed six people's care records as part of our pathway tracking process and we spent time observing the care and support people were given. We looked at the records the provider had to show how they assessed the quality of the service they provided and how they made sure there were enough staff on duty to care for people.

Care was provided for people in two units Ann Carter and Memory Lane.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Inadequate

Is the service safe?

Our findings

We looked at the information we held on the service prior to our inspection. Since January 2014 there had been six referrals made to the local authority using their safeguarding powers. The outcome of those investigations resulted in improvements in the way the provider managed people's nutrition and hydration within the home. We spoke with staff and could see they had an understanding of what abuse was and who they would report any suspected abuse to. One staff member said, "We were so concerned about one of the residents we called the safeguarding team ourselves to get help."

Some people who used the service did not have the ability to make decisions about some aspects of their care and support. The Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) set out the requirements that ensure where appropriate; decisions are made in people's best interests when they are unable to do this for themselves. We spoke with the registered manager about when an application to deprive someone of their liberty should be made. The registered manager told us they had recently reviewed all of the people who used the service and would be making 50 applications.

We spoke with staff to confirm their understanding of what a deprivation of someone's liberty may mean in practice. Staff told us they had not received training in this area but they knew it was being organised. Some of the staff we spoke with did not know what this meant and did not know what would constitute a deprivation of a person's liberty.

During our visit, we had called for staff assistance when we saw one person had slipped from their chair. Once the person had been made safe we spoke with the person in charge. They told us that usually a lapbelt was placed on this person to prevent them from slipping out of the chair. We were also told that a member of staff unfamiliar with the person's needs had taken it off and this action had caused the person to slide. We looked at the care records for this person. We found no reference in any record instructing staff to use the lapbelt. We spoke to care staff who confirmed that the belt was used. No application to deprive this person of their liberty had been made. The nurse in charge made an urgent application to the Local Authority on the day of our visit. We spoke with the registered manager about this and they confirmed that this person was not one of the 50 people they had identified as requiring an application. This meant that despite a system being in place to prevent people being unnecessarily deprived of their liberty it was not working effectively for all people who used the service. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Staff had failed to recognise that restraint was being used and put arrangements in place to protect people.

We also observed the care and looked at the care records of a person who needed support by staff on a one to one basis. We found that staff were not always clear about who should be doing this and when. Staff had made their own system to record this themselves. The person needed to be observed for 12 hours per day but staff did not know when this started or ended. We asked staff about how the one to one support should be given, we were told, "As long as we can see them, they're okay." We asked why the person needed this level of support and we were told, "Because they are agitated and aggressive at times." We saw the person walking around the unit arm in arm with another person who used the service. They were unobserved because the care worker who identified themselves as doing the one to one observation was helping another person at this time. This meant that staff had failed to protect not only the person who should have been observed but the person they were escorting around the unit. We spoke about this with the registered manager and they told us a new system of recording would be put into place so that staff would be clear who was doing 'one to ones'.

We looked at the systems the provider had in place to make sure there were enough staff on duty. We found that each person had an assessed dependency level and this was considered when staffing levels were decided. We saw evidence of this in practice during the visit. We spoke to a manager who told us that staffing rotas had been a 'mess' and required a lot of work to get them right. The manager also confirmed that whilst they were satisfied the number of staff on duty was correct they still needed to do further work to make sure that the skill mix was effective so that the right people with the right skills were on duty. When we spoke with staff they confirmed that over recent months (January to July 2014), the staff rota had caused them concern because staff had not turned up for work when they should have and vice versa. This meant that some shifts had not been covered and others had extra staff. This in turn had led to an increase in the use of agency staff and

Inadequate

Is the service safe?

affected the continuity of staff and consistency of care for people who used the service. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Staff were not always suitably skilled or experienced to care for people who used the service.

Inadequate

Is the service effective?

Our findings

We spent time talking with staff about the training and support they were provided with. They told us that over recent months training had reduced. One person said, "I'd say since January it's been on the slide and we haven't had any, training here used to be excellent." We asked staff if they had the opportunity to have a one to one conversation with a supervisor. The staff were unanimous in telling us they did not. One person said, "I'm dying for supervision, there are so many things I can see that we could do better, I just need an opportunity."

