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 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 inspection took place on 7 and 8 January 2016. The first day of the inspection was unannounced. This inspection was conducted by one inspector, an expert by experience and a specialist advisor. An expert by experience is someone who has experience of caring for someone who uses 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 us had experience and knowledge in nursing care.

We spoke with seven people who lived at the home and seven people's visitors or relatives. We spoke with four nurses (one of which was the clinical/deputy manager), four care staff, two members of staff involved in preparing and serving food to people and two activities coordinators. We also spoke with the chef, the trainer, an administrator, the registered manager and the Regional Director.

We reviewed the information we held about the service. We looked at information received from 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. We also spoke with two visiting health professionals during our inspection visit.

We also reviewed the information in the provider's information return (PIR). This is a form we asked the provider to send to us before we visited. The PIR asked the provider to give some key information about the service, what the service does well and improvements they planned to make. We found the PIR reflected the service provided.

We looked at a range of records about people's care including eight care files. We also looked at other records relating to people's care such as 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 personnel files for three members of staff to check that safe recruitment procedures were in operation, and that staff received appropriate support to continue their professional development.

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 felt safe living at the home. People were protected from risk because staff knew how to safeguard people from potential abuse and there were enough staff available to care for them safely. The provider recruited staff of good character to support people at the home. Medicines were not always stored and administered safely.

Is the service effective?

Good

The service was effective.

Staff completed induction and training so they had the skills they needed to effectively meet the needs of people at the home. Where people could not make decisions for themselves, people's rights were protected; important decisions were made in their 'best interests' in consultation with health professionals. 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.

Care staff treated people with respect and kindness and knew people well. People had their privacy and dignity respected and staff supported people to maintain their independence. People were involved in making decisions about their care, and were consulted about their preferences with regard to care at the end of their lives. This was recorded in a care plan so everyone would be aware of their wishes.

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. Care records described the care people needed and how staff should support them, in accordance with their wishes. 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.

Is the service well-led?

Good

The service was well led.

The management team was approachable and there was a clear management structure to support staff. The manager was accessible to people who used the service, their relatives, and members of staff. People were asked for their feedback on how the service should be run, and feedback was acted upon. Quality assurance procedures identified areas where the service could improve, and the manager took action to improve the service.

Overslade House

Detailed findings

Background to this inspection

We inspected Overslade House on 7 and 8 January 2016. The inspection visit was unannounced.

Overslade House is divided into three separate units and provides personal and nursing care for up to 89 older people, including people living with dementia. There were 77 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 associated Regulations about how the service is run. There was a registered manager in post at the time of our inspection. We refer to the registered manager as the manager in the body of this report.

At our last inspection in July 2014, the provider was in breach of Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing. The registered person had not taken appropriate steps to ensure that, at all times, there were a sufficient number of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity. At this inspection visit we found there were enough staff to care for people safely.

Medicines management required improvement to ensure people received their prescribed medicines safely and medicines were stored safely. People were supported to access healthcare from a range of professionals inside and outside the home and received support with their nutritional needs. This assisted them to maintain their health.

People were protected against the risk of abuse as the provider took appropriate steps to recruit staff of good character, and staff knew how to protect people from harm. Safeguarding concerns were investigated and responded to in a timely way to ensure people were supported safely.

The manager understood their responsibility to comply with the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. Decisions were made in people's 'best interests' where they

could not make decisions for themselves.

People had interests and hobbies offered to them that met their needs and their personal preferences. People were involved in deciding how they wanted their care and support to be delivered and care records reflected the care and support people received. Permanent staff knew people well and could describe people's care and support needs.

Care staff treated people with respect and dignity, and supported people to maintain their privacy and independence. People made choices about who visited them at the home. This helped people maintain personal relationships with people that were important to them.

People knew how to make a complaint if they needed to. Complaints received were fully investigated and analysed so that 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. Quality assurance procedures identified where the service needed to make improvements, and where issues had been identified the manager took action to continuously improve the service.

