Otterburn Health Care Limited

Otterburn

Inspection report

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16 November 2016

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

Summary of findings

Overall summary

We carried out this unannounced inspection on the 08,10 and 16 November 2016. Otterburn provides care and support for up to 30 people with complex health care needs including rare forms of dementia, physical disabilities, mental health needs, brain injury and neurological disorders. The home is divided into three ten bed units called Otter, Fox and Squirrel.

We undertook a comprehensive inspection of this home in November 2015 when we identified that improvements were needed throughout the service. We judged the home to require improvements in all five of our key questions. We undertook a focussed inspection in May 2016 to look specifically at the key question of 'safe.' We looked in detail at the risk management processes for people who were at an increased risk of falls.

This inspection identified that significant effort and improvements had been made in all areas of the homes operation, however these had not been fully effective. The registered provider was not meeting all the legal requirements and people could not be certain their needs would consistently be met.

The home has a registered manager who was present throughout 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.

People told us using words and gestures that they felt safe living at the home. Staff had knowledge of possible signs of abuse and could describe action they would take in reporting any concerns. Action had been taken to improve the number of staff available. However there were not always enough staff available to meet people's requests for support.

The provider had identified risks to people and had put measures in place to minimise the risk for the person. The systems in place to reduce these risks to people had not all been used accurately and were not being used consistently to be effective.

People received their medicines safely and there were systems in place to monitor medicines administration.

Staff told us they had received induction, sufficient training and on-going support. Feedback we received during our inspection indicated that staff did not always have the specialist knowledge they needed or benefitted from robust and effective handovers between shifts.

Staff had some knowledge of the Mental Capacity Act (MCA) (2005) and described how they supported people with making choices. Our observations showed that staff did not work consistently in line with the

principles of the MCA when supporting people. Relevant applications had been made and kept under review for people whose liberty was deprived.

People had access to regular healthcare and specialist advice. It was not always evident that people were always supported to attend healthcare appointments or to take the action advised by healthcare professionals.

Significant improvements had been made to the choice and quality of food served, however people had not always been appropriately supported with their specific dietary needs. You can see what action we required the provider to take at the back of this report.

Relatives were happy with the care provided by individual staff and told us that staff were kind and caring. Staff enjoyed working at the home and many knew the people they supported well. During our observations we saw some good staff practice but we also observed that people were not consistently treated with dignity and respect.

People had some opportunities to be involved in planning their care to meet their individual needs and care was reviewed with people to ensure people were still happy with the care they were receiving.

People had the opportunity to join in with activities in the home and out in the community. These were not as often as some people wished, and we observed periods of time when no opportunities were provided for people to receive stimulation, participation or company.

People, relatives and staff all had a positive relationship with the management team and felt able to approach them at any time. Opportunities had been provided for people to feedback their experience of living, visiting and working at the home. The systems in place to monitor the quality and safety of the service had not been entirely effective. While numerous developments and improvements had been achieved since our last inspection people could not be certain they would receive a consistently good, safe service that would meet their needs and wishes.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

There were not always adequate numbers of staff on duty, and the staff available did not always have knowledge about the people they were supporting.

Risks people experienced were not always accurately assessed and measures to reduce and mitigate risks were not always used.

People felt safe. Relatives were not always confident that their loved one was receiving safe care.

People were supported to take their medicines safely and as prescribed.

Is the service effective?

Requires Improvement

The service was not always effective.

People could be confident restrictions on their liberty would be identified and the appropriate DoLS applications made. People's human rights were not always upheld by staff.

People were offered plenty to drink but were not always provided with the food they required to maintain good health.

People had access to a wide range of health professionals. Some people's health conditions had improved or stabilised. People did not consistently receive the healthcare they required, and health related records were not always complete.

Staff were provided with induction, training and ongoing support.

Is the service caring?

Requires Improvement

The service was not always caring.

People did not consistently have their dignity protected.

People did not always receive good support to plan their end of life care.

Individual staff demonstrated kindness and compassion towards the people they supported and their relatives. People were supported to celebrate special events, and to invite their family to parties held at the home.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Concerns and complaints were identified, investigated and feedback provided. People were not always confident sustained changes would result.

Opportunities for people to undertake activities they enjoyed had increased, however these opportunities were not consistently provided throughout the home.