We spoke with the support manager about the lack of training and support for staff. They told us that they had identified that standards had dropped and training had not been kept up to date but following an internal audit they had now produced an action plan to get things back on track for staff. On the days of our visit some staff were taking part in training. The manager showed us records which included plans for more staff training. The registered manager told us that no staff had had a supervision since January 2014. This meant that despite a system being in place from the provider to support its staff it was not working in this home and staff did not feel supported. This was a breach in Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Staff did not receive the training, supervision and appraisals that would enable them to work effectively at the service.

The provider had produced menus for people so that they were aware of the menu choices for the day, and this included alternative choices for each day. We observed lunchtime on both units. We found a marked difference in people's experience. People who on Ann Carter unit, were seated at tables that were laid with cutlery, wine glasses, napkins and condiments. We saw that each person was offered a choice of red or white wine with their meal. The meal time experience was unhurried and people were laughing and chatting with one another through out.

For those people who were eating their meal on the Memory Lane unit, the experience was very different. We saw 10 staff gather at the food trolley in the dining room, there were 10 people seated at the tables in the dining room. This made the room very cramped. The tables were not laid; there was no cutlery or glasses for people to use. We saw that all staff were rushed and confused about which person had eaten what meal. We saw three people sat at one table, two of them had a meal the other person did not. They were told, "Your care worker hasn't got to you yet." They continued to wait 10 minutes and watch the others eating. No one on Memory Lane was offered a glass of wine with their meal; no one had a choice of being able to use a mug or glass. Every person was given a plastic winged beaker. Every person had a beaker of tea and juice with their meal. We did not see staff ask people if this was what they wanted.

We saw one person being supported to eat their meal by a member of staff; the experience lasted approximately three minutes. During that time there was very little interaction from the staff member. The food on the spoon was in such great quantity the person was barely able to get it into their mouth.

We saw another person had their eyes closed before staff arrived to help them. The staff did not speak with this person but they lifted them up the chair so quickly it made the person jump. Staff responded by saying, "It's alright don't worry." Staff members were talking over the top of this person as they began to feed them. The person seated in the chair closed their eyes and disengaged with the process. The staff member then offered a cup of tea and juice one after the other until it had gone.

We asked staff if meal times were always as busy at this, one person said, "There's a 150 million things going, it's always like this." This meant there had been a breach in Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Staff did not treat people with consideration and people were not treated with respect

Prior to our visit we looked at the information we held about how the service supported people to have sufficient food and drink. We did this because following an investigation by the Local Authority under their safeguarding powers said the system needed to be improved in order to protect people from dehydration, unplanned weight loss and malnutrition. We found that improvements had been made. There were better systems in place to record the amount of fluid and food people were consuming.

We saw in people's records that information was kept up to date and staff could demonstrate where they had taken

Inadequate

Is the service effective?

action where changes in people's conditions had been evident. We also saw that each person who used the service was assessed by the staff to determine the risks associated with nutrition and hydration.

We spoke with people about how they were supported by staff to maintain good health and access to other healthcare services. People told us they were able to see their GP when they wanted to and if they needed help from a specialist this was done. We saw how people had been visited by specialists that included Speech and Language Therapist (SALT), Dieticians and Physiotherapists.

We spoke with one person about their sore skin; the person had developed a small pressure sore. They told us and we saw from records that the nurse who specialised in skin care had been contacted and had visited them. Staff had recorded the advice from the specialist into the person's care records for staff to follow. We saw evidence that showed staff had followed this instruction and the person's skin was beginning to get better.

Requires Improvement

Is the service caring?

