Braunton (Wrafton Road) Limited

# The Harriet Nanscawen Nursing Home

## Inspection report

25 Wrafton Road
Braunton
Devon
EX33 2BT

Tel: 01271812115

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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 |

# Summary of findings

## Overall summary

The Harriet Nanscawen Nursing Home is a residential care home with nursing for 23 people with dementia and conditions associated with old age and frailty. The service is set over two floors with communal lounges and dining areas all on the ground floor.

At our last inspection we rated the service good. We did rate one key area-safe as requires improvement. This was because the service did not have enough slings to help prevent infection control and people did not have personal evacuation plans. The registered manager assured us these matters would be dealt with swiftly and she provided information to show they had resolved these areas. At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and on-going monitoring that demonstrated serious risks or concerns.

This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

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Why the service is rated as good.

People said they enjoyed living at the service and felt safe and well cared for. Comments included "This place has a very good reputation - one of the best smaller ones" and "They are very good here with the care

People were supported to maintain their independence and live fulfilling lives doing the things they enjoyed and being encouraged to try new things. Some people did comment there were no outing organised.

The home had a registered manager. 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. The registered manager had returned to work at the service in the summer of 2017 to retake up the role of manager. They had reapplied to CQC and had been re-registered as the registered manager in February 2018.

Staff were caring and knowledgeable about people's needs, wishes and preferred routines. This helped them to plan personalised care. People, their families and visiting healthcare professionals were positive about the care and support people received. This considered their changing needs and healthcare needs.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. People told us they could choose what time they got up and where they wished to spend their day.

Care and support was person centred and well planned. Staff had good training and support to do their job

safely and effectively, although training records did not reflect all the training which had been completed.

Risk assessments were in place for each person. These identified the correct action to take to reduce the risk as much as possible in the least restrictive way. People received their medicines safely and on time. Accidents and incidents were carefully monitored, analysed and reported upon.

There were effective staff recruitment and selection processes in place. Staff understood about how to keep people protected and who to report abuse to.

Quality assurance processes and audits helped to ensure that the quality of care and support as well as the environment was closely monitored. This included seeking the views of people and their relatives.

We have made recommendations in relation to some records being more robustly maintained and kept up to date.

Further information is in the detailed findings below

## The five questions we ask about services and what we found

We always ask the following five questions of services.

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|---|---|
| **Is the service safe?**<br>The service has improved to Good. | **Good** |
| **Is the service effective?**<br>The service remains good. | **Good** |
| **Is the service caring?**<br>The service remains good. | **Good** |
| **Is the service responsive?**<br>The service remains good. | **Good** |
| **Is the service well-led?**<br>the service remains good. | **Good** |

# The Harriet Nanscawen 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.

This inspection took place on 2 May 2018 and was unannounced.
This was a routine comprehensive inspection carried out by one adult social care inspector, a pharmacist inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

During the inspection we spoke with eight people living at the service and four relatives. We also spoke with the registered provider, two nurses, cook, administrator, housekeeping staff and five care staff. Following the inspection we sought feedback from three healthcare professionals and had responses from one.

We used information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed other information we held about the service. This included previous inspection reports, safeguarding alerts and statutory notifications. A notification is information about important events which the service is required to send us by law.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us due to their dementia.

We reviewed information about people's care and how the service was managed. These included: three people's care files; three staff files which included recruitment records of the staff recruited since our last inspection; staff induction, training and supervision records; quality monitoring systems such as audits,

complaints; incident and accident reporting and minutes of meetings.

Good

# Is the service safe?

## Our findings

People said they felt safe and well cared for by staff at Harriet Nanscowen nursing home. Comments included "Overall this place is very friendly and people are well cared for" and "I am very happy here".

Relatives were also confident that their family member was safe and being well cared for. One said "They gave him 8 weeks to live when he was in hospital 4 months ago but he's still here."