People and their relatives had some involvement in planning and reviewing their care .

Is the service well-led?

Requires Improvement

The service was not consistently well led.

A registered manager was in post, however people did not benefit from strong, consistent or effective leadership throughout the home.

Systems were in place to monitor quality and these informed the registered provider's improvement plan. These had resulted in some significant improvements throughout the service, however they had not been adequate to ensure people consistently received good, safe care.

People, relatives, staff and visiting professionals had the opportunity to make suggestions, provide feedback and impact on the development of the service.

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.

This unannounced inspection took place on the 08, 10 and 16 November 2016. On the 08 November the inspection team consisted of one inspector and a specialist advisor who had clinical knowledge of the needs of the people who lived at the home. On 10 November the inspection team comprised of one inspector and an expert by experience. An expert by experience is someone who has experience of caring for someone who uses this type of care service. On the 16 November the inspection was carried out by one inspector.

As part of the inspection we looked at information we already had about the provider. Providers are required to notify the Care Quality Commission about specific events and incidents that occur including serious injuries to people receiving care. We refer to these as notifications. At our last comprehensive inspection we found the provider was in breach of five legal regulations and not consistently meeting people's needs. After that inspection we met with the provider and they provided us with an action plan. The registered provider and registered manager have provided us with regular updates throughout the year. We reviewed the information from notifications and the information we had received in the action plans to help us determine the areas we wanted to focus our inspection on. We also received feedback from the local clinical commissioning group who monitor the quality of the service.

We visited the home and spoke with five people. We met all the other people who lived at the home. Some people living at the home were unable to physically speak with us due to their health conditions. We spent time in communal areas observing how care was delivered and we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with the registered manager, operations manager, assistant operations manager, the training co-ordinator, five nursing staff and seven care staff. We spoke with nine relatives. We had feedback from three

healthcare professionals. We looked at records including parts of five care plans and medication administration records. We looked at three staff files including a review of the provider's recruitment process. We sampled records from training plans, incident and accident reports and quality assurance records to see how the provider monitored the quality of the service.

Requires Improvement

Is the service safe?

Our findings

At our last inspection we identified a breach in Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the registered provider had not ensured people had consistently received care and treatment that met their needs. Progress had been made but the breach had not been fully met. Further work was required to ensure people received a consistently good, safe service.

In November 2015 we also identified a breach in Regulation 18 of the Health and Social Care Act 2008 (Regulated activities) People had not always been supported by adequate numbers of staff with the skills and experiences required to meet people's specialist needs. This inspection identified that action had been taken to recruit and retain staff. The provider had assessed the number of staff required to provide safe care and developed rota's based on this. We were informed that there continued to be shortfalls with staffing however we found this was largely due to short notice absence and not the registered provider's provision of staff. We assessed that this breach was met.

Since our last inspection the registered provider had invested heavily in staff recruitment and commenced a number of initiatives to increase staff retention. Despite this, people and their relatives told us that they did not consistently experience adequate numbers of staff on duty. They also reported that staff did not always have knowledge of their loved ones needs if they had been moved from a different unit of the home. One person we spoke with described their experience of living at Otterburn positively, but when we asked about staffing they told us, "Well that's where it all gets a bit naff." they went on to describe occasions when the numbers of staff had been inadequate to provide them with the support they required. Other people living at Otterburn told us, "I need to be hoisted sometimes and it's a long time waiting if they're short of staff. If I need the toilet they help me straight away," and "The night staff can be short staffed."

Relatives we spoke with told us, "Staff cover at weekends is appalling," and "I would like to see the number of staff increase and the turnover of staff decrease." Relatives we spoke with described occasions where their loved ones had not received their care in a timely manner, or where the relative had to wait to leave the home as staff could not be located to take over supporting the person.

During our inspection we observed adequate numbers of staff to support people promptly when they requested help. We looked back over weekend and night shift records and identified that there had been occasions when the number of staff had dropped below the level the registered provider had assessed to be required on the units. This was usually due to short notice changes in staff availability such as sickness. We spoke with the registered manager and operations manager about these concerns. They confirmed that on occasions the numbers of staff on duty had dropped below the number assessed to be required. They described the on call arrangements which would ensure additional nursing staff support would be obtained for the home in event of a medical event. They also described the actions they were taking to improve and manage staff absence and levels of sickness. The staff we spoke with confirmed that the number of staff on duty did sometimes drop due to short notice absence. The staff we spoke with described the way they worked together to cover the units of the home, and to minimise the impact on people when shortages

occurred. The staff we spoke with were unaware of any negative effects staffing had on people. Improvements had been made to the number of staff on duty and the delegation of staff within the home. The registered provider had commenced work to ensure that people could be sure adequate numbers of staff would always be on duty to support them.

