Barchester Healthcare Homes Limited

Cheverton Lodge

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We carried out an unannounced inspection of this service on 10 and 13 February 2017. We also carried out a focused inspection on 17 August and 11 September 2016 in response to previous concerns that we had received. From the focused inspection we did not find any breaches of regulation but we did note that improvements were required to aspects of risk assessment updating, care plans and consistency of management. Improvements had been made and recently the service had identified further improvements required to care recording as people's needs changed and to ensure these changes were consistently recorded from the care plan to the care folders that were kept in each person's bedroom.

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

The home did not have a registered manager. However, a manager had been appointed in September 2016 and they had submitted an application to register with the Care Quality Commission (CQC). 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.

Care plans described people's support needs but the care and support provided was not clear in some cases. Updating care records to reflect the level of personal care required, for example how frequently they wished to have a bath or shower, for some people needed to be more accurate and also reflect positive changes in care as people's conditions improved. However, we noted that this issue had recently been recognised by the provider who told us of the steps they were taking to address it.

The turnover of managers within the home had previously led to an unstable management structure. Information we had previously received from a healthcare professional and relatives indicated that the lack of consistent management had impacted on communication with them. The situation had improved. More effective communication had been established with health and social care professionals, which we had been told by professionals, for example commissioning and nursing and assessment team members in the local authority. Feedback at the most recent relative's meeting was also positive and the issues around communication that had arisen last year were improving.

Medicines were managed well and safely. However, there had been an error on the typed medicines audit for January 2017, which was later clarified.

There had been several staff vacancies within the home from the middle of 2016. The recruitment programme which the provider had focused on had achieved success with almost all permanent staff posts now filled. There was much less reliance on temporary staff. Staff were recruited safely. There were enough

staff on each floor during our visits and we saw that staff were able to spend time with people at other times when not supporting people with care tasks.

The staff team had access to the organisational policy and procedure for protection of vulnerable adults from abuse. They also had the contact details of the local authorities who largely placed people at the service. Staff said that they had training about protecting people from abuse and we were able to verify that this training did occur. Staff we spoke with had a good knowledge and understanding of their responsibilities to keep people safe from harm.

Risk assessments had improved and these were being recorded and updated in a timely way, which is an improvement to what we had found at our previous focused inspection. Information provided at handovers between staff was also clear.

People were provided with a wide choice of food and this reflected people's preferred choice with other options being readily available. Most people and their relatives were complimentary about the standard of meals provided at the service.

There were policies, procedures and information available in relation to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) to ensure that people who could not make decisions for themselves were protected. The service had applied the principles of the MCA and DoLS appropriately and had made the necessary applications for assessments when these were required.

People were supported to maintain good health. Nurses were on duty at the service 24 hours and a local GP visited the home each week, but would also attend if needed outside of these times. People told us they felt that healthcare needs were dealt with well and we saw that staff supported people to make and attend medical appointments when necessary.

Improved systems had been established to assist clear communication between staff and management at the home, and this received praise from staff.

People's views were respected and we received positive comments about how caring and attentive staff were. We observed respectful and considerate interactions between staff and those using the service and there was a relaxed atmosphere around the home.

All staff we spoke with did know people well and what their current needs were. However, signed consent to evidence people, and / or their relatives, involvement in care planning, including end of life advanced care planning, required improvement. The provider was taking action to address this.

The service complied with the provider's requirement to carry out regular audits of all aspects of the service.. The provider sought people's feedback on how well the service performed and responded to feedback about areas of improvement that people thought may be required.

As a result of this inspection we found that the provider was not in breach of any regulations but improvement was required in the area of responsive.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. Staff were aware of how to keep people safe. Risks that people faced were identified and responded to.

Staff were recruited in a safe way. There were suitable staffing resources available to meet people's needs.

Medicines were being handled and administered safely and appropriately. The premises were well maintained and infection control was managed well.

Is the service effective?

