Care Worldwide (Bradford) Limited

Owlett Hall

Inspection report

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Ratings

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

Overall summary

This inspection took place on 18 May 2015 and was unannounced. At the last inspection in August 2013 we found the provider was meeting the regulations we looked at.

Owlett Hall is a care home with nursing and registered to provide personal care and accommodation for up to 57 older people. The home is purpose built and set over three floors, and each room has an en-suite shower room. The ground floor unit provides an intermediate care service. The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At this inspection we found people were happy living at Owlett Hall. They told us the staff were kind and caring. Throughout the day we observed staff providing care in a caring way. Staff knew the people they were supporting very well.

Summary of findings

People told us they felt safe and didn't have any concerns about the care they received. However, there was a risk to people's safety because safeguarding procedures were not always followed.

Some incidents between people who used the service had not been reported to the appropriate agencies. Medicines were not always managed consistently and safely. We found people lived in a clean and safe environment.

People enjoyed a range of social activities and had good experiences at mealtimes. People we spoke with told us their health needs were met and care records showed health professional advice was followed.

People consented to their care and treatment. Their care needs were assessed. However, guidance for delivering care was basic and sometimes not up to date so people's care needs could be overlooked.

The provider was increasing staffing numbers to help ensure there were enough staff to keep people safe. Robust recruitment and selection procedures were in place to make sure suitable staff worked with people who used the service. Staff felt supported but the arrangements for supervising and training staff required improvement to ensure staff had the right skills and knowledge to fulfil their role properly.

People told us they would feel comfortable raising concerns or complaints and provided positive feedback about the registered manager. People were involved in the service and helped to drive improvement. Although the provider had a number of systems for monitoring quality and safety these were not always effective.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014. You can see the action we have told the provider to take at the end of this report.

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?
The service was not safe.

People told us they felt safe but the provider was not working within safeguarding guidance.

People were not protected against the risks associated with the unsafe management of medicines.

People lived in a clean and safe environment.

Inadequate

Is the service effective?
The service was not always effective.

Staff were not always appropriately trained and supported so people may be cared for by staff who do not have the right skills and knowledge.

People were asked to give their consent to their care, treatment and support. The service met the requirements of the Deprivation of Liberty safeguards.

People received appropriate support with their healthcare and a range of other professionals were involved to help make sure people stayed healthy.

Requires improvement

Is the service caring?
The service was caring.

People told us staff were caring and kind.

Staff knew people well and had a good understanding of their individual needs and preferences.

People looked well cared for and were comfortable in their home.

Good

Is the service responsive?
The service was not always responsive to people needs.

People felt the care was person centred, they felt consulted and had choice in their lives.

In the main, people's needs were assessed. However, care plans were basic and did not always sufficiently guide staff on people's care so individual needs could be overlooked.

Requires improvement

Is the service well-led?
The service was well led.

People spoke positively about the registered manager and said the home was well managed.

Requires improvement

Summary of findings

People were asked to comment on the quality of care and support through surveys and meetings. They were encouraged to help drive improvement.

The provider had systems for monitoring quality, however these were not always effective.

Owlett Hall

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 inspection took place on 18 May 2015 and was unannounced. Two adult social care inspectors, a specialist advisor in nursing, and an expert-by-experience visited. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert had experience in older people's services.

Before this inspection we reviewed all the information we held about the service. This included any statutory notifications that had been sent to us. We also contacted health professionals, the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

There were 57 people staying at the home when we visited. We spoke with five people living at the home, five visiting relatives, a visiting professional, twelve staff which included an activity worker, care workers, chef, ancillary staff, nurses, deputy manager and registered manager. We observed how care and support was provided to people. We looked at documents and records that related to people's care, and the management of the home such as staff recruitment and training records, policies and procedures, and quality audits. We looked at five people's care plan records. After the inspection we received feedback from two health professional teams who had been involved with the service.

Inadequate

Is the service safe?

Our findings

When we asked people if they felt safe everyone we spoke with said they did. One person said, "I feel safe. I was on my own before." Another person said, "I do and I sleep well, it's a super bed is this." A visiting relative said, "Absolutely." They went on to tell us there had been no instances of any problems and no one was aggressive. Another visiting relative said, "My relative is relaxed, well looked after and safe." Another visiting relative said, "Most definitely. I'm just so relieved that my relative is here. Looked after, safe, engaged with."

We spoke with staff and the management team about safeguarding people from abuse. In the main, staff were confident people were safe and told us they would report any incidents if they were concerned. They also said the management team would treat any concerns seriously and deal with them appropriately and promptly. When we asked staff about their understanding of safeguarding adults, some thought this related to general safety rather than protecting people from abuse. Staff were aware the provider had a whistleblowing policy and knew who to contact if they wanted to report any concerns. 'Whistleblowing' is when a worker reports suspected wrongdoing at work. Although people who used the service told us they felt safe and staff were confident people were safe, we found people were not always protected against potential abuse because the provider was not working within safeguarding guidance.