Requires Improvement

Is the service safe?

Our findings

People gave us mixed feedback about whether there were enough staff available to care for people safely and meet people's care and support needs. One person told us, "I think there are enough staff." Another person said, "The carers are lovely, but if they had one more it would be great." A third person said, "Sometimes I use the bell and staff don't always come straight away, I can wait half an hour."

Some relatives we spoke with told us they thought there should be more staff available to respond to people's needs. This was because staff did not always answer call bells in a timely way. One relative told us, "[Name] often rings her call bell without response," they added, "The ratio of staff to residents isn't ideal."

We asked staff whether they felt there were enough staff at the home to meet people's needs safely. All of the staff told us they felt there were enough care staff employed at the service to assist people effectively and safely. One staff member said, "Yes, there are definitely enough staff on the shift to support people."

We observed how staff responded to people when they activated their call bells at the home. On one occasion we saw one person waited for around twenty minutes before staff answered their call bell. A staff member had cancelled the call bell from ringing in the corridor, but it was some time before they were able to assist the person in their bedroom. However, on other occasions we saw people were responded to almost immediately. We asked the manager why they felt call bells were not always answered promptly. They explained they were changing the way call bells were answered at the home, the current system allowed staff to turn off the call bell from the main floor of the home. On occasion staff were distracted from the task of providing support to the person before they reached the person's room. This meant the person might wait until the staff member was able to attend to them. Other staff would not be aware the person was still waiting for assistance. The call bells were being changed so that they could only be turned off by a staff member from the person's room, which meant this issue would not occur in the future. In addition call bell checks had been put in place to monitor staff response times, to ensure there were always enough staff available to assist people at the home.

We asked the manager how they ensured there were enough staff to meet people's needs safely. They told us staffing levels were determined by the number of people at the home, their needs and their dependency level. We saw each person had a completed dependency tool in their care records. This assessed how much care and support they required. The manager used this information to determine the numbers of staff that were needed to care for people on each shift. We asked the provider and manager about the number of staff vacancies at the home, they told us they currently did not have any vacancies and they had enough staff to fill all the shifts so that agency or temporary staff were not used at the home.

We observed there were enough staff during our inspection visit to care for people effectively and safely. Staff were available to respond to people's requests for assistance. We saw that in addition to the nurse and care staff on shift, there was a trainee nurse, the manager (who was a registered nurse) and the clinical manager (who was also a registered nurse) available to cover care duties at the home when needed. In addition to these staffing levels, other staff members worked alongside care staff, such as cleaners and

kitchen assistants. This meant care staff could concentrate on providing care support to people who lived at the home.

We observed medicines being administered on three separate occasions. Staff who administered medicines were trained nurses, and had received specialised training in how to administer medicines. Their competence to administer medicines safely was checked regularly by the manager or their deputy. However, we observed some procedures for the safe administration of medicines were not being followed. Medicines were not always stored safely. On two separate occasions we observed nursing staff left the medicines trolley unattended. In one instance the trolley was locked, but medicines were available for people to access on top of the trolley. In another instance the trolley was left unlocked. People were present in the areas where the trolleys were left unattended. This posed a risk to people at the home, as they could access medicines without a staff member being present.

Each person at the home had a Medicine Administration Record (MAR) that documented the medicines they were prescribed. MAR records contained a photograph of the person so that staff could ensure the right person received their medicines. This was important as the home could use staff to administer medicines who might not know the people there. Administration records were signed by nursing staff to state people received their medicines as prescribed. However, we observed medicine being given to people by a member of staff who did not sign the MAR when they gave people their medicine. The Medicine Administration Record (MAR) was signed by a different member of staff, which was incorrect. In addition, some people were prescribed creams for their skin. These were administered by care staff. We found that MARs and daily records were not completed to show when creams had been applied. This meant there were no records of when people were receiving some of their prescribed medicines.

