Care Quality Commission

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Northcourt Lodge Nursing Home

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

Overall summary

This was an unannounced inspection which took place on 14 July 2015.

Northcourt Lodge Nursing Home is registered to provide care (with nursing) for up to 22 people. There were 17people resident on the day of the visit, one of whom was in hospital. The house offers accommodation over two floors. People have their own bedrooms, five are en-suite with toilets and wash hand basins. The shared areas within the home have limited space but the home try to make best use of them to suit the needs and wishes of people who live in the home. The gardens are spacious well maintained and regularly enjoyed by people.

There is a registered manager running the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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 told us they felt safe in the home. Staff were trained in and were able to fully describe their responsibilities with regard to keeping people, in their care safe from all forms of abuse. The home had enough staff to ensure people received safe care. The recruitment process was robust and the service tried to make sure that staff employed were suitable and safe to work with people who lived in the home. People were given their medicines in the right amounts at the right times by qualified staff. The home took all health and safety issues seriously to ensure people were kept as safe as possible.

The service had taken any necessary action to ensure they were working in a way which recognised and maintained people's rights. The staff team understood the relevance of the Mental Capacity Act 2005, Deprivation of Liberty Safeguards (DoLS) and consent issues which related to the people in their care. The Mental Capacity Act 2005 legislation provides a legal framework that sets out how to act to support people who do not have capacity to make a specific decision. DoLS provides a lawful way to deprive someone of their liberty, provided it is in their own best interests or is necessary to keep them from harm. The registered manager had made or was making the appropriate DoLS referrals to the Local Authority.

People were supported to contact GPs and other health professionals when necessary. People told us their health was well looked after. Health professionals told us the service worked with them to ensure people were kept as healthy as possible. People were offered good quality and nutritious food.

Care staff had built strong relationships with people who lived in the home. Staff members had good knowledge of people and their needs. The service recognised people's individual needs. They provided activities designed to encourage participation so that people enjoyed their life. However, their choices were respected. People were treated as individuals and they were treated with dignity and respect.

People and staff felt the home was well managed. They said the registered manager and her management style was open and supportive. The staff team were supported by the management team to ensure they were able to offer good quality care to people. The service had ways of making sure they kept the quality of care they offered to a good standard. They were making improvements to areas identified as having shortfalls by themselves and the local authority commissioning team.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service is safe.

Medicines were given in the correct quantities at the right times by qualified staff.

Staff were properly trained and knew how to protect people from abuse or harm. People felt they were safe living in the service.

Any health and safety or individual risks were identified and action was taken to keep people as safe as possible. The service had written plans so that people knew what to do in the event of an emergency.

Good

Is the service effective?
The service is effective.

Staff understood consent, mental capacity and deprivation of liberty issues. People were helped to make as many decisions and choices as they could.

People were helped to see GP's and other health professionals to make sure they kept as healthy as possible.

Staff were trained to ensure they could meet people's needs.

Good

Is the service caring?
The service is caring.

Staff treated people with respect and dignity at all times.

People's requests for assistance were answered as quickly as possible. Staff interacted with people positively, with patience and understanding.

People were helped to keep in touch with their families and other people who were important to them.

Staff had developed strong, positive relationships with people.

Good

Is the service responsive?
The service is responsive.

Staff knew how to care for people in the way they chose and preferred.

The service provided activities that people could choose to do.

Care staff responded to people's requests for help quickly.

Good

Is the service well-led?
The service is well-led.

The registered manager made sure that staff maintained the attitudes and values expected.

Good

Summary of findings

The registered manager and staff regularly checked that the home was giving good care. Changes to make things better for people who live in the home had been made and development was continuing.

Records in some areas needed improvements which were underway.

Northcourt Lodge Nursing Home

Detailed findings

Background to this inspection

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

This was an unannounced inspection which took place on 14 July 2015. It was completed by one inspector.

Before the inspection we looked at the Provider Information Return (PIR) which the provider sent to us. 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. We also looked at all the information we have collected about the service. This included notifications the registered manager had sent us. A notification is information about important events which the service is required to tell us about by law.

