Barchester Healthcare Homes Limited

Cheverton Lodge

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We carried out an unannounced focused inspection of this service on 17 August 2016 as a result of concerns that we received. We received further concerns and returned to the home on 11 September 2016. The concerns related to a high turnover of staff and unstable management, communication between healthcare professionals, relatives and staff at the service, quality of food and issues around the external environment. This report only covers our findings in relation to the concerns recently raised. At our last comprehensive inspection in December 2015, we found that the service was meeting all of the standards that we inspected.

Cheverton Lodge is a 52 bed nursing home which provides nursing and/or personal care for up to 46 older people and 6 young people with physical disabilities. Each person has their own bedroom and there are communal lounges and dining areas on each floor of the home.

The home did not have a registered manager. However, there was an interim manager in post at the time of our inspection. 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 previous registered manager had left the service in May 2016. Since this time there had been three interim managers at the home. The current interim manager was leaving in September 2016 and a further interim manager was due to take over. We were advised that the new interim manager would be applying to be the registered manager.

The turnover of managers within the home has led to an unstable management structure. Information received from a healthcare professional and relatives that we spoke with indicated that the lack of consistent management had impacted on communication with them.

There were several staff vacancies within the home, specifically around nursing staff. However, the home had recently recruited to these posts and were waiting for staff to start. Seconded nurses from other Barchester homes, regular agency staff and bank staff were being used to ensure consistency of care.

One person that had been diagnosed with a terminal illness three weeks prior to our visit did not have a risk assessment of care plan in place about this.

Most risk assessments were appropriate and information about risks had been carried over into people's care plans. However, for two people with known risks, there were no risk assessments in place.

Information provided at handovers was not always clear and some people's monitoring charts were not always completed. People had files in their bedroom with information on care tasks that had been or needed to be completed by staff. Information from these files was not always carried over onto handover

sheets kept in the offices on each floor of the home. Staff did not always have up to date information when handing over between shifts to ensure continuity of care.

People were provided with enough food and drink. Food looked and smelled appetising, was of good quality and offered choice. People that were on special diets such or had swallowing difficulties were given appropriate food, although on occasions, one person who had a specific diet did not receive food that met their dietary needs.

The home was currently undergoing refurbishment. This was due to be completed by the end of September 2016. The home was clean and tidy on the days that we inspected.

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. Risk assessments were usually good, but for two people they did not always provide guidance to mitigate identified risks.

There had been a high turnover of staff in the past four months. The service used seconded and regular agency nursing staff however, this impacted on the continuity of care and communication between staff and healthcare professionals.

The home was undergoing a refurbishment. Despite this, the home was clean and tidy on the day of the inspection.

Is the service effective?

Requires Improvement

The service was not always effective. Handover sheets were not always completed correctly. Information contained within people's personal files kept in their rooms did not always reflect information on handover notes.

People received a good choice of different foods. Food was appetising and there were generous portions. The home provided a high quality of food for people that required special diets, although one person did not always receive their specialist diet.

Agency staff received induction prior to working at the home.

Staff training had been increased and nursing staff were being supported to obtain their revalidation as registered nurses.

Is the service well-led?

Requires Improvement

The home did not have a registered manager. There had been three interim managers since the previous registered manager left. This had an impact on continuity and leadership of the home.

There was a high vacancy rate for nursing staff although some of these posts had been filled and the home was waiting for appropriate recruitment checks before the new staff commenced employment.

Communication between management and relatives was not always effective.	

Cheverton Lodge

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.

We carried out an unannounced focused inspection of this service on 17 August 2016 as a result of concerns that we received. We received further concerns and returned to the home on 11 September 2016. The concerns related to a high turnover of staff and unstable management, communication between healthcare professional and staff at the service, quality of food and issues around the external environment. This report only covers our findings in relation to the concerns recently raised.

During our inspection we also spoke with ten people using the service, four relatives who were visiting and 14 members of staff including four nurses, six care assistants, the registered manager, the Area Manager, the Divisional Director and the Divisional Clinical Lead nurse for Barchester Healthcare. Prior to our inspection, we spoke with the commissioner for older people in Islington.

As part of this inspection we reviewed five people's care plans and risk assessments. We looked at staffing and rotas for August and September 2016. We observed the environment of the home and external areas as well as looking at menus and quality of food that was provided to people living at the home.