Medicines were not always administered to people at the right time. For example, some people at the home needed to have their medicine before food so that the medicine did not cause an adverse reaction. We saw one person who needed to have their medicine before their breakfast. We observed the person did not receive their medicine before their meal.

There were protocols for the administration of 'as required' medicines, such as pain relief medicines to direct nursing staff when the medicine should be administered. , For example, information was provided to staff on the signs people might display when they were in pain. People told us they received their medicine when they should, one person told us "I feel no pain, as I have the right pain relief medicine." However, a system was not in place to ensure people received their medicine with an appropriate time gap between doses. Some people required a four hour gap to be left between doses. A gap between some medicines is important to prevent people receiving too much medicine. Nursing staff did not record the time people were given their medicine. This meant they could not ensure an appropriate time gap was observed. For example, on one day we saw the morning medicines round did not finish until after 10.45am. One person was given pain relief medicines at this time, which required a four hour gap before their next dose. The next medicines round was scheduled to start at approximately 12.30pm. We were concerned that if a different member of nursing staff conducted the next medicine round, they would not know when the person had received their medicine, or when the person could receive their next dose of pain relief.

We brought these issues to the attention of the manager during our inspection visit. Following our visit the manager confirmed, "Nurses have had follow up training in the administration of medication." They added, "We are now recording the time of when 'as required' medication is given to ensure people receive their medicines at the right time, and with an appropriate gap between their medicines. We are also now recording when creams are administered."

All the people we spoke with told us they felt safe at the home. One person said, "Yes, I feel safe here." A relative told us, "My relative is safe. Staff here have been really good, I think it's fantastic."

The provider protected people against the risk of abuse and safeguarded people from harm. The provider notified us when they made referrals to the local authority safeguarding team where an investigation was required to safeguard people from harm. They kept us informed with the outcome of the referral and actions they had taken. Staff attended safeguarding training regularly which included information on how staff could raise issues of concern with the provider. All the staff knew and understood their responsibilities to keep people safe and protect them from harm. Staff told us their training assisted them in identifying different types of abuse and they would not hesitate to inform the manager if they had any concerns about anyone. They were confident the manager would act appropriately to protect people. One staff member said, "I would also make sure immediately that the person concerned was safe before doing anything else."

Staff told us and records confirmed, people were protected from the risk of abuse because the provider checked the character and suitability of candidates prior to them being recruited to work at the home. For example, criminal record checks, identification checks and references were sought before staff were employed to support people.

The manager had identified potential risks relating to each person who used the service, and care plans had been written to instruct staff how to manage and reduce potential risks to each person. Risk assessments were detailed and reviewed regularly. Risk assessments gave staff clear instructions on how to minimise risks to people's health and wellbeing. For example, care workers undertook checks of people's skin where they were at risk of developing skin damage. People had the equipment they needed, such as specialist mattresses to minimise the risks to their skin. Staff we spoke with had a good understanding of the risks related to each person's care.

The provider had taken measures to minimise the impact of some unexpected events happening at the home. For example, emergencies such as fire and flood were planned for so that any disruption to people's care and support was reduced. There were clear instructions for staff to follow in the event of emergencies. This was to minimise the risk of people's support being provided inconsistently.

Good

Is the service effective?

Our findings

People told us staff had the skills they needed to support them effectively. One person said, "Staff are very good." Staff told us they received an induction when they started work which included working alongside an experienced member of staff, and training courses tailored to meet the needs of people who lived at the home. The induction training was based on the 'Skills for Care' standards and provided staff with a recognised 'Care Certificate' at the end of the induction period. Skills for Care are an organisation that sets standards for the training of care workers in the UK. This demonstrated the provider was acting to continuously improve staff induction procedures.