We looked at five care plans, daily notes and other documentation relating to people who use the service such as medication records. In addition we looked at auditing tools and reports, health and safety documentation and a sample of staff records.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with eight people who live in the home and a local authority professional over the telephone. We received written information from local authority commissioners and written comments from two health professionals. Additionally we spoke with five staff members, the operations director, the human resources manager and the registered manager. We looked at all the information held about five people who live in the home and observed the care they and others were offered during our visit.

Good

Is the service safe?

Our findings

Eight people told us that they felt safe in the home. One person said, ‘‘yes I’m very safe, safer than in my own home’’. Another person told us, ‘‘I wouldn’t put up with any of that abuse, I’ve seen it on the telly and I wouldn’t have it’’. A health professional told us they visited the home regularly and had never seen anything they weren’t comfortable with.

Staff were fully aware of and able to clearly explain their responsibilities with regard to protecting people in their care. They told us they had received training and knew how to recognise signs of abuse. Training records showed that all 19 care staff had received safeguarding training. They were able to tell us the action they would take in response to witnessing abuse or suspecting abuse had taken place. Staff members were able to explain what they would do if they were concerned about a colleague’s poor practice. They said they were aware of the whistle- blowing policy and knew which outside bodies to report concerns to, if necessary. However they said they were confident the management would take any necessary actions to protect people. Staff had easy access to the local authorities’ safeguarding procedures which were displayed in staff and communal areas.

People’s care plans included any necessary risk assessments. They described the risks and instructed staff how to support people as safely as possible. Identified areas of risk depended on the individual and included areas such as mental health deterioration, smoking and bathing. The service used recognised assessment tools for looking at areas such as nutrition and skin health. Relevant staff had been trained in the use of the assessment tools.

The home had accident and incident reports which were completed when such an event occurred. For instance any unexplained bruising was recorded and the registered manager and staff were able to clearly describe the actions taken as a result of the ‘investigation’ into how the bruising had happened. However, the investigation had not been recorded. It was therefore not clear what the outcome was, what ‘learning’ had taken place and how the service was going to minimise the risk of recurrence. Information from incident reports, body maps and accident reports were often not cross-referenced to and from care plans and daily notes. This meant that staff may be unable to find important information or instructions for changes, quickly.

The service had systems in place to keep people, staff and visitors as safe as possible. There were up-to-date generic risk assessments which included individuals’ rooms, the garden, disposal of clinical waste and radiators. Up-to-date maintenance certificates such as gas safety, electrical installation and the bacterial analysis of water (legionella) were available. Health and safety check lists were completed by senior staff members every month. A fire safety assessment was completed in January 2015. People had personal emergency evacuation plans detailing the support they required should they need to be evacuated from the building. The service had an emergency plan called the ‘Business Continuity Plan’ in place. It took the form of a check list and was available in an emergency file, by the front door and in the medicines storage room.

The recruitment procedures made sure, as far as possible, that staff were suitable and safe to work with the people who live in the home. These procedures included taking up of references, police checks, the checking of permission to work visas and checks on people’s identity. Application forms were completed and checked to ensure people had included their past employment history.Interviews were held and records of interview questions and responses were kept. Some staff members began their induction prior to references and police checks being received. However, a risk assessment was completed and they were supervised at all times during this period.

The registered manager told us that people’s money was dealt with by their families or the local authority and they requested funds on people’s behalf, as required. The service did not accommodate people with behaviours that caused themselves or others distress or harm currently.

There were enough staff on duty to deliver care safely. Staff told us the home was usually well staffed, they said that occasionally they ‘struggled’ if staff called in sick at short notice but this was unusual. Staff covered shifts for others and agency staff were not used. People told us there were always staff available to help them if they needed assistance. They said that call bells were usually answered very quickly although they occasionally had to wait a while if other people needed help at the same time. There were a minimum of four staff on the morning shift, three in the afternoon and two at night. A registered nurse was on duty at all times. The care staff were supported by a team of ancillary staff including a part time activities co-ordinator. Rotas for June 2015 and July 2015 showed that the staffing

Good

Is the service safe?

levels did not drop below those stated as minimum. On the recommendation of local authority commissioners the registered manager had completed a dependency assessment for people. She then calculated how many care hours were required for individuals and added the hours together to ensure the appropriate staffing numbers were provided to meet people's needs. The service was providing more staffing hours than was calculated to be necessary, at the time of the inspection.