Before we carried out the inspection we received information about a safeguarding concern and although the registered manager was aware of the allegation they had not reported this to the Care Quality Commission (CQC). A registered person must notify CQC about these events.

During the inspection a safeguarding concern was raised with us. This had been shared with some staff who worked at the home prior to the inspection but no action was taken to raise the concern with the local authority. The registered manager said the full extent of the concerns had not been shared previously.

When we reviewed five people's care records we noted that there were two other incidents that should have been reported to the local safeguarding authority and notified to CQC but they were not. Both concerned unexplained bruising and people who used the service alleged these were caused by care workers. There was evidence the registered manager had followed up both of the concerns, however, they had not followed safeguarding procedures which states they must raise a concern with the local authority which meant the provider was not working within safeguarding guidance. This was in breach of Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager agreed to ensure the safeguarding issues raised at the inspection would be raised with the local authority and notifications sent to CQC.

We looked at the systems in place for managing medicines in the home and found there was a lack of consistency and therefore concluded that appropriate arrangements for the safe handling of medicines were not in place.

All medication was administered from separate boxed items held in a locked cupboard in people's rooms. We observed medicines were not being administered in line with the provider's policy and not to a standard which complied with good nursing practice. We found that during the morning medicine round, medicines to be administered at lunchtime and late afternoon had been taken from their box and placed in unmarked medicine pots within the person's locked medicine cupboard. We brought this practice to the attention of the registered manager who agreed to ensure this stopped immediately. A student nurse was being mentored by the nurse who was incorrectly administering medicines. The Nursing and Midwifery Council (NMC) places responsibility on trained nurses to provide support and guidance and act as positive role models to nurses in training: our observations proved this not to be the case.

Some people were prescribed medicines with specific instruction. There was little or no information for staff to follow to enable them to support people to take these medicines correctly and consistently. One person had Parkinson's Disease and was taking medication at specific times of the day but there was no reference to this in their care plan. Another person had Diabetes which was controlled by medication. There was no information to help staff understand why the person required the medicine or deliver the care to meet the person's individual needs and preferences.

Inadequate

Is the service safe?

One person was given their medicines covertly (hidden in food) without their knowledge and/or consent. Best practice guidance states that covert administration only takes place in the context of legal and best practice frameworks to protect both the person who is receiving the medicines and the care home staff involved in administering the medicines. We reviewed care records and discussed the arrangements with the registered manager but found the correct procedure was not followed. We saw a letter from a health professional confirming the person lacked capacity with regard to compliance with medication. The care records listed people who had been consulted in the process. However we did not see any documentary evidence from the best interest meeting which arrived at the decision to administer medicines without the person's knowledge. The provider's medicines policy described good practice with regard to the need for a multi-disciplinary team review of the practice of administering covert medicines not less than three-monthly. We saw no evidence of any review taking place.

The provider had a medication policy. This provided guidance on the safe administration of medicines and made reference to out of date guidance for the safe handling of medicines in social care establishments. The provider's guidance should refer to the National Institute for Health and Care Excellence (NICE) guidance, 'Managing medicines in care homes guideline (March 2014)'.

The NICE guidance states care home providers should ensure all care home staff have an annual review of their knowledge, skills and competencies relating to managing and administering medicines. We asked to look at competency assessments for staff who administered medicines but were told these were not available.

The provider had carried out regular audits of medicines with the intention of ensuring medicines were safely administered and accurately accounted for. The outcome of the audit was reviewed and we saw evidence of actions taken to remedy shortfalls. However the audit was not comprehensive enough and did not include observation of staff practice. This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although we concluded appropriate arrangements for managing medicines properly and safely were not in place, we noted some aspects were being well managed. On the intermediate care unit staff were enabling people to regaining independence. One person with diabetes was self-administering their insulin and participating in checking their oral medication. People were assessed as to their capability to self-medicate.

We looked at people's medicine administration record (MAR) and reviewed records for the receipt, administration and disposal of medicines. In the main they were well completed although on a small number of occasions nurses had not signed the MAR sheet. Staff recorded reasons why medication was not taken, for example, if the person had refused to take it. Stock levels were correct which indicated medicine's had been given as prescribed and medicines were available at the home when people needed them.

We looked at one person's MAR sheet who had been prescribed warfarin. The appropriate dosage of warfarin was dependent on the outcome of a regular blood clotting test. The outcome of the test indicated the dose of warfarin to be given over the coming period. We saw the registered manager had introduced a specific protocol for all to follow to ensure the blood results were accurately recorded and the correct dose of warfarin administered. We saw one person was receiving their medicines via a syringe driver. We saw the method of administration was being effectively and safely delivered.