Staff told us the manager encouraged them to keep their training and skills up to date following their induction training programme. The provider employed a dedicated training manager to plan and arrange staff training. They maintained a record of the training staff attended, so they could identify when staff needed to refresh their skills. Staff told us that each member of staff received an individual training programme tailored to their specific job role. For example, nursing staff received specialist training in medicine administration. One member of staff told us, "The training is good. We can request extra training if we want." Staff told us the provider also invested in their personal development and they were supported to achieve nationally recognised qualifications. One staff member said, "They have been very supportive in helping me achieve recognised qualifications."

Staff used their skills effectively to assist people at the home. For example, staff used their manual handling skills to assist people to move safely. Staff used the correct equipment for each person, and people's privacy and dignity was protected.

Staff told us they were supported with regular meetings with their manager to discuss their role and any training or staff development needs. One member of staff said, "I get a meeting with my manager every few weeks. It gives me a chance to talk about any concerns I have or any training needs." They also had yearly performance appraisals to assess if they were carrying out their role to the standards expected by the provider.

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

We checked whether the manager was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The manager was able to explain to us the principles of MCA and DoLS, which showed they had a good understanding of the legislation. Mental capacity assessments were completed when people could not make decisions for themselves. Staff

demonstrated they understood the principles of the MCA and DoLS. They gave examples of applying these principles to protect people's rights, for example, asking people for their consent and respecting people's decisions to refuse care where they had the capacity to do so. Where people could not make decisions for themselves, records confirmed important decisions had been made in their 'best interests' in consultation with health professionals. The manager reviewed each person's care needs to assess whether people were being deprived of their liberties. Several people had a DoLS in place, and their care was being managed in accordance with the MCA.

Most of the people we spoke with told us they enjoyed the food on offer at the home, and could make choices each day about what they wanted to eat. One person told us, "The food is OK." Another person said, "If I don't like something on the menu they will make something else for me." We observed people being served breakfast at the home. People were offered a choice of cooked breakfast, toast, and cereals. The majority of people ate their breakfast in the dining room, some people ate in their bedroom. One member of staff confirmed to us that this happened each day, they said, "People can have what they want to eat. They can also have this at a time that suits them."

We observed a lunchtime meal at the home. There were a number of dining rooms available for people to use. Dining tables were laid with table clothes, cutlery and flowers to make the mealtime experience enjoyable. The dining rooms were calm, and there was a relaxed atmosphere. Where people needed assistance to eat their meal, staff assisted people at their own pace and waited for people to finish before offering them more food. In one unit of the home, where people had dementia and nursing needs, the lunchtime service was staggered with an interval of approximately half an hour. This was so that there were enough staff to assist people with eating their meal, and so that people were not left waiting for assistance whilst other people ate. We saw this arrangement worked well for staff and people. People did not wait for their meal, but were offered food at the same time as other people who shared the dining area. Food was served from a 'hot trolley' so that the meal was at the right temperature when it was served to people.

A daily menu of the food on offer was displayed on the notice board at the home. People were able to choose from a range of options and staff asked people for their food choices before their meal was served. We did not see staff plating meals and offering people a choice of food visually, however, one staff member told us, "If people couldn't tell us what they wanted, we would show them the food options available to see what they preferred." The manager told us, "We have also started to photograph the meals, so that in around a month's time we should have pictures of the range of food on offer, so that people can be shown picture cards to help them choose their preferred meals." Where people were unable to make decisions themselves, staff made choices based on the individual's likes and dislikes. These were recorded in the care records we reviewed. We saw people were consulted about the food on offer at the home. Each day one person was picked by the chef, to discuss what their food preferences were and whether the menu was meeting their needs. This information was reviewed when new menus were drawn up.

People were offered drinks and snacks throughout the mealtime, and during the day in accordance with their needs. Drinks were available in people's bedrooms and were in easy reach. One relative told us, "[Name] always gets regular drinks." People were offered food and drinks that met their dietary needs. Kitchen staff knew the dietary needs of people who lived at the home and ensured they were given meals which met those needs. For example, some people were on a soft food diet or fortified diets (where extra calories are added such as cream or butter). Information on people's dietary needs was kept up to date and included people's likes and dislikes.

