Barchester Healthcare Homes Limited

Atfield House

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

About the service:
•□Atfield House is part of Barchester Healthcare Homes Limited and is registered for 68 people. It is a care home with nursing that accommodates people with dementia care needs and people with frail elderly care needs across three units. At the time of the inspection 65 people were using the service.

People's experience of using this service:
•□The provider had systems in place to help safeguard people from the risk of abuse and staff knew how to respond to possible safeguarding concerns. There were also systems in place to identify and mitigate risks people face while receiving care.

•□The provider ensured there were enough staff on duty to meet people's needs. They also ensured safe recruitment procedures were in place and followed.

•□Medicines were managed and administered safely.

•□People's needs were assessed prior to moving to the home. Care and support were delivered and monitored in line with current good practice guidance.

•□Staff had up to date training, supervision and annual appraisals to develop and maintain the necessary skills to support people using the service.

•□People's dietary and health needs had been assessed and recorded so any dietary or nutritional needs could be met. People were supported to maintain healthier lives and access healthcare services appropriately.

•□The principles of the Mental Capacity Act 2005 were followed so people's rights were respected.

•□We observed staff to be kind and caring. People and relatives confirmed this. People were supported to make day to day decisions and have choice and control of their environment.

•□People, and their relatives where appropriate, were involved in planning people's care. Care plans contained details of how to meet people's individual needs, including end of life wishes.

•□There was a complaints procedure in place and the provider responded to complaints appropriately.

•□The provider had systems to monitor, manage and improve service delivery and to improve the care and support provided to people.

•□People using the service and staff reported the registered manager and deputy manager were available, listened and actively promoted an open and transparent work environment.

Rating at last inspection:
•□The last comprehensive inspection was 13 July 2016. We rated the service 'good' overall with one breach of regulations in relation to safe care and treatment. In January 2017 we completed an unannounced focused inspection to check that improvements to meet legal requirements planned by the provider after our July 2016 inspection had been made, and found they had.

Why we inspected:
•□This was a planned inspection based on the previous rating.

Follow up:
•□We will monitor all information received about the service to understand any risks that may arise and to ensure the next planned inspection is scheduled accordingly. If any concerning information is received, we may inspect sooner.

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

Details are in our Safe findings below.

Is the service effective?

Good

The service was effective

Details are in our Effective findings below.

Is the service caring?

Good

The service was caring

Details are in our Caring findings below.

Is the service responsive?

Good

The service was responsive

Details are in our Responsive findings below.

Is the service well-led?

Good

The service was well-led

Details are in our Well-Led findings below.

Atfield House

Detailed findings

Background to this inspection

The inspection:
•□We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) 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 Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
•□Two inspectors carried out this inspection.

Service and service type:
•□Atfield House is a care home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided and both were looked at during this inspection.

•□The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
•□This inspection was unannounced.

What we did:
•□Before the inspection, the provider completed a 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. Prior to the inspection we also looked at the information we held on the service including the provider's last inspection, notifications of significant events and safeguarding alerts. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about. We also contacted the local authority's safeguarding and placement teams to gather information about their views of the service.

•□During the inspection we observed how staff interacted with people. We spoke with six people using the

service, six relatives, five care workers, three nurses, the deputy manager, the registered manager, the senior regional director, four health care professionals and a social care professional.

• We viewed the care records of seven people using the service and eight staff files that included recruitment. We looked at training, supervision and appraisal records for all staff. We also looked at medicines management for people who used the service and records relating to the management of the service including service checks and audits.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

Good: People were safe and protected from avoidable harm. Legal requirements were met.

Systems and processes to safeguard people from the risk of abuse

• People and their relatives told us they felt safe. Comments included, "Feels safe here", "I think [person] is safe", "It's a safe environment" and "I like that they have security doors and notices not to let anyone in."

• Staff were able to tell us the action they would take if they witnessed any possible abuse, including reporting to the management and, should the provider not take any action, reporting to outside agencies.

• The provider had safeguarding adults' policies and procedures in place and raised concerns appropriately with the local authority and any other relevant agencies such as the Care Quality Commission (CQC) and the police. We saw evidence that safeguarding concerns were investigated. However, investigation and learning outcomes were not always clear. The registered manager agreed to implement a more uniform system that made outcomes and learning more explicit.

