Nugent Care

James Nugent Court

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

This inspection took place on 07 and 08 January 2016 and was unannounced.

At our last comprehensive inspection of this service on 07 and 08 January 2015, we found breaches of legal requirements. After the inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to medicines management, meeting nutritional needs and consent to care and treatment. At this inspection we saw these actions had been completed.

James Nugent Court is a modern, purpose built home in Liverpool close to many local amenities including Sefton and Princes Parks and public transport links. It has single bedrooms with en-suite accommodation situated over two floors and includes hairdressing facilities, coffee shop and landscaped gardens. Car parking is provided at the front of the building. Residential care is provided for older people including those who have dementia and the home is registered for 56 people. At the time of our inspection, there were 47 people living in the home.

The home required a registered manager and the current registered manager had been in post since February 2015. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered

Summary of findings

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.

The atmosphere in the home was warm and pleasant and both the people living there and the staff told us that the home had improved a lot in the last year.

Staff were recruited with safe recruitment processes and received safeguarding training. Medication administration was improved but we saw that the medication trolley was left unlocked and that keys to the medication room were used by staff who gave them to other staff not entitled to have them.

People and relatives told us that the home was caring and we saw that staff treated them with courtesy and respect.

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.

Staff were recruited safely. They had received safeguarding training and were able to tell us how to report a concern.

The medicines administration was satisfactory.

Good

Is the service effective?
The service was effective.

Staff skills were improving and the training records showed that more training sessions were planned.

People told us the food and drink they received was improved.

The Mental Capacity Act and the associated Deprivation of Liberty process had been implemented.

Good

Is the service caring?
The service was caring.

We saw good interaction between staff and the people living in the home.

People were treated with respect and dignity and were able to be private when they wished.

Good

Is the service responsive?
The service was responsive.

The care planning and assessment was person centred.

People were able to take part in a range of activities.

Good

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

There had been a manager in post for a year who was registered with CQC.

Good

James Nugent Court

Detailed findings

Background to this inspection

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

This inspection took place on 07and 08 January 2016 and was unannounced.

The inspection team consisted of two adult care inspectors, an expert by experience and a specialist advisor. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The specialist advisor was a qualified nurse.

We reviewed the information that we held on our systems, including any concerns or statutory notifications which had been sent through to us. We also checked with the local authority quality assurance team and the local Healthwatch organisation to see if they had any concerns or information about the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We were able to talk with six people who lived in the home, with seven care and support staff, two health care professionals, two relatives and another visitor as well as the registered manager. We also spoke with three visitors to the home, two of whom were relatives.

We reviewed six care files, four staff files, the training records and various other records relating to the running of the home.

Good

Is the service safe?

Our findings

The people who lived in the home and their relatives all told us that they felt safe. One person told us, "I am happy to say that I feel safe". Another person told us, "I'm very comfortable in this place".

Records showed us that senior care staff had received recent and up to date training through internal resources such as eLearning and external organisations, which had also checked staff competency. We were told by staff able to administer medication, that they also received additional supervision specific to medication from the registered manager.

We observed the afternoon medicine round. No one living in the home managed their own medications, which were administered by a senior staff member, also called the 'designated person on duty'. This staff member we observed told us they had completed medicines training and who had been assessed for their competence. We confirmed this to be the case through their training records. Their practice was seen to be safe and within the boundaries and recommendations of legislation, protocols and policies. This staff member wore a red tabard which stated that they were administering medication and not to be disturbed, however this staff member admitted that this was difficult to maintain as they were often interrupted.

We saw and heard that people were given a description of their medication by staff, who checked with them they that they wanted or needed the medication. The medication administration record (MAR) sheets were correctly completed and signed by the staff member as each person was given their medication and were clear and legible. The MAR sheets had photographic identification for each person whose sheet we looked at.