The home had attained an award for encouraging people to gain nutrition and maintain their weight from the food that was provided at the home, rather than receiving nutritional substitutes. The chef told us, "We

cater for people's individual tastes, we can prepare special meals for people. We recently had someone here that enjoyed Caribbean food and so we prepared rice, beans and jerk chicken dishes to meet their preference." They added, "As a home we really care about people's health, and helping them to maintain this through good quality food. Every month we hold a meeting to discuss people's health changes, to see whether we can provide any specialist support."

Staff were able to respond to how people were feeling and to their changing health or care needs because they had a verbal handover at the start of each shift. We reviewed the records from a number of recent handovers. Records showed these were attended by the nurse on duty and care staff. The handover provided staff with information about any changes since they were last on shift. Staff explained the handover was recorded, so that staff who missed the meeting could review the records to update themselves.

Nursing staff and people told us the provider worked in partnership with other health and social care professionals to support people's needs. Care records included a section to record when people were seen or attended visits with healthcare professionals so that any advice given was clearly recorded for staff to follow. Records confirmed people had been seen by their GP, a speech and language therapist, mental health practitioner, dietician and dentist where a need had been identified. We found people were referred to see health professionals in a timely way to address their healthcare needs. For example, we saw one person was referred to see a specialist regarding pain management and the specialist advice was being followed. The manager told us the doctor and other health professionals visited the home when needed, we observed the doctor visited the home during our inspection visit. We found advice given by health professionals was being followed. We spoke with two visiting health professionals on one day of our inspection visit, one told us, "We enjoy coming here, staff are very helpful."

Good

Is the service caring?

Our findings

People told us staff treated them with respect and kindness. Relatives and visitors also told us staff were caring, and treated their loved ones with respect. One relative said, "If they didn't care for [Name] I would take them home," they added, "The manager and staff are lovely." Another relative said, "I am happy with the care to my relative."

Staff told us they enjoyed working at the home, because of the interaction they had with people who lived there. One staff member said, "I love my job, the people and my team are lovely." We observed staff interacting with people at the home in a respectful and caring way using people's preferred names. Staff communicated with people effectively using different techniques. We observed staff touching people lightly on their arms or hands to provide them with reassurance and comfort. Staff assisted people by talking to them at eye level and altering their tone of voice to help people understand them. People laughed and smiled at staff, and enjoyed their interactions.

People told us they made everyday choices about how they spent their time. One person told us, "I like to spend time in my room, which the staff respect." We saw most people at the home spent time in their room according to their preference, rather than in the communal areas of the home.

Staff promoted people's independence by encouraging them to do things for themselves, where possible. For example, staff encouraged people to stand and move around with assistance rather than being hoisted or assisted to move fully by care staff, which was supported by relevant risk assessments. Staff encouraged people to dress and do everyday tasks themselves, where they could.

People told us their dignity and privacy was respected by staff. We observed care staff respected people's privacy and knocked on people's doors before entering, and announced themselves. One member of staff said, "I knock on doors before entering and make sure people are covered up. I always ask permission before doing anything for someone."

People and their relatives were involved in care planning where possible and people made decisions about how they were cared for and supported. For example, people had information recorded in their records about their religious beliefs and their personal history, so that staff could support people in accordance with their wishes.

There were a number of rooms, in addition to bedrooms, where people could meet with friends and relatives in private if they wished. People made choices about who visited them at the home and were supported to maintain links with friends and family. One person told us, "Visitors can come in without any restrictions." We saw people and their visitors were offered drinks and snacks and used communal areas of the home which helped to make them feel welcome. On the ground floor of the home there was a café which was stocked with snacks and hot drinks; all of the people who lived at the home and their visitors could use the area whenever they wished.

