Barchester Healthcare Homes Limited

Overslade House

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

We inspected Overslade House on 04 January 2018 and then returned on16 February 2018. Both days were unannounced. We returned because we were made aware of a serious incident which took place after our first inspection day and currently remains under investigation. Overslade House is divided into three separate units over two floors, and provides personal and nursing care for up to 89 older people, including people living with dementia and physical disabilities. There were 80 people living at the home when we inspected the service.

A requirement of the service's registration is that they have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and the associated Regulations about how the service is run. There was a registered manager in post at the time of our inspection visit. We refer to the registered manager as the manager in the body of this report.

We last inspected this service in January 2016 when we rated Safe as 'Requires Improvement' because we found staffing numbers required improvement, with an overall rating of Good. At this inspection we found whilst improvements had been made to staffing levels, there is a lack of clarity about what happened with regard to the serious incident at the home, and we have therefore continued to rate Safe as Requires Improvement.

Since our previous inspection in January 2016 we have reviewed and refined our assessment framework, which was published in October 2017. Under the new framework certain key areas have moved, such as support for people when behaviour challenges, which has moved from Effective to Safe. Therefore, for this inspection, we have inspected all key questions under the new framework, and also reviewed the previous key questions to make sure all areas were inspected to validate the ratings.

We found risk management plans were established to ensure the environment and premises were managed safely, and environmental risks to people were minimised. In addition, we found people had individual risk assessments completed and staff were instructed on how to minimise risk to people's health and wellbeing.

Most people told us there were enough staff at the home to provide them with safe care. We saw there were enough staff during our inspection visit to ensure people were cared for safely. However, three people told us they sometimes had to wait for assistance to go to the toilet, or for personal care, at busy times. The manager assured us staffing levels were worked out to ensure people received safe care. Although there were busy times of day, there were sufficient staff to meet people's needs. Quality assurance procedures were in place to monitor staffing levels remained safe.

All necessary checks had been completed before new staff started work at the home to make sure, as far as was possible, they were safe to work with the people who lived there. People were supported by a staff team

that knew them well, as the manager did not employ temporary staff.

Staff received training and had their practice observed to ensure they had the necessary skills to support people. Staff treated people with respect and dignity, and supported people to maintain their privacy and independence.

People had been consulted about their wishes at the end of their life. Plans showed people's wishes about who they wanted to be with them, and the medical interventions they had agreed to. People and their relatives told us the care they received at this difficult time was excellent.

People received their medicines as prescribed to maintain their health and wellbeing. People were supported to access healthcare from a range of professionals inside and outside the home, and received support with their nutritional needs which assisted them to maintain their health.

The provider, manager and staff understood their responsibilities under the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS) to ensure people were looked after in a way that did not inappropriately restrict their freedom. The manager had made applications to the local authority where people's freedom was restricted, in accordance with DoLS and the MCA requirements. Decisions were made in people's 'best interests' where they could not make decisions for themselves.

People were supported to take part in social activities and pursue their interests and hobbies. People made choices about who visited them at the home, which helped people maintain personal relationships that were important to them.

People knew how to make a complaint if they needed to. Complaints received were investigated and analysed so the provider could learn from them. People who used the service and their relatives were given the opportunity to share their views about how the service was run; action was taken in response.

Quality monitoring procedures identified areas where the service needed to make improvements. Where issues had been identified in checks and audits, the manager took action to address them to continuously improve the quality of care people received.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People told us they felt safe living at Overslade House and staff had been recruited safely. The manager consistently reported and investigated accidents, incidents and safeguarding issues when these arose, and analysed these to learn from them. However, there was an on-going police investigation into a serious incident at the home which we were unable to investigate as part of our inspection process. People had up to date risk assessments, which provided staff with the information they needed to minimise risks to people. The premises were clean and well maintained. There were enough staff employed at the home to ensure safe care for people. Medicines were administered to people safely.

Is the service effective?

Good

The service was effective.

Staff completed an induction and training so they had the skills they needed to effectively meet people's needs. People made choices about their care. Where people could not make decisions for themselves, important decisions were made in their 'best interests' in consultation with health professionals. People were supported to see healthcare professionals when needed. The design of the premises supported people to move around safely. People received food and drink that met their preferences and supported them to maintain their health.

Is the service caring?

Good

The service was caring.

Staff knew people well and respected people's privacy and dignity. Staff treated people with care and kindness. People were able to have friends and relatives visit them when they wished. People made decisions about how their care and support was delivered.

Is the service responsive?

Good

The service was responsive.

