Isle Care (Axholme) Ltd

Nicholas House Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Nicholas House Care Home is a residential care home that was providing personal care to 24 people aged 65 and over at the time of the inspection, some of whom were living with dementia. The service can support up to 40 people.

The care home accommodates people in one adapted building that has been extended over the years and is on two floors. One area of the home on the ground floor is used to support people living with dementia

People's experience of using this service and what we found
People living at Nicholas House did not receive a safe, effective or well led service. During the inspection, we identified concerns relating to people's safety which included poor oversight of fire safety issues by the provider, a lack of training and guidance for staff on how to support people in the event of a fire and insufficient staffing levels during the night which all put people at significant risk of harm. The provider had also failed to take appropriate action to ensure the premises were safe because windows on the first floor were single paned and were not fitted with safety glass.

The service did not have sufficient infection prevention and control measures in place. Areas of the premises were found to be unclean, and the condition of furniture and equipment was poor.

Medicines were not managed safely. Staff did not always have guidance to ensure they administered 'as required' medicines to people safely. Medicines were not stored safely, and stock levels of medication including controlled medicines were not recorded. Staff had not been trained or assessed to carry out key tasks for people such as medicine administration.

Systems were not in place to monitor accidents and incidents.

Safeguarding concerns had not been reported by staff and management. The registered manager was not clear of their role and responsibility in relation to safeguarding. Staff demonstrated a limited understanding of safeguarding and records showed they had not received appropriate training in this area.

Staff members we spoke with raised concerns about the management of the service.

The provider had failed to carry out inductions with newly recruited staff to ensure that they were fully prepared to support people using the service in a safe and effective manner.

Staff were not provided with supervision, appraisals or training in line with the provider's policies.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service

did not support this practice.

The provider had no oversight of the safety and quality of the service. Quality assurance systems were not established and operated effectively to ensure compliance with regulations.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 12 July 2019) and we found a breach of one regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
This inspection was prompted by serious concerns we had received about the service in relation to safeguarding. This is subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident. As a result, we carried out a focused inspection to review the key questions of safe, effective and well-led.

We have found evidence that the provider needs to make improvements. Please see safe, effective and well led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Nicholas House Care Home on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to fire safety and managing risks, management of medicines, staff training and support, failing to operate effective monitoring systems to improve the quality and safety of the service, poor recordkeeping, notification of incidents and safeguarding people from risk of harm or abuse.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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 was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

Nicholas House Care Home

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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The Inspection team consisted of one inspection manager and one inspector on both days of the inspection.

Service and service type
Nicholas House Care Home 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 on both days.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We looked at information we had received about the service since the last inspection such as notifications about incidents, safeguarding alerts and discussions with the registered manager. We asked the registered manager to send information such as staff rotas and staff training prior to the inspection. We sought feedback from the local authority and commissioners of the service and used all this information to plan our

inspection.

During the inspection
During the inspection, we spoke with four people who used the service, eight relatives, five care staff, three team leaders, the maintenance worker, the chef, the registered manager and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included six peoples care records and multiple medications records. We looked at seven staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were also reviewed.

After the inspection
We continued to seek clarification from the nominated individual to validate evidence found. We looked at training data, information relating to fire safety and a staff recruitment file. On the first day of the inspection, we reported our concerns regarding fire safety to Humberside Fire and Rescue service and we contacted the local authority with our concerns.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate.

This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
• The provider did not always keep people safe from the risk of abuse. Staff members concerns about alleged abuse had not always been fully investigated or alerted to the local authority safeguarding team. Staff told us about some of these concerns when we inspected the service.
• The provider had policies and procedures to deal with allegations of abuse, but staff did not follow these consistently.
• Staff training was not up to date and staff told us they were not aware of the correct safeguarding and whistle blowing procedures. This meant a culture had developed where safeguarding concerns were not raised.