Good

The service was effective. Staff received regular training, supervision and appraisal to ensure they had the skills and knowledge to meet the needs of people using the service.

People's capacity to make decisions about their own care and support was assessed and action was taken if anyone was possibly thought to lack capacity.

People were provided with a varied diet and had the opportunity to make choices about what they would like to eat and drink.

The service took appropriate action to address healthcare needs in liaison with other healthcare professional's as required.

Is the service caring?

Good

The service was caring.

Staff were observed treating people in a respectful and dignified way and took time to get to know people. Staff spoke about people with respect and demonstrated that they knew how to ensure people's rights and dignity were upheld.

Staff showed patience with people when providing assistance and explained to people what they were doing and asked for their permission.

The home was working with people and their relatives to update advance care plans to ensure people's end of life wishes were

accurately recorded. However, at the time of the inspection, signed agreement to confirm consent had not been obtained in some instances.

Is the service responsive?

Requires Improvement

The service was usually responsive. Changes to people's care and support needs were usually identified. However, clear recording and updating of current care and support needs required improvement. The service was not able to evidence fully how people or their families had been involved in planning their day to day care.

People were engaged in activities, and the most recently appointed lead activities co-ordinator was taking steps to expand on the range of both internal and external activities.

Is the service well-led?

Good

The service was well led.

The provider assessed the performance of the service and took steps to make any improvements that were identified.

Surveys were carried out of people using the service and relatives. People using the service and relatives were usually very, or highly, satisfied with the service provided. Where this was not the case the service took people's views seriously and took steps to make improvements in a timely way.

Cheverton Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection was unannounced which meant the provider and staff did not know we were coming. The inspection took place on Friday 10 and Monday 13 February 2017. The inspection team comprised of two inspectors and an expert by experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we looked at notifications that we had received and communications with people, their relatives and other professionals, such as the local authority safeguarding and commissioning teams and the local specialist NHS trust nursing team.

During our inspection we spoke with six people using the service, six care staff, three nurses, the activity coordinator, chef and maintenance officer, the manager, the clinical lead and the regional director for the provider.

As part of this inspection we reviewed eight people's care plans. We looked at the training, appraisal and supervision records for the staff team. We reviewed other records such as complaints information, quality monitoring, audit information, maintenance, safety and fire safety records.

Good

Is the service safe?

Our findings

When we asked about the attitudes of staff towards people we were told, "The staff are always aware of you and check you are ok when you are moving around the building," "Staff will come and help when you need them" and "Staff work very hard."

At our previous focused inspection on 17 August and 11 September 2016 we found in most cases that risks were appropriately assessed and the action taken to mitigate identified risks was recorded. We had, however, found that action was needed to mitigate against the risks were in some cases unclear and not detailed. At this inspection, actions to manage and minimise risks were more detailed and were documented within the care plan. Each person had a pre-admission assessment of risks and care needs and a more thorough assessment of risks within the care plan. Risk assessments were filed with the relevant care plan and were reviewed on a monthly basis as part of the monthly evaluation of care plans. Risk assessments included falls risk assessments, Waterlow scores which assessed the risk of pressure sores and Malnutrition Universal Screening Tool (MUST) scores which identified risk of malnutrition.

We had previously received concerns about the high turnover of staff at the home. We were informed, and shown, details of the efforts to recruit staff and almost all vacancies had now been filled. We looked at staffing levels at the home and the rota for the two months leading up to this inspection and found no alteration to the numbers of staff on duty to that which we had seen at previous inspections. The rota showed that staffing was in line with the allocated number for each of the three floors, although some staff said that staffing was an issue at times. We raised this with the home manager and provider's regional director who stated that staffing levels had remained unchanged even though the home was operating at ninety per cent occupancy. During this inspection we found that staff were not rushed and had time to attend to people as needed, even spending time talking with people rather than purely engaging in personal care tasks.