The provider had a robust recruitment process in place and had checked the suitability of staff to work with people prior to them commencing work at the home. These checks included obtaining Disclosure and Barring Service Checks (DBS) before staff worked with people. Staff we spoke with confirmed these checks had taken place, one newly recruited member of staff told us, "I had all the recruitment checks, an interview, application form, DBS checks and references before I was offered a start date." Routine checks had been carried out on the registration of nurses working at the service to ensure that their registration was current. Completing these checks is a way of ensuring people are supported by staff suitable to work in Adult Social Care.

We looked at how the service managed known risks to people. Individual risks to people had been identified although we found that steps had not always been taken to minimise the risk for the person. People were at risk from a wide range of health related conditions, including choking, falling, developing sore skin, becoming constipated, and becoming malnourished. The registered manager had ensured these risks were assessed using the relevant professional tools. We found that the risk assessments had not always been completed fully or accurately. Failing to complete these forms correctly can result in people not receiving the care and support that is consistent with the risk they are experiencing. In some instances the risk assessment identified an action that should be taken to reduce the risk, such as helping the person change position every few hours. Both our observations and records we viewed provided evidence that these actions were not consistently followed.
We spoke with staff about one person whose care we looked at in detail. Our observations and records we viewed indicated the person was due to change position to relieve pressure. Staff we spoke with were unsure of when the change was due, they went and checked and reported back, "Oh he is overdue now." This indicated the person had been at risk of not receiving the pressure care they needed to stay well. Our inspection identified other examples of known risks being poorly managed. These included people being given food that was not prepared in the way they required or not being given as required medicines when records provided evidence that they had not been able to use the toilet. While we did not find that people had experienced actual harm, these actions did not protect people as much as they should. People could not be confident that all their known risks would be consistently well managed.

Records showed that when accidents or incidents had occurred immediate checks had been made on the person's well-being. We saw that one person had been experiencing regular falls in the months prior to this inspection. While it was positive some further professional advice had been sought for the person the registered manager had not ensured that everything possible to reduce the impact to the person when they fell had been taken. Specialist practitioners with knowledge of falls management had not always been asked for advice. National good practice guidelines were not available in the home, and had subsequently had not been used to review and direct staff practice. People were at some risk of not being protected from avoidable harm. Failing to take action to mitigate known risks to people leaves people at risk of developing unnecessary health related conditions. This was a breach of Regulation 12 of the Health and Social Care Act 2008. Regulated Activities. 2014.

People told us or indicated using gestures that they felt safe living at the home. Comments we received from people included, "I'm alright, yes alright", and "As far as I am concerned I am happy and not worried about anything." Another person told us they felt confident with their care and able to raise any minor concerns. One person we met gave us the 'thumbs up sign' and another person showed with their facial expression

they were happy with the service. Relatives we spoke with gave us mixed feedback about the level of confidence they had that their loved one was safe. Some relatives told us, "I have complete peace of mind when I leave here, "and "I do feel he is safe.....They're trying to minimise his risks, and to keep an eye on him." Other relatives told us they had concerns for their loved ones safety and their comments included, "It feels like you always need to be here to keep an eye on things" and, "Things haven't always been great. I do go home and worry about him."

People were supported by staff who had a good knowledge of the signs of abuse and what action they would take should they have concerns. Staff told us they had received safeguarding training to ensure they were aware of current processes to follow and the signs to be aware of. One member of staff we spoke with told us, "I know how to recognise the signs of abuse and how to report it. My first contact would be the nurse on duty or the home manager." The staff told us that they felt people were safe, and their comments included, "I've never seen any bad practice here" and, "Everyone who works here does truly care. They do a lot to keep people safe." The staff member went on to describe safe working techniques they had been trained in, and the use of documentation such as body maps when they noticed a bruise or mark on a person's skin. The registered manager was aware of their responsibilities to report any safeguarding concerns that may arise. This knowledge and confidence within the staff team ensured people could be certain potential abuse would be identified and reported.