Some people at the home had been consulted about their wishes at the end of their life. We reviewed care records which documented their preferences. Staff told us this was to provide good quality care to people nearing the end of their life, and to respect their cultural or religious beliefs. People had up to date 'end of life' care plans which were comprehensive. Plans showed people's wishes about who they wanted to be with them at this time and the medical interventions they agreed to. The manager confirmed that people made these choices in consultation with health professionals, their relatives and staff, so that their wishes could be met.

The home supported people and their families during this difficult time. For example, for those people nearing the end of their life, arrangement had been made for people's relatives to access bereavement counselling. The home also provided a quiet room for families where they could relax and spend time together.

People were supported to access advocacy services. Most people had a relative they could ask for support from, however, where people did not, the manager provided access to advocacy services. Although no-one at the home was currently using an independent advocate, we saw advocacy services were advertised and promoted in prominent places around the home. An advocate is a designated person who works as an independent advisor in another's best interest. Advocacy services support people in making decisions, for example, about their finances which could help people maintain their independence.

Good

Is the service responsive?

Our findings

Care records were available for each person who lived at the home. Records gave staff information about how people wanted their care and support to be delivered. For example, care plans included information on maintaining the person's health, their support needs and their personal preferences about how they wished their care to be provided. The PIR stated care planning was undertaken with the person, their loved ones and family members. Care reviews took place monthly. We were able to confirm this happened. One relative told us, "I am happy with the care. There is a lot of 'family involvement' and we can always approach staff or management if we have any concerns." Another visitor stated, "They are involving me, although I'm not the person's next of kin, they recognise my relationship with the person and involve me."

We reviewed eight care records in detail for people who lived at Overslade. In two of the records we found the records were not consistently up to date and did not clearly provide staff with the information they needed to care for people responsively. For example, in one person's care records we saw the person had breathing difficulties. Although there was a care plan in place for this condition, the care records did not describe the treatment that could be provided to the person. We spoke with staff about this, who explained the person frequently refused medical intervention for the condition, which was why treatments were not documented. Information about the person frequently refusing care and support for their condition was not clearly documented in the care records. In another person's records we saw they had a weakness on one side of their body, and needed to have a call bell in reach on the other side of their body. We saw that the call bell had not been placed in the position documented in the care records. Staff told us the records were incorrect, as a mistake had been made in documenting the correct position of the call bell. We brought this to the attention of the manager, who immediately had both of the records updated during our visit.

Although we found these minor issues with the care records, we found no impact to the care people received at the home. Staff could describe to us the support needs of people at the home. The information matched what people told us, which demonstrated permanent staff knew people well. Staff told us that generally care records were kept up to date and provided them with the information they needed to support people effectively.

We asked people whether they enjoyed the activities and events on offer at the home. People told us they did. Each person had a record of activities in their care records which they might enjoy. We spoke with two members of the activities team. Both staff members told us they tried to arrange specific activities for people, based on their personal preference. We saw examples of where this had happened, for example, we saw one person had been taken to see a family member after not seeing them for several years. One visitor told us how responsive the home was in organising events that people might enjoy. They explained, "It's so lovely here, they will do anything for people. They recently arranged a tea party for someone."

We observed people sitting in the communal areas of the home listening to the television and to music. We observed one person enjoying a one-to-one activity with the activities co-ordinator. We saw other people chatting with their relatives and friends in their bedrooms which they enjoyed. We spoke with a member of staff who organised activities at the home. They said, "We offer a range of activities for people to take part in.

This includes games, quizzes and trips out and about. We have a mini-bus and can take people out." A list of planned activities was on display in the communal areas of the home for people to refer to. Activities included trips into the local community, church services, coffee mornings, entertainers, and reading activities." Another member of staff told us about the local radio station, they said, "We also take part in the BBC Coventry and Warwickshire Radio station every two weeks where we talk about the care and life at Overslade. Some residents here find this interesting." During our inspection visit we saw people take part in group activities in different communal areas of the home, as more than one activities organiser was available. This offered people a range of things they might enjoy each week.

