ADR Care Homes Limited

St Nicholas Nursing Home

Inspection report

1-3 St Nicholas Place
Sheringham
NR26 8LE
Tel: 01263 823764
Website: None

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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 inspection took place on 28 May 2015 and was unannounced.

St Nicholas Nursing Home provides accommodation and care for up to 11 older people, some of whom may be living with dementia. It no longer provides nursing care.

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

During inspections in December 2014 we identified serious concerns about the safety and welfare of people living in the home. We took action to ensure the service no longer delivered nursing care and imposed a restriction the numbers of people who could live at the home so that risks to their welfare were reduced. At inspection in February 2015 there were continued concerns about the safety and effectiveness of the

Summary of findings

service. We took enforcement action to ensure that the provider made improvements to systems for assessing, monitoring and improving the safety of the service and for managing risks. There were also concerns that risks to people's safety in an emergency had not been properly assessed and medicines were not managed safely. The principles of the Mental Capacity Act 2005 and associated codes of practice had not been properly applied. At this inspection, in May 2015, we found that there were significant improvements in all of these areas.

Risks to people's safety in an emergency had been assessed with plans in place to mitigate these. People's care needs were clearly identified, taking into account risks to which they were exposed. These were regularly reviewed to ensure that their plans of care provided up to date guidance for staff about supporting people. Improvements had been made to ensure people's medicines were managed safely.

Staff understood the importance of supporting people to make decisions and choices. The ability of people to make informed decisions about their care was assessed so that any action taken reflected their best interests. However, the process was not always recorded fully. The manager understood when an application to deprive someone of their liberty under the Deprivation of Liberty Safeguards should be considered and acted upon, to ensure people's rights were protected.

The quality and safety of the service was monitored and checked on a regular basis. Action plans took into account where improvements could be made and ensured risks were properly addressed and managed. People living in the home and their visitors recognised that the quality of the service had improved considerably since our last inspection.

Staff knew the importance of recognising signs that might suggest a person had been abused or harmed in some way and of reporting any concerns promptly. People were supported by enough competent staff who had been properly recruited to ensure they were suitable to work in care.

People had a choice of enough to eat and drink and enjoyed their meal times. Staff assisted them where it was necessary. People were referred promptly to other health professionals, such as the dietician or doctor, where this was needed to ensure their health or well-being.

Staff responded to people in a kind and caring manner and attended to requests for assistance promptly. They were knowledgeable about how they should support people with their personal or health care. Staff were respectful of people's privacy and dignity and knew about people's likes and dislikes. People had opportunities to join in activities which they enjoyed, including occasional outings.

People and their relatives were more confident that the manager would listen to their concerns and respond to complaints properly.

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 was safe.

People received their medicines when they needed them and in a safe way.

Staff understood the importance of reporting anything that affected people's safety. There were enough suitable staff to meet the needs of people living in the home.

Good

Is the service effective?
The service was effective.

Staff understood the principles of supporting people who were not able to make their own decisions about their care. The manager was aware when an application to deprive a person of their liberty might be necessary.

People were supported to eat and drink enough for their needs and to see health professionals such as their doctor or a dietician when this was necessary.

Good

Is the service caring?
The service was caring.

People were supported by kind and caring staff who took time to encourage them with making choices. Staff respected people's privacy and dignity.

Good

Is the service responsive?
The service was responsive.

People's care needs were assessed and reviewed promptly when their needs changed. Staff responded flexibly in order to meet people's needs.

People were confident that the manager would listen to and act on any concerns or complaints they had.

Good

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

Systems to assess and monitor the quality and safety of the service had improved significantly. The manager had completed an application to register with the Care Quality Commission and had secured improvements in standards of care and the morale of the staff team.

People who lived in, visited or worked at the home had confidence that they could make suggestions for improvement.

Good

St Nicholas 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.

The inspection took place on 28 May 2015 and was unannounced. It was carried out by two inspectors.

Before the inspection we reviewed the history of the service, including action we had taken previously to ensure that improvements were made. We reviewed the provider's action plan which told us what improvements they were making so that we could check the action had been taken.

We also reviewed information we hold about events taking place in the service such as injuries or deaths. The provider is required to submit notifications to CQC about these. We received information about the progress the service was making from the quality monitoring team at Norfolk County Council and a report from the fire safety officer.