Requires Improvement

Is the service safe?

Our findings

In most cases, risks were appropriately assessed and the action taken to mitigate identified risks was recorded. Appropriate referrals had been made to Tissue Viability Nurses (TVN's), Occupational Therapists (OT's) and Speech and Language Therapists (SALT) as a result of identifying a risk. Where a pressure ulcer risk had been identified for one person, through regular pressure ulcer assessments, a TVN had been requested. Staff were following TVN advice in terms of treatment and we saw evidence that staff treatment was improving the wound for this person. However, we also found that some risk assessments were in a tick box format and information on how to mitigate identified risks was not always carried over into the risk section of the care plan. For example, one person had been assessed as being at a high risk of developing a pressure ulcer. This was not detailed in the care plan. There was no information for staff on how to address or mitigate this risk for this person.

A relative told us that it had been agreed for her relative not to have bed rails in the up position as it made them feel claustrophobic. This had been agreed and the relative had signed a risk assessment. However, when we looked at the care records in the person's room, on several occasions the bed rails had been raised. Staff were not following the risk assessment guidance. One staff member told us that the person had shouted out a lot during the days when the bed rails were in the up position. The person told us that they did not want their bed rails in place and that they were trying to tell staff.

One person had been diagnosed with a terminal illness three weeks prior to our inspection. We looked at this person's care records, including the risk assessment. We found that there was no risk assessment related to the person's current health issues or advanced care plan in place around how staff should work with the person. We raised this immediately with the interim manager who was unaware that no risk assessment or care plan was in place. We asked the home to send us a risk assessment and care plan relating specifically to this person within 24 hours. An up to date risk assessment and care plan was provided within the required timeframe.

We had received concerns about the high turnover of staff at the home. On both days of the inspection we looked at staff rotas and the deployment of suitably trained and qualified staff across the home. Staff that were noted on the rota were on duty on the days that we inspected.
The registered manager confirmed on the first day of inspection that there were several staff vacancies within the home. However, the home used seconded and regular agency nursing staff. Rotas confirmed that there were regular agency staff on duty for the month of August 2016. The staff rota for August 2016 and the current rota up to 25 September 2016 showed that the staffing allocation had been recorded every day of the week. Only several vacant shifts later in the month in the Young Person's Disability Unit (YPDU) remained to be filled, which the management team was working on.

On the second day of the inspection, there was an agency nurse and care assistant on the ground floor in the YPDU, a nurse and three care assistants on the first floor as well as a permanent nurse and four care assistants on the second floor. Three nurses, from two of Barchester's other homes had been seconded to cover three nursing vacancies on the first floor. The nurses were working at the home for an extended period

until such time as some new nurses had been recruited. The staff we spoke with were knowledgeable about Barchester procedures and the people they were caring for at the home. Our observations of staff interacting with people indicated that they had a good knowledge of the people they were caring for and their needs. Staff confirmed they were told the relevant details for each client at handover. The care assistants on duty were all permanent staff.

At night, permanent nurses and care assistants worked on the second floor. Two named agency nurses were also used at night on the first floor and also covered the YPDU at night. However, the area manager told us that they planned to reduce the use of agency nurses at night as a permanent Barchester nurse had been transferred to the home. A recent vacancy arose when another nurse resigned but that person was still doing bank shifts. The current rotas showed that for September most shifts throughout the day throughout the home were covered by permanent nurses and care assistants, with the exception of the first floor where seconded nurses, a regular bank or two regular agency nurses were covering, the agency and bank nurses were covering night shifts.

The home had a small outside area where people and relatives could relax. We had received concerns that the smoking area in the gardens was dirty and at times inaccessible. On checking the gardens, we found that the smoking area was clean at the time of the visit and readily accessible. The lockable garden gate into the outside area was unlocked. The area manager said the bolts on the inside of the gate were secured at night, but during the day, a latch was on. This was a reasonable security measure as it meant that people approaching the home from the car park or main entrance did not have free access to the garden without first making themselves known to staff. However, we were informed by a relative that at weekends staff sometimes forgot to unlock the gate which meant that this area was inaccessible to people and relatives. We raised this with the interim manager who said that she would look into this issue.