Some prescription medicines contain drugs controlled under the misuse of drugs legislation. These medicines are called controlled medicines. At the time of our inspection a number of people were receiving controlled medicines. We found controlled drugs were accurately recorded and accounted for. In discussion with nursing staff and the review of the MAR sheets we were assured staff attempted to understand and investigate the cause of untoward behaviour rather than resort to medication.

We noted the date of opening was recorded on all liquids, creams and eye drops that were being used and found the dates were within permitted timescales. Creams and ointments were prescribed and dispensed on an individual basis. The drug refrigerator and controlled drugs cupboard provided appropriate storage for the amount and type of items in use. The treatment room was locked when not in use. Drug refrigerator and storage temperatures were checked and recorded daily to ensure medicines were being stored at the required temperatures.

Inadequate

Is the service safe?

We looked at how risk was managed for people who used the service and found there was a lack of consistency in how this was done. We reviewed the recording of accidents and incidents and found that, in the main, incident reports were comprehensive and completed thoroughly. Some, however, were not completed fully and it was difficult to clarify what had taken place or what follow up action had been taken. The registered manager agreed to ensure these forms were reviewed and future report forms were appropriately completed.

People lived in a safe environment. We reviewed fire safety records and maintenance certificates for the premises such as gas safety, electrical wiring and passenger lift and found checks were carried out within the recommended timescales. In one lounge there was a TV monitor standing unfixed on a relatively narrow window sill. This was attached to a nearby DVD recorder which had loose, dangling cables. The registered manager agreed to address the loose cables to ensure they were not a trip hazard. Two visiting relatives told us there had been on-going problems with the passenger lift but had since been resolved. The provider had notified CQC at the time and provided updates.

We looked at a range of assessments which showed that risks to people were identified and managed. Each person's care file contained a range of assessments such as falls and the use of bedrails, nutritional risk, moving and handling, pressure area care and an overall dependency rating. People were provided with equipment to help reduce the risk of harm, which included pressure relieving equipment and equipment to help prevent falls. We noted in some people's care files there were completed falls risk assessments and appropriate action was taken in the event of a fall, however, the falls record was not always completed, which would cause confusion if these were being used to assess or monitor the level of risk. The registered manager agreed to review the use of these documents.

Each person had a Personal Emergency Evacuation Plan (PEEP) in place. A PEEP tells staff and emergency personnel of an individual's abilities in terms of mobility and helps them assess how to evacuate people in an emergency situation. However this document was placed at the very back of the individual's care plan. This meant, if an emergency was to arise this plan could be difficult for staff and emergency personnel to access, leading to unnecessary delays in the evacuation of residents to a place of safety. The registered manager agreed to review this so information could be located easily.

Three members of the inspection team arrived at 8.50am and entered the home. The front door was unlocked and there was no door bell. Once inside, the inspection team went unchallenged even though they wandered in one of the corridors where people were in bed. A member of staff entered the building and passed the team but did not ask who they were or if they needed assistance. After ten minutes a member of the inspection team approached a member of staff. The registered manager said they were usually in their office which is located next to the entrance and throughout the day the administrator was normally present in reception and supervised entry and exit. There was a keypad to exit. The registered manager said they would review security.

We visited different areas of the home and noted it was generally well decorated. Pictures, photographs and ornaments were displayed in communal areas as well as in individual rooms to create a homely environment. The home felt spacious with wide corridors and large windows in the lounges.

A health professional told us, "With respect to the intermediate care side of the home I do feel that the home is safe. The patients are well looked after and if there has been any deterioration in their condition the home have promptly transferred them to casualty." They told us some concerns had been raised about the type of people who were admitted to the intermediate care unit and felt staff had been proactive about this and were trying to tighten up the admission criteria. They said, however, that it didn't help when there was only one nurse for 15 people. They also told us they were aware some people had raised concerns about the length of time it had taken staff to respond to call bells. They said, "I think the staff try their best to respond to their patients and most of the time I believe they achieve this."

We received a mixed response when we asked people who used the service and visitors if there were enough staff to care for them. One person said, "If I use the buzzer I don't have to wait long. They come as soon as they are free." Another person said, "No, they're short of staff, all the time." Another person said, "Definitely not. If I use the buzzer I don't wait so long but long enough." Another person said,

Inadequate

Is the service safe?

"'The nurses are always so busy. I suppose they could do with a few more." A visiting relative said, "My relative has been told that she must use the buzzer. They're very attentive and have time for you." Another visiting relative said, "My relative sometimes has to wait a bit. There's a problem only if there's a flu bug or something. They're not understaffed."