The medication room was lockable, large and contained lockable units for the storage of medication. The temperature of the room was taken daily as was the temperature of the medication fridge and we saw that these were within recommended levels.

New medication was checked in and signed for. We saw that medication was stored safely and appropriately and that stock levels tallied withy the MAR sheets. Any medicines which needed disposal or return were kept in a tamper proof container and locked away. We saw these medications had been recorded in a returns book and regularly returned to the pharmacy. All the medicines used for people living in the home were 'in date'. 'As required' (PRN) drugs were similarly recorded, stored and administered. Eye drops and some creams were discarded 28 days after opening as recommended and this was recorded. Homely medicines, such as cough linctus or 'over the counter medication', such as skin creams, were also managed and recorded according the providers policy and safe practice. Monthly stock checks of the medication were completed by the registered manager or the deputy manager.

When we checked the storage of controlled drugs (CD) in the home, we were told by staff that there were no controlled drugs being stored; however, the CD cabinet could not be opened due to the lock not working, for us to check this. This also meant that if a person was prescribed a CD, there may be a delay in the home being able to store it properly. We did see that the CD cabinet was secured appropriately to the wall and itself was within the medication room, which was also locked. We read the CD register which recorded that there were no CD drugs stored. We noted that on previous occasions where a CD was prescribed for a person, two staff signatures had checked and confirmed the administration of the drug.

We were concerned about safety and security of the medicines. Examples were that the medicine room and cabinet keys are supposed to be held only by the 'designated person on duty'. We saw a bunch of keys which included these keys being handed over to another carer who needed a passkey to open one of the doors. We also observed the 'designated person' leaving the keys in the medicine trolley, which was unsupervised. We discussed this with the registered manager who agreed to take immediate action to resolve these issues.

We asked about safeguarding procedures and we saw that there were policies and procedures in place. We saw safeguarding information on notice boards around the home and there was also 'easy read' information for people who lived in the home. We saw that there was an audit trail of safeguarding concerns and investigations and the local authority and CQC had been notified accordingly.

We looked at staff training and saw that the majority of staff had received safeguarding training. We spoke with staff and they were able to describe to us what action they would take if they had concerns. They were also able to tell us about different types of abuse and what signs and

Good

Is the service safe?

behaviours to look for if they were concerned that someone was being abused or at risk from harm. We also saw that safeguarding and responsibilities had been discussed at a recent team meeting and the policy distributed for staff to read.

We observed that safe practices were used throughout the home and an example was that one person was seen by a staff member to be mobilising unaided, when they had been assessed to need the support of a walking frame. The person was quickly provided with their frame and accompanied to their destination.

We noted that the care records contained various risk assessments for activities and tasks each person undertook, such as using various pieces of equipment such as hoists. There were other nationally recognised health related risk assessment tools such as a Waterlow tool, (which is a method of undertaking a pressure ulcer risk assessment), SALT (speech and language therapist tool) and MUST (malnutrition universal screening tool) within the care records. We saw that there were suitable emergency evacuation plans and that the service regularly checked firefighting equipment and had fire drills. Other regular maintenance checks were completed on installations such as electric and gas and the home had a certificate to say that the water system was operating at the correct temperatures and was clear of legionella virus.

We looked at staff recruitment files. We saw that staff had been recruited according to the legal requirements. All staff had been checked for criminal records using the disclosure and barring scheme (DBS), qualifications, their right to work in the UK and all had at least two references. Staff had not been allowed to work with people who lived in the home until these requirements had been met and a satisfactory interview had taken place. We noted that staff were required to join the DBS update service. This meant that their criminal status could be rechecked at any time. We saw records of application forms, interview notes, offer letters and other documents in the staff recruitment files. The new employee had also had to sign that they had read and confirmed their understanding, of the 'safety handbook'.

The provider had various policies relating to employment, such as disciplinary and grievance procedures. This showed that there was clear guidance about the relationship, expectations and requirements between the employer and employees.