Staff recruitment processes were robust although we did raise a question about a recent applicant. The person had one former employer reference on record when the provider usually sought two. The manager told us they would follow up on obtaining another former employer reference if possible. All other background checks had been completed which included Disclosure and Barring Service check (DBS) to ensure the staff were not a known risk to people, identity checks and permission to work in the UK from the home office where required. Staff files contained a recruitment checklist at the front to indicate that all necessary information was present, although the discrepancies noted above suggest that this had not been done thoroughly in all cases.

The service had access to the organisational policy and procedure for protection of vulnerable adults from abuse. They also had the contact details of the local authorities that had placed people at the service if people, relatives or staff wanted to raise any safeguarding concerns.

Staff wore uniforms to designate their role, for example nurse, care assistant or ancillary staff, and they each wore name badges. There was a board on each floor displaying the names, photos and role of each member

of staff so that they could be identified by people using the service and other visitors. There was a book at reception for all visitors to sign so that there was a record of those visiting the premises.

Staff reported that they had regular training about safeguarding people. Training records confirmed this and staff were able to explain the process for raising a safeguarding concern. Each staff member knew who to report concerns to, for example unit manager, other senior staff, the manager, or regional manager if necessary. All were able to provide definitions of different types of abuse when asked. All staff we spoke with were aware of the provider's whistleblowing policy. If safeguarding concerns were reported the service took the necessary action to respond to these and cooperated with any subsequent investigations.

People were supported with their medicines and these were stored safely. We observed a nurse as a part of their round of morning medicines administration. The nurse took the necessary time to carry this out safely and that all morning medicines had been given to people at the time most suitable to them. For example, if people had not got up and had not had breakfast they were provided with their medicines when ready to take them rather than for the convenience of staff. The nurse showed us what they did to ensure staggered medicines times, four hours minimum recorded, as needed for each person. Medicines Administration Records (MAR) had been fully completed by nursing staff. These records showed that people had received all their medicines as prescribed. Where people needed patches, for example for pain relief, there were clear charts showing the part of the body on which they were applied. The location of the patch was changed each time and charts showed the different area of the body where it was applied each time.

Three people required the use of a percutaneous endoscopic gastrostomy (PEG) tube, which is a tube through which people received nutrition, hydration and medicines due to swallowing difficulties. These tubes are supposed to be rotated at least once each week to prevent them becoming embedded into the person's body. The rotation charts were well kept for two of the three people at the home who required a peg tube. However, the chart of one person had not been signed on two occasions in the last two months although the time of rotation of the tube had been entered. We raised this and later found that the unit manager had gone back to the chart and signed it. We mentioned this immediately to the regional director and the unit manager apologised and said they had done this to be helpful. The service was asked to verify with the nurse who had been duty if the rotation of the peg had been done which they later did.

Staff told us that they received training in infection control and training records confirmed this. We saw that staff wore appropriate personal protective equipment when they were attending to personal care, and disposed of this appropriately when they had finished. Domestic staff used colour coded cleaning equipment for different areas of the home. Infection control audits were carried out regularly and any action required was attended to, which we confirmed when we asked about action on the two most recent audits that we were shown.

The service had undergone a major refurbishment in 2016. The communal areas of the service were clean and well maintained as too were people's bedroom and bathing facilities. There were appropriate records of health and safety checks of the building and we viewed the certificates and records were in place for gas, electrical and fire safety systems. Hoists and slings were checked and cleaned weekly and these checks were up to date to support people's safety. Each person had their own separate slings to use for transfers in order to minimise the risk of infection. The provider had emergency contingency plans for the service should the need arise.

Good

Is the service effective?

Our findings

People using the service told us, "Having the internet is good, I can contact my family who live abroad, it's my magic carpet to seeing the parts of the world where they live, I feel I know where they are" and "They built me up since I came here, I am now able to go on transport without a carer [staff member]."

The two new staff we spoke with explained their understanding of the induction process and told us this included mandatory training and shadow shifts. We saw evidence of induction training for the two new members of staff and the induction folder used by new staff to progress their induction program including a period of shadowing. These new staff were undertaking induction shifts on two days of our inspection, each shadowing other more experienced staff and were additional to the regular number of care staff on duty.

