Barchester Healthcare Homes Limited

Overslade House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected this service on 2 July 2018 and returned on 3 July 2018. On the first day of our inspection we arrived at the home during the afternoon, we stayed throughout the evening to get a better view of the service during the evening and when the staff changed to the night shift. The inspection was unannounced on 2 July 2018, and we told the registered manager that we would return on 3 July 2018.

Overslade House is a 'care home' operated by Barchester Healthcare Homes Limited, who are a large provider of care services. Overslade House is a purpose-built home which provides accommodation with personal and nursing care for up to 89 adults, including people living with dementia and physical disabilities. End of life care is provided at the home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Of the 89 beds, 15 are contracted by the local Clinical Commissioning Group (CCG) for people discharged from hospital and in need of personal and nursing care. Ten of these beds are offered on a 'Discharge to Assess' basis; for an initial six-week assessment period. The home is split into three units. At the time of our visit, there were 79 people living at the home.

A requirement of the services' registration with us is that they 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. There was a registered manager in post at the time of our inspection visit.

We last inspected this service on 4 January 2018 to undertake a planned comprehensive inspection. We then returned on 16 February 2018 because we were made aware of a serious incident which had taken place in the home. At that inspection, we rated the safety of the service as Requires Improvement because there was an on-going external investigation into the serious incident that had occurred. We gave the service an overall rating of Good.

We undertook this inspection following further information of concern received. This inspection focused on two key areas; the safety and governance of the service. At the time of this inspection, the investigation into the serious incident remained on-going.

Overall, staff knew how to keep people safe because risks were assessed and actions implemented to mitigate risks of harm or injury. However, staff did not always recognise when people's behaviours or their own practice created risks that could compromise people's safety. This meant some risks were not assessed which could put people at risk of harm or injury.

People had their prescribed medicines available to them. Medicines were given to people by trained staff.

Staff understood their responsibilities to protect people from the risks of abuse. Staff had been trained in what constituted abuse and would raise concerns under the provider's safeguarding policies. The provider checked staff's suitability to deliver care and support during the recruitment process. Staff received training and, overall, used their skills, knowledge and experience to provide safe care to people.

People and their relatives had no complaints about the service. However, some people and relatives felt more staff were needed because at times staff took over five minutes to answer call bells.

Staff on shift met people's individual needs, however, staff were very busy and rushed. This had been recognised by the provider who was recruiting to an additional nurse post for day shifts.

The registered manager and provider had systems in place to monitor the quality of the service people received. Increased spot checks had been implemented following a serious incident that had occurred so the provider could be assured there was a more robust quality assurance process within the home.

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?

Requires Improvement

The service was not consistently safe.

Most risks were assessed and plans were in place to reduce risks of harm or injury. However, this was not consistent.

Staff were safely recruited and people's needs were met by trained staff. Management had recognised that staff were very busy on shift and recruitment was underway for an additional nurse post during the day. People had their prescribed medicines available to them. The home was clean and well presented.

There remains an on-going police investigation into a serious incident at the home.

Is the service well-led?

Good

The service was well led.

Quality assurance systems and processes were in place to assess the service provided. The management team had implemented increased quality assurance to monitor the quality of the service following a serious incident that had taken place in the home. Spot checks were undertaken by management to ensure staff followed policies and implemented knowledge and skills from their training. People, relatives and staff felt the management were approachable.

Overslade 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 focused inspection took place on 2 and 3 July2018. The inspection was unannounced on 2 July 2018 and we told the registered manager and regional manager we would return on 3 July 2018. Further opportunity for people and staff to give us feedback about the care provided at Overslade House was given by us displaying a poster displayed in the home about our inspection visit, together with our contact details. We also sent emails to some staff, asking for their feedback about the service, who we were unable to speak with over the two days of our visit. Two inspectors, one assistant inspector and a specialist advisor undertook the inspection. The specialist advisor who supported this inspection visit had experience and knowledge in nursing care.

Prior to our inspection visit, we received information of concern. An external investigation into a serious incident that took place at the home during February 2018 is on-going. We undertook this focused inspection to look at the safety of the service and whether it was well led.