People were supported to take part in social activities in accordance with their interests and hobbies. People had personalised records of their care needs and how these should be met. People were able to raise complaints and provide feedback about the service. Complaints were analysed to identify any trends and patterns, so that action could be taken to make improvements. There was end of life care planning in place to involve people in decisions that took into account their wishes and preferences at this time.

Is the service well-led?

Good

The service was well led.

The management team was approachable and there was a clear management structure and vision to support staff. The manager and provider responded to incidents and concerns at the home, so that lessons were learnt and people were protected. People were asked for their feedback on how the service should be run, and feedback was acted upon. Quality assurance procedures were in place to assess areas where the service could make improvements. The provider sought advice from specialists in their field, and shared information across their homes, to improve the quality of care people received.

Overslade House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was 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 comprehensive inspection took place on 04 January 2018, and the 16 February 2018. The inspection visits were unannounced on both days. On the first day of our inspection visit the inspection was conducted by two inspectors, an expert-by-experience and a specialist advisor. On the second day of our inspection visit the home was inspected by one inspector. An expert-by-experience is someone who has personal experience of using, or caring for someone who has used this type of service. A specialist advisor is someone who has current and up to date practice in a specific area. The specialist advisor who supported this inspection visit had experience and knowledge in nursing care.

The second day of our inspection visit was prompted by the notification of an incident following which a person using the service sustained a serious injury. This incident is subject to a police investigation and as a result at this inspection we did not examine the circumstances of the incident. However, the information shared with CQC about the incident, indicated potential concerns about the management of risk and staff training. On the second day of this inspection, we looked to see that people's care was managed safely and that staff had the right level of competency and skill. When the investigation is concluded we will consider any further action we may have to take.

Overslade House accommodates up to 89 people and specialises in providing nursing care, and personal care to people living with short term memory conditions and dementia. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Before our inspection visit, we looked at and reviewed the Provider's Information Return (PIR). This is a document that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We found the PIR reflected the service provided.

We reviewed the information we held about the service. We looked at information received from the statutory notifications the provider had sent to us and commissioners of the service. A statutory notification is information about important events which the provider is required to send to us by law. Commissioners are representatives from the local authority who provide support for people living at the home.

Some of the people who lived at the home were not able to tell us in detail, about how they were cared for and supported because of their complex care needs. However, we used the short observational framework tool (SOFI) to help us assess whether people's needs were appropriately met and to identify if people experienced good standards of care. SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

On the first day of our inspection visit we spoke with four people who lived at the home and 12 people's visitors or relatives. We gathered feedback from several members of staff including the registered manager, the senior operations director, the chef, the provider's nutritional consultant, three nurses, a student nurse, the clinical team leader, an activities co-ordinator, an administrator, and four members of care staff. We also received feedback from a health professional who had regular contact with the management team at the home.

On the second day of our inspection visit we spoke to a further five people who lived at the home, a visitor, and two people's relatives. We also spoke with the registered manager, the clinical team leader, a member of care staff, a designated trainer, a nurse and two of the provider's representatives.

We looked at a range of records about people's care including nine care files. We also looked at other records relating to people's care such as nine medicine records and fluid charts that showed what drinks people had consumed. This was to assess whether the care people needed was being provided.

We reviewed records of the checks the manager and the provider made to assure themselves people received a quality service. We also looked at recruitment and supervision procedures for members of staff to check that safe recruitment procedures were in operation, and staff received appropriate support to continue their professional development.

Requires Improvement

Is the service safe?

Our findings

We last inspected this service in January 2016, when we rated Safe 'Requires Improvement'. This was because we found there needed to be improvements in the number of staff available to answer people's calls for assistance. At this inspection we found staffing levels had been increased, however, we were notified about a serious incident involving a person who has high care needs and was dependent on staff for their care. We have therefore retained the rating of Requires Improvement.

All the people we spoke with told us they felt safe at the home. Comments included; "I visit every day, it's very safe" and, "I've never felt unsafe at all."

We looked at how people were protected from the risk of abuse. Care staff told us they completed regular training in safeguarding people from abuse. Care staff and nursing staff were knowledgeable about the procedures for identifying and reporting any abuse, or potential abuse. The designated trainer confirmed other staff as well as care and nursing staff were trained in recognising and reporting concerns, as they also interacted with people at the home. The policies and procedures for reporting abuse were displayed in staff areas around the home. A clear message was, staff should act if they had any concerns, the policy stated 'doing nothing is not an option'. Staff spoken with told us they were comfortable with raising any concerns they had with their manager, and were confident any concerns would be investigated and responded to. One member of staff told us, "If there was anything of concern I would tell the nurse or the manager straight away."