The service made sure people received their medicines safely. Staff used a monitored dosage system (MDS) which meant that the pharmacy prepared each dose of medicine and sealed it into packs. The medication administration records (MAR) were accurate. Written guidelines for when people should be given medicines prescribed to be taken as necessary (PRN) were provided. The registered manager had recently discussed with the GP changing instructions which said to be taken 'as directed' to specific instructions. Medicines were stored safely in a locked room, in locked trolleys. The temperature of the room was checked regularly and action was taken to cool the temperature, as necessary. Only qualified nurses gave medicines and the senior nurse (clinical lead) took responsibility for all aspects of medicine storage and administration. Controlled medicines were properly recorded, administered and stored. The pharmacy completed an audit of the medication system on 18 November 2014. They made some minor recommendations which had been complied with but found no major issues and noted that a follow up visit was not necessary.

Good

Is the service effective?

Our findings

People told us, ‘‘the home couldn’t be better’’. One person said, ‘‘it’s beyond fine, It’s marvellous’’. They told us they were, ‘‘amazed’’ at the good care they received as they’d read how terrible nursing homes were. Another said, ‘‘we have quite a good lifestyle’’. A health professional commented that they felt, ‘‘they know their patient's very well and provide good care’’. Staff told us they were happy that they, ‘‘gave people very good care’’.

Staff were trained in the areas relevant to their role and to the care of the individuals who live in the home. Special areas of training included use of bed rails end of life care and equality and diversity. Registered nurses received refresher training in subjects such as wound care and stroke. Training was delivered by a variety of methods which included e– learning and face to face training. All were pursuing the care certificate and completing refresher training to enable them to achieve this. A large percentage (13 of the19 care staff) had completed a qualification course. Staff told us they were supervised regularly and the registered manager or senior staff were always available to assist them if necessary. Staff felt very well supported to effectively complete their tasks and meet the needs of people in their care. Staff told us and records showed that they completed an appraisal each year. Health professionals told us that staff were, ‘‘well trained and very proactive’’ and, ‘‘there is always a trained nurse on duty to whom I can speak, should the need arise’’.

Staff were able to clearly describe their understanding of consent, mental capacity and Deprivation of Liberty Safeguards (DoLS). They told us they had received Mental Capacity Act training and records showed that 13 0f the 19 care staff had completed it. Staff explained that everyone must be assumed to have capacity unless there is reason to suspect that this is not the case. They also noted people’s capacity could vary for different reasons. Staff told us how they made sure people gave their consent to care on a daily basis. The registered manager told us that most people in the home had capacity for most areas of their care. One person lacked capacity and another four were being assessed with regard to their capacity. Best interests meetings were held and minutes and outcomes were recorded for issues such as the use of ‘covert’ medicines. People’s care plans noted who had power of attorney (people who had a legal right to make particular decisions on a person’s behalf) but did not contain a copy of the paperwork to show what powers they had. The registered manager had submitted DoLS applications, for everyone, to the local authority at their request. However, they were reviewing the appropriateness of a ‘blanket’ approach with the local authority with regard to people’s individual capacity assessments.

People told us the home was, ‘‘very comfortable’’.The environment was homely and well-kept. The service had made changes to the environment following discussion with the local authority commissioning team. They were using the King’s Fund (specialists in dementia care) environmental assessment as a guide to make the home more suitable and comfortable for people living with dementia. The home had been adapted to meet the needs of people with physical disabilities and there was a lift to enable people to access the first floor. Specialist bathing and mobility equipment was provided as necessary.

People told us that the food was, ‘‘good’’ and there was, ‘‘plenty of it’’. One person told us the main meal was fine but sometimes the evening meal was a bit, ‘‘samey’’. However others said they could request alternatives if they chose. The menus were well balanced and included healthy fresh food. The chef was able to tell us about special diets and providing food for people’s cultural needs and lifestyle choices. Nutritional assessments, weight, food and fluid charts were completed for individuals, if necessary. Staff helped and encouraged people to eat their meal, as described in the care plan. People were encouraged to interact socially with staff and other people. There was laughter and humour during the pleasant and relaxed lunch time service.

