Barchester Healthcare Homes Limited

PaterNoster House

Inspection report

Paternoster Hill
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Ratings

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

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 pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

The inspection was unannounced. When we completed our last inspection of Paternoster House on 25 September 2013 we found that the provider complied with their legal requirements in the areas we looked at.

Paternoster House provides personal and nursing care for up to 108 people, some of whom may be living with dementia. The home is required to have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to

Summary of findings

manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider. At the time of our inspection the registered manager had been in post for three years.

People felt that they, or their relative, were safe at the home. The home had taken appropriate steps to protect people from abuse and staff were trained in procedures for safeguarding adults.

CQC is required by law to monitor the operation of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. We found that the service had complied with the requirements of MCA and DoLS.

The steps staff should take to manage the identified risks to people were clearly documented in risk assessments. In the case of checks of people who used bedrails these were not always followed. People were therefore at increased risk of harm because of the failure to complete the checks. This was a breach of Regulation 9 of the Health and Social Care Act 20018 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

People were supported to maintain their health and well-being. Appropriate referrals were made to other health and social care services as was necessary

There were enough qualified, skilled and experienced staff to meet people's needs. Staff members received regular supervision and had completed appraisal interviews.

People were protected from the risks of inadequate nutrition and dehydration, although delays in serving people's food meant that it was not as appealing to people as it could have been.

Staff were kind, compassionate and understood people's needs. The interaction between staff members and people was positive and respectful. People's privacy, dignity and independence were respected.

Care was planned and delivered in a way that was intended to ensure people's safety and welfare. People had been involved in the planning of the care they or their relative received. Care plans were personalised, detailed and reviewed on a monthly basis.

People who used the service were asked for their views about their care. Meetings were held on each unit of the home to discuss people's opinions of the service. A satisfaction survey of people who lived at the home was carried out on an annual basis.

There was an effective complaints procedure and comments and complaints people made were responded to appropriately. Relatives of people who lived at the home found the manager and deputy manager to be easily accessible.

Regular staff meetings were held on each of the four units. Most staff members felt supported by the manager at the home

The provider had a system to regularly assess and monitor the quality of service that people received, although there was uncertainty about the effectiveness of this. The system included monthly provider visits and quality audits by the manager. Action plans had been produced to address areas for improvement identified during the visits and audits and following the satisfaction survey.

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?

Requires Improvement

Some aspects of the service were not safe.

The steps staff should take to manage the identified risks to people were clearly documented in risk assessments but were not always followed. People were at risk of harm because of this.

The service had complied with the requirements of MCA and DoLS.

There were enough qualified, skilled and experienced staff to meet people's needs.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

There were long delays in the food being served at meal times and consequently the food was not as appealing to people as it could have been.

Staff members received regular supervision and had completed appraisal interviews.

People were supported to maintain their health and well-being. Appropriate referrals were made to other health and social care services as was necessary.

Is the service caring?

Good

The service was caring.

Staff members interacted with people in a positive and respectful way.

Staff members were able to demonstrate that they knew the people that they cared for and the way in which they should be supported.

Is the service responsive?

Good

The service was responsive.

People were asked for their views about their care and action plans had been produced to address the areas for improvement identified.

Care plans were personalised, detailed how care was to be delivered and were reviewed on a monthly basis.

Comments and complaints people made were responded to appropriately.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well led.

The areas for improvement noted in our inspection had not been identified by the system in place to assess and monitor the quality of the service provided.

Summary of findings

The manager and deputy manager were easily accessible and people could raise any concerns with them. .

Regular staff meetings were held which enabled staff to be made aware of best practice and be involved in discussions as to how it should be implemented.

PaterNoster House

Detailed findings

Background to this inspection

The inspection team was made up of two inspectors, a specialist advisor with knowledge of end of life care and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the statutory notifications we had received from the provider. Statutory notifications tell us about important events at the service, which the service is required to send us by law

During our inspection we spoke with healthcare and other professionals who were involved with the home, including one of the GP's, a community physiotherapist and an independent physiotherapist. Following the inspection we spoke with a community nurse for tissue viability, a member of the dietetic team and a community mental health nurse who had attended the home on a frequent basis.