Our findings

People we spoke with said the staff treated them with kindness and compassion. Some people gave us examples of how the staff had supported them to maintain links with the community and spend time away from the home. People told us they were involved in decisions about their care and treatment. One person told us, "I speak with the staff regularly and I am satisfied the care I get is what I want." However we also spoke with two relatives, one of whom said, "The care has deteriorated and this makes me feel bad, the care isn't to my standards but other homes are a lot worse. I am about 60 – 70% satisfied with the care here." Another relative told us, "The staff are too rushed at times but they do care," and "I don't always trust that they will give my [relative] all the care they need." One relative told us that their mother's care was poor at times.

We spent time observing the care and treatment people received on the Memory Lane and Ann Carter units. On Memory Lane we saw people were not always treated with respect or dignity. We saw one person was sliding out the chair where they were seated. The person's clothing had risen up and exposed their underwear. We saw three members of staff in the same room talking amongst themselves and did not help the person until we intervened. The person then had to wait for further assistance because staff were unable to find the hoist to safely move them.

We saw eight people walk around the Memory Lane unit without footwear, some were wearing only socks and one person had bare feet. One person walked around the unit and outside into the courtyard area still only wearing socks. People's clothing was soiled and their general appearance was 'dishevelled'. We saw another person try to remove their clothing in the lounge area; they almost exposed their genitals before staff intervened. One relative we spoke with told us when they saw their relative's feet, it was clear that no care had been given, the feet were dry and crusty and their toe nails had not been cut.

When we arrived on Memory Lane unit we saw two people in a side room together but they could not get out, we did not know how long they had been in the room on the day of our inspection. We asked why they were in there, staff told us, "The lock on the door is broken, been like it for two weeks now, the manager knows." We were with a manager from another home who was supporting the registered manager. They took action immediately to free the people from the room and have the lock on the door repaired immediately. On another occasion we saw a person repeatedly kick the door of the unit to try and leave, no staff intervened to help them .

On Ann Carter unit, people's experience was different. They told us that staff spoke to them respectfully and answered call bells promptly. We saw staff help one person move from a chair to a wheelchair with staff using a hoist. Staff explained the whole procedure and put the person at ease throughout the whole manoeuvre.

We looked at six people's care records as part of our pathway tracking process. This process helped us judge if people were getting the care and treatment they needed. We saw that each person was assessed by staff for their risk of injury from falls, from developing pressure sores, malnutrition and dehydration and risks involved when people need to be moved with assistance. Staff told us they had time to read these care records but they said at times the care plans were confusing and contradicted themselves and did not give clear guidance. We saw one example where a person's communication care plan could have been written better. The person's first language was not English, staff had written in the care plan, "Staff to speak slowly in English". When we spoke with staff about this they told us of a variety of ways in which they communicated with the person, none of these were included in the care plan. They told us they got the information about care from people who used the service and staff handovers. Clear care plans would be helpful for new staff in order to understand the person's care needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. People did not always get the care and support they needed.

Inadequate

Is the service responsive?

Our findings

We spoke with people about the care and treatment they received. Most of the people we spoke with said they were happy with the care and felt the staff team did a good job of meeting their needs. One person told us they had struggled to get staff to give them medication when they wanted it. This problem tended to be worse when agency workers were on duty because they did not understand the person's needs. We saw evidence of how this lack of knowledge placed someone at risk when we observed a person sliding out of a chair. The agency worker had undone the lapbelt that would have usually kept the person safe from sliding out of the chair because they were not aware of the person's needs. We spoke to staff about this and we were told, "It was undone because you're here." This action had not been challenged by staff and as a result had meant a person was placed at risk.

On the two days of our visit we saw activities taking place. People told us, "This sort of thing doesn't usually happen." When we spoke with staff about how people were occupied during the day, one person said, "Things only happen when there are special visitors in the building like you, there's nothing usually going on." We saw people on the Memory Lane unit had very little in the way of stimulation. We saw one person kicking the door to try and get out. We saw people walking round and round the unit and no one spoke with them. Most people sat in their armchairs with their eyes closed. One relative told us, "There's nothing for them really to take part in, I don't think they know what to do for [relative]."

The provider had employed staff to carry out activities within the service but staff told us their time was limited and often meant they were unavailable to support people. One member of staff told us, "The activity board outside is a work of fiction, it never happens."