Comments about staffing numbers were generally favourable with only one visitor being aware of occasional shortages. People told us that the continuity of staffing had improved after the transfer of some agency staff to permanent employment at the home. We saw the staff rotas for the previous four weeks and the current and next two weeks. During each day, there were nine staff including one or two supervisory staff, plus the manager, on duty. At night, there were six support staff and one supervisory staff member on duty. In total, the home employed 34 staff including domestics and the catering staff. A health care professional told us, "They manage the staffing rotas much better now". Another said, "They do use more agency here but it's to get the full staff quotas, not like some other homes who work with what they've got".

The service was a faith based one and there were several retired clergy of one religion living in the home. However, we were assured that the home welcomed multi-denomination faiths as well as varied cultures and could provide for peoples cultural and spiritual needs.

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Good

Is the service effective?

Our findings

A health care professional told us, "Their understanding of the needs of residents is improving; it's not on our radar" and a second said, "The GP's have more confidence in them now".

We checked to see whether the service had met our requirements to manage consent in relation to the Mental Capacity Act legislation and also in relation to nutrition and hydration. We found that the service had been able to achieve improvement in these areas.

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. The application procedures for this in care homes and hospitals are 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 were being met.

Staff had received training in this area and the manager demonstrated conversance with the recent legal ruling, 'The Cheshire West' judgment. This ruling related to the possibility that some people in a care home may be deprived of their liberty. We saw that where a person was identified through a mental capacity assessment as not having capacity, there was a 'best interest' meeting and recorded decisions. DoLS applications were made if required and copies of the paperwork retained in peoples records. The registered manager told us that she was completing the required applications as quickly as possible. At the time of our inspection, eight applications had been made and two DoLS authorised. An emailed comment made from a social care professional from the local authority was, 'The [DoLS] referrals are now starting to trickle through'. We discussed with the registered manager the need to submit appropriate applications to the local authority as quickly as possible, in order to comply with legal requirements. She agreed to make that a priority.

We asked staff about training and support. They all told us that they felt the manager was very supportive towards them. Staff also told us that they regularly received training and supervision sessions with their supervisor to enable them to carry out their roles effectively.

A person living in the home told us, "I am very impressed with the amount of training which goes on here".

We looked at the training matrix and saw that training was regular and covered all the requirements for staff working in care homes. The manager had identified gaps in some staff's training and had arranged sessions accordingly. We looked at six staff member's supervision files and saw that five of them had recently received supervision. The manager told us that she had scheduled the sessions in for the next year to ensure they took place on a regular basis. All new staff was registered for the new Care Certificate accredited by Skills for Care. One health care professional told us, "If the manager was absent, I am now confident that the staff have the training and confidence to continue to provide the service". This professional also said, "they are vigilant; we've given the registered manager advice relating to training and they have followed it".

We saw that staff meetings were held on a monthly basis. We noted that the minutes had not all been typed up and made available for staff to read. The manager said that this was an action she needed to prioritise.

We looked at the kitchen and the records and menus. The kitchen looked clean and tidy and we noted that it had a five star food hygiene rating, which was the highest available. We talked with staff about the routine of the kitchen and we were told there were opening and closing checks at the start and end of each shift. However, we noted that some required records had not been completed, such as temperature checks for the hot trolley and signatures to say that aspects of the kitchen cleaning had been done. There was space for a manager's signature on the daily sheets, but these had not been filled in. When we asked the registered manager why this had not been done, she told us she was not aware that this was part of her duties and that she would include this check from now on.

Good

Is the service effective?

The chef on duty showed us a communication book for the kitchen staff, but told us they were the only one to use it. They also told us they had plans to improve all the kitchen duties, records and menus. They said, “I am trying to improve menus and get people to have their ‘five a day’ by making their plates of food more appealing” and “People with dementia like colour on their plate”. One person told us, “We get well fed”. All the people and relatives we spoke with commended the food. We sampled lunch which was hot and tasty and noted that there was an alternative offered.