During the inspection we interviewed three staff and the manager of the service. We also spoke with five people living at the home and four relatives. We used pathway tracking for two people. This is a way of checking how people are supported at each stage of their care. We reviewed care records for three people and medicines records for six people. We also looked at records relating to staff, minutes of meetings for people living at the home and their visitors and other records associated with the management of the service.

Good

Is the service safe?

Our findings

At our last inspection on 3 February 2015, we found that the service was not as safe as it should be. There was a lack of assessment of risk and guidance for supporting people safely in an emergency and medicines were not managed safely. The provider told us what they were going to do to improve. At this inspection, we found that action had been taken in both of these areas.

We noted that each person had an individual plan about how to evacuate them safely from the service in the event of fire. The assessment of risk of fire within the home had been updated to properly reflect how the risks of fire were to be minimised. The assessment showed that arrangements had been made with a local church to use their hall as a temporary place of safety should the home need to be evacuated. Staff told us how they took part in fire drills and had practiced with the new evacuation 'sledges'. These had been purchased to assist in getting people out of the home safely. We received confirmation from the fire and rescue service on 18 May 2015 that the arrangements the service had made were now satisfactory.

At the last inspection, medicines due for disposal or return to the pharmacy were not properly accounted for. At this inspection we found improvements had been made. The record of medicines for disposal was within the medicines trolley. This showed clearly any medicines that were due for disposal. Each tablet was clearly labelled in a small sachet with the time it had been due for administration, why it was due for disposal and the person for whom it had been prescribed. These were stored securely in the trolley with the disposal record. We reviewed the register for controlled drugs and cross-referenced the register with the medicine administration record (MAR) charts for four people prescribed these medicines. We found that the entries in both sets of records matched. The balances of these medicines recorded as in stock, corresponded to the amounts available.

People told us that they received their medicines when they were needed. MAR charts were fully completed with no missing entries, showing whether people had taken their medicines, refused them or did not require them for any reason. Where people had variable doses of a medicine, for example for pain relief, the amount that was given was recorded. This enabled staff to able to see whether the person was approaching the maximum permitted daily amount for their safety. There was guidance about medicines prescribed for occasional use so that staff would know the purpose of these and when it would be appropriate to offer them to the person. Medicines for external use (for example eye drops or creams,) were dated when they were opened so that staff could be sure they remained safe and effective to use.

Two senior staff who administered medicines told us that they had completed relevant 'e-learning' training. They said that they also observed experienced members of staff and were then observed themselves until they were confident in the procedure. Their competency was assessed and records of these kept in their files. Medicines trolleys were locked when they were not in use and staff retained possession of the keys to ensure medicines were stored safely.

One person at high risk of developing pressure ulcers told us that they were happy with their care and that staff made sure they were comfortable. They had a pressure relieving mattress in place and records confirmed that the person was assisted with repositioning every two hours to help regain their skin integrity.

Staff told us how risks to specific individuals associated with mobility, eating and drinking or from pressure ulcers were managed. These risks were assessed within people's plans of care. We noted that the assessment tool for the risk of pressure ulcers contained minor omissions. Information about whether people took medicines that could increase their risk and the specific link between severe weight loss and higher risk 'scores' was absent. The manager and deputy were made aware of this and undertook to review the form in use. However, the omissions had not adversely impacted upon individuals and staff knew who was vulnerable to problems in this area. We found that support from the district nursing team was obtained when it was needed and their advice was incorporated into the regime for reducing risk.

We found that one person's risks associated with choking and swallowing difficulties had been identified and addressed. Advice from the speech and language therapist about managing this was incorporated within their plan of care as guidance for staff. During the inspection we observed staff followed this in relation to the way the person's food was prepared, how it was given to them and the use of the correct thickener for their drinks to ensure they were supported safely.

Good

Is the service safe?

We noted that, where staff and the management team had noted concerns about an increasing risk of falls, they had taken advice from the GP and ensured referrals to the falls clinic were made.

People we spoke with or their relatives told us that they felt safe in the home. One person said, “The staff are wonderful and I am looked after well.” They and their relatives told us they could now talk to any staff member and that action would be taken if they had concerns about the way they were treated.

Staff were able to tell us about what might lead them to suspect someone may be being abused or harmed. They were clear about their obligation to report concerns and said they always had access to the telephone numbers for the manager and deputy manager. They went on to say that if they could not raise concerns with either of the management team there was information about contacting the local safeguarding team. We found that this was accessible to staff and visitors within the entrance area of the home.