People living at the home required support to receive their medicines safely. People told us that the daytime medicines were usually administered without any problems, but that sometimes the night time medicines could be administered very late if the nurses on duty were involved in an incident or staffing was short. Comments we received included, "It works perfectly in the morning, but in the evening you can wait anytime until 11.45pm for them," and "I know what medications I'm taking. The nurses bring the tablets round." Only the nursing staff could administer medicines. Training had been provided to ensure nurses were aware of how to administer specific medicines, including medicines via syringe drivers safely. Nurses who were new to the home and newly qualified underwent competence assessments to ensure they were safe to administer medicines. Staff had access to clear information and guidance about when a person may need their 'as required' medicines, although we found these needed to be kept up to date when people's prescriptions changed. Audits of medicines had taken place which was used as a way to check medicines had been given as prescribed and signed for. This meant there were systems in place that ensured people received their medicines safely. Significant improvements had been made to the management of medicines since our last inspection, and with the exception of a few isolated incidents we found medicines were well managed and people could be confident they would receive their medicines as prescribed.

Requires Improvement

Is the service effective?

Our findings

At our last inspection we identified a breach in Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people had not always received the support they required to eat and drink adequate amounts. After our inspection we met with the registered provider and they provided us with written information about the action they would take to ensure this was addressed. At this inspection we found that improvements had been made although the requirements of the law had not been met. Further work was required to ensure people consistently received food they enjoyed and which met their needs.

People who had specialist dietary requirements did not always have their needs met well. People's medical conditions often meant they found swallowing difficult, that they required the texture of their food altering and that they were at increased risk of malnutrition. Good practice guidelines for people with these needs includes fortifying and enriching meals which condenses the nutritional value of a meal into a smaller volume of food to eat. Good practice is also to have a range of nutritional foods available at all times, to enable people to eat when they feel hungry and motivated to do so. We looked in detail at the support some people received to eat and drink. We observed some people being supported to eat large volumes of food, that had not been enriched, and which would not help the person maintain or build their body weight. Staff informed us that at this mealtime the person was motivated to eat, and we considered this a missed opportunity to provide the person with a high calorie, nutritious meal.

We looked at the records of meals that had been offered to another person in detail. The person required their food to be fortified and staff informed us the person's meals were fortified with a sugar free sweetener as the person had diabetes. Adding sweetener to food adds no additional calorie or nutritional value. We observed two meals served to a person who had multiple medical conditions and required an altered diet to ensure these were well maintained. The person was served foods that were unsuitable for the person's assessed needs. The registered provider told us additional assessments of the risks associated with some aspects of the person's eating had been undertaken.

On one day of our inspection we noticed no snacks were offered from the kitchen throughout the morning, although we were informed fresh smoothies were always provided. Although some snacks such as crisps, biscuits and yogurts were available in each unit, this meant some people went over four hours between meals without a nutritious snack. This was not consistent with people's plans of care, or the homes own policy on meals and nutrition. We looked at people's weight records to see if people had maintained or increased their body weight, as a way of helping us determine if the foods provided were meeting people's needs. Some records showed that people's weight had increased, some people had not been weighed with the frequency required, and for some people we were not confident that the weight records were accurate as significant swings in weight from week to week had been recorded. Staff we spoke with were unaware of these recordings. We not confident that people were consistently receiving the food or support they required to eat and drink adequate amounts to maintain good health. Failing to provide food and drinks suitable to meet people's needs is a breach of Regulation 14 of the Health and Social Care Act 2008. Regulated Activities 2014

Many new meal time initiatives had been developed and introduced since our last inspection. Specialist training had been provided to kitchen staff and the appearance of the food, especially for people who required the texture of their diet altering was much improved. A relative we spoke with told us, "I think the appearance of the food has really improved. That's important, you eat with your eyes" Attractive serving dishes had been purchased that improved the presentation of soft and puree meals. Specialist cutlery and crockery had been purchased and we saw a wide range of cups and beakers in use around the home. These enabled people to eat and drink safely and as independently as possible. Some people were fully reliant on a feed administered directly into their stomach. We looked at the management of these feeds and found staff were following professional guidelines to ensure people had adequate amounts of fluid and nutrition. This ensured people reliant on a PEG feed were nourished and hydrated.

