Care Quality Commission

Colten Care (2003) Limited

Abbotts Barton

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?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on the 11 July 2017 and was unannounced. The inspection continued on the 12 July 2017 and was announced. Abbotts Barton is a residential nursing home situated on the northern edge of Winchester registered to provide accommodation for up to 60 people. There were 54 people using the service on the days of our inspection. Rooms are over three floors, single occupancy and all have an ensuite with a wash basin and toilet. Specialist bathrooms are available on each level of the home. There are a range of public areas including a lounge on each floor, dining room, library and café. There are communal secure gardens with good access from the building.

The home has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People who were administering their own medicines were placed at an increased risk of harm because risk assessments and reviews were not being completed consistently. Medicines given by staff had been ordered, stored and administered safely including the application of topical creams.

People were supported by enough staff although people told us at times they felt they had to wait too long for help with care. Records showed us that the service had put actions in place that had reduced the length of time call bells were being answered. Staff had been recruited safely and had been given an induction and on-going training and support to enable them to carry out their roles effectively.

People felt safe and were cared for by staff that had been trained to recognise signs of abuse and knew the actions they needed to take if abuse was suspected. Risk assessments relating to peoples assessed risks had been completed and reviewed regularly and actions put in place to minimise risks to people. People had access to healthcare in a timely way and when appropriate.

The principles of the Mental Capacity Act were being followed. People had been supported to make their own decisions and records showed us that when they couldn't decisions had been made in their best interest. Deprivation of Liberty Safeguards had been applied for when people needed their liberty to be restricted for them to live safely in the home.

Peoples eating and drinking needs were understood by both the catering and care staff including peoples likes, dislikes and any special dietary requirements. Menus provided a choice of nutritious meals and snacks which were available 24 hours a day.

People and their families described the staff as caring, kind and patient. Interactions between people and staff were relaxed and friendly. Staff had a good knowledge of people which enabled effective communication. People felt involved in decisions about their care and told us that they felt their privacy,

dignity and independence was respected. A complaints procedure was in place and people felt if they used it they would be listened to and actions taken if possible.

Assessments had been completed and were regularly reviewed with people. The information had been used to create care and support plans which gave clear instructions on how a person wanted to be supported. Activities were available seven days a week and included group events in the home, individual activities specific to a person's ability and interest and activities in the community.

Staff spoke positively about the organisation and the home and described the Registered Manager as approachable and effective. Communication was described as good and staff had a good understanding of their roles and responsibilities. The home had made links with the local university and was involved in a student nurse mentoring scheme and also provided a preceptorship scheme for newly qualified nurses. A 'Clinical Excellence Conference' had been held by the organisation which had focused on nurses continuing development ensuring safe and effective practice.

The home had quality assurance processes in place that led to improvements for people. This included a range of audits at both an operational and home level.

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 not always safe.

Medicines were not consistently administered safely as risk assessments were not consistently being completed for people who self-administered their medicines placing them at an increased risk of harm.

People were supported by enough staff that had been recruited safely.

Risks to people were assessed, regularly reviewed and actions put in place to minimise harm whilst respecting people's choices and freedoms.

Staff had been trained to recognise signs of abuse or poor practice and knew the actions they needed to take if needed.

Is the service effective?

Good

The service was effective.

Staff received an induction, on-going training and the support and professional development to carry out their roles effectively.

People's rights and choices are respected in line with the principles of the Mental Capacity Act.

People have their eating and drinking needs understood and met.

People have access to healthcare and are supported to access it if required.

Is the service caring?

Good

The service was caring.

People received kind, compassionate care by staff who had a good knowledge of them as individuals.

People were involved in decisions about their care.

People's dignity, privacy and independence was respected.

Is the service responsive?

Good

The service was responsive.

People had their care needs assessed and regularly reviewed. Staff had a good understanding of how people needed to be supported.

A complaints process was in place and people felt that if they used it they would be listened to and actions would be taken.

Is the service well-led?

Good

The service was well led.

The culture was open and positive with an emphasis on inclusion and team work.