People told us their health was well looked and gave examples of actions the service took to meet their health needs. Healthcare professionals told us the staff always liaised with them if they had any concerns. They said the home had arrangements in place to obtain fast GP access and regular nursing staff who follow the joint health care plans made. Each person’s healthcare needs were described in their care plans and healthcare records were kept. Specialist healthcare support, such as community psychiatrist nurses, continence advisors and speech and language therapists were sought as required. The service had recorded 21 deaths during the past 18 months. No concerns had been raised about any of the deaths or the circumstances surrounding them. The staff reflected on

Good

Is the service effective?

each death at staff meetings and completed a de-brief to ensure there was nothing they could have done better and took any learning forward to improve their end of life care. Deaths were reported to the provider who discussed them with the registered manager to ensure all appropriate actions were taken and care was given.

Good

Is the service caring?

Our findings

People described staff as, ''very respectful'', ''kind'' and, ''caring''. Another said when they moved in they had big reservations but the staff are, ''lovely and really do the business''. A health professional said, ''staff are caring and I have always witnessed respect towards the residents''. Staff told us they treated people in the way they would want their parents and grandparents to be treated. The service had received written compliments about the care, friendship and attention people's family members had received whilst resident in the home.

People told us that their friends and relatives visited regularly and were welcomed to the home. People were helped to maintain relationships with people who were important to them. There were no restrictions on times or lengths of visits. One person told us their relative visited every day and another received visitors at least three times a week. Staff were very knowledgeable about the needs of people and had developed good relationships with them. Staff were able to describe the varying needs of people in their care. They described how they maintained and promoted people's privacy and dignity. They gave examples such as closing doors, drawing curtains and interpreting people's behaviour to ensure they were comfortable with what staff were doing.

During the inspection staff interacted and spoke with people at all times. They included them in all conversations and encouraged them to interact with their fellow residents. People were given choices by a variety of methods such as showing them different meals and were supported to make as many decisions as they were comfortable with. Staff described what they were doing and why and people were asked for their permission before care staff undertook any care or other activities. Personal care was offered as discreetly as possible.

People were encouraged to be as independent as they were able. Care plans noted how much people could do for themselves and noted how staff should encourage or support them to retain their independence for as long as possible. People told us that staff helped them to do as much as they could and always asked before they offered assistance. People were involved in their care planning as far as they were able.

People's end of life wishes were recorded and care plans for people who required end of life care were put in place, as necessary. Do not attempt resuscitation (DNAR) forms were in place for those people who chose to have them. Where they were in place they had been completed appropriately and signed by the GP. One person had one that had been signed by a hospital consultant during a hospital stay but the registered manager was discussing this with the GP.

People's emotional, cultural and spiritual needs were noted in their care plans. Some staff had received specialist training in equality and diversity and others covered this topic in induction. Staff described how they made sure people received person-centred (individualised) care and respected people's differences. One staff member told us how they taught colleagues some words in the language of a person so that they could communicate with them better. They told us they also shared cultural knowledge to aid staff's understanding of the individual's behaviour. Another described how they obtained information from colleagues and people's families to ensure they understood people's cultural needs and choices.

Good

Is the service responsive?

Our findings

People told us that staff were available when needed and said, ''they can deal with most things''. During the visit staff were responding to people's requests quickly and positively. They were pro-active in responding to people's needs. One person told us, ''we're always listened to'' and, ''there are plenty of staff, they're always there for us''. Staff responded quickly to people if they asked for or showed that they needed assistance. They were able to identify when people, who did not clearly verbally express their needs, wanted help by their body language and facial expression.

Each person had individualised care plans which described people's needs, tastes, preferences and choices. Care planning was changing to a new system because of concerns expressed by the commissioning team of the local authority and the identification of issues in the current system by the service. The changeover had not been completed which had created some shortfalls in the care plans including those identified in the previous care planning system such as a non-individualised clinical approach to care planning. There were blank areas in some of the plans and some did not include all the necessary information to inform staff of how to care for people. However, the staff team generally knew people and their needs well. Additionally they had a robust communication system, such as three daily handover meetings, which meant that staff were kept up-to-date with individuals' current needs. The registered manager had developed an action plan which stated that all care plans would be completed by 20 August 2015.

