Broadoak Group of Care Homes

William Court and Nunn Court

Inspection report

9 Glebe Road
West Bridgford
Nottingham
Nottinghamshire
NG2 6DS

Tel: 01159819181

Date of inspection visit:
12 July 2022
14 July 2022
29 July 2022

Date of publication:
22 September 2022

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service
William Court and Nunn Court is a residential care home providing personal care for ten people at the time of our inspection. The service can support up to twelve people. The purpose built home consisted of one and two-bedroom apartments, with a bathroom, kitchenette, lounge and dining area.

People's experience of using this service and what we found
Based on our review of safe and well-led the service was able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.

Right Support
People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. Staff delivered care and support tailored to people's strengths and needs. People's interests, abilities and wishes were promoted, ensuring people had fulfilling and meaningful everyday lives.

Right Care
Staff fully understood how to protect people from poor care, neglect and abuse. Staff completed safeguarding training and recognised and reported abuse. Staff assessed, identified and mitigated individual risks. People were supported and encouraged to take positive risks in order to achieve personal change and growth.

Right Culture
People received support and care from staff who were dedicated, kind and caring. People's quality of life was improved by the services positive, transparent culture and desire to improve. People received good quality care, support and treatment because there were enough trained staff to meet each persons' needs and wishes. Staff ensured people and those important to them were fully involved in planning their care.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 21 March 2019) and we found one breach of regulations. The provider completed an action plan after the last inspection to show what they would do and by when to improve staffing. At this inspection we found improvements had been made and

the provider was no longer in breach of regulations.

Why we inspected
This inspection was prompted by a review of the information we held about this service.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

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 changed from requires improvement to good based on the findings of this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for William Court and Nunn Court on our website at www.cqc.org.uk.

Follow up
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?

Good

The service was safe.

Details are in our safe findings below.

Is the service well-led?

Good

The service was well-led.

Details are in our well-led findings below.

William Court and Nunn Court

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.

Inspection team
This inspection was completed by one inspector.

Service and service type
William Court and Nunn Court 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. William Court and Nunn Court 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 service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was not a registered manager in post. However, the provider was in the process of recruiting a manager to support the deputy manager.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used information gathered as part of monitoring activity that took place on 20 May 2022 to help plan the inspection and inform our judgements. We used all this information to plan our inspection.

During the inspection
We spoke with nine people using the service, two relatives and eight staff including the deputy manager, senior carer, carer and area manager. We reviewed a range of records. This included five peoples care and medicine records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including incident records were reviewed.

Good

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 changed to good. This meant people were safe and protected from avoidable harm.

Staffing and recruitment
At our last inspection we found the provider failed to ensure there were enough staff to meet people's needs, this was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found enough improvement had been made and the provider was no longer in breach of regulation 18.

- People were supported by enough suitably trained staff to safely meet their needs. This included staff to provide one-to-one support to ensure people took part in activities they enjoyed when they wanted.
- People told us they were supported by kind staff who knew them well. For example, one person told us, "I love all the staff here but [staff member] is just my favourite, they help me with everything I need and take me shopping which I really like."
- The providers dependency tool ensured staffing levels were determined on people's individual needs, staff rota's we reviewed demonstrated there were always enough staff on duty.
- Staff were recruited safely, all staff received safety checks prior to employment including a Disclosure and Barring Service check (DBS). DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Systems and processes to safeguard people from the risk of abuse
- People were kept safe from the risk of abuse because staff knew them well. Staff understood what action to take to safeguard people from potential risks.
- People told us they knew who to speak to share any worries or any incidents which made them feel upset. For example, one person told us, "I would go straight to [staff] they always know what to do to make things better."
- Relatives we spoke with told us people were safe and well cared for. For example, a relative we spoke with told us, "I know my [relative] is safe and in good hands, nothing is too much trouble, they phone me immediately if anything happens."
- Staff received training in safeguarding and understood what concerns were and who they should report them to. For example, where a person was assessed as being at high risk of abuse, the deputy manager had taken prompt action in order to protect them.
- People and their relatives had a copy of the service user guide which detailed the safeguarding process in a format they could understand.

Assessing risk, safety monitoring and management
● People lived safely and free from unwarranted restrictions because the service assessed, monitored and managed safety well.
● Care plans were accurate and legible which helped people get the support they needed. Staff ensured all risk assessments were updated as people's needs changed. For example, we found monitoring records were updated following any periods of distress.
● Staff managed the safety of the living environment and equipment in it through regular checks and actions to minimise risk. Plans were in place to ensure all people could evacuate in case of an emergency.

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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

Using medicines safely
● People were supported by staff who followed systems and processes to administer, record and store medicines safely. Staff received training in medicine and had their competency assessed.
● People had detailed medicine care plans in place. These reflected any support needs due to people's capacity, what medicines were prescribed for and how they liked to take them.
● Staff understood and implemented the principles of STOMP (stopping over-medication of people with a learning disability, autism or both) and ensured people's medicines were reviewed by prescribers in line with these principles.
● Staff completed medicine audits to ensure any issues with medicines were acted on without delay.

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 meeting shielding and social distancing rules.
● 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 accessing testing for people using the service and staff.
● 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.
● The provider was facilitating visiting in line with current guidance.

Learning lessons when things go wrong
● Staff managed incidents affecting people's safety well. Staff recognised incidents and reported them

without delay, the deputy manager investigated incidents and shared lessons learned.

Good

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 as requires improvement. At this inspection the rating has changed to good. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

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

- The provider and deputy manager worked hard to ensure the culture was one of openness and inclusivity. Staff ensured people's rights were respected and their individuality promoted.
- People described their home as being safe and caring.
- Management were visible in the service, approachable and took an interest in what people and staff had to say.
- Staff felt supported by the management team and said they felt able to raise concerns with both the deputy manager and area manager. Staff were supported by a detailed whistleblowing policy.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The provider was open and honest with people following incidents. People told us, staff said sorry when things went wrong and records, we reviewed supported this.
- Relatives we spoke with told us the provider was open and honest and apologised when things went wrong.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The service did not have a registered manager in place however the deputy manager with the support from the provider had the knowledge and experience to ensure the home was well led. The provider was actively recruiting a registered manager.
- The deputy manager and staff were clear about their roles and knew people well. Staff were able to discuss their role without referring to documentation.
- The deputy manager and staff completed audits in areas such as medicines, infection control and care plan reviews. Action was taken following audits to drive service improvement.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People, and those important to them worked alongside staff and the management team to develop and improve both the service and support they receive.
- Care and support plans were fully developed and reviewed with people, their families and external services. This ensured support people received considered all of their individual needs.

● The provider ensured feedback was sought from staff, people and those important to them. For example, staff were encouraged to share their views in staff meetings and regular supervision sessions. People told us they had regular meetings with staff and the management team to give feedback on their support.
Continuous learning and improving care; Working in partnership with others
● The provider and deputy manager were dedicated in continually improving the service to ensure people using the service lived fulfilled and empowered lives.
● The provider used lessons learnt following incidents as training opportunities in order to improve the quality of care people received.
● Staff worked closely with external health and social care professionals in order to improve people's quality of life. For example, staff worked closely with specialist professionals in order to manage and reduce periods of distress people may experience. A professional we spoke with told us staff knew people well and any requests for information was sent without delay.