We did not ask for a Provider Information Return (PIR). This is information that we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. However, during our inspection visit, we gave the provider the opportunity to give some key information about the service, what the service does well and improvements they planned to make.

During our inspection visit, we spent time with people and observed communal areas where people interacted with staff. This helped us judge whether people's needs were appropriately met and to identify if people experienced good standards of care.

During the inspection we spoke with 10 people that lived at the home. We spoke with nine relatives, four care staff, five nurses, the deputy manager, registered manager and the regional manager.

We reviewed six people's care plans, daily records and 11 medicine administration records. This was so we could see how people's care and support was planned and delivered. We also looked at other records, including three staff recruitment files and supervision records, the provider's quality assurance audits and electronic call bell response logs and audits. This was so we could see how the manager and provider assured themselves people received a safe and well led, quality service.

Requires Improvement

Is the service safe?

Our findings

At our last inspection on 4 January 2018 and 16 February 2018, we rated this key question as Requires Improvement. This was due to a serious incident involving a person who had high care needs and was dependent on staff for their care. The incident was the subject of an external investigation which remains on-going at the time of this inspection visit.

People told us they continued to feel safe living at the home and protected from the risk of abuse.

Since the incident, the provider had ensured all staff had completed refresher training in how to safeguard people from the risks of abuse, and how to report any concerns. Staff spoken with could tell us what signs to be aware of that might indicate a person was at risk of abuse, and how they would report any concerns they had. One nurse told us, "If I suspected anyone was being abused, I'd report it straight away to the manager. I'd go further if needed."

Information on how to report concerns was displayed in the home. Posters were accessible to staff and visiting relatives and friends. The information told people how they could 'whistle-blow' to external agencies; the local authority and Care Quality Commission, if needed.

The registered manager and regional manager understood their role and responsibility to alert the authorities should an adult be at risk of harm or abuse. The registered manager told us there had been no safeguarding incidents since our last inspection visit.

Overall, we found risks to people's health and wellbeing were identified and risk management plans were in place for staff to follow. For example, one staff member told us that hourly visual checks were completed on people who were cared for in bed.

However, we found staff did not always recognise when people's behaviours or their own practice created risks that could compromise people's safety. One relative told us about their concerns when they observed staff tilting a wheelchair backwards, whilst a person was lowered into the wheelchair from the hoist. On the second day of our inspection visit, our observations confirmed that staff were using unsafe practices when transferring one person using a hoist. Staff had placed the front wheels of the wheelchair on the hoist and the wheelchair was lent backwards so all weight was on the back two wheels of the wheelchair whilst the person was lowered into the wheelchair. Only then were the front wheels of the wheelchair wheels put on to the floor, giving the wheelchair full stability.

We discussed our observation with staff, who told us they believed the technique they were using was safer than the technique they had been taught in their training. One staff member told us, "This person slides out of the wheelchair when we lower the hoist, so we tilt the wheelchair." We found this person's mobility care plan referred to them as being able to walk, with staff support. There was no assessment of risk in using the hoist and tilting the wheelchair backwards. We discussed this with the registered manager and regional manager who confirmed this moving and handling technique was not taught to staff and staff had not

escalated their concerns about how to safely move this person. The registered manager's spot checks had not identified this poor practice and the potential need for a healthcare professional referral so a safe transferring practice could be identified for this person.

We spoke with another person who independently accessed their bedroom en-suite toilet facility. They told us they did not always feel safe in getting to the toilet and demonstrated how they managed it. The person sat on the side of their bed and held on to the handle of the open bathroom door which used to pull themselves up. The handle and the door were moving and were not a safe aid for this transfer. This person told us they had fallen the previous night, which staff and records confirmed.

Staff told us this person liked to be independent and they were aware of how they were using their en-suite door and door handles to manoeuvre. Staff had not considered reporting this to managers and one nurse told us they had not considered making a referral to a healthcare professional to assess whether grab rails or a walking aid might mitigate risks when this person transferred independently. Staff had instead referred to this person as 'refusing help.' There was no assessment of the risks posed by the manoeuvre used by this person to mobilise.

