Friends of the Elderly

Retired Nurses National Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Retired Nurses National Home is a residential care home providing personal care and support for up to 52 people. The service provides support to older people, some of whom are living with dementia. At the time of our inspection there were 32 people using the service.

People's experience of using this service and what we found
People were not always protected from harm and abuse as safeguarding concerns had not been identified by staff and referrals were not always made to the local authority. Staff had received safeguarding training but had not always reported concerns. Some records completed by staff, did not demonstrate dignity and respect were given to people living at the home. Risks people faced were not always assessed robustly enough to support their safety. Risks regarding people's health conditions were not always mitigated, especially where they could develop into a medical emergency.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not always support this practice. The service had not notified the CQC of all incidents that took place within the service as legally required. The provider wrote to us following the last comprehensive inspection to tell us how they would ensure they would meet the regulations. We found that some of these actions and improvements had not been sustained.

Management oversight within the home and at provider level was not robust. This was because their systems had not identified the shortfalls found within the inspection. During and after the inspection the provider had been responsive to address the issues identified and took action to make improvements.

People and their relatives told us they were happy with the care they received from the Retired Nurses National Home. Recruitment processes were in place to ensure staff had the right skills to work with people and various checks were carried out. People were protected from avoidable infections as safe procedures were in place which promoted a safe, hygienic environment. People were able to move safely around the home including to outside spaces.

People had access to healthcare and the home worked well with health and social care professionals. Staff had training for them to carry out their role. People received their medicines as prescribed. People had enough to eat and drink. The home sought feedback on the care it provided, people were consulted through meetings. Staff received training to support them in their role.

Staff felt appreciated and were complimentary about their colleagues. We received positive feedback about the management of the home.

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

Rating at last inspection
The last rating for this service was requires improvement (published 26 January 2022). The service remains rated requires improvement. This service has been rated requires improvement for the last two rated consecutive inspections.

Why we inspected
We received concerns in relation to safeguarding people from harm and abuse, safety of medicines and the management of the home. As a result, we undertook a focused inspection to review the key questions of safe, effective, and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has remained as requires improvement based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, and well led sections of this 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 Retired Nurses National Home on our website at www.cqc.org.uk

Enforcement
We have identified breaches in relation to safeguarding people from harm and abuse, consent, safe care and treatment and the management of the home.

Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Retired Nurses National 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 Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by 3 inspectors and a specialist pharmacist.

Service and service type
Retired Nurses National Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Retired Nurses National Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. However, there was a home

manager in post, who we will refer to as, 'the manager' throughout this report.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and safeguarding teams. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 9 people who used the service and 6 relatives about their experience of the care provided. We spoke with and received feedback from 15 members of staff including the nominated individual, home manager, deputy manager, regional director, chef, and care workers. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We received feedback from 2 health and social care professionals who work with the home.

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 reviewed a range of records. This included 32 people's care records and 10 people's medicine records. We looked at 2 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 reviewed.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse

● People were not always protected from harm and abuse. We found incidents of abuse and potential abuse had not been identified, followed up, or raised with the local authority. These incidents included allegations of physical and verbal abuse. The management team told us they were unaware of the incidents. The management team reviewed all incidents and sent alerts to the local authority during the inspection. Some of the incidents were subject to investigation by the local authority safeguarding team.

● Staff had received safeguarding training. They were able to tell us how to recognise the signs and symptoms of abuse and who they would report concerns to both internally and externally. However, we found that allegations of abuse were not always reported by staff to the management of the home.

● Staff made records of people's care and interactions. However, some of the language used by staff did not demonstrate dignity and respect. We raised this with the management team, and they immediately took action to address this with staff.

Systems were not in place to ensure people were protected from abuse and improper treatment. This placed people at risk of harm. This 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.

The provider responded immediately during and after the inspection. They sought to improve the reporting process within the home, staff training and guidance and made referrals for specialist support for people living at the home who experienced emotional distress.