People told us that staff responded to their needs promptly. One person commented, “If I need anything I just ring my bell.” Another person told us, “I never have to wait long if I need help.” They went on to say, “They [staff] are always ready to help when you need help.”

We observed that the call bell sounded only once during the inspection and was responded to straight away. There were three staff on duty to care for 11 people. The deputy manager was also present to assist staff. In addition, there was a maintenance person, cook and cleaner. We saw that staff had time to engage people and their relatives in both conversation and activities. Staff maintained a calm and unrushed demeanour. We concluded that there were enough staff to safely support the people who lived at the home.

Three staff recently appointed told us about the checks that were made before they were confirmed in post. This included providing an employment history, referees and proof of their identity so that checks could be made to ensure they were not barred from working in care for any reason. This was confirmed by records reviewed and showed that recruitment processes contributed to ensuring people were protected against the service employing unsuitable staff.

Good

Is the service effective?

Our findings

At the last inspection in February 2014, we found that the service was not as effective as it should be. Arrangements for acting in accordance with the code of practice for the Deprivation of Liberty Safeguards (DoLS), associated with the Mental Capacity Act (MCA) 2005, were not satisfactory. After the inspection the provider told us what they were going to do to improve. At this inspection we found that action had been taken.

We found that there was information on file showing that the capacity of people to understand risks associated with leaving the home unaccompanied had been reviewed. The manager had completed applications in accordance with the DoLS where she considered this appropriate. This helped to ensure people's rights would be protected if they were subject to any restriction on their freedom of movement.

We found that one person living in the home was assessed as not having the capacity to make an informed decision about a medicine. This was being administered covertly but the process of assessing the person's capacity in this area was not clearly documented. We followed this up with three staff who administered medicines. Each was able to tell us about the efforts they had made to explain the purpose of the tablet to the person and encourage them to take it. They told us that the person had not understood the implications of refusing it and had become ill as a result. They sought medical advice and the person's doctor agreed with staff what was in the person's best interests. The doctor had given written agreement to covert administration but the involvement of the person with power of attorney for health and welfare decisions was not recorded. For other people their capacity to consent to aspects of their care was appropriately assessed and recorded. We concluded that, although it was not always documented, staff understood the importance of obtaining consent and acting in the best interests of the person concerned.

Staff who had been recruited since our last inspection told us about their induction. They said they felt this covered relevant areas and had equipped them for their roles. They told us how they had completed shadowing shifts with experienced carers who knew people living at the home and found this helpful. The staff commented that there was a programme for staff supervision so that they could discuss their performance and any development needs. One told us how they had been put forward for further training in team leading and management to support them in their role as a senior carer. Staff also confirmed there was access to further training such as Diplomas in Health and Social Care.

Staff responsible for administering medicines told us they completed e-learning for this, shadowed others and their competency to give medicines had been assessed. Two senior staff told us how they sometimes worked as carers and not in their 'senior' capacity. They said that this kept them in touch with the care that people needed. We concluded that staff were supported and trained to deliver people's care competently.

People told us that they enjoyed their meals and had enough to eat and drink. One person said, "Lunch was lovely." We saw that the staff member who was preparing the main meal checked people's choices and preferences during the morning. Staff also checked at lunchtime whether people were enjoying their meal or needed anything else. We saw that people were offered a choice of desserts. Between meal times people were offered drinks including tea and coffee, with biscuits if they wanted.

Staff told us how one person had been unwell and had lost weight. They explained in detail what action had been taken to ensure the person had food supplements at that time and that they were now eating their meals well. The person's intake of food and drink was being recorded so that any further concerns could be identified promptly. People's weights were monitored regularly. Where it was not possible to weigh them for any reason, bicep measurements were used to ensure that people were not losing weight so remedial action could be taken if it was needed. Where people had lost weight, we could see that the doctor was consulted so that a referral to the dietician could be made if required.

Staff gave us clear information about one person whose health had deteriorated. They told us what advice they had been given by the health professional and what they had done to help the person recover. We noted from care plans reviewed that people's health care needs were identified. We found that some people had recently had an annual health care check to ensure their health was maintained. The records demonstrated that staff referred any concerns

Good

Is the service effective?

to the doctor or other health professional. For example, we could see that people had access to the continence advisor, district nursing team, speech and language therapist and chiropodist.