Following a recent serious incident involving someone who was fully dependent on staff for all their care needs, the manager had put in place additional measures to protect people, whilst a full police investigation is taking place. This included three daily 'walk rounds' by the manager to observe staff practice at the home, a full check on everyone's care records to ensure they were fully up to date and risk management plans were in place for any risks to their health. The manager had also organised additional training for staff in safeguarding procedures and how to raise concerns about safeguarding and manual handling training. The manager has said that after the outcome of the investigation is known, they will again review their processes and take action as required.

The manager and provider had procedures in place to report safeguarding concerns to local authorities for investigation, and to CQC. We found safeguarding concerns had been referred to the local authority and CQC promptly. Previous concerns had been investigated fully.

We found risks to people's health and wellbeing were being identified and risk management plans were in place for staff to follow. For example, one person required two staff to assist them to move around. There was a risk assessment and risk management plan in place to instruct staff on how they should move the person, which equipment they needed to use, and how many staff should assist the person. We saw one person who displayed behaviours that could be challenging to them and others. When the person became anxious staff knew how to reduce their anxiety levels because their risk mitigation plans explained to staff what distraction techniques they should use.

Staff told us and the PIR confirmed, people were protected from the risk of abuse because the provider checked the character and suitability of staff. All prospective staff members had their Disclosure and Barring Service (DBS) checks and references in place before they started work. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with people who use services. The provider also checked the registration of nurses with their regulatory body to ensure they maintained their professional registration.

Accidents and incidents were recorded consistently across the home. Accidents and incidents were monitored to show when and where accidents happened in the home, and whether risks could be mitigated to reduce the number of accidents. The provider had taken measures to minimise the impact of unexpected events happening at the home. This was to ensure people were kept safe and received continuity of care. For example, emergencies such as fire and flood were planned for, so any disruption to people's care and support was reduced. People who lived at the home had an up to date personal emergency evacuation plan (PEEP) to instruct staff and the fire service about how they should be supported when evacuating the building.

Staff knew how to manage people's anxiety and documented any incidents where people became anxious or distressed so that triggers for this type of behaviour could be avoided in the future. When one person began to shout out and became anxious, a care worker went to the person straight away to ask what was wrong and to reassure them. They also provided physical reassurance by, stroking the person's hand. Another person became anxious as the person began to shout, so the care worker reassured them and used a distraction to calm them. They spoke about what was on the TV and asked if they would like something to drink.

We found the home was clean and well maintained. One relative said, "Everything is nice and clean here." Infection control procedures were in place to prevent the spread of infection. There were regular cleaning schedules and enough housekeeping staff to keep communal areas and people's rooms clean. The manager checked on the cleanliness of the home through regular daily walk rounds, and also monthly auditing procedures. Nursing staff adhered to current infection control guidelines to prevent the spread of infectious diseases.

Care staff wore the correct personal protective equipment (PPE) such as gloves and aprons to protect people from cross contamination and infection. Staff told us they always wore PPE when providing personal care. Regular monitoring of the laundry ensured dirty and soiled items were kept away from freshly laundered items. Domestic staff cleaned daily and regularly completed a 'deep clean' to limit the risks of cross infection.

We looked at how the maintenance of equipment and the premises was managed. We found there was a maintenance worker on site. The manager explained how regular checks of the premises and equipment were completed, to ensure people were safe. Maintenance and safety checks included the utilities and water safety. Records confirmed these checks were up to date.

Most people told us there were enough staff at the home to meet all their needs, and that staff were quick to respond to their calls for assistance. Comments from people included; "There is always someone [staff] to do anything that's needed", "There's always staff here, there's never been a problem", "Staff have time to talk to you", and, "Staff always respond in less than five minutes."

During our inspection visits we saw there were enough staff to care for people safely and promptly throughout both days. Since our previous inspection the provider and manager had increased the numbers

of staff employed throughout the home. The manager was confident there were enough staff at the home to meet peoples' needs. People on each unit were cared for by a consistent staff team who understood their needs.

However, some people raised concerns that staff were not immediately available when they needed them, and they had to wait for assistance with their personal care if staff were on a break. We raised the comments with the manager who told us staffing levels had recently been increased, and were determined by the number of people at the home and their needs. We saw each person had a completed dependency tool in their records which assessed how much staff support they required. In addition the manager explained nursing staff levels were calculated to offer personalised care to people at the end of their life. The provider's representative confirmed additional staff were employed above the recommended level if it was felt they were required.