People and their relatives gave us mixed feedback about the ability of the staff to support people effectively. Comments from some people and their relatives included, "The staff here have been first class," and "The care [name of relative] is given is very good. I couldn't fault the personal care. There are never any bad smells, and my relative is always helped to look nice." Throughout the inspection relatives we spoke with shared concerns about the turnover of staff, the movement of staff between different units of the home the effectiveness of handovers and the specialist knowledge of the staff team. Feedback we received from relatives included, "The staff do get a detailed, seven day induction but I think it takes a good while to build up the specialist knowledge in the conditions that people here experience. I'm not sure that knowledge is secure within the team." Other relatives told us that staff they spoke with regularly told them they had limited or no knowledge of their loved ones needs as they had been moved to the unit from another of the units within the home. Comments included, "I'm so often told, 'I've not worked here before', or 'I'm not sure I only came on duty at 2pm.'

Many of the relatives we spoke with expressed frustration that the handover of information and induction of staff to units they had not worked on before seemed inadequate to enable staff to effectively and safely meet people's needs. During the inspection we spoke with seven care staff. They staff we spoke with were all able to give a detailed description of the needs and wishes of the people they most commonly supported. It was also apparent from these conversations that staff knowledge of people had gone beyond purely what people needed in relation to their care and the staff demonstrated a genuine relationship with the person and their relatives.

Staff told us they had received sufficient training to carry out their role effectively. Staff starting work at Otterburn received a seven day induction that covered safe working practices and some of the specific needs and conditions of the people they would support. One newly recruited member of staff we spoke with told us, "Induction was steady. They didn't drop me in it. I did the classroom learning and then some shadowing. (Working alongside a more experienced member of staff.) The team were really supportive to me." Staff that are new to care, are required to undertake a nationally recognised induction called the Care Certificate. When staff required this, it had been provided. Staff told us training was on-going and that they felt well equipped to provide good care. Comments from staff included, "The training is good. Non-stop," and "The Company are brilliant with regards to training opportunities." Registered nurses are required to undertake continuous professional development to meet the requirements of the Nursing and Midwifery Council (NMC) and to ensure that they maintain current, best practice knowledge. Nurses we spoke with confirmed training that would help them meet this requirement as well as support with their revalidation was provided.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When people lack mental capacity

to take particular decisions, any decision made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA. People told us they were involved in decisions about their care, and where possible people had signed their care plans. Staff had received training on the MCA and had some knowledge of how it applied to people living at the home. Staff explained that they involved people in daily decisions about their care and had knowledge of best interest decisions. One staff member told us, "We always ask for people's consent. If people are not able to verbally say what they wish we just go carefully to check the person is happy to go ahead with the care or activity." Although staff had some knowledge of the MCA we saw that care practice did not consistently follow the principles of the MCA. We observed some staff approach people who were sitting in wheelchairs and take them out of the room without attempting to seek their consent and with no explanation about where they were going. In some instances the staff told other staff in the room of their intentions for the person. This didn't show staff practising these principles of consent and involvement.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service had applied for DoLS appropriately and whether any conditions on authorisations to deprive someone of their liberty were being met. Where people had identified restrictions on their care the registered manager had applied for DoLS appropriately, some of which had been approved. Staff were aware of who had a DoLS approved and how this impacted on the person's care. There were systems in place to review and if necessary re-apply for DoLS before they expired to ensure the person continued to receive the support they required.

Most people were unable to tell us about the healthcare they experienced. One person we spoke with told us, "Healthcare is alright. We get the GP and we get all the people to check glasses, the optician comes and the dentist." Records we viewed contained inconsistent levels of auditable information to help us determine if people had received the healthcare they required. In some people's files we saw letters inviting people for appointments. Records made did not confirm the appointment had been kept, or what the outcome of the appointment was. For some people we viewed letters from health professionals detailing the action they required the nursing staff to take. Staff we spoke with were unable to confirm from the records available if the appointments had been attended or not. It was not always evident that this action had been taken.

We observed one member of staff supporting a person with a medical condition during our inspection. They had supported the person well, and were assertively seeking additional guidance from the Doctor, when the planned care had not achieved the required results for the person. The registered manager had forged stronger links with the specialist teams of health professionals that support people living at Otterburn. This had ensured people benefitted from the input of staff who had specialist knowledge about their condition. People's healthcare needs were not consistently well met.