Good

Is the service caring?

Our findings

People told us that staff treated them well and that staff asked them about their care. One person commented, "Everyone here treats me with dignity." Another person told us, "Every one of the girls are great. I cannot fault them." One person told us that, in the past, people were not really involved or consulted for their views. They contrasted that with the approach of staff over recent times and told us, "It has improved so much." They went on to say, "Everyone is so kind and the carers are very good." A visitor told us about their previous concerns about how their relative was cared for. They felt that staff and the new manager were much more receptive to their views about the person's care and support and what was needed. They told us that they felt standards of care had improved "…enormously."

We observed that staff offered people reassurance and encouragement where this was needed. When one person had a visitor with them, staff still directed their conversation to the person who lived at the home to make sure that they were involved. Conversation was not confined to the specific tasks in hand, for example assisting someone with their meal. Throughout the course of the inspection we saw that people were encouraged to chat together and with staff. The atmosphere was relaxed and friendly with lots of smiles and laughter between people and staff.

We saw that staff took time to allow people to respond and make choices. This included, for example their choice of meal and drinks, about activities or where in the home they wanted to spend their time. Interactions were polite and respectful, with staff making eye contact with people.

There was background information about people's life histories and the things that were important to them in two of the three records we reviewed. One person did not have full information but their notes showed they had declined to take part and staff should try talking to them at another time. Their permission to share information in their care plans was recorded although notes did not always show that they or their relatives had been involved. However, staff were able to give us examples of how, as keyworkers, they involved people in discussions about their care plans. They gave us examples of the things people told them they liked and how they tried to ensure their preferences were met. We found that one person liked to use their second name rather than their first given name. This was recorded in their plan of care and we saw that staff respected this, using their preferred name.

People's independence was encouraged. One person told us that their keyworker had been encouraging them to get more active in the life of the home and that they appreciated this. Staff gave people time to move themselves around the home if they were able to do so. For another person we found that their care plan clearly recorded what staff should encourage them to do for themselves to maintain their independence and skills.

We observed that people's dignity and privacy was respected. Where people spent time in their own rooms, we saw that staff knocked on their doors before entering and greeted people in a friendly and polite way. Staff did not talk about people who lived in the home within earshot of others and, when they needed to share information with one another, did this discreetly.

We saw that people's personal information in their plans of care, were kept in the office near the main door so that they were not accessible to anyone without legitimate reason to see the information. Other daily records or handover notes were kept in the staff office. We concluded that people's confidentiality was respected.

Good

Is the service responsive?

Our findings

Staff gave us examples of how they met people's needs for support with their personal care. In doing so they were able to tell us how this differed for each person. We concluded that the care people were offered was adjusted in a way that reflected each individual's needs. For example, one person's care records showed that their preference had been for staff to assist them to get washed and dressed at 11am. We could see that this had changed over time with their health. Their plan of care had been amended to reflect that the person used to have a preferred time to get up but was now flexible. It went on to say that staff should still ask at 11am whether the person wanted to get up, and to go back later if they declined. We saw that this happened during our inspection showing that staff were flexible and responsive to individual needs.

At handover between staff, information was shared about how people were. This included whether there were any concerns about their wellbeing and how staff should follow this up. There were 'handover sheets' for staff to refer to if they needed a brief summary or update about people's health and welfare.

In one care plan we did notice some out of date information about the mobility of the person indicating that they could walk with a frame. However, detailed monthly reviews showed that the person was no longer weight bearing. The reviews provided clear information for staff about the equipment they needed to assist the person to move. We saw staff using this and concluded that staff were aware of, and responded to, the person's changed needs. Plans of care were reviewed routinely every month and promptly when people's needs changed.

People's interests and backgrounds were contained in notes we reviewed with the exception of one person who was recorded as having declined to take part. Staff were able to tell us about people's particular preferences. For example, one staff member explained how a person liked to wear nice beads and another liked to go to church. They told us what arrangements there were to ensure these preferences were acted upon and we confirmed this with one of the people concerned. They said, "We know if we want to go out we may have to plan this but at least we are supported to get out."