The provider had a safe system of recruiting staff. We looked at the files for three staff members that had been recruited since our last inspection and saw Disclosure and Barring Service (DBS) checks and references were undertaken prior to staff commencing work at the home. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with people who use services. The provider also checked the registration of nurses with their regulatory body to ensure they maintained their professional registration.

The registered manager told us staffing levels were determined by the dependency needs of people and was confident there were enough staff on shift to safely meet people's needs. They gave us examples of when extra care staff had been put on a shift and during our inspection we saw one person, who was anxious and had behaviours that could challenge, had one to one care support.

Overall, staff cared for people in a safe way and promptly although they were very busy and worked at a fast pace. Night staff felt there were enough staff on shift at night, and they told us, "Yes, we've enough staff." However, daytime nurses felt an extra nurse was needed. One nurse told us, "We never stop, it is always busy." Nurses told us they felt their role was often task orientated and they would like time to spend with people or supporting relatives at difficult times, such as when a family member died. Nurses also gave us examples of when they ran out of time to do some tasks, such as ordering a stock of cream for a person and updating records, because they needed to prioritise people's hands-on care. One nurse told us, "The workload is so much during the daytime, especially with the high number of admissions we have. We need another nurse really."

We received mixed feedback from people and relatives about staffing levels. Overall, people and relatives felt staff worked hard and met people's needs. However, some people shared examples of when they believed extra staff were needed to safely meet people's needs. For example, one relative told us, "My family member has needed to wait over half an hour on several occasions when they needed to be supported to the toilet. The staff are often busy with someone else or tell us they are working on a different unit and cannot support my family member." One person told us, "They could do with more staff."

We discussed the feedback we had received with the registered manager and regional manager who informed us the provider had approved an additional full-time nurse post for the daytime. The registered manager told us, "This will mean there will be four nurses covering the three units during the daytime shifts."

The post had been advertised and the registered manager hoped to recruit soon. The registered manager told us nursing staff were not aware of this staffing increase as it had only recently been authorised. They told us they would inform staff and keep them informed during the recruitment process.

Some people told us that there were times they had to wait a 'long time' for staff to answer their call bell. One person said, "At night you have to be very patient, waiting for staff to come." We looked at electronic call bell logs and found most were responded to in less than five minutes. However, there were occasions when response times were over five minutes and up to 15 minutes. The deputy manager told us they audited the call bell logs and where staff response times had been lengthy, a reason had been recorded. These included 'staff busy with another service user' and 'staff getting lunch ready.' We discussed this with the registered manager and found they had no overall tool to look for patterns of busier times. The registered manager agreed this was something they could do in the future.

The provided had taken action to improve the responsiveness of staff since our last inspection visit. Five hundred extra care hours had been used since January 2018 to increase staffing levels so people could, overall, be responded to in a safe and timely way. The registered manager told us with the further recruitment of an additional nurse post, this would also improve staffing levels.

On the first day of our inspection visit, we stayed into the evening so we could attend handover from the day shift staff to night shift staff. We observed staff handovers on two units and at each handover, both the night nurse and care staff were present. This ensured staff coming on shift had up to date information about the people living in the home. Important matters were handed over such as clinical issues, lack of interaction, sleep patterns, food and drink as well as any issues regarding people's behaviours that the night staff may need to be aware of. For example, one person, living with dementia, had been looking for holes in the floor. When this was handed over, the nurse explained this person used to work in engineering and in their mind, they were tracing pipework. This demonstrated that staff knew people well and that information was effectively shared between the day and night staff.

We looked at how the maintenance of equipment and the premises were managed. One relative told us about their concerns regarding hoist equipment (used to transfer people from their chair to wheelchair). This relative told us of their concerns that related to week prior to our visit. They said some hoists had not been working and they had observed people suspended in elevated hoists while staff had to change battery packs due to repeated charge failures. We discussed this with the registered manager and regional manager. They confirmed that two of the three hoists on one unit had recently broken. Records showed that immediate action was taken to rectify the issues and on the day of our inspection visit all hoists in the home were working and up to date with their six- monthly maintenance checks. There was a maintenance staff member on site to deal with any day to day issues that arose in respect of the premises.