Staff said that they had regular supervision although one was uncertain about how frequently. Records showed that staff supervision was carried out on average every two months, unless staff had been on long term absence. The supervisions were conducted by the unit manager on the floor on which they worked, or another senior member of staff, with outcomes being discussed and recorded. Staff were receiving an annual appraisal and the service were able to show that these had taken place within the last year for all, except very new staff.

Staff told us they had regular training updates and were able to tell us about their most recent training sessions. Staff received regular training to ensure they had the skills and knowledge to meet the needs of people using the service. Staff training included safeguarding adults, Mental Capacity Act 2005 (MCA), customer care and risk of choking among other topics. The manager received quarterly updates on the compliance levels for staff in completing training and refresher training. The most recent report in February 2017 showed that between 75 and 95 per cent of staff were up to date with training. Where some staff had not completed the required training, we discussed this with the manager and regional director who were able to describe the action was being taken and why some staff had not met the training level required.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf for people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lacked mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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 procedure is for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Staff we spoke with were aware of the right of people to freely make decisions and told us that physical restrictions other than the use of bedrails for their safety, when approved or freely agreed by them was the only physical barrier to people's freedom of movement.

Most people at the home were not subject to the mental capacity act or deprivation of liberty safeguards. We were shown the approvals for all seven people where MCA and DoLs was currently applied and had been authorised in early February 2017. The service had also kept CQC informed as required about such approvals. DoLs assessments involved the use of bedrails as no other restrictions to people were necessary, or used.

People gave some mixed responses to what they thought of the meals provided. A person told us, "The food here is good, but too rich for my condition they are working on food that would suit me after my family helped me to tell them, it is getting better" and "They make sure I have additional biscuits and a drink to keep my system in balance." Three people were less happy about the food, which the chef told us they had discussed with these people and would do so again. During our observations during two lunchtimes we saw no reason for concern about the quality or variety of meals on offer. Catering staff served people on each floor with their meals which also helped these staff to obtain direct feedback from people about the quality of the meal.

There were menus clearly displayed on notice boards and on each table in the dining rooms. Before being served, each person was shown the menu and plated food and asked what they would like. Mealtimes were all unhurried and people were given ample time to enjoy their meal without being rushed to finish. The atmosphere at each meal was relaxed and jovial. Where people required help to eat, and in particular where people ate in their room, staff assistance was readily available if people needed this help and they were not made to wait for their meal. The home had received highly positive feedback in the most recent satisfaction survey, and a relatives meeting, which included a discussion about the standard of meals.

In addition to comments directly from people, we viewed the comments made at the most recent relatives meeting in December 2016. Food was a topic discussed at that meeting and, apart from one person, the feedback from people was highly positive.

Two people said "The food is not good here, it's not what I like or used to" and "I haven't complained about the food although I don't like it, I am not the sort to complain." We explored these comments further and the manager was aware of the clients who held those views and had asked the chef to talk with them, which the chef later told us they had, but would do so again.

Two people told us they did not get snacks in the evening. Snack foods were available in kitchens on each floor which we saw, in addition to when people were being given tea and biscuits in the morning. We did, however, pass these comments to the manager and regional director to explore further with people.

Each care plan had a separate section with a monthly Malnutrition Universal Screening Tool (MUST) score and weight monitoring. The MUST is a means of monitoring and preventing people who are at risk of malnutrition becoming dehydrated, suffering weight loss and therefore being prone to ill health as a result. There was a separate care plan for diet and nutrition with evidence of food preferences, allergies and information on individual needs and risks. For example, the need for fortified or pureed food, difficulty swallowing or assistance required to eat were all recorded. People who were at risk of malnutrition or losing weight were monitored closely with daily food and fluid records and weekly weights. There was documented evidence of referrals to dieticians and speech and language therapy teams and the advice that was received.