Staff were able to describe personalised (person –centred) care and demonstrated their understanding of what this meant. They told us that the care plans and their knowledge of people meant that each person was treated in the way they wanted and according to their needs.

People attended their review meetings and were involved in their care planning, if they chose to. People told us they knew what was in their care plans and who their key worker was. Care plans were looked at by key workers every month and people's views on their care were noted on the reviews. Some of the monthly care reviews were not very detailed. However, this did not impact on the care of the individuals. One person said they didn't always get to see all of their 'paperwork' but said they'd ask to do so in the future.

People's interests were identified in care plans but activities were not particularly individualised. Activities were available if people chose to participate in them. The activities people did were recorded in their daily notes. People told us they had enough to do and got involved, ''if and when I want to''. Another person said, ''I prefer to do my own thing''. The weekly activities 'calendar' was displayed in communal areas. The service had a part time activities co-ordinator and care staff carried out this role at other times.

The service responded to other professionals and worked co-operatively with them. One professional told us, ''the homes manager liaises effectively ''. Another said, ''the home works co-operatively with me in caring for the residents''. The service had made and is continuing to make changes and improvements to meet recommendations made by the local authority commissioning team.

People told us they had, ''no concerns about the home, no concerns or complaints at all''. They said they knew how to make a complaint and would do so, if necessary. People told us they would be very comfortable to raise a concern with any staff member or with managers. They said they were confident they would be listened to and any necessary action would be taken. The service displayed the new complaints procedure and flow chart in a communal area where it was easily seen by visitors and people who live in the home. Complaints had not been appropriately recorded in the past. However, the new procedure ensured that complaints, actions taken as a result and complainant's satisfaction with the outcome were fully recorded. The service had received two complaints and 11 compliments during the past 12 months.

Good

Is the service well-led?

Our findings

People told us the registered manager was, ‘‘very nice’’. They said the home was run very well. One person said, ‘‘you can talk to the manager or anyone from the office, we’re always listened to’’. Staff told us, ‘‘the manager is fair and listens to what we have to say’’. Another said, ‘’this a good place to work, like a family for staff and residents’’. Others described the registered manager as, ‘‘supportive’’ and, ‘‘open’’. A staff member reflected what others felt when they said, ‘‘the management is very supportive and I feel very comfortable to approach them with any concerns, ideas or anything else’’.

Residents meetings were held twice a year and at least one residents and family meeting was held every year. Quality assurance surveys were sent to people and their families every year, the last one was completed in March 2015. No concerns were noted and positive comments included, ‘‘our decision for [our family member] to stay in the home has been re-inforced by the care [name] receives’’. Another noted, ‘‘the care and attention given to [family member] by an amazing and dedicated staff team has been incredible, and at no time have I had to worry about [their] welfare’’. Staff meetings were held approximately monthly. Their content included training, reflective practice and discussions about new procedures. Staff felt they could discuss any issues during these meetings and their views would be listened to.

The home had a variety of reviewing and monitoring systems to ensure the quality of care they offered people was maintained and improved. Results of all the quality assurance monitoring systems, along with any action plans, were displayed in the hallway so they could be seen easily by all interested parties. The registered manager regularly worked in the home alongside care staff. She monitored staff attitudes and values whilst working with them to ensure they were offering care to the expected standard and according to the principles of the statement of purpose. The statement of purpose had been reviewed in June 2015. Audits and checks included dependency profiles completed weekly to monitor staffing levels, weekly medicine checks and weekly environmental (walkthroughs) checks.

Changes made as a result of listening to people and the various quality assurance and monitoring and reviewing systems. These included making the garden more attractive and useable for people, decoration of communal areas, menu cards on dining tables and making better use of communal spaces. A staff member, who had worked in the service for a number of years, told us, ‘‘a lot has changed and things have improved over the years, the past two especially. If you ask things get done’’.

The registered manager, staff, other professionals and people who live in the home knew what roles staff held and understood what responsibilities these entailed. The operational director and registered manager told us that the registered manager was given the authority to make decisions to ensure the safety and comfort of the people who live in the home. These included emergency maintenance and repair issues and ensuring staffing levels could meet people’s immediate needs.

Some records relating to people who lived in the service were of variable quality and content. However this issue was being dealt with by the management team. Records relating to other aspects of the running of the service were well - kept and up-to-date.