Staff understood their roles and responsibilities and felt ownership for the organisations values.

Quality assurance processes were effective in leading to improved outcomes for people.

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Abbotts Barton

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

The inspection took place on the 11 July 2017 and was unannounced; it continued on the 12 July 2017 and was announced. It was carried out by one inspector and an expert by experience. An expert by experience is a person who has person experience of using or caring for someone who used this type of care service.

Before the inspection we looked at notifications we had received about the service. A notification is the means by which providers tell us important information that affects the running of the service and the care people receive. We also looked at information on their returned Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we spoke with 15 people who used the service and three relatives. We spoke with the registered manager, the operations manager, clinical manager, quality manager, three nurses, and a specialist dementia nurse visiting the service, four care workers, two activity staff, the chef, two waiters and an administrator. We reviewed nine peoples care files and discussed with them and care workers their accuracy. We checked four staff files, care records and medication records, management audits, staff and resident meeting records and the complaints log. We walked around the building observing the safety and suitability of the environment and observing staff practice.

Good

Is the service safe?

Our findings

People who were administering their own medicines were placed at an increased risk of harm because risk assessments and reviews were not being completed consistently. The provider had a medicine policy detailing the procedure to follow when a person had indicated they would like to administer their own medicine. We found this procedure was not consistently being followed. One person had a risk assessment part completed which did not include answers to any of the risk assessment questions and this had not been signed by their GP. Records told us that the person had suffered a possible stroke but this had not led to their risk assessment being reviewed to assess the person was safe to continue self-administering medicines. Another person had a risk assessment dated 14 May 2014 which to date had not been reviewed. The person self-administered two prescribed medicines but only one had been written on the medicine administration record (MAR). We discussed our findings with the Registered Manager who agreed the process was not operating effectively. During our inspection actions were put in place to minimise any risk of harm. These included reviewing each risk assessment and medicine care plan and contacting people's GP's to confirm they were happy with the arrangements. In addition the medicine audit tool was reviewed and changes made to ensure the procedure for self-administering medicines was expanded in order to capture the issues found during our inspection.

Each floor had a medicine room were medicines were stored. MAR had been completed which provided a full history of medicines people had been administered by trained staff. A fridge was in each room solely used for storing temperature sensitive medicines. The fridge temperature needed to be recorded each day to ensure it was within safe parameters. This had not been consistently completed. We looked at one chart and over the previous 10 days four days had not been recorded. This meant that medicines were at risk of not being stored safely. When medicines with a limited shelf live were opened they had been dated to ensure they were not used for longer than recommended. Some medicines had been prescribed for as and when required (PRN). Protocols were in place that detailed what PRN medicine had been prescribed for, dosages and other information to support decisions when administering the medicine. We spoke with nursing staff who were able to explain the actions they needed to take if a medicine error occurred. Care staff had undergone training on the application of topical medication which included a competency assessment. This meant that staff had the skills needed to support people to manage skin conditions.

People were supported by enough staff most of the time but described occasions when they felt staffing levels meant they had to wait to long for help with care. One person told us "The staff are very rushed in the mornings. They could do with two or three more. You feel you're not getting their full attention. You know they are coming back, but you know it might be a long time. They say five minutes but it might be longer. It's a long time if you're sitting on a commode". Another told us "I've timed it; you can wait 10-15 minutes. Five minutes should be enough". One person explained "One night I had a long period of waiting for a change of blankets. It can be bad at night waiting for the bell to be answered". A relative shared with us "We call for staff and sometimes they come and say can we cancel (the call bell) and come back; I have waited 20 minutes". We read resident and relative meeting minutes for January 2017 were answering call bells had been discussed and people were told they would be kept under review. Call bell audits had been completed that demonstrated improvements. Call bells taking more than five minutes to answer had reduced from

24.2% at the start of the year to 7.7%. We saw records were a person became acutely agitated due to an infection and additional staff had been organised so that they could have one care worker with them at all times to ensure their safety until they recovered. Staffing levels had been regularly reviewed to reflect the changing dependency needs of people living in the home. We spoke with nurses and care workers who all told us they felt that staffing levels were good. One care worker told us "I feel there are enough staff, only the odd day if somebody goes off sick. The senior carers do meds and care as well so they will help and it's good as they can then see things from all angles".