We also received a mixed response when we asked staff. A member of staff said, "The girls work really hard. They manage. Everybody will help if I ask for help." Another member of staff said, "The carers work really hard. They're under enormous pressure. No, there aren't enough staff. Even one more would make a difference per shift. A lot of people need two staff and if they are on breaks or dishing up meals, there aren't two available for toileting and transferring. At times, staff are really stretched and struggling. They're worked flat out when they're here." Another member of staff said, "Staffing is not consistent. Sometimes we are short if there is sickness and then it is difficult. We provide good care if there is enough staff." Another member of staff said, "People get well looked after but we don't have time to talk. People buzz when they are ready but sometimes they have to wait." Another member of staff said, "There is enough staff to keep people safe and to provide care but there is not enough to spend quality time with people."

The registered manager told us they did not use a formal system for calculating the appropriate staffing levels, however, they had listened to feedback from staff at the beginning of the year who raised concerns that the staffing levels were low. As a result, during the day, they had increased the number of staff on shift and were trying to ensure that ten care staff were working between the hours of 8.00am-2.00pm and nine care staff were working 2.00pm-8.00pm, however, this was not a formal agreement so when staff were absent, for example off sick, the revised staffing numbers were not maintained.

We looked at the staffing rotas and saw the staffing levels varied. At times there were ten care staff between 8.00am and 2.00pm, however, this was not consistent. We spoke with the registered manager after the inspection who said the revised staffing levels were being formally agreed and would be maintained. They said they were also looking at a dependency tool to help ensure appropriate staffing levels were provided.

We found there were effective recruitment, retention and selection processes in place, which were underpinned by a written policy. We looked at a random sample of six staff files. Records showed robust recruitment procedures were followed and relevant checks were carried out before an offer of employment was made. These included full employment history, proof of identity and two references. All registered nurses supplied details of current registration with the Nursing and Midwifery Council (NMC) which the registered manager checked. We saw evidence all staff had Disclosure and Barring Service (DBS) clearance before commencing employment. The DBS is a national agency that holds information about criminal records. We saw all applicants completed an application form and were interviewed by the registered manager.

People lived in a clean environment. People we spoke with were complimentary about the standards of cleanliness. A person who used the service said, "It's as clean as it can be. We've got some decent cleaners." Another person said, "Yes it is clean, the en-suite is very clean." A visiting relative said, "It is clean. Last Friday my relative told me their room had not been cleaned. As soon as I mentioned it, a cleaner was sent who said that she had been four times earlier but didn't want to intrude on doctors, care workers, etc." Another visiting relative said, "Yes, it's always been clean. I've been impressed with the cleanliness. Carpets are thoroughly cleaned." Another visiting relative said, "When we mentioned marks on the walls of our relative's room, they came and redecorated quickly. The cleaner shampoos the carpet. We liked this home because it didn't smell."

We looked around the home and saw it was clean and there were no offensive odours. Some areas of the home were cluttered. In two of the lounges there were piled boxes of Christmas trees, Christmas decorations, and glass and pottery vases. The lower floor lounge had six cardboard boxes, some which were quite large, and a plastic crate near a window. These were a hazard and could not be easily moved so would make cleaning difficult. The registered manager told us an external storage shed had been damaged and they were waiting for a storage container to be delivered.

During the day we observed staff washing their hands between various activities and making use of protective gloves and aprons (PPE) when required. A member of domestic staff talked to us about cleaning schedules which identified daily routines and periodic deep-cleaning. We

Inadequate

Is the service safe?

saw cleaning products were available and safely stored in a locked room. All cleaning products had been subject to Control of Substances Hazardous to Health (COSHH) assessments. We were told of a coloured cleaning cloths and mops system which ensured separation of cleaning materials for toilets, kitchens and bedroom surfaces. We observed the correct use of the cleaning cloths in practice. We asked the member of domestic staff to describe their role in the event of an infection out-break. Their answer demonstrated a competent understanding.

During the inspection some concerns were raised about the reduced availability of PPE. The registered manager explained they always had stock available but had revised their ordering system because they had been previously storing excessive stock.

Requires improvement

Is the service effective?

Our findings

People we spoke with said staff had the right skills to support them. One person said, "You couldn't have it better. It's not like these on television. They do their best." Another person said, "I think they're marvellous." A visiting relative said, "My relative is well looked after." Another visiting relative said, "My relative's diabetes is well controlled. I've been much happier with the care they've had here than when they were in hospital."

We observed staff confidently and competently deal with a difficult situation during lunch. One person started shouting and swearing. Members of staff politely but firmly spoke with the person who calmed down and everyone continued to enjoy the meal.

One health professional told us, "On the whole I believe that the home is effective with respect to our rehabilitation work. They work well with the intermediate care staff and many of the patients have an effective and well planned discharge." Another health professional raised concerns about the skills, knowledge and understanding of some staff who had been allocated to work in the intermediate care unit, which they felt was leading to ineffective care. They told us on some occasions staff were allocated to the unit who had little vision as to the philosophy of the unit. They told us care staff were focussed on the long term care of people with efforts being made to protect people from harm and mitigate risks but the intermediate care unit was to stretch people's abilities and prepare them to return home. This required people to be assessed as to their ability to cope with risk. We were told sometimes these two care philosophies were in conflict with each other. The health professional told us they had a recent meeting with the registered manager to ensure there was a common understanding of people's needs; they said early signs were of an improving situation.