● People and their relatives were happy with the care provided at Retired Nurses National Home. Some of their comments included: "I feel safe here", "I am quite happy here. They look after you well", "I feel safe because the staff come quickly", "I think my loved one is safe living there, as there are always staff passing by", "I feel my relative is safe, since they have been there, they have been the happiest they have been."

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

● People did not always have risk assessments in place to ensure they were kept safe. Where people had an identified risk, assessments were not always in place to reduce or remove the risks. For example, records for one person stated they struggled to eat certain foods, no actions were listed to ensure they were safe from the risk of choking. There had been an emergency related to choking for this person. Another example was where a person used bed rails, a risk assessment had not been completed to ensure they were safe to use.

● People's risk assessment and support plans were not always person centred and detailed, this meant people were at increased risk of harm. They contained some generic signs and symptoms instead of being

related to the person. Staff did not always have clear instructions on how to provide care consistently, especially for people living with dementia.
● Risk assessments were not always clear to support people with risks from their health conditions. Two people with insulin dependent diabetes had diabetes support plans, with information on blood sugar monitoring. Neither of them contained person centred details on expected or acceptable blood glucose ranges. There were no details on what actions should be taken if blood glucose readings were at specific levels and conflicting information about insulin doses. This meant there was a risk staff would respond inconsistently to varying blood sugar levels, action might not be taken when appropriate or the incorrect dose may have been given.
● Accident and incidents were recorded and reviewed monthly. However, where new risks were identified, re-assessment had not always taken place. This meant lessons were not learnt, people were not always protected, and risks were not managed for them to be reduced.

Practices had not been established to assess, monitor, and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection by completing risk assessments for people as required and seeking input to improve all records relating to people's care and support.

● Risks within the environment had been assessed, actions taken to mitigate the risk. Utility checks and equipment maintenance was in order. People had personal emergency evacuation plans in place, which gave information on the support they needed to leave the building in an emergency. Fire safety procedures were carried out within the home including tests and emergency fire drills.

Using medicines safely
● People's medicines records showed that they received their medicines in the way prescribed for them.
● When medicines were to be given 'when required' there were protocols to help guide staff to when these should be administered.
● There was guidance for staff on applying creams and other external preparations. Records were kept when these were applied, and risks were documented.
● There were suitable arrangements for storage, recording and disposal of medicines, including those needing cold storage and extra security. Staff told us there had been some issues with medicines supplies. However, ordering systems were in place to make sure that staff had time to follow up on any items not delivered before the start of each medicines cycle so that doses were not missed.
● Medicines incidents or errors were reported and investigated, and monthly audits took place to identify areas for improvement. Staff were trained in safe medicines handling, and their competencies had been rechecked recently.

Staffing and recruitment
● There were enough staff on duty. People and their relatives told us staff were available when they needed them.
● The home had a recruitment procedure in place and checks the service made, demonstrated staff had been selected on their skills and experience. Many staff at Retired Nurses National Home had long service.
● Staff were welcomed to the home by a comprehensive induction which was a blended learning of classroom and practical training. This meant staff were confident in their role before working alone.
● Staff files contained appropriate checks, such as references, health screening and a Disclosure and Barring Service (DBS) check. DBS checks provide information including details about convictions and cautions held

on the Police National Computer. The information helps employers make safer recruitment decisions.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● Visiting to the home was supported in line with good practice and government guidelines.

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 our last inspection we rated this key question requires improvement. At this inspection the rating has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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 MCA 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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

At our last inspection the provider had failed to ensure systems were in place and robust enough to ensure the service had the necessary lawful authority for people to be deprived of their liberty for the purposes of providing care or treatment. This placed people at risk of harm. This 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.

Whilst some improvements had been made, not enough improvement had been made at this inspection and the provider was still in breach of regulation 13.

● People's rights and freedoms was not always respected fully. One person did not have the necessary record of conversations or legal applications to live at the home. This meant it was not clear if the persons rights were being respected. We raised this with the manager, and they told us they would speak with the person. However, there was a continued risk, as the improvements made had not been completely effective or embedded within the home.