During the course of our inspection we spoke with 11 people and nine relatives of people who lived at the home. We also spoke with the manager, the deputy manager, the chef and 10 nursing and care staff members. We reviewed records and carried out observations, including observations of the lunchtime meal on all of the four units at the home. We used the short observation framework tool (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We looked at the care records of 10 people who lived at the home. We reviewed the complaints records and tracked two complaints to check whether these had been investigated and an appropriate response had been sent. We also reviewed records of quality audits that had been completed by the provider and manager. We looked at the home's policies and procedures to check that these were up to date and staff records to confirm that staff members received appropriate supervision and appraisal. We looked at documentation relevant to the safety of the home.

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.

Requires Improvement

Is the service safe?

Our findings

We saw that, where bedrails were in use, the assessments in place to manage the risk of harm to people required that people were checked on an hourly basis. This was to reduce the risk of significant harm to them should they have trapped any of their limbs in the bedrails and was in accordance with the provider's policy. We noted that there had been no checks of people who used bedrails recorded for a four hour period on the day of our inspection. The manager confirmed that the checks had not taken place and could offer no explanation as to why this was the case. The records also showed that where a person had returned to bed one afternoon they had not been checked for a period of six hours. Again there was no explanation as to why this had occurred. The provider had failed to ensure the safety of people who were using bedrails. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People and the relatives of people we spoke with told us that they felt that they, or their relative, were safe at the home. When asked, one relative said, "Yes I do feel [relative] is safe." A satisfaction survey of people who lived at the home was carried out on an annual basis. We saw that 31 people had responded to the last survey, completed in 2013. Of these 100% had stated that they felt that the home was a safe and secure place to live.

We saw that the home had an up to date policy on the safeguarding of adults. We spoke with members of staff who told us that they had received training in respect of safeguarding. This was confirmed in the records we looked at for all staff groups. The staff members we spoke with were able to demonstrate a good understanding of the types of abuse that may occur and the steps that they would take to report any suspicion of abuse.

The provider had a system to identify, assess and manage risks to the health, safety and welfare of people who lived at the home. People and their relatives were involved in determining the risks associated with their care and support needs. They determined the level of acceptable risk which would enable them to retain their independence whilst maintaining their safety. The staff members used standardised tools for assessing risks connected with tissue viability and malnutrition. The steps staff should take to manage the identified risks to people were clearly documented. There were assessments of the risks in relation to the running of the home, such as emergencies, fire and the failure of utilities. However, we saw that there was refurbishment work being completed on one unit. When we asked to see the risk assessments connected with this the manager told us that none had been completed. People were not therefore protected against the risks involved with the completion of this work as they had not been identified.

Where people had capacity to make decisions for themselves these were respected. One relative told us, "[Relative] does make decisions, to go outside or walk to the [shop]." Staff members had received training on the Mental Capacity Act 2005 (MCA) and were able to demonstrate that they were aware of the requirements of it. They explained that decisions were made in the best interests of people where they did not have the capacity to make or understand the implications of decisions themselves. One relative told us they had been involved in making decisions about their relative's risk of falls and had agreed that it was in their relative's best interests for a sensor mat to be placed by their bed to monitor them at night.

CQC is required by law to monitor compliance with the Deprivation of Liberty Safeguards (DoLS) requirements of the Mental Capacity Act 2005 (MCA). The MCA sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected, including when balancing autonomy and protection in relation to consent or refusal of care or treatment. This includes decisions about depriving people of their liberty so that they get the care and treatment they need where there is no less restrictive way of achieving this. Members of staff had received training in DoLS as part of their MCA training and were able to demonstrate an understanding of when DoLS applied. They were involved in making applications for authorisation to restrict people's freedom. The deputy manager showed us the recording system that was in place to monitor the applications that had been made to the relevant local authority and the staff members who had made them.

One person told us, "It is safe here. There are enough staff." Another said, "The girls are marvellous, there's enough staff for me." Two relatives also told us that there were sufficient staff to ensure that their relative was checked regularly. One relative told us, ""The staff tell me everything – there is enough staff, five in the day when there is the most

Requires Improvement

Is the service safe?

disruption." However, some people we spoke with felt that there should be more staff available. One person told us, "There are not really enough staff, especially at weekends." When asked about call bells they said, "The staff are busy, they do go but it might be a little while."