• A social care professional confirmed the provider took appropriate action in a safeguarding incident they were involved in and told us, "The family were involved, the records were accurate, up to date, concise and able to cross reference notes to the care plan."

• The provider recorded incidents and accidents and included the immediate action taken and the long term action to prevent reoccurrence. We saw care plans and risk assessments were updated after an incident or accident. There was also a monthly online analysis by managers of incidents, accidents and safeguarding alerts.

Assessing risk, safety monitoring and management

• The provider had systems in place to identify and manage risks to people using the service. Care records we viewed contained risk assessments associated with bed rails, the risk of falls, moving and handling, the use of call bells, choking and pressure sores.

• Risk assessments were regularly reviewed and provided appropriate guidelines for staff to meet people's needs and minimise risks.

• A further check included a 'wellbeing' form that was completed daily and recorded when people were turned, bedrail checks, mattress setting checks, personal care offered and hourly welfare checks where required.

• Three people using the service had one to one care and we saw the staff sitting and walking with them to

help maintain their safety.

•□We viewed wound care records for four people. These were clear and included a care plan for skin care, specific care plans for each wound and a wound assessment document that included the treatment to be given, a record of each dressing change and the condition of the wound and photographs were taken each week or more often if required, so the progress of each wound was monitored.

•□We saw risk assessments for pressure ulcers were also in place. These were updated monthly to monitor people's skin integrity. Pressure relieving equipment including mattresses and cushions were in use where it had been identified people required them.

•□The home had checks in place to ensure the environment was safe which included environmental risk assessments and fire risk assessments. Each person had a personal emergency evacuation plan (PEEP). Maintenance checks were up to date. The local authority's 'food premises inspection audit' on 29 January 2019 awarded the home a 5 star rating of 'very good'.

Staffing and recruitment
•□One person using the service told us, "Staff are very busy, but they are very good. I couldn't complain about the staff. If I do ask something they do it fairly quickly and they're very nice" and a relative said, "The carers are a lovely bunch. It's busy and they are worked very hard but they come and see [person]. If I say to them, they do things very quickly. They are always quick to answer."

•□Staff we spoke with told us it was a very busy home and particularly so if a staff member was off unexpectedly. Three staff members had recently left the home and the provider was recruiting to these posts. The registered manager told us they used a dependency tool, which monitored the dependency of people using the service and calculated staffing requirements. They then ensured the necessary staff complement was in place.

•□Recruitment procedures were in place to ensure only suitable staff were employed to care for people using the service. This included appropriate checks for agency staff working in the home.

Using medicines safely
•□People received their medicines safely and as prescribed and medicines were being stored securely. Controlled drug stocks tallied with the numbers supplied and administered.

•□There was a list of 'homely remedies' that had been signed and approved by the GP and these were seen in each person's medicines record. We noted that one medicine being used as a homely remedy was not listed but this was rectified during the inspection.

•□The medicines administration record charts (MARs) provided clear instructions for the administration of each medicine.

•□For people receiving 'as required' (PRN) medicines a PRN protocol was in place for each medicine so staff were clear when to administer the medicine.

•□Where people receive blood thinning medicines, they are at higher risk of bruising if, for example, they have a fall or other injury. This risk had not been identified in the records we viewed, so staff were aware of the risks and of the action to take to manage such risks. The registered manager said they would discuss this

with the provider and include the information in care records in the future.

• The service had external scrutiny on the way medicines were managed. The pharmacist from the local Clinical Commissioning Group had visited the home on 4 October 2018 and recorded, 'Good Medicines management at the home.'

• Staff administering medicines had appropriate training and competency testing to ensure they had the skills required to administer medicines safely.

Preventing and controlling infection
• The provider had an infection control policy in place to help protect people from the risk of infection and staff had attended training on infection control. Staff had access to, and used, protective personal equipment such as gloves and aprons. The environment was clean and well maintained.

Learning lessons when things go wrong
• There was evidence the registered manager and team reflected on how to improve service delivery, particularly after an incident. For example, through monthly home quality and clinical governance meetings.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

Good:People's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
•People's needs were assessed prior to moving to the home to confirm their needs could be met by the provider and to which unit they should go. One relative said, "[Registered manager] made us welcome and they went to the hospital to assess [person]. The beginning was very good."

•The pre-assessment was used to inform the person's care plan. People and their relatives, where appropriate, were involved in this process.

