Otterburn Health Care Limited

Otterburn

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We carried out this unannounced inspection on the 06 April 2017. Otterburn provides nursing care and support for up to 30 people who may be living with a range of neurological conditions. At the time of our inspection 30 people were residing at the home. The home is divided into three separate units, that accommodate ten people each.

We undertook a comprehensive inspection of this home in November 2016 when we identified that improvements were needed throughout the service. We judged the home to require improvement in all five of the key questions we inspect. [Is the service safe, effective, caring, responsive and well led?] The registered provider had breached three of the legal regulations. This was because the systems in place to monitor the safety and quality of the service had not been effective, people could not be confident they would receive safe care and treatment and people could not be certain their needs relating to nutrition and hydration would be well met. We issued a warning notice in regard to the legal breach about Governance. Warning notices are one of our enforcement powers. This inspection was planned and undertaken to look at the key questions of safe and well-led, to check that the action required in the warning notice had been taken, and to provide assurance that people using this service were now safe and receiving a good quality service.

This most recent inspection identified that the requirements of the warning notice had been met in full, and that people could be more confident that their needs would be met and their safety maintained. We received positive feedback about the difference this had made to people's quality of life and safety. We did not look at the action taken to meet the requirement about nutrition and hydration. The registered provider had produced an action plan informing us that improvement had been made. We will look at this in detail at our next inspection.

We undertook this focused inspection to check and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for (Otterburn) on our website at www.cqc.org.uk.

The home did not have a registered manager. 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 provider had recruited a new manager and we were informed that they had commenced the process of applying for registration. Throughout the time the home has been without a registered manager, the registered provider had arranged for another senior member of staff to be in day to day control of the home.

We looked at risks people were exposed to that were related to their health care needs and lifestyle choices. These had been assessed using professionally recognised tools, and had been kept up to date. The checks

we made confirmed that people's needs in relation to falls, choking, malnutrition and dehydration, and the risks relating to them developing sore skin had been well managed. We observed staff providing care consistent with the written plans, and staff we spoke with had a good knowledge about how to keep people safe.

Everyone told us that the management team had made a positive impact on the quality of care, environment and atmosphere of the home. People, their relatives and staff told us they felt able to approach the management team with concerns or feedback. People had been supported to provide feedback about their experience of using the service.

The systems in place to monitor the quality and safety of the service had been mainly effective. The management team and systems in place had driven improvement throughout the service and ensured that changes were taking place in practice and becoming embedded. The inspection identified some instances where the audits and checks had not been entirely effective, and where further work and time was required. While these issues did need to be addressed to ensure people's needs were well met, the issues identified would not have had such a significant impact on people's safety as we had found in previous inspections. People could have greater confidence that they would receive a good, safe service that would meet their needs and wishes.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People could be more certain that the care provided would be safe, and help them to maintain good health.

Most people received their medicines as prescribed, supported by staff who used safe medicine management techniques. Further work was needed to ensure the good management of medicines administered to people directly into their stomach.

People could be confident they would be supported by adequate numbers of staff who knew their needs well.

Is the service well-led?

Requires Improvement

The home was not always well led.

Systems to monitor quality and to drive forward improvements had been used and had been effective at ensuring many changes occurred. Further work was required to ensure these checks were entirely effective.

People, relatives and staff had the opportunity to feed into the way the service was run and developed.

Otterburn

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The unannounced visit was undertaken by three inspectors.

As part of the inspection we looked at the information we had about this provider. Providers are required to notify the Care Quality Commission [CQC] about specific events and incidents that occur including serious injuries to people receiving care and any safeguarding matters. Appropriate notifications had been sent by the registered provider. We also spoke with service commissioners (who purchase care and support from this service on behalf of people who live in this home) to obtain their views. The registered provider produced an action plan after our last inspection. All this information was used to plan what areas we were going to focus on during the inspection.

During our inspection we spoke with five people who used the service and five relatives. We spoke with the manager who was in day to day charge of the home, the clinical nurse manager, the regional manager, three registered nurses, at length with five care staff and one maintenance staff. We completed a SOFI (Short observational tool for inspection). SOFI is a way of recording the experiences of people who may not be able to talk with us.

We sampled some records including parts of four people's care plans to see if people were receiving their care as planned. We sampled records maintained by the service about quality assurance. We sampled the management of medicines on two of the three units of the home.

Requires Improvement

Is the service safe?

Our findings

We last inspected this service in December 2016. During that inspection the evidence that we gathered confirmed that people were not consistently receiving good, safe care. We had brought these concerns to the attention of the registered provider at our previous inspection, and although action had been taken, this had not been adequate to fully address the concerns. We required the registered provider to take action to address these shortfalls. During this inspection we tested the changes and improvements the registered provider had made. We found that people were receiving much safer care. Risks people experienced related to their health conditions or lifestyle choices had been assessed, the risks and actions required by staff had been kept under review. The care and support we observed was consistent with people's known needs. The feedback during our inspection confirmed that the necessary improvements had taken place.