All the staff we spoke with said they felt there were enough staff to care for people safely. However, one member of staff said, "At times in the afternoon residents sometimes have to wait to go the toilet." Another staff member said, "Bells are answered as soon as possible by staff." The manager accepted there were sometimes occasions when people waited for staff to be available but were confident people were always supported safely and promptly. The manager told us they had introduced a tool to record how long staff took to answer requests for assistance, which they used to monitor whether there were enough staff to assist people at busy times. The manager was also available daily on site to see how staffing levels met the needs of people.

As well as nursing and care staff assigned to each area there were a number of other staff members to assist people at busy periods." These included the manager and their deputy, student nurses, an activities co-ordinator, and additional catering staff to assist people at mealtimes. Some people required care staff to support them on a one to one basis due to their complex care needs, and had a member of staff assigned to support them individually, at certain times of the day.

Staff who administered medicines received specialised training in how to administer medicines safely; they completed training before they were able to administer medicines and had regular checks to ensure they remained competent to do so. Medicines were administered by both nursing and care staff, who were trained to administer medicines such as topical creams. People told us they received their medicines when they should. Comments from people included; "I have pain relief four times a day, they [staff] always stay while I take it", "I have medicine four times a day, it's on time. They [staff] always test my blood pressure to make sure it's safe to take it" and, "I do get pain sometimes. Staff give me a fast acting pain relief liquid quite promptly."

We found medicines were stored safely and securely. Medicines were monitored to ensure they were stored at the correct temperatures, so they remained effective. Each person at the home had a medication administration record (MAR) that documented the medicines they were prescribed. MARs contained a photograph of the person so that staff could ensure the right person received their medicines. The MARs we checked confirmed people received their medicines as prescribed.

Some people required medicines to be administered on an "as required" basis. There were protocols (plans) for the administration of these medicines to make sure safe dosages were not exceeded and people received their medicine consistently. This supported nursing staff to make consistent decisions about when people needed the medicine. Daily and monthly medicine checks ensured people received their prescribed medicine when they should.

Good

Is the service effective?

Our findings

At this inspection, we found staff training continued to improve and support staff to meet the needs of people at the service. Food and nutrition continued to be managed to support people in maintaining their health. We rated Effective as 'Good' at our previous inspection, we continue to rate Effective as 'Good'.

Everyone we spoke with was complimentary about the effective health care people received at Overslade House. One health professional told us, "Overslade is normally the home of choice for the majority of our patients where nursing level care is required."

One person had recently been admitted to the home on end of life care and had survived more than two weeks longer than expected. Their relative told us this was due to the quality of care the person received at Overslade House. They told us this extra time had allowed them to be together for Christmas, a birthday, and at New Year, which was precious to them.

Another person told us they had been admitted to the home because they were expected to die and were not well enough to return to their family home. The person's health had improved since moving to Overslade. They felt the care they had received had given them more time, and they were now able to return to their family home and leave Overslade House. The manager was looking into whether this would be possible, and how the person might be supported going forward.

On both days of our inspection visit we saw staff used their training and skills effectively to support people when assisting them to move around the home safely. Staff used the correct equipment when moving them from chairs to standing positions, and also from standing positions into seated positions. Nursing staff used their skills to effectively utilise equipment at the home, such as specialist feeding equipment and syringe drivers.

All staff received an induction when they started work at the home which included working alongside experienced members of staff. Induction courses were tailored to meet the needs of people who lived at the home, and the different roles each member of staff performed. Staff told us their training was then kept up to date, and their skills were refreshed so they continued to be competent in their role. One nurse told us they had been supported to revalidate their nursing qualification saying, "The management have arranged training days. I've also gained a lot of experience in end of life care and tissue viability which Overslade are particularly good at."

On the second day of our inspection visit we reviewed staff training in safe manual handling techniques, safeguarding procedures, recognising the signs of abuse, and how staff should report incidents and accidents. We found training to be robust; the manager had brought staff in for refresher training between our visits in these areas to ensure all staff had the skills they needed to support people safely.

Staff told us they received regular support and advice from their immediate line managers and nurses, which enabled them to do their work. There was an 'on call' telephone number they could call outside office

hours to speak with a manager, however, there was always a nurse on duty at the home. Regular team meetings and individual meetings between staff and their managers were held. These gave staff an opportunity to discuss their performance and any training requirements.

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. 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).

Where people lacked the capacity to make all of their own decisions, mental capacity assessments had been undertaken, to establish what support was needed to make specific decisions. Decisions were recorded when they were taken in the person's 'best interests'.