•The assessment included people's religious, medical, communication, personal care, pain, behavioural and cultural needs as well as their preferences.

•We saw evidence care and support was planned, delivered and monitored in line with current evidence-based guidance, legislation, standards and best practice.

Staff support: induction, training, skills and experience
•People using the service were supported by staff with the skills and knowledge to effectively deliver care and support. Comments from relatives included, "I feel that the whole home is very good. The staff have the right skills" and "I found the care here extremely good. In other homes I had to go and check daily. Here I don't have to come every day. They seem to be better trained in dementia. When they have really challenging residents, [staff] are really calm, and they seem to just distract them and I find that really reassuring. They work as a team, so they are never overloaded. [Registered manager] chips in as well."

•A healthcare professional told us, "It's a lovely home. The staff do know about their service users" and a social care professional said, "Never been kept waiting by staff. Consistency of staff stands out. That's paramount. They are advocates for their people here and that stands for caring. This is one of the most professional set ups I've been to."

•Staff told us they were supported in their roles and we saw evidence of relevant training, supervisions and annual appraisals to ensure they had the appropriate skills to care for people.

•Training was recorded electronically, and the system alerted managers to when training, supervisions and appraisals were due, so these could be addressed.

Supporting people to eat and drink enough to maintain a balanced diet
•Most people said they liked the food provided. Comments included, "The food is very good. You can have

what you like. You wouldn't be hungry or thirsty" and "We get a choice. There is a menu. The food varies. Can be very good or sometimes a bit boring. If I don't like the food they will take it back and bring something else." One relative said, "The food is excellent. It's not just bland food. They have a very multicultural cuisine. They have a choice and if they don't like something there is something else. [Person] loves the food here and they are quite fussy." Another relative said, "We have lunch with [person] here and we're always very welcome to do so."

•□We saw referrals made to the GP, dietician and Speech and Language Team (SALT) where staff were concerned about people's nutrition. A healthcare professional told us if they asked staff to monitor people's weight, staff did.

•□People were supported to maintain good nutrition and care plans recorded any specific needs such as the use of thickeners or a diabetic care plan. People's food preferences were also recorded.

•□Catering staff were aware of people's specific nutritional needs and a nutrition meeting had last been held with the chef in January 2019. A 'Food Committee' meeting was held in 4 December 2018 and fed back to catering staff people's views of the meals and suggestions for improvement.

•□Meal times we observed were pleasant, and where required, people were supported by staff with their meals, appropriately.

Staff working with other agencies to provide consistent, effective, timely care
•□We saw evidence in people's records of working together through input from healthcare professionals including the GP, tissue viability nurse specialist, physiotherapist and chiropodist.

•□A handover meeting was held each morning with senior staff and each shift had a handover to ensure staff were aware of any changing needs.

Adapting service, design, decoration to meet people's needs
•□The home was purpose built and the design and décor was dementia friendly. Different colour schemes were employed, the home had wide corridors with suitable pictures on the walls, and toilets and bathrooms had clear pictures on the doors to make it easier for people to know what was behind the door.

•□People's bedrooms were personalised to their own taste and wishes.

•□There were a number of different areas in the home that people and their relatives could access. One relative said, "There are a number of areas we can chat alone. It's lovely to have other rooms. We use facilities as you would at home. We use the garden."

Supporting people to live healthier lives, access healthcare services and support
•□People and relatives we spoke with told us people had appropriate access to health care and this was confirmed by the care records we viewed. One relative said, "They do make sure [person] sees health people. We got a dentist to sort out their dentures" and another noted, "If [person] has a urine infection or something they will call me and tell me what they did, so I never have to ask. The chiropodist [has] come in and an optician and hearing person."

•□One healthcare professional said, "They keep people safe. The care plans are very good. The feedback is good and shows they are looking after their clients." Another said, "[Staff] very much have the skills. They

call me if there are any problems. Sensible about how they deal with patients. Nursing staff excellent. They totally follow through on instructions."

•□Food and fluid charts were used where a concern had been identified. People were weighed each month and the records we viewed showed people's weights were quite stable. Wound care records were clear with specific care plans for each wound.

•□When concerns around people's health were highlighted we saw appropriate referrals were made.

Ensuring consent to care and treatment in line with law and guidance
•□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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

•□Staff generally understood the need to ask people to consent to their care. We observed staff giving people choice about day to day activities such as what they would like to eat or drink.