Nurses were on duty at the service 24 hours and a local GP visited the home twice each week, but also attended if needed outside of these times. The home provided an escort to go with people to the hospital in an emergency or to other appointments if their relatives were unable to attend. We saw during this

inspection that the home had provided a member of staff to escort someone to hospital due to a sudden illness.

Records of other health care professionals visit, such as, dieticians or podiatrists, were well maintained and clear about the date of the visit and contained information on any recommendations.

Good

Is the service caring?

Our findings

People told us "They (staff) are very kind and caring" and "Staff come from many countries and they have brought a family approach. It feels like I am part of a family."

There was an advanced care plan in each person's care file to document advance wishes in relation to end of life, funeral arrangements as well as any legal status relating to the person. However, the advanced care plan had not been completed in all care files we looked at. In one file, it had not been completed at all. In another file, it had only been partially completed. In a third file, the end of life information was contradictory. The plans did not clearly record whether the person or their family had been consulted about decisions relating to care or had consented to it. Action was being taken to address this. Involvement in care planning had been discussed with relatives at meetings in November and December 2016. Minutes of the meetings were available and letters had been sent to relatives inviting their involvement in care planning.

We observed that staff were polite and patient with people, talking clearly and making eye contact when communicating with them.

Interactions we observed demonstrated that staff were gentle and considerate when attending to people's needs. Staff took time to talk with people even when they were walking past them and were on their way elsewhere.

All staff we spoke with were familiar with people's needs and personalities and were able to explain their routines, risks and how they were cared for. Care staff were able to describe methods used to ensure that dignity and privacy were respected. For example, closing bedroom doors and offering choice before delivering personal care. We observed that staff knocked on bedroom doors before entering. We spoke with staff about how they sought the views and wishes of people who used the service. Staff clearly knew people's life histories and how to communicate with people. We found this in conversations we had with staff and by observing how they approached and interacted with people. Care plans described people's cultural heritage as well as whether or not people chose to adhere to a religious faith. However, some staff were less clear about lesbian, gay, bisexual and transgender matters and we mentioned this to the manager and regional director. Diversity and equality training was provided to staff as a part of the providers customer care training and we asked that the service check staff awareness. Staff were, however, all very clear that they should treat people as individuals.

The provider had a system called, 'resident of the day'. A specific person was focused on each day, and on the first day of our visit this was the person who was celebrating their 100th birthday. We saw that staff made it a special event, involving people who lived at the home and the person's family. People living on other floors at the home were invited to attend if they wished to, and many did.

People's bedrooms were personalised according to their wishes and, within reason, people could bring their own items of furniture into the home. Rooms were personalised to people's own taste, with ornaments and pictures along with other personal items they wanted to bring with them when they came to live at the

home.

Requires Improvement

Is the service responsive?

Our findings

Care plans contained information about people's likes, dislikes and routines. Each care plan showed personal outcome objectives and the actions required to support the person and meet their needs. The care plans we reviewed were handwritten and although generally clear some were difficult to read due to poor legibility. There was, however, limited evidence on five of the eight care plans we looked at about how much the person or their family had been involved in decisions about the care plan.

Accuracy of care recording was an issue we raised at the focused inspection in August and September 2016. There was a separate folder kept in individual rooms used for recording aspects of care such as personal care, nightly checks, mattress checks or other regular monitoring for example food and fluid intake or re-positioning. These folders contained written notes of staff involvement in providing care and were up to date in most areas of care for each person. There was a chart showing people's preferred bathing schedule in the nurse's office on each floor showing the day of the week that different people had a bath or shower. However, it was unclear on each floor whether this was adhered to as in two instances of the eight care plans we looked at the record of having a bath or shower conflicted with the people's recorded preferences. For example, these people had said they wanted a bath or shower twice weekly in their care plan when only once a week was recorded in their care notes.