Requires Improvement

Is the service caring?

Our findings

People and their relatives gave mixed feedback about the involvement they had in planning care in order to state how they wished to be supported. One relative told us, "They do ask us. Staff come and ask us together how we feel about the care." Another relative told us, "They don't always involve me. I don't always find out until after a significant change has been made." Care plans contained details of people's likes and dislikes and their preferences for care but people's views and preferences were not consistently sought. The records of care would not always ensure that people received care in the ways they preferred.

The registered manager had introduced 'Dignity champions' into the home. These are staff that promote people's right to dignity and look for opportunities to challenge practices that might compromise this. Staff we spoke with described the actions they could take to ensure people's dignity was maintained. These included closing doors and blinds for example when providing personal care and where possible offering people staff of the same gender to support them. Despite this during our inspection we observed some interactions where staff did not promote people's dignity. These included staff sharing personal and confidential information in front of other people living at the home, people not being adequately supported so they accessed other people's room without invitation, staff not seeking people's consent to care or intervention, and staff speaking with people in a way that did not reflect their age or a professional relationship. We observed staff help people to take their oral medicines in a dignified way and staff asked people for their consent before supporting them to take their medicines. We observed some people who needed their medicines administering via a tube directly into their stomach. (PEG). We observed staff administer these medicines in communal areas of the home, requiring the staff to expose the person's stomach in view of other people living, working and visiting the home. This didn't protect the person's dignity. People could not be certain their dignity would always be maintained.

Many of the people living at Otterburn had been diagnosed with medical conditions that were degenerative, and would mean they would require nursing care until the end of their life. We looked at the opportunities people and their relatives had to be involved in planning end of life care. Good practice guidelines suggest that this end of life planning process should cover at least the last 12 months of a person's life and does not just relate to the 'last days' of a person's care. It is anticipated planning in this way will help people have reduced hospital admissions and enjoy a greater quality of life, and to ensure the care people receive is aligned to their needs and preferences. One of the people whose care we looked at in detail had received good support and advice had been obtained from local specialist end of life practitioners People important to the person had been involved in this care planning process. This had been recorded in a written plan, which is a way of ensuring the decisions made and person's wishes are recorded and available for all who need to know this information. For other people whose care we looked at in detail this area had not been well planned, and often just stated if the person wished to be resuscitated or not, and the person's funeral preferences. The staff knowledge and practice about this area of care would not ensure people would consistently experience good planning for their end of life care.

The relatives of people living at the home shared with us many positive examples of the compassion they had witnessed staff demonstrate towards their loved ones. Comments we received included, "Staff really

love [name of relative], and they genuinely care. That gives me great comfort and peace of mind." Another relative told us, "The carers are lovely. So good. You only have to ask and they will help you as soon as they can." Relatives went on to describe how staff had supported them to go on holiday with their loved one, and to celebrate milestone birthdays and special wedding anniversaries with a party in the home. One relative described the various ways they had been supported in previous years to celebrate Christmas with their relative, which included helping to put up decorations around the home. Family members described the joy these events brought to them and their wider family, and the importance of them in maintaining some element of 'family life' despite the person being ill and requiring nursing care. These activities helped people maintain important relationships and reduced the risk of social isolation.

Staff told us they enjoyed working with the people who lived at the home and commented that this was the best part of their job. Staff told us, "I love working here. I love seeing a smile on people's faces and knowing that I have made a difference," and "The small things we do are really satisfying, knowing we have made a difference to people's happiness and comfort." We observed numerous kind, caring interactions between people and staff and saw staff take the time to sit and talk with people about topics that interested them. Many of the staff had a relaxed and friendly manner, and we saw people could easily approach these staff and enjoy their company and communication where possible.

When people had no families or friends people had the opportunity to access advocacy services and there were details available in the home should anyone request this service. This demonstrated that people had the opportunity to seek support from services that were separate from the home.

Requires Improvement

Is the service responsive?

Our findings

Some people and their relatives had been involved in planning and reviewing their care. One relative told us, "As for everything major I am involved." Other relatives told us they had not been involved as much as they had wished and one comment we received was, "I'm kept in the dark. However when they gave him the flu jab I was consulted about that."