● People's rights were not always being fully respected and in accordance with the MCA. Some people did not have consent or capacity assessments in place for the decision of having a monitoring device in place.
● Where people had given a relative or loved one the legal authority to support them to consent to their care

this was respected. However, the home did not first establish if the person could make the decision for themselves. In one case, consent was signed by someone else on behalf of the person, but that person did not have the legal authority to do so.
● Staff knowledge around the requirements of the MCA was not as robust as it needed to be to ensure people's rights were fully respected.

Systems were either not in place or robust enough to ensure the service was working in accordance with the Mental Capacity Act 2005. This placed people at risk of harm. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection by carrying out some MCA assessments.

● People told us staff respect their decisions and always as for consent. One person told us, "Staff always get my permission."
● Staff told us they knew the importance of asking for consent on a day-to-day basis, such as to give medicines and personal care. One staff member said, "People with and without capacity have rights."

Supporting people to eat and drink enough to maintain a balanced diet
● People had enough to eat and drink. People were given a choice of meals and there were alternatives and lighter meals available for them. People's comments about the food included: "No complaints, you get choice and other options", "I eat as much or as little as I like and we can have snacks in between meals", "They ask in the mornings what we would like for the following day", "The food is lovely and traditional", "Sometimes there is a buffet, I have been to one of their lovely BBQ's."
● People were given the opportunity to discuss their likes and dislikes.
● People's preferences and dietary needs were recorded in their care plans, and in the kitchen. Input from dietary specialists was included where required. Dietary needs were assessed and recorded which included cultural needs, special diets, and allergies.
● We observed the mealtimes to be a relaxed social occasion with people having various discussions between themselves and with staff. Where people were supported to eat, this was carried out in a respectful way.
● Feedback was sought through meetings and people had meal choices each day.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People were supported to receive health care and medical input on a regular basis. Referrals were made from the home to professionals, such as doctors and nurses.
● The manager and senior team said they worked well with all professionals and were comfortable seeking their input when needed.
● People had a summary of care needs and risks within their electronic care planning system.
● Instructions from medical professionals were recorded in people's electronic care plans and communicated to staff through handovers. This meant that people were receiving the most up to date support to help meet their needs.
● Health and social care professionals were positive about how care was sought for people in a timely manner. A health and social care professional told us, following a person refusing their medicines they sought help for a review. A health and social care professional told us, "Staff always contact us when there are concerns."

Staff support: induction, training, skills, and experience

● Staff were selected to work at Retired Nurses National Home on their values, experience, and training. They had been assessed through their application, interview, and references.

● Staff told us they received enough training to enable them to carry out their role effectively.

● Staff induction included a programme of both online learning and face to face practical sessions. During induction, staff had training in subjects such as safeguarding, infection control, health and safety as well as completing shadow shifts. Staff new to care undertook, The Care Certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.

● Staff told us they felt supported, they had received supervision sessions with senior staff and records showed these were two-way. Opportunities were given for staff to receive feedback on their performance and request development if they needed. The manager told us they were working on improving the confidence of senior staff and enhancing their skills to be able to supervise other staff in the home.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● People's needs were assessed before they moved into the home. This information formed the basis of their care plan. Where appropriate relatives had been involved in the planning and completion of people's care plans.

● People's outcomes were identified during the care planning process; guidance for staff on how to meet these were in their plans. Staff training and knowledge about moving and handling demonstrated the plans had been created with evidence-based practices in mind.

● Care plans and assessments included any specialist equipment needed, such as moving and handling equipment.

Adapting service, design, decoration to meet people's needs

● The Retired Nurses National Home was an older style, adapted building. The décor was in keeping with the age of the building. The home had a continual improvement and maintenance plan in place and had recently appointed new staff to focus on maintenance and the environment.

● The home was accessed over two floors, by stairs or lift and had plenty of outside spaces for people to enjoy. The home had wider corridors and access for wheelchairs. People told us they were happy with their bedrooms and living at the home.