There were plenty of cold drinks available and people were given cups of tea and coffee throughout the day. One person commented, “I get regular drinks in between meals”.

The chef also told us they had a list of things needed for the kitchen, such as a cupboard to store protective coats and hats for visitors to the kitchen and said, “The manager is very supportive and accommodating”. They went on to tell us that the manager had already purchased some equipment and ordered other things.

The chef told us how they prepared food for people with dietary needs and also told us they knew they could accommodate any special storage, equipment or cooking requirements relating to people’s cultural or religious needs. The chef said they wanted to encourage people to eat and often made special things. The activities co-ordinator told us, “[Name[often makes cakes for our coffee shop”.

The premises were purpose built with wide and accessible corridors. The bedrooms all were en-suite and there were several communal bathrooms and toilets. The other communal facilities such as the lounge and dining rooms were pleasantly decorated and furnished. There was a range of fixed and mobile equipment in place to assist people with mobility needs and we saw this was maintained, and checked regularly.

Good

Is the service caring?

Our findings

We observed that the people living in James Nugent Court appeared comfortable and at ease with the staff supporting them. We saw that staff treated people with respect and courtesy, whilst often having a joke or exchanging some banter with them.

People and their relatives were complimentary about the care people received. One person told us, "I'm very comfortable in this place" and a relative said, "We can't speak too highly about the care".

A relative emailed us just after our inspection and wrote, 'I previously had concerns about JNC but I am now very happy with the care my mum receives'.

A senior clergy officer told us they were happy with the care given to their fellow clergy who lived in the home.

One health care professional we spoke with told us, "This is probably one of the best homes in the area" and "I wish this was the standard for all the other homes in the area".

Another told us, "I would place my relative here. It is a work in progress still, but it's so good now". They went on to say, "The kindness and empathy is there; it's caring and supportive".

At the time of our inspection, there were no people receiving end of life care, although we were told that one person was approaching this stage of their life. Staff were sensitive to this person's deteriorating health, we were told by the registered manager.

The home used the 'six steps' pathway for end of life and staff had been trained in this. 'Six steps' ensures that there is open and honest communication, assessment and planning. It ensures that the person themselves is at the heart of the process, with other people such as relatives and care professionals included and operating in a co-ordinated way. The person's need for dignity and respect is vital, as is the need to deliver high quality service in the care setting. It is a recognised end of life quality mark for care homes and other organisations.

We saw that people's cultural and spiritual needs were met. A visitor commented about a friend who was of a different ethnic group than the majority of people using the service, "We are satisfied that their likes and dislikes are well known". The chef told us this person had been offered a diet similar to the traditional one of the country of their birth, but they in fact preferred 'anglicised food'.

A staff member told us that the home had their own 'in house priests' who provided support to anyone who needed it. They told us that one person of a different religion to the priests had been given care and support by them and that, "They couldn't have given [Name] a more dignified end of life". A staff member told us, "We ask if they have any spiritual needs and it's also very important to re-check when they are end of life".

We observed that throughout the home, in all settings and during all occasions, such as when being supported to mobilise, or receive medication, that people were treated with dignity and respect.

We noted that people were supported to retain their independence, such as being able to access external events and to be involved in activities. Their confidentiality was maintained through the secure storage of their personal information.

Good

Is the service responsive?

Our findings

One person told us, “All my needs are being met, I’ve no complaints”.

Another person told us that they were ‘fussy’ but that staff treated them as an individual and provided the support the person wanted.

Most of the care files we saw were person centred and contained relevant information. The registered manager told us she had started to review the files to ensure they were up to date. Most files recorded that an assessment of people’s needs had been made, including risk assessments and that contact details of family, friends and health or social care professionals in involved in their care and support, were recorded. We also saw that information about GP, hospital dentist and optician’s appointments and outcomes, were noted.