People's individual risks were identified to keep people safe. For example, risk assessments for falls, mobility, general safety awareness, aids for daily living, self-medication of medicines and the workplace environment. We noted that window restrictors had not been included in the check list of environmental checks but the administrator was confident these were checked on a regular basis. We checked a sample of windows and found they had restrictors fitted which were in good working order.

People's medicines were managed safely. There were systems in place so that people could look after their own medicines if they wished, if it had been assessed as safe for them. Nurses recorded medicines administration on medicines administration records (MARs). We checked 13 people's MARs and these showed that people were given their medicines correctly in the way prescribed for them. Most MAR charts were printed by the supplying pharmacy. However there were some handwritten entries on people's charts that had not been double signed as being checked by a second member of staff. This could lead to the risk of errors, and is not in line with current guidance. However these entries were correct on the charts we saw. There were separate protocols with directions for medicines prescribed to be given 'when required' to guide staff on when it would be appropriate to give doses of these medicines.

Staff recorded the application of creams and other external preparations on the MAR charts and there were clear directions for the application of these products in people's rooms. There were suitable arrangements for ordering, receiving, storing and disposal of medicines, including medicines requiring extra security. Storage temperatures were monitored to make sure that medicines would be safe and effective. Records showed they were within the recommended range.

There were policies to guide staff on looking after medicines, and information on people's individual medicines was available. There was a reporting system so that any errors or incidents could be followed up and actions taken to prevent them from happening again. There were three types of medicines audits being carried out, and we saw that actions were identified from these audits to help improve medicines management in the service. There were procedures in place if people were given their medicines covertly (without their knowledge of consent) if it was considered to be in their best interest. One person's care plan had a mental capacity assessment and 'best interest' decision recorded. However the details of who had been involved in the decision or advice from the pharmacist had not been documented, and the mental capacity assessment was not specifically relating to taking medicines.

We recommend that the recording of some aspects of medicines management are reviewed, including the

process for handwriting additions to MAR charts, and recording of best interest decisions around covert medicines administration.

There were effective recruitment and selection processes in place. Staff had completed application forms and interviews had been undertaken. In addition, pre-employment checks were done, which included references from previous employers and Disclosure and Barring Service (DBS) checks completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

Staff showed an understanding of what might constitute abuse and what to look for. Staff had received training in safeguarding adults and knew how to report concerns within the organisation and externally such as the local authority, police and the Care Quality Commission (CQC). The registered manager demonstrated an understanding of their safeguarding role and responsibilities. There had been no new safeguarding alerts made in the last 12 months.

People were cared for by confident and competent staff. There were sufficient staff each shift to ensure their care needs were met. Most people said there were enough staff to meet their needs in a timely way. One person said "Oh yes, I think they have enough staff" and "They answer the bell quite quickly." Another person commented that staffing was decreased in the afternoons and they sometimes had to wait longer for their call bell to be answered. We asked a nurse about this and they said, they always answered call bells promptly but may ask the person to wait until another task had been finished unless it was an emergency.

There had been improvements in infection control arrangements since the last inspection because people had their own slings for use when using equipment. The provider had an infection control policy which reflected best practice guidance. Staff had completed infection control training, washed their hands regularly and used protective equipment, such as gloves and aprons to reduce cross infection risks. Care staff said they had plentiful supplies of gloves and aprons available. We observed staff using gloves and aprons. There was hand gel at the entrance and a notice to remind people coming into the home to use it.

Learning from incidents and investigations took place and appropriate changes were implemented, where needed. The registered manager had an overview of accidents and incidents within the service and looked at trends and patterns. Health and social care professionals were asked to review people's plans of care and treatment to see if there was anything further the service could do to reduce accidents such as falls.

Emergencies were planned for. This included each person having a personal evacuation plan in case of a fire or other emergency. The Devon fire and rescue service had recently inspected the building and the provider was looking at quotes to update their fire alarm system and equipment as this had been a recommendation from the fire safety officer.

Good

# Is the service effective?

## Our findings

People said they were being supported by a staff team who understood their needs and had the right skills. One person said "Staff know what they are doing; they help me when I need it and leave me when I can manage." One relative said "They are good with him. They know what his needs are, such as thickened fluids and pureed food."