Staff had been recruited safely which included obtaining and verifying employment history, references and checks to ensure they are suitable to work with vulnerable people. Policies and procedures were in place and effective at managing unsafe practice.

People and their families described the care as safe. One person said "No one has said anything to ever make me feel unsafe". Staff had completed safeguarding training and understood how to recognise signs of abuse and the actions they needed to take if they suspected a person was at risk of abuse. Staff were aware of external agencies they could report concerns to should they feel it necessary.

Risk assessments relating to peoples assessed risks had been completed and reviewed regularly and actions put in place to minimise risks to people. One relative explained "My (relative) has had falls. They installed lasers and alarms everywhere to warn them if he is restless and gets up". The Registered Manager told us of another person who had been having multiple falls. An alarm system had been fitted which alerted staff and had led to a 90% reduction in them falling. People had their weights monitored regularly and a monthly audit had been completed which was reviewed by the Registered Manager and the chef. Actions to support people's weight and safe eating and drinking had included a high calorie smoothies menu, fortifying food with additional calories and referrals to GP's for specialist support. Some people had been assessed as at risk of skin damage and needed specialist mattresses. These needed to be set to match a person's weight in order to offer maximum protection. We checked four mattresses and they were all correctly set and staff had signed to confirm the mattress setting had been checked each time a person was supported into bed. We spoke with staff who were able to describe the risks people lived with and the actions they needed to take to minimise the risks. This meant that people were at a reduced risk of harm.

Accidents and incidents were recorded and then reviewed by the Registered Manager. Records demonstrated that reviews had led to actions that included changes to the environment, referrals to health and social care professionals and reporting safeguarding concerns. This meant that people were supported safely by staff who were proactive in supporting people to remain living in the home.

People had personal evacuation plans which meant staff had an overview of what support each person would require if they needed to leave the building in an emergency.

Good

Is the service effective?

Our findings

People were supported by a staff team that had completed an induction and on-going training that had given them the skills to carry out their roles effectively. Induction included completion of the Care Certificate. The Care Certificate is a national induction for people working in health and social care who did not already have relevant training. Each department had a separate induction booklet that included competencies specific to people's roles. One person told us "The nursing care is very good. They are very competent". Training that staff undertook included infection control, moving and handling, food hygiene and health and safety. Training had also been specific to people living at the home. One nurse shared with us details of an external end of life training course they had attended. They said "It enabled reflection and we looked at case studies. It made us all more aware, including the carers, and made us realise how important it is that we respect people's wishes".

Nurses explained to us how they were supported to keep their clinical skills up to date. One told us "What I have found is that we have regular training and we now get a Nursing Times (professional publication) with the facility to access their on-line training".

Staff told us they felt supported and encouraged to develop their professional skills. Staff received regular supervision and an annual appraisal. Opportunities for professional development had included staff taking a hearing aid course and becoming a hearing aid champion for the home, another had completed additional training in order that they could train colleagues in safe moving and handling practice. We spoke to staff who had completed diplomas in health and social care and saw that this was an ongoing programme.

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 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.

People had been supported to make their own decisions and records showed us that when they couldn't decisions had been made in their best interest. Best interest decisions had included discussion with people's families and health professionals involved in their care. Examples included a person who needed to have their meal texture changed to a soft texture, meeting a person's personal care needs and the use of bed rails for a person at risk of falling from bed. Records showed us these had been made in line with the

principles of the MCA.

Deprivation of Liberty Safeguards had been applied for when people needed their liberty to be restricted for them to live safely in the home. At the time of our inspection there were no conditions on authorisations.

We observed staff supporting people to make choices about their day to day care throughout our inspection. Examples included the time people wanted to get up, where they wanted to spend their time, how they would like to spend their day and what they would like to eat and drink. One person told us "They do listen to what I say". Another told us "They always ask what I want". This meant that people had their rights and wishes respected.