In terms of the lack of consistency in care planning and recording the internal home audit on 13 February 2017 identified these issues. The audit concurred with what we had found during the inspection which showed that the service was recognising improvements that were needed. We spoke with the clinical lead at the home and the clinical development manager for the provider who was visiting. They informed us that all care plan monthly evaluations were being reviewed immediately and inaccuracies would be verified and correct information updated.

Two people told us they did not think there were enough activities of interest to them. However, most were complimentary and told us "I really enjoy art therapy," "I hope there will be more outdoor activity, like doing gardening, going on trips to parks, countryside seeing birds and animals." Another person told us that they thought that the activities coordinator "is brilliant."

We were informed that to expand the variety and amount of time given to activities another activities coordinator was being recruited. The activities co-ordinators, one part time and one full time, did cover weekends although could not do so on both days every weekend. We mentioned the comments from two people who did not think that there were enough activities to the manager and regional director for their information. They agreed to explore comments of this kind further in terms of the wider consultation they regularly had with people using the service.

We observed and spoke with the senior activities coordinator when they were carrying out a personal activity with someone. We saw that they had a positive relationship, with a lot of laughter. The activities co-ordinator spoke with us at length about what activities took place in the home and what external activities were being planned once the weather was warmer. There was also a music therapist present on the first day

of this inspection. We observed input from the activities staff throughout both days in the communal areas which was enthusiastic and engaged those people who were present. Staff reported that the activities staff visited those who remained in their rooms and spent time conversing with them, bringing them reading materials, helping with communication such as using mobile phones or organising shopping errands if required. We saw instances of this happening during this inspection. There was limited record of participation in activities in the home in the care files whether this involved engagement in group activities or one to one sessions. This had been identified by the provider as an area for improvement and the activities coordinator had begun to make these records, two of which we viewed during this inspection.

We asked people about whether they felt listened to and were told, "I would complain to the staff" and "I would feel able to complain to the manager."

We looked at the complaints that the home had received since our previous comprehensive inspection in December 2015. We found that very few comments of concern were made and often comments were received praising the quality of care. The provider had a clear complaints system which was reviewed by the manager and the service provider. Complaints that the home had received were in respect of the period during 2016 when there had been a change of management at the home. These concerns had been resolved, although initially with some delay.

Good

Is the service well-led?

Our findings

Audits covered the day-to-day operation of the service from staffing, catering, maintenance to monthly care planning and medicines. We saw evidence of medicines audits carried out each month on each floor.

Most people using the service did not give us specific feedback about the manager. However, one person told us, "The manager comes round and they remember my name and details about me. That is nice." Some people did tell us that they were aware that changes had been made to their care at their request and were positive about that having taken place.

There was a clear management structure in place and staff were aware of their roles and responsibilities. Staff were positive about working at the home and said that the home had an open and respectful culture, with good team work amongst staff. They felt that recent changes in management and high staff turnover had been unsettling but that this had settled down. Staff were positive about the current manager who they said was accessible and visible in the home. All felt that they could approach the manager or other senior staff with any concerns and reported that management were supportive of the staff.

Staff reported that there were regular staff meetings within the home as a whole, the two most recent staff meeting minutes we viewed, which they found useful. Topics included reporting abuse, interacting with people and staffing at the home. Staff were also praised for areas of good and effective work. Staff told us there were daily handover meetings at which people's progress could be discussed and any concerns could be addressed. We observed a morning handover on one of the three floors and each person was discussed. The handover was well organised and staff made plans for the day to monitor and respond to each person's care needs as well as who would take responsibility for other events occurring during the day.

Surveys were carried out by an independent survey company on behalf of the provider. These were carried out on a rolling basis and the most recent results from the end of 2016 showed that over 90 per cent of 36 people who took part had a high degree of satisfaction with how the service was run. A wide range of questions were asked from the standard of catering, staff, being treated with dignity and respect among other topics. The scores for the questions asked were between 83 and 100 per cent with almost all responses to the question scoring above 90 and up to 100 per cent satisfaction. Views from stakeholders were also obtained on an on-going basis.