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. We checked whether the service was working within the principles of the MCA and found they were. Care staff received mandatory training on the MCA and were aware of how it applied to their practice. People said staff gained their consent before carrying out any care or support. Staff were required to record they had gained people's consent when providing care and support. Where people lacked the capacity a best interest decision had been completed to decide about restrictive practices such as the use of bedrails and pressure mats to keep people safe.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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 of authorisations to deprive a person of their liberty were being met. One person had DoLS authorisation and there was a list of other people's applications pending. Staff understood what these authorisations meant and how to work with people in the least restrictive way.

People's healthcare needs were fully assessed, monitored and where needed referred to healthcare professionals. This included the community nurse team, GPs and hospital specialist teams. People confirmed they were able to see their GP as requested. Daily records and handovers showed staff kept a close eye on people's specific healthcare conditions.

Staff were confident and competent to meet people's needs. This was because there was access to ongoing training, support and supervisions to ensure staff had the right skills to do their job. This had not always been kept up to date; however staff confirmed they had regular training, meetings and one to one supervisions to discuss their role and ongoing training needs. This included an induction process for new staff. Any staff who were new to care completed the Care Certificate (a set of standards that social care and health staff adhere to in their daily working life). Staff also completed equality and diversity training.

We recommend training and supervision records are kept up to date as an audit of how staff are being supported in their role as is best practice.

People were supported to enjoy a balanced and nutritious diet to help maintain good health. This included plenty of drinks and snacks in between the three main meals of the day. Where someone had lost weight, staff monitored their food and fluid intake and if needed referred to their GP for supplements. People were complimentary about the menu choices. Comments included "I find the food very good." And "It does the job here very well indeed. I have put on weight. I stuff myself! It's great - I get three meals a day – and they will always give me extra if I ask."

Good

# Is the service caring?

## Our findings

People said they were happy with the care and staff approach. They said they enjoyed positive relationships with the staff group. One person said "Staff here stay, they don't have a lot of changes, so we get to know them well and they get to know you. That's good; I like to know who is caring for me."

Relatives were similarly impressed with the caring attitude of the staff. One said "The staff here are brilliant – and she likes the cleaner who comes to have a chat with her. Respect and dignity are certainly important and maintained here."

Our observations showed the atmosphere within the home was relaxed. People chatted with staff and it was clear they had caring bonds and knew people well. Staff spoke about people in a respectful manner. They were able to describe the things which were important to people and what their interests and preferred routines were. One staff member said "We all get on; the home is very friendly, family like. It is a pleasure to come to work."

Respect, dignity and privacy upheld at all times. People were supported with their personal care in private and staff were discrete when checking if people needed support. We noted that not all bathrooms had locks on them, but a sign could be used to let people know the bathroom was engaged.

We recommend the provider looks at best practice in terms of privacy and dignity in ensuring bathroom doors can be locked.

Staff we spoke with had a good understanding of people's individual backgrounds, ages, likes and dislikes. Their interactions showed they knew people well, what helped comfort people when distressed and what people enjoyed talking about. There was lots of laughter and cuddles and people were given time and encouragement to chat with staff and each other.

Care plans detailed people's cultural and religious preferences and whether people practised a faith and whether members of the local religious community visited the home. The provider had equality and diversity policy in place and staff had received training in this area. People's diverse needs were considered. For example staff spent time with one person in quiet reflection because they understood they enjoyed this time.

People's friends and relatives were able to visit and keep in contact freely. Visitors were in and out all day on the inspection. Relatives said they were always made welcome and were offered refreshments. They confirmed they could spend time with their family members in private if they wished. People were supported to stay in touch using Skype, emails and phone calls. People's post was delivered to them unopened.

The service had received many letters and cards complimenting the care and support being offered.

Comments included "Thank you for taking such wonderful care of my mother." And "Thank you for all the comfort and care you gave to (name of person). We know that during her time with you she felt safe and well cared for. The staff were wonderful and caring."