The manager had a good understanding of the MCA legislation and reviewed each person's care needs to assess whether people were being deprived of their liberty, or their care involved any restrictions. Several people at the home had an authorised DoLS and additional applications had been made to the local authority and were awaiting a decision.

Staff asked people for their consent before doing certain tasks for them, or offering them assistance. People confirmed staff regularly asked them for their verbal consent before supporting them.

People ate their meals with pleasure. At meal times, there were a number of dining areas available for people to use which included a dining area in each household. The dining rooms were calm and there was a relaxed atmosphere. Tables in the large communal dining area were set with tablecloths, mats, cutlery, flowers and condiments to make the mealtime experience a sociable and enjoyable event. People told us they could choose where to eat their meal.

People made choices each day about what they wanted to eat from freshly prepared food. A daily menu was displayed in the different dining rooms. For those people who had short term memory loss or dementia, a visual choice of meal was made at the mealtime, so they could see and smell the choices on offer. Comments from people included; "I have tried the food, it's good. [Name] gets the menu and choses" and, "Staff come round with the lunch menu in the mornings. I have a choice."

During lunch people had access to drinks of their choice to accompany their meals. Other people sat in easy chairs with lap tables to eat, while others ate in their rooms with support from staff. Where people needed support to eat, we observed staff provided this appropriately and sensitively. One relative told us, "I see staff helping people eat, there are no delays in serving them." We noted the manager arranged for people to eat at different times on some of the units, so people were not waiting for assistance to eat, and there were always enough staff to support people with their meal.

Food and drinks were available throughout the day to encourage people to eat and drink as much as they liked. People and their relatives could help themselves to snacks and drinks in the café. People also had drinks available in their room and they were always placed within their reach. One person said, "Yes, drinks and cake are always available." Another person commented, "I can have a drink whenever I want."

Staff supported people to choose what snacks they wanted to eat and when. For example, we observed one care worker asking someone if they wanted some fruit. The options in a fruit bowl in the communal area

were apple or pear. The person said they wanted an orange, so another care worker went to the kitchen and fetched oranges to add to the fruit bowl.

We spoke to the chef at the home who told us people could ask for alternative meals if they wished. Kitchen staff knew people's dietary needs and ensured they were given meals which met those. For example, some people were on a soft food diet or were diabetic. Information on people's dietary needs was kept up to date and included people's likes and dislikes.

Staff told us care records were usually kept up to date and provided them with the information they needed to support people effectively. Staff could describe people's individual support needs, which matched what people told us and the information in their care plans. This was because everyone's needs were assessed when they came to the home. This provided staff with clear information on what support people needed, and could ensure people were supported safely and effectively by staff whilst they got to know them. People's care records were developed further when staff knew their individual preferences. This ensured care plans were person centred and met the needs of each person.

Staff and people told us the provider worked in partnership with other health and social care professionals. Care records included a section to record when people were seen or attended visits with healthcare professionals, and their advice. The manager told us the doctor and other health professionals visited the home when needed. For example, in one person's care records we saw the home were in regular contact with the palliative care team and nutrition specialist.

Advice from health professionals was transferred to care documents, and care plans were updated to incorporate the advice. For example, one person required support with their nutrition. Advice had been sought by a specialist and transferred to the person's records, to ensure the person received the correct level of nutrition and hydration. Some people who were on special diets had charts in place to record whether they ate and drank enough each day to maintain their health. We found the charts were up to date, and action was taken by staff if people were not eating or drinking enough.

Each person had their own room and were able to decorate or furnish their rooms how they wished, according to their personal health and care needs. In each person's room we saw rooms were personalised, people had pictures of family and friends around them. Some people brought in treasured items and furniture from their family home. One person said this made them feel as if Overslade was their home, and said, "The room is how I like it. The bed came from Italy."

The environment at the home was designed to assist people with finding their way around, and also to meet people's individual needs. For example, the corridors were wide and flat, with smooth floors, and were accessible for people with motorised wheelchairs to move around easily.

We saw that signs and information that could help people with their memory could have been improved on the unit where people with dementia were cared for. There was little or no signage to help orientate people living with dementia. A small number of room doors included photographs and pictures to help people locate their rooms, but not all. One way to support people living with dementia is to add personal items to display boxes located by their bedroom doors. We raised this with the manager. They explained the unit had recently been decorated and things had been removed from the walls to update the décor. The manager had contacted the dementia specialist who worked for the provider and they were due to come to the home to renew the signs in the unit. The manager said, "There is a plan in place to enhance the lives of our residents living with a dementia by providing enhanced dementia training for staff, and making improvements to their environment."