People had their prescribed medicines available to them. Nurses gave people their medicines and told us they had observed checks from the registered manager to ensure they were following safe practices. One nurse told us there were rare occasions when they ran out of stock of a medicine, and such incidents were quickly rectified.

We looked at 11 people's medicine administration records (MAR). These people had all received their medicines as prescribed. However, one person did not have a MAR for the date commencing 3 July 2018 for their blood thinning medicine. The nurse on the unit assured us this person had been given their medicine at the correct time. The nurse said they had not filled in a new MAR, as needed, for the medicine and told us this was on their 'to do' list for the day. The nurse explained an urgent care task had taken priority. Immediate action was taken to implement the MAR showing the correct details of the administration that

had taken place over five hours earlier.

Topical preparations, such as creams, were prescribed for some people. Body maps were available to show staff where creams should be applied on the person's skin and staff had recorded when they applied these had been applied to people's skin.

Some people had medicines prescribed 'when required,' for example medicines for pain relief. Protocols were in place to give nurses guidance on when these should be given which ensured a consistent approach was taken.

Medicines were stored safely and securely. Some medicines required two staff to complete checks and one to be a witness when the medicine was given to the person. We observed two nurses follow the correct legal procedures for administering these medicines, with each nurse signing a special log book after the medicine had been given.

The provider's infection control procedures prevented the spread of infection. Relatives thought the home was well maintained and kept clean and free of any strong odours. One relative told us, "It's always clean here, spacious and airy." The registered manager checked the cleanliness of the home as part of their daily walk round.

We observed two nurses following infection prevention best practices when they prepared two syringes of medicine for injection. However, the worktop surface in one clinic room, where injections were prepared, had one edge of seal missing. This meant effective cleaning could not take place and there was a risk of cross infection. The registered manager was unaware of this, but told us they would ensure a new seal was fitted.

The registered manager and regional manager told us lessons were learnt when things went wrong. The regional manager told us that following the disposal of medicines following the serious incident, the provider had agreed to review their policy on keeping medicines and now planned to keep them until all investigations into incidents had been resolved and not just for 7 days after a person had died.

The registered manager told us 'lessons learnt' meetings were held with staff to communicate important information, such as the correct process for reporting safeguarding concerns.

Good

Is the service well-led?

Our findings

At our last inspection we rated this key question as Good. At this inspection we found the home continued to be led by a management team that was approachable and who checked the quality of care delivered to people, so continuous improvements could be made. The rating for how well led the service is, continues to be Good.

Following a recent serious incident at the home the registered manager, regional manager and provider had put in place additional measures to protect people whilst an external investigation was taking place. This included three daily checks by the registered manager to observe staff practice, and spot-check on people's care records to ensure they were up to date and risk management plans were in place. The regional manager visited the home each week and reviewed the registered manager's daily checks, and progress against any actions identified. However, on this inspection we found two people's risk management plans that were not reflective of risks that staff were aware of, and the manager's spot checks had not identified these issues. When we discussed these concerns with the registered manager, they took immediate action to make referrals to other healthcare professionals and update the care records.

Since our last inspection, the registered manager had organised refresher training for staff in safeguarding procedures and manual handling. The registered manager now personally undertook regular one to one supervision meetings with all staff. Where performance issues were identified, such as when staff did not adhere to the provider's policies and procedures, the registered manager acted to discipline staff. Observational checks were also made on staff to ensure best practices were followed. For example, unannounced spot checks at night had been completed in January, April, and May 2018.

The provider had amended some policies and procedures in response to risk. The regional manager told us learning had been taken from a decision to allow a staff member to work a 16- hour shift. The provider had changed their policy so staff could no longer work more than a 12-hour shift. The regional manager was confident this change in policy would reduce the fatigue of staff, and mitigate the risks of staff making errors due to tiredness.