One staff member told us, "More staff are needed all of the time, to have a bit more time to spend with the residents to do the activities. There is always something to do." Staff members on one unit told us that it was regularly short off staff. On the day of our inspection one member of staff from the unit had become unwell and had gone home whilst another was escorting someone to a hospital appointment. We saw that a member of staff from another unit was transferred to cover the absence whilst the member of staff was escorting the person to their appointment.

The deputy manager told us that staffing levels were determined by the level of support that people needed and showed us the duty rotas for each of the units. These showed that, at times, the number of staff on duty exceeded the levels calculated as needed. The deputy manager told us that when units were short of staff it was sometimes necessary to move staff members between units. In addition, both they and the manager were available to assist with care and support for people when there were staff absences. The rotas we saw showed that each unit had at least the level of staffing in accordance with the provider's calculations for each shift during the period we looked at. During our inspection we had noted that the staff were visibly present on each unit and both the deputy manager and manager had provided care and support to people when they were on the units.

We observed two staff members as they assisted a person to transfer from their wheelchair to an armchair in the lounge. This was completed safely with good verbal communication, instruction and guidance for the person, such as helping them to hold the correct handles.

Requires Improvement

Is the service effective?

Our findings

People were provided with a choice of suitable and nutritious food and drink. Most of the people enjoyed the food and drink provided. One relative said, "They do nice food although the desserts could be more varied, there are lots of sponges and custard." We observed the lunchtime meal on all of the four units at the home. We saw that most people were offered choices about what they ate and where they sat. One person told us, "If I don't like the food I can have egg and chips or cheese on toast."

The chef showed us charts which detailed people's specific dietary requirements, including their cultural needs. These, together with people's likes and dislikes, were updated by the nurses on a monthly basis. We later spoke with a member of the dietetic service who told us that the home followed advice and instructions that were given about people's diets.

During the lunchtime meal we identified that on three of the four units there were delays in people being served their meals of up to an hour from the time the meal arrived on the unit. On one unit it was seen that the containers in the heated food trolleys were left uncovered between serving people. This meant that the food given to the people who had to wait would have cooled considerably and would not have been as appealing as it could have been. People may not, therefore, have eaten as much as they would have done had they been given their meal without the delay.

People were supported to be able to eat and drink sufficient amounts to meet their needs although we noted differences in the way in which people were supported. Some staff members explained what they were doing and spoke with people as they assisted them to eat whilst other staff members were observed to have little or no communication with the people they assisted. This did not promote the people's dignity.

People found the staff to be well trained. One person told us, "Social services come on a regular basis – they are concerned about my health and happiness and I say come here, everyone here is happy to do their best for you, I have no regrets about coming here." Another person told us, "They are really hard working caring bunch who are all really well trained by their senior." The relatives and the healthcare professionals who we spoke with agreed that staff were aware of their duties and responsibilities. One said the staff members on one of the units for people who were living with dementia were, "… fantastic." Members of staff explained the various methods of communication that they used with people who could not tell them what they wanted. Staff told us that they used body language, facial expressions and offered choices by showing people items. One member of staff said, "We pick things up and show them and ask them until we get it right." Another staff member told us. "We are observant and go through everything and then they nod and say yes." We saw that people were offered the choice of meal at lunchtime by the member of staff showing them both meals and interpreting their responses.

People were cared for by staff who were supported to deliver care safely and to an appropriate standard. We saw that there was an 'at a glance' scheduler held by the deputy manager to manage supervision and appraisal meetings with staff members. We looked at the records of two staff members. These showed that they had received regular supervision meetings with the deputy manager or the registered nurse on their unit who provided supervision to the care workers. Both staff members had also completed an appraisal interview in April 2014 at which they had discussed the skills they had developed, their personal development plan, their strengths and their weaknesses.

Staff members we spoke with told us that they had received training on fire, moving and handling, the safeguarding of adults, infection control, dementia care, catheter care and end of life care. They were able to demonstrate that they used the learning from their training in the day to day care and support provided to people. We observed a member of staff use the techniques they had learned at their training to calm a person who had become upset. Staff who worked on the units which accommodated people who were living with dementia told us that they had received training to understand the needs of the people they cared for. The deputy manager told us that staff were required to undertake regular training in areas that were considered essential for their roles by the provider. The staff were advised when their training was due to be updated and their completion of the training was monitored.