•□The provider had applied for and tracked DoLS applications and authorisations and was aware of any conditions relating to the authorisations.

•□Where required, mental capacity assessments and best interests decisions had been undertaken. For example, to put bedrails in place where these were indicated and people had been assessed as not having the mental capacity to give consent.

•□People, or those with the legal right to do so on their behalf, had signed consent forms and these were contained in the care records.

•□The provider ensured that appropriately completed Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders were in place, where indicated. This document gave staff guidance on whether the person should be resuscitated if their heart was to stop or if they stopped breathing.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

Good:People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; equality and diversity
•We observed staff being caring, patient and kind with people. For one person whose first language was not English, a care worker was able to speak with them in their first language, so they could communicate more effectively.

•A relative told us, "All I can say is whenever I come they're looking after [person] and paying attention to them. If they want something, they get it. [Staff] look after [person] and they joke with them. They're very good with [person] and calm them down." Another relative told us when they were away, they emailed the registered manager photos and messages that were then shared with the person's relative.

•At mealtimes staff were available to give assistance to those who required it and did so in a gentle and encouraging way.

•We saw staff get down to people's eye level when speaking with them and listened to what people had to say.

•People who were independently mobile were able to move around the units and as well as the main dining and sitting rooms, there were areas for people to sit and rest in each unit.

Supporting people to express their views and be involved in making decisions about their care
•People had written information about the service, but we did not see much information in easy read formats such as pictures, to help people who might have communication needs. When we discussed this with the registered manager, they said they would address this.

•People told us they were involved in decision making and their views respected. One person said, "They always ask me what I want" and another person said, "[Staff are] very welcoming and considerate of what people need. They are very willing to help you with what you ask for." A relative noted, "I think it is very good. They seem to go along with how people act. At the moment [person] doesn't like getting up but [staff] are fine and they keep going back to get them up when [person] is ready."

•Care plans included communication needs, so staff had guidelines for how to interact with people in a way that suited the person's needs.

•Care plans also included life stories, spiritual and social values and hopes for the future which provided staff with context for when they were caring for and talking with people.

Respecting and promoting people's privacy, dignity and independence

•□People's privacy and dignity was respected. One relative told us, "Staff treat [person] with dignity. They are lovely. It's like coming into a larger family. Everybody is very nice and friendly. Very quickly [attended] to and staff remember names".

•□Staff were mindful of supporting people in a dignified manner and gaining consent when undertaking personal care. One staff member said, "I let them know what I am going to do. 'I am going to take off your cardigan, I'm going to wash you.' We tell them otherwise they might get confused or scared."

•□Another staff member spoke about promoting independence and told us, "We try to find what things they can do by themselves. When we wash them, we ask them if they can wash their face and we supervise them until the point they can't do it and then we help them."

•□We observed a member of staff helping a person to use their electronic device to contact a friend, so they could communicate with them.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

Good:People's needs were met through good organisation and delivery.

Improving care quality in response to complaints or concerns

•People and relatives, we spoke with knew how to make a complaint. One relative had made a complaint and said it had been satisfactorily addressed by the registered manager.

•The provider kept a log of all complaints and their outcomes. There had been two formal complaints since the last inspection and we saw these were investigated and responded to. However, the way the complaint was investigated and the learning outcomes were not always clearly recorded. The registered manager agreed to implement a more uniform system that made outcomes and learning more explicit.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

•People using the service and relatives told us they were involved in planning people's care and that their needs were being met. One person stated, "I have a care plan. They're quite good. They ask. There is a certain amount of organisation but it is very thoughtful." Relatives told us, "There are times they have gone through the care plan. I think they are quite good about keeping you up to date" and "They keep adding things when they need to. I'm due to sit down with the nurse to go through the whole care plan and medication."

•Care plans recorded people's needs and preferences and contained information about how to meet the identified needs. Staff we spoke with were knowledgeable about the needs of the people they supported.

•The provider employed two activities coordinators, one of whom was a trained massage therapist. They were currently in the process of reviewing and changing the activity programmes, so there were more opportunities for more people to join in. Activities were also discussed at family and resident meetings.