The regional manager told us the provider had made changes to other procedures at the home in response to investigations into concerns raised. This included the way staff signed care records, and changes to working practices so that records were updated in 'real time' rather than at the end of a shift.

Some people had high care needs and were assessed as needing support from two staff. Since our last inspection, measures had been implemented to monitor that two staff always undertook care tasks where a need had been identified, such as re-positioning a person. A 'wellbeing' form had been introduced where staff had to individually sign their full name rather than enter their initials, which enabled the registered manager to make more vigilant checks.

The regional manager completed regular checks on the quality of the service provided. This was to highlight any issues and to drive forward improvements. For example, the regional manager directed the registered

manager to conduct regular checks on care records, medicine administration and infection control procedures. A care record audit undertaken in May 2018 identified one person did not have a completed life history and action was taken to complete this. Most audits did not have any identified actions because the registered manager believed the quality was satisfactory.

The provider's quality assurance team produced quarterly reports about how the home was performing against business plans. Outside agencies also visited the home every three months to complete clinical audits. Where checks had highlighted any areas of improvement, action plans were drawn up to make the necessary changes. Action plans were monitored for their completion by the provider during regular quality monitoring visits to the home.

External audits by other agencies included reviews by the local authority monitoring team. Any actions identified in these visits were followed up using a service improvement plan. All actions on the service improvement plan were monitored for their completion by the provider. A monitoring visit in April 2018 had identified the need for a phone log of calls to be made, when the registered manager contacted the local authority regarding safeguarding concerns or investigations. This log for phone calls had been implemented.

The registered manager was part of a management team which included a clinical lead, and a supervising nurse on each unit, to support staff with their daily work. The management team acted to mitigate risks when concerns were raised with them.

Information and communication between registered managers across the provider's service was encouraged. The registered manager attended regular monthly meetings with other managers in the group to exchange information, and to learn from each other about events that had happened at other homes. This discussion forum was to assist in finding innovative ways to improve services. For example, the registered manager of Overslade House was piloting an improvement project to recycle cleaning products and improve cleaning practices at the home. The results of the project would be shared to inform control practices across the group.

The values and vision of the provider were embedded in the ethos of the home, which were to put people at the heart of what they did. Staff understood that the home was a 'home for life' for the people so if people's needs changed there was no requirement for them to move to another home. Staff also supported people's relations to cope with the changes to their personal lives. One relative told us, "Staff came to pick me up from my home, so I could be with my family member. Nothing is too much trouble. Staff go above and beyond and are always available. We can stay over if we want too. Staff offer us food and drink. We are always welcome."

There was a positive atmosphere in the home. Staff were encouraged to work within the values of the home, which were discussed with in regular staff meetings, and the provider recognised the contribution of staff to the way people felt about the home.

People, relatives and staff spoke positively about the registered manager. One staff member told us, "My manager even came to change people's incontinence pads with me. You don't get that in other places. It's very good and the manager is very helpful and supportive". A relative told us, "The manager is a lovely person." Another relative said, "Both of the managers are approachable. I have never had a problem."

People or their relatives could give feedback to the registered manager at any time, as they were on site and operated an 'open door' policy. Suggestion boxes and comment books were distributed throughout the

home asking people for their feedback.

The registered manager organised regular surveys to ask people's opinion about the home, and consulted people about any forthcoming changes at meetings for 'residents' and relatives at Overslade House. At each meeting the minutes and actions of the previous meeting were discussed, to ensure people were provided with responses to any concerns or suggestions they had raised. The meetings were advertised around the home, and a senior manager attended. Outcomes from meetings were fed back to people and their relatives via noticeboards around the home.

Efforts were made to keep staff informed of things that happened at the home. Monthly meetings were held for different teams, and the management team included heads of department meetings, health and safety meetings, nutritional support and monthly clinical meetings. Information was shared between staff and managers about different units of the home and relevant information about different departments.

The registered manager understood their role and their responsibilities to report issues and concerns to CQC. They also ensured the rating from our previous inspections was clearly displayed in the entrance area to the home.