However one of the care records we saw related to a person who had been admitted within the previous month. We noted that there were large amounts of information missing. A second care file for another person who had been in the home for at least a year also had a lot of missing information. This meant that staff were unable to access the right information in order to support these people properly.

The care and support we observed was person centred and enabled choice in many aspects of people’s lives at James Nugent, such as where people wanted to eat, how to dress and what people wanted to do with their time.

There was a full time activities co-ordinator employed in the home. We found there were many dementia specific activities which people enjoyed doing. The activities co-ordinator had received role specific training for the post and was described by another staff member as, “A breath of fresh air”. This staff member was also praised by staff for “Doing so much" and for, “Totally understanding the meaning of the activities.

The home had recently purchased an iPad and some of the people living in the home were using it to build ‘memory trees’. There had been a coffee shop opened and when the activities co-ordinator was off duty, other staff had access to the activities room and store cupboard.

Activities offered were things such as poetry, bingo and piano playing. People were able to enjoy a group of school children visiting the home every fortnight and a group of volunteers, sponsored by a local large business, had tidied the garden for the people to enjoy.

We saw that the complaints policy had been reviewed in 2015. We noted that a copy of it was available on the notice board in the foyer of the home and it detailed who people needed to speak to if they wished to make a formal complaint.

We looked at the complaints file and saw that comments, compliments and concerns were also documented as well as formal complaints. We saw that any general concerns raised had been recorded and the actions taken were also written next to the comment. There had been one formal complaint since our last inspection. Appropriate action had been taken by the manager in response to this complaint and this was recorded.

People told us that they had no complaints at the time of our inspection but that they knew how to make a complaint if necessary. They said that staff were approachable and that they felt comfortable taking any concerns to them. They went on to tell us that any issues were quickly resolved.

We noted that one person, at the time of our inspection, was beginning to require nursing care. We saw that there were discussions about this transition between James Nugent Court, their relative, health and social care professionals involved in the care of this person and another service. Their relative told us that all the staff had been very supportive, despite the difficulties caused by the person’s behavioural changes.

Good

Is the service well-led?

Our findings

One person told us that the new manager, "Was very good".

Comments we received from staff included, "Her door is always open to us" and, "She always makes time to listen to you."

A health care professional said, "She's [the manager] fantastic" and "It [the home] is a work in progress still but such an improvement".

Another told us that they had a good working relationship with the manager and with the staff and went on to say, "It was worrisome, but since I have been coming here again, the difference has been remarkable".

The registered manager was available during our inspection and had been in post for over a year and had been registered by CQC in February 2015.

They had submitted all the required notifications to CQC and met the registration requirements. Staff told us the registered manager and any other of the providers management team were easy to talk with and open and transparent. They told us they had a good relationship with them. Many staff told us they were happy to work in the home, especially in the last year.

We saw that the home had various policies and procedures related to its running, staff and its practices. The service required systems or process's to be effectively operated to ensure compliance with the requirements. The provider employed a quality assurance officer who checked and audited many of the systems of work and the registered manager also did some of this work. These included the fire system, maintenance logs and the equipment in the home.

The interaction between the registered manager and the people living in the home showed us that the people were very familiar with them and that they knew each other well. There was a lot of chat and banter between them as we were shown around the building and we noted that people and staff were very relaxed with them and with us.

The registered manager and the other staff we spoke with were very keen to keep abreast of current practice and research and had been supported by the provider to improve dementia awareness in the home. The health care professionals we spoke with told us that the working relationship with the staff and the home was good and the social care professional who had emailed us also confirmed that the home was working with the local authority.

We saw that residents and relatives meetings were held in the home on a bi-monthly basis. We saw the minutes from two that were held in 2015 and that dates had been arranged for all of 2016. These dates were displayed on posters in various places around the home including the lift, to ensure that people and their relatives were aware when the meetings were due to take place.