•People using the service showed us written activity planners they received weekly and were generally positive about the activities. They told us, "Yes there are enough activities. On Friday we had a trip to Richmond Park which was rather nice" and "Now I'm going to the activities and find people on the same wave length as me. I enjoy the quizzes." A relative said, "[Person] has improved in their communication because carers talk to them a lot and the activities [they join in] so they feel wanted. If someone prefers to sit on their own, the carers will go around and sit with them. They have outside entertainers come in every week and there is music and dancing" and "The chef makes very good cakes. They made a special effort for a cake and card for [person's] birthday. We had family time on the day and booked lunch for five [members of the] family in the dining room. They have lots of activities for the residents and gave a card and gifts which were much appreciated."

End of life care and support

•□Care records we viewed all had an advanced care plan so people's end of life care needs had been assessed and recorded appropriately. This helped ensure that people's needs could be met appropriately and according to their wishes and preferences, should these needs develop.

•□We saw 'do not attempt cardiopulmonary resuscitation' consents were in place for people. These had been completed in consultation with the person, or where they were unable to make decisions for themselves, with the involvement of their relatives or representatives. They were signed by the GP and clearly set out the reasons why resuscitation should not be attempted.

Good

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

Good:The service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility

•The senior staff were visible on the floor, promoted an open and transparent culture and were approachable. All the stakeholders we spoke with indicated the service was well run.

•A relative said, "It works perfectly. It really does. There is nothing I can say about any of them except they are all nice, kind, lovely people and obviously they have chosen them well. [Deputy manager] is lovely and very pleasant when I call. If there is anything they would call me right away." A healthcare professional said, "The welcoming is very good from when you come in the door. [The registered manager] is really excellent. [They] do listen, and act on whatever." A staff member said, "The managers are really supporting us. It's rare to find such good managers. Whatever you have, it doesn't matter, all the time they are there."

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

•The provider had a range of processes and systems to monitor the quality of services provided in the home so any areas that needed improvement were identified and addressed. These included a number of audits and checks. We saw evidence of root cause analysis of home acquired pressure ulcers, action taken and future prevention. Monthly home quality and clinical governance meetings which included actions from the previous meeting and a review of safeguarding alerts. There was an incident / accident analysis, monthly documentation audit, medicines audit and pressure damage charts.

•Audits provided information on areas where the provider could improve service delivery and were actioned by the registered manager and followed up by the senior regional director.

•The provider had a clear staffing structure and staff were appropriately supported and managed so they understood their roles and responsibilities.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

•The provider involved people and their relatives in the way the service was operated in a number of ways including through residents' and relatives' meetings. In terms of the meetings, relatives told us, "[The registered manager] is very open to anybody raising things. I think things do get taken up and acted upon. I feel it is a well run service. The senior staff I think are exceptional" and "They hold regular relatives' meetings and I think they are very beneficial. I can bring up a care issue and know what's going on. You can bring

those up with the manager and they listen. That's very reassuring. It's a good firm."

•□The provider had arrangements to collect people's views about the quality of service provided in Atfield House. We saw a 'My Care rating survey' for residents and relatives, with analysis that indicated overall, people were satisfied with the care and support they received.

•□Staff felt listened to and told us they provided feedback during supervisions and had the opportunity to contribute at team meetings. There was also an employee of the month initiative to acknowledge staff members' positive contributions to the home. One staff member said, "The place is homely. Get good support from your manager, colleagues and care assistants. Interpersonal relationships between the staff are very good and we always work as a team."

Continuous learning and improving care
•□Barchester has a training and accredited dementia care programme called 10.60.06 which 'is designed to enhance both the dementia care environment in participating homes and to improve interactions between staff, people living with dementia, relatives and health professionals. It focuses on reducing distress, increasing well-being and improving quality of life.' Atfield House is accredited in the 10.60.06 programme.

•□In addition to ongoing training, the home had champions to lead in good practice for end of life care, falls, tissue viability, medication, contingency, documentation and dignity. This helped ensure that people received safe and appropriate care and treatment.

Working in partnership with others
•□The provider worked in partnership with various other health and social care professionals. Where appropriate we saw they worked with the local authority to improve outcomes for people and a social care professional said, "[Registered manager] is on the case. She keeps us informed by email and phone correspondence."

•□The registered manager and her staff coordinated the care of people when working with other agencies to help ensure people get care that was safe. A GP attended the home twice weekly and other healthcare professionals involved with people using the service included tissue viability nurses, physiotherapist, the rapid response team, chiropodist, dietician and the Speech and Language Team. The provider also provided placements for student nurses from a local university.