People told us that they enjoyed the activities on offer. One person said, "I do like the activities it gives me a chance to talk to others." Another person commented that the activities had greatly improved. They told us that they were being asked for their views on what should be available throughout the day. They felt that people were more included in the life of the home since the new manager had arrived. Relatives also told us that more stimulation and activities had been introduced. We saw a group of people engaged in a quiz and conversation while they were having their afternoon tea. A staff member also told us how they were hoping to capitalise on their experience as a florist by encouraging people who wanted to, to make floral table decorations.

During the course of the inspection, many people received regular visits from family and friends. We saw that staff welcomed them to the home. There were no restrictions on the time that they could visit. We saw one person had a visitor with them for most of the morning, through lunch and into the afternoon.

We concluded that people received care that took into account their individual personal and social needs as well as their preferences.

People told us that they were confident any concerns or complaints they had would be listened to now. They said this had not always been the case. One person commented, "You couldn't talk to the manager before." They did not think that the person had listened to them or been interested if they had concerns. They described it as much better now. Another person told us, "If I am unhappy I feel I could talk to anyone who works in the home." One visitor told us how they had complained in the past but that this did not result in much improvement. They went on to say that this had changed. They said that they were confident if they raised any concerns now improvements would be made. Information about how to complain was available in the front entrance to the home. The complaints record showed that none had been received since January.

Good

Is the service well-led?

Our findings

At our inspection in February 2015, we found that the service was poorly led. This was despite previous inspections indicating clearly where improvements needed to be made. Systems for monitoring the quality of the service, managing risk and meeting regulations were inadequate. We took action to ensure the provider made improvements. At this inspection we found that action had been taken.

We saw that much more robust audits were in place. For example, there were regular checks on cleanliness, safety and on record keeping. We also saw that incidents such as falls were reviewed on a monthly basis. The manager had received additional support and advice from the local authority quality monitoring team and was able to tell us how accidents were analysed. For example, this included reviewing whether there was a pattern involving individuals which needed investigating. This represented an improvement, as previously such checks were either not completed regularly or lacked rigour in identifying improvements that were needed.

There were regular checks on the safety and accuracy of medication systems highlighting whether any improvement or change could be made. As a result, improvements had been made in the prompt recording of medicines due for disposal and obtaining more up to date reference material for staff. Care plans were also sampled at the rate of four a month to ensure records were up to date and any changes for individuals had been incorporated.

A representative of the provider was also making more regular visits to the service and recording their findings. Both the provider and manager checks had taken place regularly each month since our last inspection. Both identified where improvements could be made. In house audits had accompanying plans showing what action was needed and these were annotated to show when improvements had been completed.

People and their visitors told us that they were asked for their views and expressed greatly increased confidence that their ideas and suggestions would be listened to. People said there were "residents' meetings" they could go to and relatives also attended these. Minutes seen showed that the manager asked people for their views about the service, how things were going and what could improve. The meetings were also used to keep people up to date with what was happening in the service. We also found that people's relatives were encouraged to meet with the manager who had made herself available on Wednesdays to discuss any issues they may have if they did not want to wait for the next meeting.

We found that people and their relatives had also completed a more formal survey. There was an action plan arising from these showing where changes could be made which was 'signed off' when action was complete. We also saw that staff were asked for their views and that the action plan arising from these indicated further discussion would take place at staff meetings. We found that two visiting professionals had also made positive comments about the service. One had recorded that there had been a "huge" improvement. We concluded that people living in, working at and visiting the home, were empowered to express their views.

The manager started work at the home in December 2014 and had completed their application to the Care Quality Commission for registration. The deputy manager had started in February 2015, just before our last inspection. Staff told us that they felt the manager and deputy manager were open and approachable. People and their relatives clearly knew who the manager was and identified how much things had improved since they took up the post. A relative commented to us that the improvements in management and staffing had affected the wellbeing of the person they visited. They said that, not only had the person's appearance and standard of dress improved, but they were much better in themselves and more cheerful. We concluded that the changes had made a positive impact on the welfare of people living in the home.

Staff described the morale of the staff team as much improved and said that they worked well together as a team. They were clear about their roles and enthusiastic about their work. One staff member told us, "I absolutely love it." Another told us, "It's a good team. Staff really work hard." We concluded that the management and staff team, including new staff, had worked hard to ensure the necessary improvements were made. The management team told us that, having established effective systems, they were committed to ensuring that standards were sustained and improved where necessary.