Staff we spoke with said they were well supported by the registered manager and colleagues. They told us they received supervision and had opportunities to talk to a senior member of staff, nurse in charge or the manager. Staff said they attended regular training sessions which equipped them with the knowledge and skills to do their job properly. We looked at the supervision matrix; this showed supervision sessions were overdue and the registered manager said these would be brought up to date shortly.

We were unable to establish if staff undertook training that enabled them to fulfil the requirements of their role. We looked at the training matrix which showed staff had completed a range of training sessions in 2014/15 and included moving and handling, infection control, health and safety, fire safety, safeguarding adults, and Control of Substances Hazardous to Health, Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The matrix had other training sessions and most staff had not completed these, which included food hygiene, nutrition and hydration, dementia, end of life care and first aid. We asked the registered manager if the provider had guidance on which training was mandatory but was told this was not available.

We looked in five staff files for training records and certificates but found these were not available. The last certificates that had been issued were dated 2012. There was no training file for one member of staff. The provider training policy stated that each member of staff would have a training record in the personnel file which will log the training attended; these were not available.

The registered manager had some attendance records with staff names for training in 2014/2015 but it was difficult to establish from these lists if all staff had attended all the relevant training. The registered manager said some training sessions included completion of questionnaires to check staff knowledge. We asked to look at these but they were not for any of the training courses completed in 2014/2015. We concluded the provider did not have a system in place to ensure staff undertook training to enable them to fulfil the requirements of their role. This was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission (CQC) monitors the operation of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). DoLS protect the rights of people by ensuring that if restrictions are in place they are appropriate and the least restrictive. No people at the home were subject to DoLS at the time of the inspection. We spoke with the registered manager who had a good understanding of the legal framework in which the home had to operate.

People's care files contained signed consent to care and treatment forms. We saw that, in the main, care plans recorded where someone had made an advanced decision on receiving care and treatment. However, this was not

Is the service effective?

always the case. We also found inconsistencies in relation to decision making processes. It was evident from reading some people's care records they did not have the mental capacity to make specific decisions, however an assessment was not completed. Other people did have mental capacity assessments and care plans showed appropriate decision making processes were followed. One person had recently received a referral to mental health services due to an increase in confusion and low mood, however despite regular references throughout the care plan relating to this sudden change, no capacity assessment had been undertaken. A decision was made to restrict a person's access to alcohol but there was no evidence that the person had been consulted or had their mental capacity assessed. The registered manager agreed to review people's care plans to ensure there was clear information about decision making processes.

Some people had 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) decisions. In the care files we looked at correct and fully completed forms were in place in all but one case. One form was an out of date version and the registered manager agreed to follow this up. The staff we spoke with knew these documents must accompany people if they went to hospital.

In one care plan it was acknowledged that the person did not wish to be resuscitated and that at this time they do not wish to discuss their preferences related to how they wish to be cared for when they approach the end of their life. This demonstrated staff had made attempts to discuss end of life care with the person and had respected their wishes by not pursuing the subject when they were not ready.

We saw the provider's restraint policy promoted a restrain free approach to care which recognised restraint as a last resort after exhausting all reasonable alternative management options. We looked at a sample of care plans for people who had bed-rails attached to their beds. Assessments of people's needs demonstrated bed rails were used only to prevent people falling out of bed or where people were anxious about doing so. We saw families had been included in discussions prior to bed-rails being used.

People we spoke with were generally positive about the food. One person said, "The food is very nice and nicely presented. Sometimes there is too much, I'm outfaced by it." Another person said, "More often than not it's very good." Another person said, "The food is quite good. They have to serve it to me." Another person said, "I think it's good. I have my meals in my room and they're definitely hot enough. There is choice each day. There is enough for me but what I get isn't enough for a man." A visiting relative said, "The food's very nice. My relative would tell you if it wasn't." Another visiting relative said, "They always make sure my relative has enough to drink. Their food is all pureed. They love their ice cream."

We observed lunch in the dining room. Tables were nicely laid with condiments and fresh flowers. Some people had special equipment to aid their eating and drinking. There were plenty of staff to support people with their meal. A choice of drinks was offered, followed by a choice of dishes. Staff we spoke with told us people were asked to choose their meal earlier the same day but during service everyone was asked again which they would prefer. On the day of the inspection people could choose from 'cottage pie' or 'sausage in onion gravy', potatoes, swede and sprouts; treacle sponge and custard or fresh fruit and ice cream or yoghurt.