Requires Improvement

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 our last inspection we rated this key question requires improvement. At this inspection the rating has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- Quality assurance systems did not operate effectively. Audits and monitoring were either not in place or had not identified the shortfalls found during the inspection. For example, safeguarding people from harm, safety from risks, and protecting people's rights in accordance with the law.
- Oversight from a provider level had not identified the shortfalls within the service. Provider visits and internal auditing had taken place in June 2023 and July 2023 and neither had identified the shortfalls found during the inspection.

The provider had failed to establish governance systems which operated effectively to ensure people were protected from harm and abuse, risks were managed, people's rights were respected with the necessary legal authority and the service improved. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection by seeking to create a robust system and process for the oversight both within the home and at provider level.

- The service had not made all statutory notifications to us as required. A notification is the action that a provider is legally bound to take to tell us about any changes to their regulated services or incidents that have taken place in them. We found that although the service had made some notifications to us, they had failed to make notifications of alleged abuse. When we alerted the manager to this, they sent the notifications to CQC retrospectively.

The provider had failed to inform CQC about events that occurred in their service as required by law. This was a breach of Regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009.

Promoting a positive culture that is person-centred, open, inclusive, and empowering, which achieves good outcomes for people

- The manager told us they were passionate about making life better for people who lived at the home. The manager and deputy manager were working on involving all the staff team in decisions, supporting confidence and initiative within the team and to improve outcomes for people.
- Staff were proud to work at Retired Nurses National Home, their comments included: "I feel appreciated

here, they go round and thank us", "I am very proud to work here it gives me great satisfaction", "I feel proud, yes, because I feel I am doing something good", "I feel heard and valued as a member of staff, I care for my residents very much and the overall work environment seems to be a positive one", "I like my job and look forward to going to work, I enjoy spending time with the residents and making a difference to their lives. I feel supported and appreciated by my manager", "I am proud to work here, and I would do anything for the residents and my work colleagues."

● We received positive feedback about the management and senior staff of the service. Some comments were: "The manager [name] is doing a fantastic job they have improved team morale", "The manager [name] is very compassionate and empathetic whilst being fair", "The manager [name] is kind, caring and approachable", "The deputy manager [name] is very nice and follows things up", "The manager [name] and the deputy manager [name] are lovely", "The manager [name] and the office manager [name] are so helpful."

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 manager and management team understood the requirements of the duty of candour, that is, their duty to be honest, open and apologise for any accident or incident that had caused or placed a person at risk of harm.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● The provider worked to seek formal feedback on the care provided at the home. However, it was not always used to shape the service and drive improvements. The provider told us they would work on the link between asking for input and making changes.

● People and staff were involved in the way the home operated through meetings and individual conversations. Relatives told us they were kept informed.

● The service worked with various outside agencies and health and social care professionals to provide support to people. A health and social care professional told us, "We have a good working relationship, staff in the home are very approachable and friendly when I visit."

● Community links were established especially through activities and events; staff told us they continued to support people to be part of their community. We received compliments about the activities within the home. A member of staff said, "It's a lovely home and I do believe we give good care and have made links with our local community as often as we can, and they are often keen to welcome us back or visit us again."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Statutory notifications had not been submitted to CQC as required.

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 11 HSCA RA Regulations 2014 Need for consent Systems were either not in place or robust enough to ensure the service was working in accordance with the Mental Capacity Act 2005.

The enforcement action we took:

Issued a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems had not been established to assess, monitor, and mitigate risks to the health, safety and welfare of people using the service.

The enforcement action we took:

Issued a warning notice.

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 Systems were not in place to ensure people were protected from abuse and improper treatment.

The enforcement action we took:

Issued a warning notice.

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 establish governance systems which operated effectively to ensure people were protected from harm and abuse, risks were managed, people's rights were respected with the necessary legal authority and the service improved.

The enforcement action we took:

Issued a warning notice.