We spent time speaking with people and their relatives about how the service responded to their concerns and complaints. People told us they were not confident that the management within the service acted on what they had told them. One person told us, "I have no problem telling the manager what the issues are and I follow the process but it just feels like it goes nowhere, you never hear anything."

We spoke with staff about how they managed people's complaints, they told us they were happy to listen and to try and resolve issues when they arose but they felt unsupported by the management in the home. One person said, "It would be nice if they came to us and spoke to us so that we knew we'd done something right."

We were also told by people that if any effective action was to be taken it was usually by the senior management within the organisation. One day of our visit we saw the Regional Director meeting with a relative. The relative had taken their concerns to the Director because they felt no action had been taken by the home management.

We saw throughout the home there was information available for people, informing them about how they could complain and who to. The provider had a system in place that enabled them to review complaints and record investigations that had taken place. We also spoke with the Regulation Manager for the organisation. They told us how the information from people's complaints was used by their team and formed one of the triggers that would mean their own inspection team would visit a home and look at issues under more scrutiny. This meant that although there was a system in place for people to raise concerns, people were not always confident they would be listened to.

Inadequate

Is the service well-led?

Our findings

The service was not well-led. It lacked strong leadership and staff felt they lacked direction. We spoke with the Divisional, Regional and Regulation Managers during this visit. We were able to see from the evidence they showed us that the provider's systems had identified problems within this service in January 2014. There had been a number of actions taken to help improve standards within the service. We were shown a copy of the provider's most recent internal inspection report dated 26 June 2014. The provider had identified issues with staffing levels and deployment of staff. They knew that staff training and supervision had reduced and had asked the manager to take action to put this right.

The internal report also highlighted the poor experience of people during meal times and shortfalls in the care records of people who used the service. We saw the action plan the registered manager had submitted and we were able to see some of the improvements had been made, although the findings of our visits showed that further improvements were needed. We saw evidence that showed us the completed audits of people's care records. This had meant records were being updated to reflect people's current care and support.

Despite the fact the provider had identified shortfalls in the service provision, the actions they had put into place had not been effective. We found that people were unnecessarily deprived of their liberty, they were not always respected and staff were not supported in carrying out their roles.

People who used the service were invited to comment on the quality of the service they received in a number of ways. They could complete an on line survey that produced an annual report called 'Your care rating'; this report was published and accessible for the public to read. The themes from the last report were reflected in this report in that people felt that staff were rushed, at times they were not treated respectfully and their care needs were not always met. People were also asked to comment and give feedback to the provider through the use of comment cards. Some people told us they did not feel confident that the management in the home would address their concerns. They told us they had raised issues and no action had been taken until senior managers had become involved.

The registered manager told us they had recently introduced the 'stand up' meeting. This meeting was held on a weekly basis with a representative from all areas of the service. It was an opportunity for staff to discuss changes in the service and update them on issues. We spoke with staff about this, not all of the staff knew what this meeting was or what it was for. One person said, "I know they have meetings but you never hear anything from them." Another person told us, "I would love the opportunity to talk to the top managers, they come round but they don't talk to us and we have some good ideas to share." We spoke with the senior managers about this. One manager told us, "I very much want to speak to all the staff, having only recently taken over this area I am making my way round everyone. I want to hear what they say."

We looked at the system in place for reviewing accidents and incidents. The registered manager reported accidents and incidents appropriately and once a month this information was scrutinised by the governance and regulation teams in the organisation. All information about safety, accidents and incidents was analysed and formed a RAG (Red, Amber, and Green) rating for the service. The information the provider had received about this service had meant the risk of not meeting standards was high and as a result it had been identified as a 'focus home'. This meant the provider knew the shortfalls in service provision and had taken steps to address this.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **People did not always get the care and support they needed.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **Staff had failed to recognise that restraint was being used and put arrangements in place to protect people.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **Staff did not receive the training, supervision and appraisals that would enable them to work effectively at the service.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **People were not treated with consideration or respect**