Lunch was calm, pleasant and relaxed. The food was served hot, looked appetising and the portions were plentiful. One person was asked if they wanted more and had a second helping. Food which went out on trays was covered and some meals were taken to another floor on a heated trolley. When lunch had finished people were given a wet wipe to freshen up.

At teatime people had a choice of 'leek bake, scampi and chips; sandwiches and salad could be made to order. The selection of desserts included chocolate cheesecake, tinned and fresh fruit, ice cream and jelly. The menus rotated on a four-week cycle, with seasonal change. During the day we noted people were offered regular drinks and snacks. We observed there were jugs of water or other drinks available in people's bedrooms.

We saw people's nutritional needs were assessed and care plans were in place. Where weight loss had been identified, appropriate referrals to the GP and dietician had taken place. All of the care plans we looked at had been reviewed at least monthly, as had the nutritional risk assessment. One person was refusing to get weighed and their assessment was completed incorrectly; staff had not

Requires improvement

Is the service effective?

explored alternative methods to calculate the person's weight although there was involvement from external health professionals and advice from the dietician had been followed.

People we spoke with told us their health needs were met through GP visits and other services such as chiropody. One person said, "They contact the GP and I go to hospital once a month." A visiting relative said "The nurses here see to dressings and eye drops." Another visiting relative told us arrangements had been made for their relative to see the chiropodist when they next visited.

The care records we looked at contained information about visits from healthcare professionals, for example GPs, district nurses and chiropody. We saw health professional advice was followed. For example, a Tissue Viability Nurse Specialist (TVN) was involved with one person. It was clear within the care plan that appropriate action had been taken and the TVN advice was being followed. Some people required regular visits to outpatients there were no unnecessary cancellations of these appointments, all were attended.

Good

Is the service caring?

Our findings

People we spoke with told us the staff were kind and caring. One person said, "You couldn't have it better. Nothing's too much trouble." Another person said, "They're all pleasant." Another person said, "I think it's very nice and very comfortable. I think they're marvellous. I think we're very lucky." One person told us, "They treat us very well." And when we asked if staff were kind they said, "Of course they are." Another person said, "I appreciate everything that's done for me. If I'd gone somewhere else I don't know if I would've got the same attention. I'd give it ten out of ten. Another person said, "The staff are kind. I don't need much."

Visiting relatives told us they had been involved in their relatives care and staff had a caring attitude. One visiting relative said, "She's well looked after. The staff are very considerate. The staff would always knock before coming in. This is my relative's home and they respect that. They lean over backwards for people." Another visiting relative said, "The family are highly satisfied. The staff are very attentive. They have time for you." Another said, "The good thing about this home is the care my relative has had." Another visiting relative told us, "They're very helpful." And when we asked if staff were kind they said, "My relative would soon let us know if they weren't. There's certain staff he really loves." One visiting relative said, "I have been involved with the care plan. It's free to look at any time."

A health professional told us staff were caring. They said they had observed, "Good examples of staff showing patience when assisting people to eat and passing on concerns if a person is not their usual self." They told us there had been a recent situation where staff had observed that a person was unwell so they reported this to health professionals, which led to close observation and then medical intervention. We were told the person was "much better thanks to their observations".

Throughout the day we observed staff providing care in a caring way. Staff knew the people they were supporting very well. We heard one member of staff talking to a person in their room. They were very kind and made sure the person was comfortable and felt warm. Another member of staff said to one person, "When I go to the shop tonight what chocolate shall I get you?" At lunch people received good support. Those who were assisted to eat received focused attention from staff and were not rushed. We saw a member of staff encourage one person to start eating and they then managed on their own. After lunch, staff asked if people were ready to leave the dining room. Before and after lunch people were observed queuing for the lift. Staff had taken people near to the lift so there was a line of wheelchairs and some people had to wait quite a long time before they could access the lift. This situation could have been better managed and the registered manager agreed to review this.

People looked well cared for. They were tidy and clean in their appearance which is achieved through good standards of care. All the staff we spoke with were very confident people received good care.

We observed there was a steady stream of visitors to the home throughout the day. The visitors we spoke with said they were welcomed at any time and could have meals on request. A drinks machine was in the dining room. A visiting relative told us, "They offer tea and coffee. It's first class. You can come at any time; just let them know if it's after 8.00pm when the door is locked." Another relative said, "There are open hour's visits." Another visiting relative said, "My relative's spouse comes every day to see them and stays for lunch."

Information was displayed to help keep people informed but because there was an overwhelming amount of leaflets and notices it was difficult to find specific information. For example, in the reception there were a large number of framed statutory notices and other documents, as well as racks of leaflets, awards and handwritten notices. These covered future staff training sessions, awards, certificates, NHS leaflets, union notices and CQC reports. Other information such as the complaints procedure and feedback forms were lost. Some information was out of date. The registered manager said they would review the information displayed to ensure people could easily access important information.

Requires improvement

Is the service responsive?