People were supported to maintain their health and well-being. People told us that they were able to see the GP who attended the home. They were able to make an

Requires Improvement

Is the service effective?

appointment if they wished to see the GP and people had been supported to see an optician, chiropodist and dentist. One person said, “The doctor comes round. If I want to see [doctor] I can. [Doctor] comes two to three times a week.” Another person told us, “I have been to the hospital for my ears and someone comes with me. The optician comes regularly.”

Good

Is the service caring?

Our findings

People we spoke with told us that the staff were kind, compassionate and understood their needs. One person told us, "The girls are marvellous; if I want anything they assist me. Care is 100%." Another person said, "100% kind carers, above average care." A third person told us, "I have got no complaints on how they treat me – they care very careful and helpful and give me a lot of support." A relative said, "The ones involved with [relative] are caring, kind and considerate." Another relative told us, "[Relative] has had a whole year of being happy here. He goes out into the garden and has lunch and a beer."

We observed that most of the interactions between staff members and the people who lived at the home were positive and respectful. Staff members demonstrated that they had a good understanding of people's needs. Although most of the interactions we observed were directly related to the provision of care we did observe staff members having conversations with people and leading groups of people in activities. These included singing, rolling a large soft dice whilst people guessed what number it would show, painting mugs and knitting in the garden.

Staff members we spoke with told us that they knew the people they cared for. They understood their likes and dislikes, what might make them become distressed or agitated and steps to take to defuse such situations. One staff member told us, "We get to know them, what they used to do, where they worked, we like to talk to them." A staff member was able to give the life history of a person they were assisting, including the details of their significant family members.

People who used the service were asked for their views about their care. Most of the people we spoke with told us that they had been involved in the planning of the care they or their relative received. One relative told us, "We saw the care plan at the start and they do consult me." However, one relative told us that they had not been consulted about their relative's care plan. The deputy manager told us that relatives were always encouraged to be involved in the development and review of people's care plans. The care plans we looked at confirmed this to be the case.

We saw records of meetings held on each unit of the home where people discussed their opinions of the service. Minutes showed that people had discussed the activities, food and music and had made suggestions as to the activities that they would like to have introduced and changes they would like to be made to the menu. One person told us, "They have an open meeting, suggestions from residents and staff. They are reasonable meetings and we can speak our minds."

The relatives we spoke with told us that they were always made to feel welcome at the home and felt that they could visit at any time. One relative told us, "I can pop in to see the manager, [manager] does not mind.

People's privacy, dignity and independence were respected. One relative told us, "They always knock on [relative's] door." We observed that staff members closed people's doors when they carried out personal care. We also observed a person as they were assisted to transfer into a wheelchair by two staff members using a hoist. The person's dignity was protected, their clothing adjusted and their legs were covered with a blanket. The healthcare professionals we spoke with all told us that the staff at the home have always been seen to maintain people's dignity and treat them with respect.

Good

Is the service responsive?

Our findings

People told us that the members of staff supported them throughout the day. One person told us, "If I want anything they assist me." Another person said, "I do what I want to do and if I cannot cope I ask a carer to help." The person went on to say, "I go to bed when I want and stay and watch a late film in the lounge if I want." We saw that two people were sat in the garden on the morning of our inspection. The sun was shining and it was quite hot. A member of staff advised them that they should wear sunhats and sunscreen to protect them from burning. Both agreed that they wanted these and the staff member fetched the items for them. We overheard one member of staff say to a person in their room, ""Can I help you with that. Where is your apron, here is your buzzer, just press it and someone will come"

Care was planned and delivered in a way that was intended to ensure people's safety and welfare. We looked at care records which showed that before people were admitted to the home a full assessment of their needs had been carried out. This included their cultural, spiritual and social values and hopes and concerns for the future. The information was reviewed on people's admission to the home and care plans to support people's needs in all areas of their life were agreed with them or their next of kin as appropriate. People's care records included a life history form that had been completed to give staff a background to the person and enable relevant activities and conversation prompts to be provided for them.

People's care was delivered in line with their individual care plan. The care plans were personalised and detailed how care was to be delivered. One relative told us, "I have relief and I give gratitude to the staff for the care they give my [relative]. It is geared to the individual resident and they cater for their own individuality."

We saw that care plans were reviewed on a monthly basis and progress and evaluation records for each care plan were completed on every review. Where concerns about people's physical or mental health had been identified the necessary referrals to healthcare professionals had been made. One record showed that the person had been referred to a physiotherapist, the dietetic service, speech and language therapist (SALT) and an occupational therapist. When it was identified that they needed a specific reclining armchair this had been provided by the home.