The people living at Otterburn require the support of staff to safely manage and administer their medicines. We looked at medicines management in detail at our last inspection. We found that people were receiving their medicines as the Dr had prescribed, and that staff administered the medicines safely. A pharmacist from the NHS had audited the medicines just before our last inspection and found them to be well managed. You can read more about the checks we made on medicine at our last inspection in the full version of our last report. At this inspection we did not look at medicines management in detail, but did look at how medicines were managed for five people living at the home. Overall medicines continued to be well managed.

Some of the people whose care we looked at in detail required medicines to be administered directly into their stomach via a tube. We identified that further safeguards to ensure these medicines would be administered safely were required. There was no recorded evidence of advice from the prescriber or the pharmacist and there were no written protocols in place to inform staff on how to prepare and administer each medicine safely. There was a risk that different staff would administer the medicines in different ways. The absence of these guidelines presented a potential risk to people's health and welfare. The management team agreed to address this.

A new system had been developed for people who required 'homely remedies' [medicines that are used infrequently and to treat minor ailments]. The system would ensure people received prompt treatment that would relieve their discomfort or pain. Protocols to ensure that staff were aware of when and how to use these treatments were not available. Providing these guidelines would ensure the medicines were always used consistently and as intended.

We looked at aspects of the care provided to four people in detail to establish if the risks associated with their medical conditions and lifestyle choices were being well managed. Overall we found that improvements had occurred, and people could have greater confidence that their needs and related risks would be well managed. People who were at risk of developing sore skin, choking and falls had all had these needs assessed using tools that were recognised by professional bodies. These had been kept up to date, and reviewed when people's needs changed. We observed staff supporting people in the ways described in the risk assessments.

Some people were at risk of developing sore skin. One of the ways to reduce the risk of this occurring is to help the person move and change position. We observed people being supported to move regularly, and staff we spoke with were aware of when people would next require help to change position. At the time of our inspection no one at the home had sore skin, and this was evidence that these measures were being effective. Some people at high risk of developing sore skin had been provided with specialist mattresses on their beds. The mattresses should be set to meet the individual needs of the people using them. This had not been undertaken or recorded. We brought to the attention of the management team the need to ensure the mattresses were set and then regularly checked to ensure they would meet people's needs. Work to address this commenced before the inspection had concluded. While this issue did need to be addressed it had not impacted on the care people were receiving.

The management team had ensured that relevant incidents had been reported as safeguarding to both the Care Quality Commission and local authority as is required. We looked at the action taken in response to some recent staff practice concerns that had been brought to the attention of the management team. While it positive that a prompt and thorough investigation had taken place, no action had been taken to ensure that people would be protected from the risks in the interim between the alert and the investigation hearing. We shared this with the management team in feedback at the end of our inspection.

People told us, and our observations suggested that people felt safe. One person told us, "I find it alright here." Two relatives we spoke with told us, "The staff are lovely, I've never seen or heard anything that has concerned me," and "We have never seen any people being neglected or left alone." During our observations we saw that people looked relaxed and calm. When possible people enjoyed the interactions and contact with staff, and people's facial expressions showed they were happy to see the staff, as they approached them. Staff we spoke with demonstrated a high regard for the people they were supporting and were clear that abusive, unkind or neglectful practices would not be tolerated. Staff we spoke with told us, "There's some really nice care offered here. There's never any nastiness." A new member of staff told us, "There isn't anything that causes me concern. The staff I have worked with have been very, very kind." Staff confirmed that they had received safeguarding training as part of their induction and that this was updated with refresher training on a regular basis. Around the home there were posters, information leaflets and policies that would guide anyone wishing to raise a concern. Staff we spoke with told us, "If I did have any concerns about safety or problems I would feel confident to report it to the nurse or manager." This ensured people would receive the support they required as well as informing the relevant authority who may need to investigate the matter to further safeguard people.

Many of the people we met were unable to stand or walk independently and relied on the support of staff and specialist equipment to change position or to move. We observed staff working with people to help them mobilise. The interactions of the staff were kind and encouraging. We saw staff use the hoist to lift people. The staff undertook these manoeuvres carefully and while offering reassurance to the person. Some people were at a high risk of falling. Specialist assessments had been completed to determine the level of risk and the support people needed to stay safe. We saw people using the equipment the assessments stated, and people being cared for in bed that had their bed at the height agreed in the risk assessment. Some people had been assessed as needing bed safety rails. The use of these had been carefully considered, and we saw checks regularly took place to ensure they remained safe to use.

Some people were at risk of not eating or drinking enough. Monitoring charts had been put in place for staff to record when the person was offered food or drink and if they had taken this. These had been kept up to date and showed people were supported to eat and drink enough to maintain good health. People's weight was also regularly monitored as a way to ensure they were eating enough calories. We identified that some people needed more of certain food types [such as protein] to help them maintain good health. The records

made and checks undertaken did not show that this aspect of their nutrition was being met. Some peoples' medical condition meant they were at an increased risk of choking. They required the texture of their food to be altered to help manage this risk. The staff had sought advice from specialist healthcare workers and we observed that the food offered, equipment used and support given was consistent with the written guidelines. Staff we spoke with were knowledgeable about people's eating and drinking needs and were also able to describe how they would respond in the event of an emergency.