Many of the people we met had conditions that changed over time, and we found that the written plans and care that was offered had sometimes been adjusted to meet people's changing needs. One person whose care we looked at in detail had care records that did not reflect a significant change in the amount of support they received each day. The care records we viewed recorded each person's needs and wishes.

The opportunities for people to take part in activities had increased, however we did not find these opportunities were consistently provided across the home. People had access to a variety of activities within the home and in the community. Recent community events had included going to the cinema, for local walks and going out shopping. Around the home we saw photographs of people enjoying a wide range of activities and several staff and relatives told us about a holiday some of the people from Otterburn had been able to enjoy this year. People we spoke with told us, "I enjoy reading the paper, putting my feet up and silence." They confirmed they were able to do this regularly and this met their needs. Another person expressed their wish to practice their faith. They told us, "I can go to church some-times, I need to go with a carer who is free. I can go but not regularly." The person was pleased when they had the opportunity to attend church but was disappointed this could not be facilitated more frequently.

We undertook observations in all three units on different days and at different times. In some units we saw staff spontaneously starting activities with people that included table top games and hand massages. On some occasions people were involved in music and craft sessions in the dedicated activity areas available on each unit. During other observations we saw people sitting for long periods of time with little interaction from staff and sometimes with nothing to do that was capturing their attention or offering them any stimulation or engagement. The care records of one person whose care we looked at in detail stated their most significant need was for social interaction. Despite this the plan of care had nothing planned or recorded about how this need would be met. We appreciated that many of the people we met had physical health needs that meant they would be unable to participate in lengthy or overtly physical activities. However people living at the home did not consistently benefit from the provision of activities which were based on their interests and needs and that encouraged stimulation and participation.

Systems had been developed to ensure staff were kept up to date about changes in people's care, however we were not confident these were always effective. We were informed that handover's took place between staff teams. These should be an opportunity to share important information about the people living at the home and their needs. One relative we spoke with told us they had raised the same issue with staff repeatedly. They told us, "I get tired of saying the same thing about [name of person] over and over." We asked why they thought the communication had been ineffective. They went on to tell us, "Staff often say, 'I wasn't on this unit this morning, or I haven't been on here before.' " The relative then questioned the

effectiveness of the handover from one staff group to another. Two other relatives told us they had in the past written notices to put in the person's room, as information they had shared not been passed on between staff. One relative told us, "I have needed to put up notices to remind staff of the things I have said." We heard staff asking each other about people's needs. On one unit the staff asked each other, "Did [name of person] eat yesterday?" Two staff told the nurse they hadn't been on the day before. This person had a reduced appetite and required additional encouragement and support to eat. It was of concern that such significant information had not been handed over between shifts. Records we viewed showed that the person had not eaten well on previous days, which increased the importance of staff having this knowledge. Information sharing systems were not consistently working well to ensure people received continuity of care which is important for people's well-being and safety.

We looked at the systems for raising concerns or complaints. The registered manager showed us the work undertaken to investigate formal complaints. The written records showed people could be confident their concerns would be taken seriously, investigated and detailed feedback provided. One person living at Otterburn told us, "If you have a problem it is dealt with pretty much straight away." Relatives we spoke with confirmed this was the case, however they told us that they had not always experienced a sustained change after making a complaint. Comments we received included, "If you speak with them about a problem they do look into it." Another person told us that they went directly to the registered manager with their concerns and described the positive outcome and apology they had received in response to their concerns. However other people told us, "If you complain they always apologise. They improve but in most instances they are back to where they were within a week. To be honest it causes me a lot of stress. Now I only say something when things get really bad."

We saw that people and their relatives were given opportunity to feedback or raise complaints within regular meetings that took place with all the people living at the home. We saw that there was a feedback box in the entrance to the home where people, their relatives, visiting professionals or staff could leave anonymous complaints if they wished and there was literature available around the home explaining the procedure for raising complaints. The registered manager and operations manager held regular 'drop in surgeries' where anyone was welcome to meet with them and share any feedback or concerns they had. Since our last inspection the registered manager had developed a, "You said-We did" board. This was a way of showing what ideas or concerns had been brought to the registered manager's attention and the action they had taken in response to the comments. While this demonstrated an open culture to complaints and feedback, people could not be certain sustained change would occur as a result of the concerns they shared.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection we identified a breach in Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the registered provider had not ensured the systems to check on the safety and quality of the service were adequate. After our inspection we met with the registered provider and they provided written information about the action they would take to ensure this breach was addressed. At this inspection we found that significant improvements had been made, but these had not been adequate to comply with the legal regulations or to consistently ensure people would receive good and safe care.