A failure to ensure systems and processes were in place to protect people from abuse was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management
• Fire safety systems at the service were not always safe and as a result, people were put at risk of significant harm.
• The provider had failed to fully risk assess people's needs in relation to fire safety.
• Not all staff had completed fire safety training, fire drills or evacuation training. This meant they may not know how to support people safely in an emergency.
• Records relating to fire safety such as, evacuation plans and guidance for staff to follow in the event of an emergency were not up to date.
• Accidents and incidents were not always accurately recorded. Falls were not followed up in line with the provider's falls prevention policy and were not fully analysed to identify emerging patterns or trends.
• Issues highlighted at our last inspection in May 2019 had not been acted upon. A recommendation was made for the provider to assess and carry out work to ensure people were safe. This work had not been carried out.
• Windows on the first floor were unsafe and needed replacing. The opening of the windows was not adequately restricted and therefore did not meet with the recommended Health and Safety Executive guidance. The glass was single pane and did not have a safety kite mark. During our inspection, the provider ensured restrictors were placed on the windows to ensure openings met the relevant standards.

The failure to adequately assess, monitor and reduce risks to people's health and safety is a breach of

Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
• Medicines were not managed safely.
• The providers medication policy was not always followed by staff.
• The provider had not ensured that all staff were trained and competent to administer medication.
• Stocks of medication and management of medicines to be returned to the pharmacy was not managed safely.
• Guidance for staff to safely and consistently administer medicines prescribed 'as and when required' (PRN) was not always in place, and where it was, often lacked important detail. This meant staff may not have full guidance to help them when making decisions about when and how much medicine to give to people.
• The controlled drugs register was not completed accurately when returning medicines to the pharmacy.

The failure to adequately manage robust medicine systems and practice was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
• People were not protected from the risk of infection.
• The service did not have robust cleaning schedules in place to ensure a safe and clean environment.
• There were no checks of the environment in place to ensure standards of cleanliness were maintained to a high standard. During inspection, we found dirty beds, carpets and items of furniture in people's bedrooms. Bathrooms were unclean and we noted malodours in areas of the service.
• Furniture was old and damaged and needed replacing and carpets in communal areas were unclean, badly stained and required replacing.
This increased the risk of infection.
• Staff were also not vigilant with aspects of people's personal care. For example, nail care as some people had long, dirty finger nails. This would suggest that increased handwashing had not been carried out or encouraged as recommended in current government guidance in relation to the COVID-19 pandemic.

The failure to prevent and control the risk of infection is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
• The provider had failed to calculate staffing levels in line with people's needs. The dependency tool that the provider used did not consider people's care needs in an emergency.
• Staffing levels on a night did not ensure that people were safe in the event of a fire emergency situation.
• Staff told us they felt they struggled with only three staff on duty at night and were worried about people's safety in the event of an emergency. The staff rota showed that some nights only two staff were on duty and this did not include a team leader, this put people at increased risk of harm.
• An induction process for new staff was not in place. Six new members of staff had started work at the service with no induction. This put people at risk of receiving unsafe care and treatment from staff who may not know their needs.

Failure to provide adequate staffing levels to support peoples care needs was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

• Recruitment processes were in place.

Requires Improvement

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.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience
• The provider had not ensured staff were suitably inducted, trained or supported to perform their roles. There were no records to show staff's competency had been checked following their completion of training.
• Staff had not received supervision and appraisal of their work performance in line with the provider's policy.
• New staff had not completed an induction, nor had they fully completed mandatory training including fire safety and infection control. This meant new staff were not given the support, skills or knowledge to effectively carry out their role.
• Not all staff had completed fire safety training and they told us they did not feel they had the appropriate skills or knowledge to support people safely in the event of a fire emergency situation.
• Staff did not feel supported by the registered manager. One member of staff said, "I do not always feel I could go to the manager with my concerns."

A failure to ensure the service had sufficient numbers of suitably qualified, competent, skilled and experienced staff is a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet; Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• Peoples nutrition and hydration needs were effectively met.
• People's nutritional needs were assessed on admission and the chef was aware of any dietary requirements that people had. People were offered choice of meals and snacks during the day. Care records identified nutritional needs and recorded people's dietary intake.
• Staff assessed and documented people's needs in relation to their care. However, preferences regarding the delivery of care were not recorded. For example, one person had requested only one gender of staff to support them and we saw this was not recorded in their care plan.

Adapting service, design, decoration to meet people's needs
• Areas of the service required refurbishment, for example the sunroom carpet was unclean and worn, bedroom furniture was old and worn and increased the risk of spread of infection.
• The accommodation was arranged across two main areas the Coach House (which accommodated people

who were living with Dementia) and the main house. Improvements had been made to the Coach House following last inspection. However, the main house remained in need of redecoration and refurbishment.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
• Staff made appropriate referrals to other agencies when required such as the falls team. However, falls and incidents were not always reviewed in a timely manner.
• The service had made some referrals when required in relation to people's health needs. For example, some referrals were made to the falls team. However, improvements were needed.