Good

Is the service caring?

Our findings

At this inspection, we found staff continued to be caring and engage people at the home, people were encouraged to maintain and develop their independence. We continue to rate Caring as 'Good'.

People and their relations said, "The staff are very compassionate and professional", "I would say they [staff] are kind and caring", "I believe the care is excellent" and, "The manager really cares about people here."

We observed good relationships between people and staff, such as staff sharing jokes with people, telling stories about activities or trips, and chatting about their environment. Staff knew people and their needs well. Staff told us they liked working in the home because people were well cared for. One member of staff said, "Personal centred care is given as much as possible here."

People's care and support was planned in partnership with them and people who were important to them, which enabled staff to deliver person centred care. Records gave staff information about people's life history and how they wanted their care delivered. Care reviews took place every six months, or when people's needs changed. One relative told us, "We all discussed [Name's] care needs when she first arrived."

Staff promoted people's independence and encouraged them to do things for themselves where possible. For example, staff encouraged people to use specialist cups and plate guards (devices that support people to eat and drink unaided) to they could continue to eat and drink independently.

The manger encouraged staff to understand how each person wished to be communicated with, as part of their support plan. The home could produce information for people that was in an accessible format, for example using large text or pictures to explain things. Some tools were available for staff to use, to help people communicate. This included staff who spoke people's 'first' language, the use of text messaging, communication picture cards, and internal internet connection (WiFi) to help people exchange messages.

Other people were supported with taking part in things they enjoyed, which took into account their diversity. For example, one person who was partially sighted enjoyed activities which stimulated their other senses. They commented to us, "I really enjoy the singing." Staff made sure the person was encouraged to take part.

There were a number of communal areas where people could meet with friends and relatives in private if they wished. This included lounges, a café and dining areas with designated homely seating areas. People made choices about who visited them at the home and were supported to maintain links with friends and family. For example, people could choose to have their relatives visit them and eat with them. Visitors to the home said, "There are no visiting problems at all, it's really nice, welcoming and friendly. Staff make time for you" and, "I can visit whenever. I like to take her out whenever I like."

People told us their dignity and privacy was respected by staff. One person said, "If the door is locked, they knock, they ask to come in." We saw staff knocked on people's doors and announced themselves before entering. Staff understood the importance of respecting and ensuring people's privacy was maintained. We

observed staff supporting people to their rooms where they needed support with personal care. One staff member told us, "Records are out of view and safely kept in the office, when talking about residents we ensure it is in an appropriate place and just with who needs to know. When giving personal care, particularly with continence and clinical care; curtains and doors are always shut."

People were assigned a specific member of staff called a keyworker. Keyworkers were responsible for maintaining a special relationship with each person they supported, ensuring their social and practical needs were met. Keyworkers also helped to maintain accurate care records for people to ensure they reflected people's current needs. We found keyworkers knew people well. People told us they knew who their keyworkers were, and felt comfortable in raising anything with them.

Good

Is the service responsive?

Our findings

At this inspection, we found staff were responsive to people's requests. Care records continued to be kept up to date. Activities and interests for people were developed according to their individual wishes. End of life care arrangements were in place that was person centred. We continue to rate Responsive as 'Good'.

People or their relatives told us how the staff at Overslade responded to some of their requests. One relative said, "We have no problems at all. I discussed a problem with [Name's] care with staff, they sorted it out." Another relative said, "Staff have responded to our questions so far, [Name] is having an assessment in January to review things."

Staff were able to respond to how people were feeling, and to their changing health or care needs because they were kept updated about people's needs at a handover meeting at the start of each shift. The handover meeting provided staff with information about any changes in people's needs since they were last on shift. Staff explained the handover meeting was recorded in writing so that staff who missed the meeting could review the records to update themselves.

There was information about how to make a complaint and provide feedback on the quality of the service in the reception area of the home and on each unit of the home. People and their relatives told us they knew how to raise concerns with staff members or the manager if they needed to. A typical response from people we spoke with was that they had never needed to make a complaint.

Previous complaints had been investigated and responded to by the provider. Complaints were analysed to identify any trends and patterns, so that action could be taken to continuously improve the home. One relative told us, "Three months ago I complained about [Name's] care, the day staff reported it to the manager. I spoke to her as well. We've had no problems since."