Another care record showed that a referral had been made to the tissue viability nurse when staff became concerned that the person was at risk of developing a pressure ulcer. This showed that the service was responsive to people's changing needs.

People who lived at the home were asked for their views about their care. One person told us, "The manager asked me if I am happy …and I talk a lot to the deputy manager." A satisfaction survey of people who lived at the home was carried out on an annual basis. We saw that 31 people had responded to the last survey, completed in 2013. Of these 100% had stated that they were happy at the home. Most, but not all the answers to questions asked in the survey were positive. We saw that an action plan had been produced to address the areas for improvement identified from answers and comments made in the survey. Some of the actions had been completed at the time of our inspection. This showed that the service was responsive to people's comments.

We saw that people and their relatives were provided with an information booklet about the home. This included information about the accommodation, admissions policy, care planning, social activities, visiting arrangements and how the home aimed to meet people's holistic needs, such as race, religion and sexual orientation. This booklet also included details of the home's complaints procedure and people's rights.

None of the people we spoke with had made a complaint. However, comments and complaints people made were responded to appropriately. We looked at the records of two complaints that had been received by the home. These had been acknowledged by the manager and fully investigated. A full response had been sent to the complainant by the provider's Regional Operations Director which explained the findings of the investigation and the actions that had been taken to prevent a similar incident from occurring.

Requires Improvement

Is the service well-led?

Our findings

The registered manager had been in post for more than three years at the time of our inspection. They were supported by a deputy manager and a training manager. Each of the four units at the home was led by a registered nurse. This meant that the staff members had a number of experienced managers with whom they could discuss any concerns about the health or well-being of people who lived at the home.

The people and their relatives we spoke with told us that they found the managers to be easily accessible. One person told us, "There is nothing wrong with the home. The carers are pretty good to me." Another person said, "Everyone here is happy to do their best for you. I have no regrets about coming here." A relative told us that they talked to the deputy manager on a regular basis and knew who the registered manager was.

The provider had a system to regularly assess and monitor the quality of service that people received. Action plans had been produced to address areas for improvement identified following various quality audits. These included a monthly provider's monitoring visit at which areas for improvement had been identified, including care profile reviews, risk assessments and staff appraisals. The deputy manager had addressed the issue of staff appraisals and care profiles had been discussed at the staff meetings. The risk assessments were being reviewed and updated.

We saw that the manager carried out regular audits of the home. The records we looked at showed that the most recent audits had identified areas for improvement in medicines management, cleanliness, soft furnishings and clutter in the home. The manager had also identified that the incident plan required updating. The action plan produced following these audits showed that these had been completed. However this was not a fully effective system to assess the quality of the service because the checks and audits that had been completed by the provider and the manager had failed to identify the areas for improvement, such as the delay in serving people's food, we found during our inspection.

Regular staff meetings were held on each of the four units. The minutes showed that topics discussed had included tissue viability, personal hygiene, infection control, care plans, uniforms, staff member's tardiness, going home early and supporting people. We saw that the discussions about care plans were to encourage staff members to make progress notes more meaningful. These meetings enabled staff to be made aware of best practice and be involved in discussions as to how it should be implemented.

The registered nurses also held their own meeting as the senior staff for each unit. The minutes showed that they discussed clinical governance, care plan audits, medicines administration and nutrition. This demonstrated that senior staff members shared knowledge and experience with an aim to improve the service.

Most of the staff members we spoke with told us that they felt supported by the manager at the home. One staff member told us, "The staff all pull together. It is good team work and we can approach management." Another staff member said, "Our senior nurse listens to us, is approachable and good with the residents." Another member of staff said, "You can go to the deputy manager. They are always walking the floor. You can go to the Manager." Another member of staff told us of how they had been supported to report bruising they had seen on one person. However, one member of staff told us that they had raised concerns with the management but "…nothing was done." When we discussed this with them they told us that they were aware of the whistleblowing policy and that they could speak with the registered manager if they remained unhappy with the way in which any matter that they had raised had been dealt with.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **People did not always receive care that ensured their welfare and safety as the documented steps staff should take to manage the identified risks to people were not always followed. Regulation 9 (1) (b) (ii)**