Good

# Is the service responsive?

## Our findings

People received personalised care and support specific to their needs and preferences. This was because staff knew people well and their care records showed care was being delivered in line with assessed needs and wishes. Care plans were handwritten into an index system for ease of reference. Plans included instructions for staff about how to provide personalised care and support for each person. It considered the risks, their needs and wishes and how best to support them with the right equipment. This might include pressure relieving equipment or walking aids.
People and their families were supported to review and develop their care plan if they wished although this wasn't always clearly recorded.

We looked at how provider complied with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. Care plans included where staff needed to consider people's sensory or hearing impairment. Staff were able to communicate with, and understand each person's requests and changing moods as they were aware of people's known communication preferences. Areas of the service were sign posted to help people find their way. There was a large white board available for staff to put up important information such as the menu for the day and the date and day to help people remain orientated.

The service offered a responsive activities programme throughout the week. This included some paid entertainers, such as musicians. There was a full time activities person who planned and delivered most of the activities. These included bingo, quizzes, games, exercises as well as one to one time with people. Some people commented that there were very few opportunities to go out on trips. The activities person explained that lots of people living at the home were frail and had complex medical conditions. This meant their health fluctuated which meant organised trips out were difficult to plan for. She did say that when the weather was good, she did try to get people out and about. She also accompanied people on their visits to hospital appointments.

There were regular opportunities for people and people that matter to them to raise issues, concerns and compliments. This was through on-going discussions with them by staff and the registered manager.
People said they would feel able to raise any concerns and would be confident they would be resolved. One person told us "I feel able to speak up about any grumbles if I have them. They are very responsive."
The service had a complaints process and records showed where complaint issues had been raised these had been investigated and resolved. For example one person had raised care practice about a member of staff. This was investigated and the staff member was given additional training on dignity and respect.

The service worked closely with the local hospice, GP s and community nurses to ensure end of life care was provided. This also helped to ensure people were pain free and specialist advice and support was sought when needed. There was a section within care plans for people to document their end of life care wishes if they were able or wished to do so. There were many compliments about the care and attention people had received in their final days. One said "Words cannot express our sincere gratitude for allowing our mother to

enjoy her final months with dignity and comfort. You are very special staff!"

Good

# Is the service well-led?

## Our findings

People and their relatives spoke positively about the service, the provider and the registered manager. One Person said "The home is well run, everything is thought about. The owner visits often."

The home had a registered manager. 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. The registered manager had day to day responsibility for the running of the service. The registered provider had a more general oversight and ensured that the environment was clean, well maintained and safe.

Staff said the management team were open and inclusive. They felt their ideas and suggestions were valued and they were encouraged to develop their skills via learning and development programmes. Staff said both the registered manager and provider listened to them as a staff group and worked as role models to show the key values and ethos of the service being a caring home form home environment. In addition staff were encouraged to help improve quality of care. To this end there were champions for diet and nutrition, End of Life Care, continence, medication, moving and handling and infection control. This helped to bring support and expertise for the benefit of the staff and people living at the service.

People, their families and staff views were sought both via general day to day feedback but also via meetings to discuss the quality of care and support being provided. The provider information return stated "The quality of the service is under constant review by talking to patients, relatives , next of kin and visitors in addition a proportion of our patients and families are requested to complete an Annual Questionnaire which enables us to assess if we are meeting the needs and expectations of our service users. As appropriate we will act on any concern or issue these to date have always been minor and achievable."

Systems and audits were used to ensure the environment was safe and well maintained, records were kept accurately and staff were following the medicines protocols. We saw there were no records for checking of window restrictors, but was assured this was done as part of the environmental checks.

The manager and provider understood their responsibilities in respect of duty of candour. Where they had reviewed incident reports or complaints and concluded the service could have done things differently, they acknowledged this.  For example, where laundry had gone missing.

The rating from the last inspection report was prominently displayed in the front entrance of the service. The provider does not have its own website.