A list of planned activities was on display in the communal areas for people to refer to and posters advertised forthcoming special events. These included events such as entertainers visiting the home, 'sing-a-longs', quizzes, games, discussion groups, and sessions where people could have one-to-one time with staff. Each morning and afternoon an activity was organised at the home. One the day we visited, people were offered time to sit and chat and have an alcoholic drink with their neighbour. The activity was designed to relax people and help people interact. The home employed a dedicated member of staff to support people with activities, hobbies and interests. The manager also expected care staff to spend time with people supporting them with interests and hobbies that might provide stimulation and enjoyment.

Other activities on offer at the home included regular visits from animals to help people enjoy their company, a hairdressing salon, and library services. The home produced a daily newsletter and a weekly newsletter which contained quizzes and information for people to discuss. The newsletter was designed to help people remember important events that had happened in history that day or week. This gave people an opportunity to reminisce and also helped people understand the date and season.

The newly appointed activities coordinator recorded in people's care plans the activities and events people had been engaged in, and 'scored' their response to them. They told us they planned to establish, through these records, what activities people enjoyed and responded to, so they could have a more tailored programme of activities. During our inspection visit, an entertainer came to the home. The activities co-ordinator told us a few people from the unit for people living with dementia had been supported to visit the area of the home where the entertainer was performing. The coordinator explained they wanted to do this more so people could access activities they liked no matter which unit they lived on.

The activities coordinator explained they would engage in one to one activity with people where they could not, or did not want to take part in group activities. This was supported by the activities records. The provider attempted to use people's past history, work and background to identify subjects to engage and stimulate them. For example, one person had worked as a school teacher and enjoyed the company of children. The activities co-ordinator had arranged for a staff member's grandchild to come to the home and read to the person, which they said the person had enjoyed.

As the home provided nursing care to people at end of life, people had been consulted about their wishes in their final days. The arrangements included decisions that had been made regarding whether people should be resuscitated following a cardiac arrest. These records were reviewed to ensure they had been discussed with people and their relations, and whether they remained valid as people's health changed.

Nursing staff told us they were trained to provide care to people which took into account their wishes, and the levels of nursing and care staff was planned to ensure nursing staff were available to provide personalised care. Plans included whether people wanted a 'special someone' with them in their last moments, or whether they had any wishes they would like fulfilled before they died. Care plans were also in place to describe which medical interventions people preferred, for example, many people expressed a wish to have a pain free experience. People's cultural and religious beliefs were also reviewed to ensure any preferences were met. A health professional told us, "The home has a reputation for excellent standards in end of life care. I particularly like the concept they have of 'granting a wish' to those dying."

The activities co-ordinator told us about how people's wishes could be granted at this difficult time. They explained, "One person wanted to smell sand from a beach they went to as a child. Staff were able to visit a beach very near to where the person went as a child, and bottle some sand. When the person smelt the sand, they said, "Aah, home!"

Where a need was identified, staff worked with other organisations such as McMillan nurses, to ensure people's needs were met and they had all the support they required at the end of their life.

Good

Is the service well-led?

Our findings

At our last inspection we rated the service 'Good' in Well-led. The home was led by a management team that was approachable and who checked the quality of care delivered to people, so continuous improvements could be made. We continue to rate the service as 'Good' in Well-led.

People or their relatives could give feedback to the manager at any time, as they were on site and operated an 'open door' policy. People visited the manager in their office during our inspection visit. Suggestion boxes and comment books were distributed throughout the home asking people for their feedback. One relative told us, "The manager's door is always open, anytime of the day you can pop in and get an answer." One relative commented on how well the home was led, "I would give them 9.5/10. I don't observe any need for improvements. They went above and beyond what they needed to do for [Name]." Several relatives told us, "I would recommend the home to anyone."

People were given regular opportunities to talk about how they wanted their care to be delivered. Every month each person at the home underwent a review of their care and support, which the staff described as 'resident of the day'. This review included staff from a number of departments who chatted to the person, and asked for their views on different aspects of their care. For example, the kitchen staff asked the person about their choices of food, their feedback on the menu, and anything that could be enhanced or changed to meet their preference.

The availability of the manager was confirmed by staff, one staff member commenting, "The manager has an 'open door' policy to anyone using our service including staff." Another comment from a staff member was, "I think the service is well-led and we have good reputation for our care and support. The other day we had a family come to look around the home and they told us they had been in a local supermarket, and a shopper told them Overslade was the best home in Warwickshire."

The manager told us how they worked in partnership with other agencies such as commissioners of services and health care organisations to support people when they first came to the home, making sure their needs were fully assessed to get the right care in place. We spoke to a health professional who had regular contact with the management team at the home. They told us, "The manager is an incredibly caring, compassionate nurse who has a very good reputation within this locality of providing first class care."