People and their families described the food as good and had their eating and drinking needs understood by the catering and care staff. One person told us "The food is really good and there's plenty of it. Eating was a big part of my problems (at home), and so being here has been really good for me". Information had been collected on people's allergies, likes and dislikes and any special dietary requirements. The chef visited people monthly to review and gather feedback. They explained how they sometimes gather information by discussing with people what they cooked for family, they said "It gets them talking". People had a range of choices at each meal and snacks were available throughout the day and night. When people needed support with their food staff assisted people at their own pace and promoted as much independence as possible including the use of specialist beakers and crockery. People were able to take their meal anywhere they chose including the garden and we observed people enjoying lunch with family and friends. The atmosphere in the main dining area was chatty and fun with one person telling us "It's a very good social club".

People had access to healthcare in a timely way. Records showed us this had included opticians, dentists, GP's, district nurses, chiropodists, community mental health team and dieticians. Records showed us this had included opticians, dentists, GP's, chiropodists, community mental health team and dieticians. One person told us "If there's a problem they are prepared to call a doctor anytime". Another said "They will always go to the dentist with you".

Good

Is the service caring?

Our findings

People and their families described the staff as caring. One person told us "The standard of care given is very high". Another said "Everybody is kind". We spoke with another who told us "The staff are lovely and very cheerful which makes a difference". We observed relaxed and friendly interactions between staff and people and care being provided in an unhurried manner at the persons pace. A relative told us "(Relative) can get frustrated and staff show real patience. All the staff talk to her by name. (Relative) really likes (member of staff) and always gives her a big smile".

Staff had a good knowledge of people which enabled effective communication. One care worker explained "I've got to know (name). If you can make her laugh it takes their low mood away. Talking about (name) life and travels; they really love that". One care worker noticed a person was without their spectacles. We observed the staff member go and fetch these, clean them and show them to the person before gently placing the spectacles on their head . One care worker explained their role in supporting people with their hearing. "I go and check hearing aids and batteries and make sure they are working. It's very important people can hear". We observed a meeting where discussions took place about a person moving into the home who had poor sight and ways to support with their communication including organising a white board for messages and information.

People had call bells in their rooms if they needed to call for staff to help them. We observed staff popping in and out of rooms throughout the day of our inspection checking whether people needed anything.

People felt involved in decisions about their care. One person told us "They do listen to what I say, like not going to bed too early at 7.30pm. I prefer to go later, like at 9pm". Another told us "They always ask what I want. They say 'What would you like to put on?'. Throughout the inspection we observed staff explaining their actions to people, giving people time and listening to what they had to say.

Information was available to people about advocacy support should they feel they needed independent support with decision making.

People told us staff respected their right to privacy. We observed staff knocking and waiting to be invited by people before entering their rooms and speaking to people in a respectful manner. People's clothes and personal space reflected a person's individuality.

People were supported to maintain a level of independence. One person enjoyed being in the garden on their own and had a pendant they could use to call for help if needed. Another person explained "I'm very independent. I do as much as I can. Staff say 'We can do that for you' but I like to do it myself. If I'm not able to I call and say I can't manage. They are always very kind here".

Good

Is the service responsive?

Our findings

Assessments had been completed before a person moved into the service and this information had been used to form their care and support plan. The plans contained clear information about people's assessed needs and the actions staff needed to take to support people. Information gathered also included details of a person's life milestones, career and personal achievements. This meant that staff had a broader understanding of the people they supported which had been reflected in care and support plans. One person experienced a low mood and their care and support plan had detailed life events that contributed to this. Actions for the staff had included recognising the person's feelings and telling them they wanted to help.

Reviews took place monthly and people and their families had been given the opportunity to be involved. We saw that one family had opted for a monthly telephone call and to attend a six monthly review meeting. Staff told us they had time to read care and support plans and were kept up to date with changes. One care worker told us "There was a review and it was decided the person only wants female carers. It's very important that we know this".