Our findings

People felt the care was person centred, they felt consulted and had choice in their lives. One person said, "They ask where you'd like your food, it's your choice. They came at 8.00pm last night and asked if you wanted to go to bed." One person said, "They always ask what I want, every day. I have a problem with my chair but they do well. It's not home from home but it's the best for me." We asked a visiting relative if people had choice and they told us, "Very much so; even though they have 58 residents to look after. There are no set places for lunch but they try to sit people together who are friendly." Another visiting relative talked to us about the keyworker system, which is where a member of staff is allocated specific responsibilities. They said, "Each person has a key worker. They will spend one hour per week chatting to their service user. It doesn't sound a lot but it makes a big difference."

Staff we spoke with said people had choice and could make day to day decisions such as when to get up, what to wear and how to spend their time. One member of staff said about the intermediate care unit, "There is no choice for service users. It's very regimented; it's a different culture to the residential."

We spoke with people about activities and social events. They appreciated the activities, especially the entertainments. One person said, "I go down for the entertainments and the monthly church service. She's very good is the activity organiser. She brings cups of tea in." Another person said, "I go to all the entertainments even if I don't like them. On the whole we've done very well this year. I use the hairdresser, she's very nice. The activity organiser comes to visit. She can come at any time." A visiting relative said, "My relative does well. They are not a great attender of lounges. They like the entertainments and the music for health."

The home had a full-time activities organiser who worked Monday to Friday and occasionally on a Saturday. They told us the home did regular fund-raising through events such as coffee mornings and fairs, and received good support from friends and relatives and enabled a good budget for entertainments. There were meetings with people who used the service and their relatives to discuss activities. Two of the visiting relatives we spoke with said they regularly participated in the meetings and fund-raising activities.

The activity programme was displayed in the home Activities in the month of May included, pamper day, gentle exercise, church service, quiz/bun making, music for health, singers 'Friends in Harmony', potting and planting, jigsaws, games day and tag making. The activity organiser said, "There is something daily and information is posted up." We were told there was a therapy room which was used for painting nails, music and quiet time with relatives. However, when we visited the room, it was being used for the storage of a bed and some mattresses.

Staff and the registered manager talked to us about the process when people moved into the home. The registered manager said a pre-admission assessment was always completed and arrangements for people to stay in the intermediate care unit were co-ordinated by health professionals and the management team at Owlett Hall. Another member of staff said, "People are cared for individually. When they move in we go through everything. We find out about them and what they like, what they want." Another member of staff said, "It's really nice to liaise with families. We get a lot of information from them."

In the reception area we saw that a batch of bantam eggs were in a small incubator. The activity organiser explained they have the periodic hatching of eggs. Once hatched, they will go into a brooding box. In the past, chickens, quail and ducklings were hatched. The activity organiser said the young birds were taken round to people who were unable to leave their room and they "got great joy from that".

In the main, people's care and support needs were assessed. Care plans we reviewed contained information that was specific to the person. There was information that covered areas such as mobility, skin integrity, elimination, personal hygiene, nutrition and hydration and communication. However, guidance about how to deliver care and support was often basic. There was a dependency rating within each care file which told staff providing care the level of involvement required by the person. There was evidence that daily notes were completed in a timely manner with meaningful entries detailing how the people spent their day.

People had information in their care records about how they liked to spend their time and how staff prevented loneliness and isolation occurring. People had documents called 'This is my life' and 'Service user profile'; however, these were not always fully completed.

Requires improvement

Is the service responsive?

Although we found care plans, in the main, identified how care should be delivered some care plans had not been updated since 2013. We found that care plan evaluations contained information about changes in people's needs but this was not then transferred to the main care plan. For example, one person required fortified foods and snacks; this is where extra nutrients have been added. This was documented in the review of the person's care plan but the care plan itself had not been updated to reflect the change in need. This meant there was risk that people's needs could be overlooked. Another person's care plan was written in 2013. A 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) was introduced in 2014. The care plan was not updated which meant the person's wishes could be overlooked.

One person's care plan stated they preferred a shower but the care plan evaluations made reference to the person having a bath with the assistance of two members of staff. There was no information relating to why this person's wishes had not been followed.

Some people had medical conditions such as diabetes and Parkinson's disease but did not have specific plans in place. For example, one person's care plan did not contain guidance about checking blood glucose levels even though another record said this should be checked fortnightly. There was no recording documented after September 2014. We concluded this placed people at risk because it could result in care and treatment being provided in an unsafe way. This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed the concerns in relation to the care planning and delivery process with the registered manager who agreed to ensure all relevant information was recorded and updated.

People we spoke with had not had to make a formal complaint. Where issues had been raised informally they said matters had been dealt with swiftly. A visiting relative said, "Once, I brought something to the attention of management and they sorted it immediately. If it was serious I'd put it in writing, there'd be no messing about." Another relative said, "If I did complain it would be dealt with straight away."