We had received concerns about the cleanliness and general state of repair of the home. We carefully inspected all areas of the home, including the bathrooms and shower rooms. All bathrooms and toilets were clean and two domestic staff were seen around the home carrying out general cleaning.

The home was currently undergoing some refurbishment, including five people's bedrooms, the young person's unit and the reception area. The refurbishment was almost completed and was expected to be finished by the end of September. We were told that the home had tried to minimise disruption to people and had ensured that work finished at a specific time each day to allow people time to enjoy their evenings without disruption. The area manager told us, and we confirmed with other staff, that new admissions to the first floor had been suspended until refurbishment work was complete.

Requires Improvement

Is the service effective?

Our findings

We had been made aware of concerns about the quality and content of information passed between staff on handovers, information provided to and from healthcare professionals and contained in the home's records.

Handover information sheets were completed by staff so that information could be passed between staff at the end of each shift (day and night). The guidance on these sheets stated that information needed to include details of visitors, food and fluid intake, tasks completed, pressure dressings, healthcare professional visits and issues, concerns or complaints. The sheet was pre-populated with risks and care requirements for each person. These sheets were not always being fully completed. For example, we noted that a number of people had been identified as being prone to constipation. In two cases, there were no records of bowel movements for two weeks. Some records stated 'Incontinence care needs met', but there was no indication that the person had opened their bowels. The information was recorded in a folder in the person's room, but was not recorded on the handover sheets.

On checking people's records, we found a number of discrepancies in what had been recorded, which could lead to confusion amongst staff. It was recorded in one person's care plan that they did not have capacity. The nurse in charge told us that this person did have capacity and that this record was not accurate.

One agency staff nurse had written in the doctor's book that a person needed to be seen by the doctor as they were at a 'very high risk of choking'. However, the permanent staff nurse told us this was not the case and the risk assessment we saw in this person's care plan confirmed they were at a low risk of choking. We were told that this information had been recorded by an agency nurse who had worked at the home for only one day. Staff said that there was with a high turnover of staff and that this had an impact on communicating information about people at home.

There were two types of care files, a blue one that was held in the offices on each floor and a red file that was located in people's rooms. The blue file contained detailed information about the person as well as their care plan. The folders in people's rooms contained records of food and fluid charts, elimination, regular repositioning and regular visits by staff where the person could not use the call bell. On checking these folders, we found that they were usually filled out correctly. However, we saw that some of the files had gaps where the required information had not been filled in. This meant that staff taking over from shift to shift did not always know if certain tasks had been completed.

Relatives were generally happy with the access their family members had to the GP. They told us that staff reacted quickly if their relative became ill. One relative also said that if their relative was unwell, "They [the home] ring me straight away."

Another of the concerns that the Care Quality Commission was told about was regarding the quality of food provided to people using the service, specifically for people that required a specialist diet such as mashed or pureed food. During our inspection, we looked at the kitchen and food preparation areas. The home

employed three chefs, one of whom was the head chef. They took it in turns to cover weekdays and weekends. The kitchen was clean and food was stored appropriately. We found that the service catered for people with differing faiths and the chef showed inspectors separate storage facilities for halal meat which was kept separately in accordance with guidance around storing halal products. There were lists in the kitchen of people who required specialist diets, such as mashed, pureed or vegetarian food. One person was noted to be vegetarian on this list. However, in the nutritional section of another person's care plan, it stated that they were vegetarian. They were not on the list of vegetarians in the kitchen. The person confirmed they did not eat meat but did eat fish. They told us that on some occasions they had been served meat. They said that this was not an issue and they had, "Scraped the meat off the plate." Two of the three staff we spoke with said they were aware that the person was vegetarian. However, there was some confusion about this in the kitchen. We discussed this with the area manager at the time of the inspection who told us that this issue would be dealt with immediately.

We observed lunch on the first day of our inspection and saw that people were served in a timely manner. The food looked and smelled appetising. Where people required support to eat, staff were patient and communicative whilst supporting them. One person allowed us to observe them being supported with her lunch in her room. The member of staff was patient and chatted to the person in between helping her to eat. We asked staff if they felt that there were enough staff around at meal times to provide support to people. One staff member said, "Yes, I think so." Another staff member said, "There's lots of us to help, everyone pitches in."