There was no registered manager in place at our last inspection and this was a breach of Regulation 7 of the Health and Social Care Act 2008 (Registration) Regulations 2014. Shortly after our inspection the home manager successfully applied to become registered. This breach of regulation was fully met.

The registered provider had assessed that each of the three units within Otterburn should have a unit manager, and in the past year there had been a significant turnover of nurses holding these positions. Feedback was that this had been very unsettling and that in some instances this had knocked the confidence of relatives and the morale of the staff team. Comments we received included, "I don't think the leadership on this unit has been good. Shifts work in isolation. No one seems to have overall oversight." Another relative told us, "It's like a new home every day. There is no follow on from one day or one shift to the next," and "The care is good, there is just a lack of common sense, joined up thinking and general management." The leadership of the home had not always been strong or effective and had not resulted in people being consistently satisfied or receiving reliably good, safe care.

A wide range of systems to monitor the quality and safety of the service had been utilised on a regular basis, in conjunction with 'spot checks' to follow up on specific issues or areas of concern. In some instances these had been used to provide assurance that the service was operating well. In other instances to identify issues that needed further investigation. However the systems in place to monitor and manage risks to people had not been entirely effective as issues including helping people to change position, and management of special diets were identified during the inspection that had not been identified by the registered providers own quality assurance processes. While the processes in place had helped to drive forward and improve the service our inspection identified further work was required to ensure that everyone experienced a safe, good quality service. Failing to have effective systems to review and improve the quality of the service offered is a breach of regulation 17 of the Health and Social Care Act 2008. Regulated Activities. 2014.

People, relatives and staff gave consistent, positive feedback about their relationship with the registered manager. Relatives told us they felt able to contact her at any time, and that interactions with her were positive and compassionate. Staff told us she had been supportive to them and their comments included, "The registered manager has been so supportive, in relation to my work, and my personal circumstances. Under her leadership I feel like I have really grown as a worker and a person." A relative we spoke with highly praised the service and told us, "This has been a top notch service. We are 100% happy, found it to be exceptional." Other relatives told us, " There was a big improvement last year after the CQC visit, personally I

feel like that is dropping off now," and " I feel like this home has all the components to be really good. There just hasn't been consistent or effective leadership."

In the past year the Operational manager and assistant operational manager had spent time in the home supporting developments and relatives and staff we spoke with also reported that they were regularly at the home, and encouraged staff to approach them directly. They told us, "I can speak to any of the manager's about anything." Another member of staff told us, "The whole organisation has been supportive."

The registered manager understood their responsibility to inform the Commission of specific events that had occurred in the home and was aware of what changes in regulations, such as the duty of candour meant for service provision. The registered manager informed us that they had recently appointed a lead clinical nurse, and they anticipated they would be able to support with the improvement and development of clinical, health related aspects of the service.

The registered manager had put systems in place to ensure feedback was sought from people living at the home. Relatives and staff told us that they had regular meetings where topics such as activities, menu planning and concerns were discussed. Feedback from staff included, "We can share our ideas at handovers, in staff meetings and team leader meetings. We talk about what works well, and what doesn't, improvements we'd like to see. The managers are always open to our opinion and we have made significant changes and improvements in the past year." The registered provider carried out surveys with people to measure their satisfaction with the service. A new survey had recently been commissioned and the registered provider was waiting feedback. A report of the feedback received last year was shared with us, and showed that action had been taken in response to feedback given about the service. The registered manager and registered provider showed a strong commitment to improving and developing the service. Significant improvements had been made in the past 12 months, however we did not find these were established and working consistently across all areas of the home or staff group.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People had not consistently received safe care and treatment that met their needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs This was because people had not always received the support they required to eat and drink adequate amounts.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The registered provider had not ensured the systems to check on the safety and quality of the service were adequate.

The enforcement action we took:

The registered provider had not ensured the systems to check on the safety and quality of the service were adequate.