The registered manager told us they had no ongoing complaints. They said people were given support to make a comment or complaint where they needed assistance. They told us people's complaints were fully investigated and resolved where possible to their satisfaction. We looked at the complaints record and saw no formal complaints had been received in the last 12 months. A concern was raised recently and it was evident the registered manager had resolved this.

Requires improvement

Is the service well-led?

Our findings

People said they would recommend the home to others. One person said, "'I had four days here first and then decided to stay. Better the devil you know. I certainly would recommend this home." When asked if they would recommend the home to others, another person said, "Yes, I would." A visiting relative said, "I would absolutely recommend this home."

The registered manager dealt with day to day issues within the home and oversaw the overall management of the service. They worked alongside staff overseeing the care given and providing support and guidance where needed. They engaged with people living at the home and were clearly known to them.

People spoke positively about the registered manager and said the home was well managed. One person said, "The manager comes round all the time, she helps if it's needed." Another person said, "I see the manager, usually in the morning. Another person said, "I don't think anything could be better." Another person said, "I like it. It's lovely." A visiting relative said, "I don't think anything could be better. I think the management is excellent. On admission, we were met by the manager who already knew part of my relative's history. She keeps an eye on everything, remembers names. Does a handover with night staff. We think it's a godsend. We can't speak highly enough of somewhere like this." Another visiting relative said, "The manager knows my relative well, talks to nurses. It's very well managed; she supervises and keeps an eye on the staff. I'm just so relieved that my relative's here." Another visiting relative said, "The Manager, she's top marks, she's brilliant." A health professional told us they had heard praises the previous day from "two separate sources" and had "heard similar praise at intervals over the years". They said, "Overall, the home from the perspective of the intermediate care service is well led. I find the manager approachable and helpful." A local health team told us, "We have no issues with Owlett Hall. They are very efficient with their work and we have not had any worrying clinical issues."

People were encouraged to make their views known. Regular 'resident and relative' meetings were held and the minutes then circulated as a newsletter to everyone. The latest minutes from a meeting held at the beginning of May 2015 covered the following topics: new external signage, external storage, staff retirement, refurbishment work, office reorganisation, menus, events during the coming month, and the names of residents who had passed away. All were told they were welcome at the next meeting. Visiting relatives told us communication with the home was very good. One visiting relative said, "Everybody's made aware. A monthly newsletter is sent round. Communications with the family are very good." Another visiting relative said, "They're straight on the phone if a GP is called. We have friendships with other service users and relatives. It's a community."

We looked at surveys completed by people who lived at the home and their relatives although these were over a year old. These showed people provided positive feedback and said they were comfortable and satisfied with their care. We saw four bereavement surveys were completed and these had scored all aspects of end of life care as either 'very satisfied' or 'completely satisfied'. Seven undated surveys from health professionals were complimentary about the service. All said the manager was professional and knowledgeable. Two commented about insufficient staffing.

Staff spoke positively about the service and told us they enjoyed working at the home. A member of staff said, "It's a lovely home. It's not about routine or regimented. We all understand it's their home." Several staff talked to us about handovers, and said these helped ensure staff were up to date and aware of any changes. Staff meetings were held where they discussed quality and safety. We looked at 17 staff surveys which had been returned. These provided a mixed response to some questions but were in the main positive. Four had stated the quality of care was poor but the registered manager had followed this up and staff had confirmed their comments related to lack of equipment such as 'pads and wipes'.

The provider had systems in place for monitoring the quality and safety of the service. However, a number of breaches and areas where they required improvement were identified at this inspection. Some areas had been identified as requiring improvement through the providers monitoring processes but others had not. We therefore concluded the systems in place were not always effective.

We looked at monitoring visit reports where the provider visited the service and checked everything was being carried out at the home. Action points and timescales were identified, and followed up at subsequent visits.

Requires improvement

Is the service well-led?

The management team were using two different systems for monitoring accidents and incidents and it was difficult to follow because some logs were handwritten whereas others were recorded on a computerised system.

Staff and the registered manager said regular checks were carried out to make sure the service was running smoothly. We looked at records which confirmed this. Checklists included water temperatures, nurse call system, portable appliance visual test and room inspection. The management team also carried out a range of audits that helped ensure the service was monitored. The registered manager had completed hand hygiene observations, protected meal observations, health and safety audits and infection control audits. We saw in a recent care plan audit that some care plans needed to be rewritten because they were out of date, however, there was no information about how or when this was going to be achieved. The registered manager agreed to ensure future audits included this information.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 12 HSCA (RA) Regulations 2014 Safe care and treatment **Care and support was not provided in a safe way for service users.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The registered person did not have suitable arrangements to ensure people were safeguarded against the risk of abuse.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Staff did not receive appropriate support to enable them to carry out their duties they are employed to perform.**