The values and vision of the provider were embedded in the ethos of the home, which were to put people at the heart of what they did. Staff understood that the home was a 'home for life' for the people that stayed there, which meant if people's needs changed there was no requirement for them to move to another home. Staff also supported people's relations to cope with the changes to their personal lives. One visitor told us, "Definitely this is people's home. After my relation passed away we still visit the home. The staff not only cared for [Name], they cared for us too and helped and supported us through a difficult time." A health professional said, "The home also cares for relatives, for example, an elderly couple that are being separated through circumstance, Overslade will allow them to be together as much as they wish."

Staff were encouraged to work within the values of the home, values were discussed with staff in regular meetings, and the provider recognised the contribution of staff to the way people felt about the home. People were asked to nominate staff for awards, and staff were offered rewards and bonuses for a job well done. We observed staff acting according to the provider's vision. Staff ensured each person's choices and capabilities were respected by asking them what they wanted when they offered them support.

The manager was part of a management team which included a clinical lead, and supervising nurse situated on each shift and each unit, to support staff with their daily work. The management team acted to mitigate risks when concerns were raised with them. For example, following a recent serious incident at the home the manager and provider had put in place additional measures to protect people whilst a full police investigation was still taking place. This included three daily checks by the manager to observe staff practice, a check on people's care records to ensure they were up to date and risk management plans were in place. The manager had also organised refresher training for staff in safeguarding procedures and manual handling.

The provider completed regular checks on the quality of the service they provided. This was to highlight any issues and to drive forward improvements. For example, the provider directed the manager to conduct regular checks on care records, medicine administration and infection control procedures. The provider's quality assurance team produced quarterly reports about how the home was performing against business plans. Outside agencies also visited the home every three months to complete clinical audits. Where checks had highlighted any areas of improvement, action plans were drawn up to make changes. Action plans were monitored for their completion by the provider during regular quality monitoring visits to the home.

Information and communication between registered managers across the provider's service was encouraged. The manager attended regular monthly meetings with other managers in the group to exchange information, and to learn from each other about events that had happened at other homes. This discussion forum was to assist in finding innovative ways to improve services. For example, the manager of Overslade was piloting an improvement project to recycle cleaning products and improve cleaning practices at the home. The results of the project would be shared across the group. In addition, auditing tools were reviewed to ensure they met the needs of each home. For example, following feedback, recent improvements had been made at Overslade to the auditing tool for medicines.

Staff were kept informed of things that happened at the home. Monthly meetings were held for different teams, and the management team included heads of department meetings, health and safety meetings, nutritional support and monthly clinical meetings. Information was shared between staff and managers about different units of the home and relevant information about different departments. Team communication was encouraged to identify issues and discuss improvements.
Following feedback from relatives and staff, that staff communication could be improved at the home, the manager had introduced daily meetings with other managers and supervisors at the home to share information. The meetings were described as 'daily stand up' meetings. These made sure communication about daily events or incidents at the home were shared, nurses and staff were kept up to date daily on any changes that were made.

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

the meal and menu changes, and any outings people might enjoy when the weather brightened.

The manager worked in partnership with the local community to enhance people's stimulation and enjoyment of activities and events planned at the home. For example, the home regularly used volunteers from local schools to participate in events and interact with people. The provider had a community initiative in place to help people maintain their involvement in the local area. Each month a local event was organised including, coffee mornings with local charities, and trips out to local centres and amenities.

We saw at a recent meeting for people's families, a guest speaker had been invited to the home to talk to families about how people's rights could be protected, and how legal arrangements could be made for families to be involved in managing their relation's care and finances.

Following feedback from people, the provider told us they had recently updated the décor in one part of the home, which was designated to support people with short term memory loss and dementia. They reviewed options for the redecoration of this area with a company with experience in decorating care homes for people with dementia. The choices for colours were designed to calm people. The manager was keen to tell us that people were part of this decision making process, and were being asked for their choices about how the home was updated.

The manager strived to continuously improve the quality of the service they provided, and had put forward the home to be part of the provider's pilot scheme to improve people's mealtime experience and test new menus and food options. The provider employed a consultant organisation that came to work with the manager and chef in developing the menu, and offering changes to how meals were served. They hoped to increase people's engagement and social stimulation at mealtimes, and increase the choice of food on offer. For example, the consultant told us they had introduced new hot options for people to eat at breakfast time, they had also already added more drink options such as milkshakes onto the drinks trolley that came around several times a day.

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