People that we spoke with were generally positive about the food and said, "It's lovely, they really do cook nice. You get something different every day", "Very good, bordering on excellent", "Quite nice" and "I enjoy my lunch." However, one relative told us that, "Food is a big issue. Some days what is on the menu is not what is on the plate." We raised this with the interim manager who told us that occasionally there is a replacement item on the menu when the kitchen had not ordered enough ingredients. The interim manager said that this was a rare occurrence and the change would only be minor. They said that people were always told of the change.

Due to the concerns raised about the food, we tasted samples of the lunchtime menu on day one of the inspection. This included testing the consistency and flavour of both puree and mashed food given to people that had swallowing difficulties. What was on the menu was what was being served to people on the day of inspection. Food that was tasted included soup, salmon fillets and mashed potato, a chicken dish and home-made apple pie. Food was flavoursome and cooked well. Mashed and pureed foods were presented well with each part of the meal being separate on the plate. The consistencies were appropriate for puree and mashed diets. The chef tried to ensure that people on special diets received a meal that looked appetising.

We observed lunch on the second day of inspection and found that food again matched what was on the menu. This included salmon, samosas and a vegetarian dish for lunch, with a soup starter and a choice of desserts. People were seen enjoying their lunch and people in their bedrooms were served quickly and did not have to wait.

Records showed that there had been a detailed audit in July 2016 of the catering department. This had been completed by an external company and the results were positive. Where areas for improvement had been identified, an action plan had been put in place.

We asked how the service ensured that agency staff received an induction when they first started working at the home. The registered manager told us that agency staff received an induction and that this usually took

around 45 minutes to complete. Records showed that the induction covered a brief introduction to the home, emergency procedures, health and safety and risk assessments and care plans and where to find them. If the staff member was a nurse, the induction included medicines information.

The registered manager told us, and records confirmed, that since she had been in post, she had arranged for numerous staff training sessions. She said that she had identified that the home had not always been providing refresher training for certain areas. Staff also confirmed that there had been more training available in recent months. This included safeguarding, the Mental Capacity Act (MCA) and moving and handling. The divisional clinical lead nurse also told us how the home was supporting all nurses to obtain their revalidation and ensure that their clinical skills and knowledge were up to date. Revalidation came into force in April 2016 via the Nursing and Midwifery Council (NMC) and is a way of ensuring that nurses can demonstrate that they practice safely and effectively.

Requires Improvement

Is the service well-led?

Our findings

We received concerns around the high turnover of staff and inconsistent management and leadership within the home. The home did not currently have a registered manager. The previous registered manager had left at the end of May 2016. From the end of May 2016 to the date of the inspection, there had been three interim managers in post. The interim manager in post at the time of the inspection was due to be replaced by another interim manager. There was a gap between the current interim manager leaving and the new interim manager taking up their post. The area manager planned to manage the home until the new interim manager came into post.

We spoke with the divisional director for Barchester who was present on the first day of our inspection. The divisional director told us that Barchester had recently held and assessment day to identify a new manager but that no candidates had been selected. Another assessment day was being organised. In the meantime, Barchester had arranged for a manager from another home to become the interim manager until the post was filled with a permanent appointment. The interim manager was due to take over on the 19 September 2016. We were advised that they would be applying to be the registered manager.

We discussed the turnover of staff with the current interim manager who told us that the home was actively recruiting. The area manager told us that there were three nursing staff starting employment at the end of September 2016 and a newly recruited clinical nurse lead was also starting later in the month.

A healthcare professional that we received information from and relatives that we spoke with felt that the unstable management of the home since May 2016 had led to a breakdown in communication with them. Relatives we spoke with were not always sure who was in charge as there had been a high turnover of staff. They also felt that there was a general lack of communication between the home and relatives. One relative thought that their relative had been limited to having two baths a week. We spoke with the interim manager about this who told us that the person was able to have more baths than this and that this was a misunderstanding. Some relatives were unsure about raising concerns and felt that raising concerns could have a negative impact on their relative. However, other relatives were happy to raise concerns and felt that the home dealt with them accordingly. Relatives told us, "I am concerned about the turnover of staff" and "No main person. I'm not sure who's in charge of my mum's care." Communication between the home, relatives and healthcare professionals was not always effective. We discussed this with the management team during our feedback. The divisional director said that she was concerned that family members did not always feel able to raise concerns and were worried about the staff turnover and that was something that the home would be looking into.