People's health conditions were understood by care staff as information had been placed in care and support files that explained the impact they could have on the person's lives. One person had a dementia and a specialist nurse had been working alongside the person and home staff reviewing the care and providing support.

Activities were arranged inside the home and also in the local community. A weekly activity programme, which included weekends, was on display in public areas and in each person's room. It included group activities such as word games, musical performers, physical exercise activities and shared seasonal events such as watching Wimbledon. One person told us "Some activities are very good. I have a go at anything. I like the quizzes". Another told us "They do a pub night with crisps and things like that. They did a tennis and Pimms afternoon. I said 'yes please' to that. They try to accommodate you". A relative explained "Activities make such a difference. (Name) was lonely at the other place". Activities in the community had included bus trips to local places of interest such as steam trains, pub lunches and picnics in the local national park.

People were supported in individual interests and activities. One person enjoyed gardening and the gardener had found activities to include them in that matched their ability such as helping deadhead plants. Another person had tickets for a celebratory speaker and a member of staff accompanied them to the event. Some people chose to spend the majority of their time in their rooms. Activities on a one to one arrangement were available. A care worker explained about one person "We read the paper together but they like to keep to themselves and spending time with their (relative). If I go into their room we talk about their photos, their granddaughter; trying to build up trust with (name)". With spoke with one person who told us "They (staff) are interested in us. They found out I used to be a nurse and they ask me about my work".

Links with the community included Winchester College students coming along to talk to people, a regular

arts class and a bible study group. People were supported to keep in touch with families and Wi-Fi and telephone services were available. The home had a café were people could spend time and enjoy a coffee and cake together any time of the day.

A complaints procedure was in place and people and their families were aware of it and felt able to use it if needed. The procedure included details of how to appeal against the outcome of a complaint and provided details of external organisations such as the local government ombudsman. We looked at records that showed us that when complaints had been received they had been investigated in line with the service procedure.

Good

Is the service well-led?

Our findings

Staff spoke positively about the organisation and the management of the home. One care worker told us "(Registered Manager) is approachable and everything is acted upon. I feel I have the backing and support I need and we can make a great difference in people's daily lives".

Staff described communication as good. Each day a Heads of Department meeting took place. We spoke with a nurse who told us "I find the meeting quite good. It is important communication; it keeps me up to date with new regulation. The minutes go onto the staff noticeboard every day. Everybody feels valued. Everybody is there, the chef, housekeeper". The chef said "It's the best way of communicating. It means were all singing from the same song sheet".

The Registered Manager had a good understanding of their responsibilities for sharing information with CQC and our records told us this was done in a timely manner. The service had made statutory notifications to us as required. A notification is the action that a provider is legally bound to take to tell us about any changes to their regulated services or incidents that have taken place in them.

Staff had been involved in setting values the organisations values of 'Friendly, Honest, Individual, Kind and Reassuring'. A care worker told us "We always talk about them (values). It hasn't necessarily changed my practice but possibly made me more reflective. It's a good talking point in supervision".

Staff had a clear understanding of their roles and responsibilities and understood their boundaries in decision making. Staff spoke enthusiastically about working as a team and told us they felt appreciated in their role and enjoyed having opportunities to developing their roles further.

The home was pro-active in linking with the local university and had a student nurse mentoring scheme in place. It also offered a preceptorship scheme for nurses. A preceptorship is a period of time to guide and support newly qualitied nurses to make the transition from student to develop their practice further. This demonstrated an open and positive culture which recognised the importance of links with education.

The organisation had held a 'Clinical Excellence Conference' for nursing staff. This had focused on revalidation for nurses and the nursing code of conduct. Revalidation is a process that all nurses need to follow to maintain their registration with the Nurse Midwifery Council to demonstrate they are practising safely and effectively.

Quality assurance processes were in place to enable feedback from staff, people, their families and external professionals. Audits were carried out at an operational and home level and provided enough detail to recognise areas that required improvement. One audit had highlighted that best interest decisions had not taken place for people having a soft diet. Records showed us this had been actioned. This reflected a commitment to quality assurance systems leading to improvements for people.