We spoke with the manager and provider regarding the number of staff employed to offer people activities. They explained there were four members of staff employed to provide people with activities, interests and hobbies that met their individual needs. The home also employed a number of regular volunteer staff to work with people at the home, to assist activities and care staff in providing support to people. For example, one volunteer ran a shop once a fortnight to offer people access to personal items they may wish to purchase. Another volunteer came in twice a week at mealtimes to assist people. One volunteer spent time reading to people. This supplemented scheduled activities at the home.

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. People and their relatives told us they knew how to raise concerns with staff members or the manager if they needed to. One person told us, "I have no concerns, if I did I know who to tell." In the complaints log we saw that previous complaints had been investigated and responded to in a timely way. The provider had acted on the feedback they received in complaints to improve the quality of their service.

Good

Is the service well-led?

Our findings

There was a registered manager at the service. People and staff told us the manager was approachable. The manager operated an 'open door policy' and encouraged staff and visitors to approach them in their office. People told us they were confident in approaching them. One person told us, "I feel confident in approaching the manager or staff if I need to."

There was a clear management structure within Overslade House to support staff. The registered manager was part of a management team which included a deputy manager/clinical manager who was also a nurse. Nurses were available to support staff on each shift. Staff told us they received regular support and advice from managers and nurses to enable them to do their work. Staff told us there was always an 'on call' telephone number they could call outside office hours to speak with a manager if they needed to. One staff member said, "It's a good team, and we support each other. The manager and deputy manager are also very good. The manager is a good nurse, and works alongside us." Another staff member told us, "You can talk to them, they are approachable."

The manager told us the provider was supportive and offered regular feedback and assistance to support them in their professional development. For example, the provider visited the service every month to hold meetings with the manager. They also discussed issues around quality assurance procedures and areas for improvement at the home. The manager said, "The provider is very good, they are really supportive." They added, "They are very responsive if we have an emergency, they help us to sort things out straight away."

The provider completed regular checks on the quality of the service they provided. The provider visited the home to conduct unannounced quality inspections. A regional audit was carried out on a monthly basis by the Regional Director which included an audit of medication and care plans. The provider also directed the manager to conduct regular checks on the service they provided. Checks included medicine administration, care records and infection control procedures. The PIR confirmed the manager also visited the home monthly during the night, to check on procedures for the night shift. The manager produced reports into how the home was performing against business plans. 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. This demonstrated the provider took action to continuously improve the quality of the service provided at the home.

People could provide feedback about how the service was run and their comments were acted on by the provider. The manager told us they encouraged feedback from people, visitors and relatives by holding regular meetings at the home. They also carried out annual quality satisfaction surveys to gather feedback. We reviewed information from previous meetings at the home, we saw the manager had acted on the feedback provided to ensure snacks and drinks in the café were restocked regularly. We saw information on the noticeboards around the home advertising relatives support groups and meetings at the home. One relative told us, "I haven't been to any of the meetings, but if I had something to discuss I would just speak with the manager."

Staff had regular team meetings with the manager and other senior team members, to discuss how things could be improved at the home. Staff meetings were held within teams. For example, nursing staff met to discuss clinical information. The PIR confirmed there was also a staff meeting held with all staff every three months. An agenda was drawn up before each meeting and staff were able to contribute their suggestions for discussion. One staff member told us, "There are regular staff meetings and minutes are taken for staff who might miss the meeting." A recent meeting record showed staff had discussed the needs of people in their care and handover arrangements. Staff told us they had an opportunity to raise any concerns they had, or provide feedback about how the service could be improved. Where staff had made suggestions, the manager had acted to implement improvements.

The provider had sent statutory notifications to us about important events and incidents that occurred at the home. They also shared information with local authorities and other regulators when required. They had kept us informed of the progress and the outcomes of investigations they carried out. For example investigations in response to accidents, incidents or safeguarding alerts, the manager completed an investigation to learn from these incidents. The investigations showed the manager made improvements to minimise the chance of them happening again.