People we met who were being cared for in bed had call bells within their reach. During the day we heard call bells ringing, and these were answered promptly. Our observations identified that adequate numbers of staff were available within the home to support people with direct care, and with non-care tasks such as keeping the home clean. When people became unsettled we saw that staff responded promptly and calmly and helped people to find something to do that helped them relax. People we spoke with told us that the number of staff had improved in recent months. A relative told us, "There's enough staff here now." Staff we spoke with told us, "Staffing has improved, we don't use agency much anymore." At previous inspections we found that staff moved between the three units of the home, and were not always confident about the current needs of the people they were supporting. Action had been taken to address this, and the staff we met and spoke with all had an in-depth knowledge about the people they were supporting. People were supported by adequate numbers of staff who were clear about their responsibilities and the needs of the people they were supporting.

We looked at the provider's recruitment practice at our last inspection in December 2016. We found then that the necessary checks were made on staff before they were offered a position within the home. We did not look at recruitment practice again during this inspection, however we did speak with one recently recruited member of staff. They confirmed that the necessary, robust checks had been made, and told us, "I had to complete an application form, interview, DBS and give references. When I started I had seven days classroom based induction, then was allocated to work alongside a team leader." These checks and induction ensures people were supported by suitable staff with the necessary skills to work in adult social care.

Requires Improvement

Is the service well-led?

Our findings

We last inspected this service in November 2016. During that inspection we found that the systems to monitor the quality and safety of the home [Governance] had not been effective. The impact of this on people was significant, as people could not be certain they would consistently receive a safe or well managed service. We issued a warning notice. This is one of our enforcement powers. The warning notice required the registered provider to take urgent action to improve the governance of the home. During this inspection we tested the changes and improvements the registered provider had made. We found that improvements had occurred in both the operation and culture of the home. The requirements of the warning notice had been met. Although improvements needed to continue we do not intend to take any further enforcement action at this time.

The registered provider had an extensive range of audits and checks to use within the home to ensure it was operating safely and offering people a good quality service. We found that these had been mainly effective at driving forward change and monitoring the quality and safety of the service. We did however identify some issues at the time of inspection that the audits had failed to identify and address. We tracked the action taken by the staff in response to issues identified during the walk around audits of the home, and issues reported in the communication book. While some tracking showed that prompt action had been taken to resolve the issue other matters had not been picked up in relevant audits or checks. These examples did not give us full confidence that the systems in place were entirely effective or working as well as the registered provider had intended. We did note however that the majority of audits and checks we looked at had enabled the management team to check, find and fix many of the issues within the service, and to provide themselves with assurances that the service was operating well.

The registered provider had recruited and employed a new home manager. They had been in post for four weeks at the time of our inspection. The manager confirmed it was her intention to apply to register with the Care Quality Commission. In recent months the registered provider had appointed a member of senior staff to be in day to day control of the home. They had been supported by the operational manager. People we spoke with were not all certain about the recent changes in management. One staff member told us, "The management of the home has been 'topsy turvey', but now it is improving. We have a strong team at the top." A person living at the home told us, "I have no idea who the new manager is, we have not met them yet." Some relatives we spoke with did know who the new manager was, and others were unsure. The work to introduce the new manager to people using the service, relatives and staff needed to continue to ensure everyone was fully informed about who is leading the service. Our inspection provided us with assurance that positive changes to the management of the home, to clinical leadership and to unit leadership were taking place. We found these changes continued to need time to become established to ensure that the leadership and governance of the home was consistent and effective.

Relatives explained to us some of the changes they had seen taking place recently in the home. One relative told us, "Things have really got better in the past few months. The care is good." Staff we spoke with confirmed that changes and improvements had been made. They told us, "Everybody is just trying a bit harder," and "I've seen a definite improvement." When we asked the staff member to explain this they went

on to tell us they had seen improvements in the menus, nutrition, the premises and the number and morale of staff. One of the health professionals we spoke with described the positive changes they had observed and the impact these had made on the care and safety of the people they treated at the home.

People and their relatives had been consulted and involved to some extent in the changes and development of the home. We saw minutes of meetings and forums where the management team had consulted people and kept them up to date about changes occurring within the service. A relative told us, "The carers often ask if we have any problems, but we haven't." Other ways that the management team had tried to involve and inform people included a "You said-we did" board in the entrance to the home, and a suggestions box in the foyer where people could leave comments or feedback.

Registered providers are legally required to display the rating awarded by the Care Quality Commission. The most recent rating was on display within the home and on the provider's website. This demonstrated transparency, as well as an understanding of the legal requirements.