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 when this is in their best interests and legally authorised under the MCA.

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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

• DOLS applications were made and there were authorisations in place.
• Assessments of some people's mental capacity were carried out for individual decisions and recorded in the care plan. However, capacity assessments and best interests decisions were not consistently carried out and some were not in place.
• Not all staff had completed training on the Mental Capacity Act and DOLs. Despite this people appeared to be supported to make decisions and given choices.

Inadequate

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.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At the last inspection the provider failed to ensure systems were in place or robust enough to demonstrate safety was effectively managed. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 17.

• The registered manager did not understand quality performance, risk and regulatory requirements.
• The provider failed to demonstrate how they were working towards improving standards at the service. Our findings showed that there had been a lack of improvement at the service which had also placed people at significant risk of harm.
• Some quality assurance processes were operated, but they did not identify concerns we found. The lack of robust systems and processes in place to identify concerns or shortfalls within the service placed people at increased risk of harm. For example, lack of staff training relating to medicines administration and failure to ensure appropriate infection prevention control measures were in place.
• The provider failed to ensure there was effective and competent management arrangements in place. They had a lack of oversight of how the service was being run.
• The nominated individual who was also the operations manager for the provider told us they had not had any oversight of the service for the past 12 months.
• Investigations and auditing of incidents and accidents were not always robust, fully completed or managed appropriately to mitigate future risks to people.
• The registered manager told us that they did not always feel supported by the provider.

The failure to operate robust quality assurance and safety monitoring systems was a breach of Regulation 17 (Good governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• A person-centred culture was not promoted within the service.
• Staff told us they felt unable to raise concerns as they felt their confidentiality would not be upheld.

• Staff did not feel supported within their roles. They had not been provided with sufficient training to ensure they had the skills and knowledge they needed. They expressed concerns over the lack of managerial support within the service.
• Record keeping had not been properly monitored at the service and this impacted on staff's ability to provide person centred care. For example, care plans were not up to date and did not always reflect people's needs and preferences.

The failure to operate effective systems for maintaining accurate records was a breach of Regulation 17 (Good governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
• The provider had not been responsive to issues and concerns.
• There was a failure to report concerns in relation to safeguarding incidents which had occurred within the service by the registered manager.
• The outcome of investigations was inconsistent and did not demonstrate an open and transparent approach to investigating concerns within the service, or those which had been received from relatives.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• Staff told us they did not feel supported by the management team which included the registered manager and the nominated individual. They told us that they did not feel their concerns were taken seriously, that no action was taken when they raised issues and that they had no voice or influence in the running of the service.

• Staff felt that communication between management and staff was poor. Staff meetings were held but some staff members felt they were not consulted or informed about issues that had arose within the service.
• Meetings were carried out with people who use the service and their families. Meetings provided feedback and included discussions on how to improve the service. For example, residents were asked what they would like to see on the menu.

Working in partnership with others
• A culture of high quality, person-centred care which valued and respected people's rights was not embedded within the service. This was evident by the breaches of regulation identified during this inspection.
• Further development of working in partnership with key organisations including the local authority safeguarding team and social services was required to ensure transparency and good outcomes for people.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure medicines were managed safely. The provider had failed to ensure robust fire safety systems were in place. As a result people were placed at significant risk. People were not protected from the risk of infection.

The enforcement action we took:

We took enforcement action but this did not proceed following the appeals process.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to ensure that robust systems and processes were in place to protect people from the risk of abuse and improper treatment.

The enforcement action we took:

We took enforcement action but this did not proceed following the appeals process.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure that robust governance systems were in place to ensure the quality and safety of the service. The provider had failed to ensure that good standards of record keeping standards were maintained.

	The registered manager did not understand quality performance, risk and regulatory requirements which put people at risk of harm. The provider failed to demonstrate how they were working towards improving standards at the service and failed to ensure there was effective and competent management arrangements in place.

The enforcement action we took:

We took enforcement action but this did not proceed following the appeals process.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure that staff were skilled, trained and competent to perform their roles. The provider had failed to ensure that staff receives supervision and had the opportunity to have an appraisal of their work performance.

The enforcement action we took:

We took enforcement action but this did not proceed following the appeals process.