Nynehead Care Limited

Nynehead Court

Inspection report

Nynehead
Wellington
Somerset
TA21 0BW

Tel: 01823662481
Website: www.tssg.co.uk

Date of inspection visit:
13 December 2017
15 December 2017

Date of publication:
31 January 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Nynehead Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

This service also provides care to people living in specialist 'extra care' housing. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The accommodation is bought, and is the occupant's own home. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for extra care housing; this inspection looked at people's personal care service.

Nynehead Court accommodates up to 44 people in a three storey historic building with a new, purpose built wing. At the time of the inspection there were 35 people using the service, five of whom were receiving respite care. There were two people in receipt of personal care who were living in the extra care housing.

There was a registered manager. A registered manager is a person who has registered with the Care Quality Commission 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.

At the last inspection in November 2015 the service was rated Good.

At this inspection we found concerns relating to safety, effectiveness and governance. The service has been rated as Requires Improvement.

Why the service is rated Requires Improvement.

There were systems in place which should have ensured adequate quality monitoring but not all areas which required improvement had been identified through that monitoring. Some records were incomplete which posed a risk of staff not responding in a timely manner. This had increased risk to people using the service.

There was some good practice in supporting people to receive their medicines in a safe way but the record of a meeting showed that not all medicines had been taken. Staff had been reminded to report medicines found to care staff straight away. Temperature records of medicine storage areas complete, although this had been highlighted twice through a pharmacist inspection. We observed the medicine trolley being left open and unsecured on one occasion during our inspection.

People's legal rights were not always understood and upheld because the service did not work in accordance with the Mental Capacity Act 2005 – people were not fully supported to make decisions about

their care.

Care staff had a good understanding how to protect people from abuse, but, until our feedback, non care staff had not received that training and were unsure how to recognised and report abuse. This training was quickly instigated.

People had their needs assessed and their care planned, with theirs, or their representative's involvement. Some care plans had included standard phrasing and lacked detail so were not person centred. We have recommended a comprehensive review of care planning at the service. Some care plans did contained good detail, from which staff could understand and provide the required care. Staff were providing person centred care and were conscientious in their work.

Staff received training in subjects relevant to their work. This had not led to all staff feeling confident or competent in the work.

People were treated with kindness and respect. Their dignity and privacy were upheld.

People were very happy with the service they received and spoke unanimously about the good care and support they received from staff and the registered manager. None had any negative comments to make. A health care professional said they had "No major concerns" and staff would "Go above and beyond" for the people using the service.

Staffing numbers and deployment had ensured there were enough staff to keep people safe.

People had a wide variety of activities of interest available to them. Where possible, people had been able to continue with their hobbies/expertise, such as painting and music. Activities staff and the transport enabled people to enjoy the gardens, go shopping or visit attractions. People were able to follow their faith.

The premises was kept in a safe state and people lived in a warm, fresh, adapted building. Diverse needs were able to be met.

There was a strong ethos of wanting to provide a quality service, which people said they did receive.

We found three breaches in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we asked the provider to take at the back of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not fully safe.

The management of people's medicines was not consistently safe.

People were not safeguarded from abuse until non care staff received instruction in how to recognise and report abuse.

Staffing arrangements ensured people were safe.

Accidents were recorded and monitored.

Individual risks to people were understood and managed.

The premises were kept in a safe, clean and fresh condition.

Is the service effective?

Requires Improvement

The service was not effective.

People's legal rights were not always upheld because they were not supported to make specific decisions at the best time for them to do so. Staff were not always working in accordance with the Mental Capacity Act 2005.

People received a varied and nutritious diet suitable for their needs. They enjoyed the food.

Equality and diversity were promoted so each person was able to live as they wanted to.

Staff received training and were encouraged to take qualifications in care. Staff received regular supervision of their work.

Health care needs were met with the support of external health care professionals who said they had no major concerns about the service.

Is the service caring?

Good

The service continued to be caring.

Is the service responsive?

Good

The service was not fully responsive.

Some poor record keeping meant staff might not have the information necessary to make judgements about people's care needs. Some care plans lacked detail and did not reflect person centred care planning. Some were very detailed.

Staff knew people well and worked hard to provide an individual service.

People had a wide variety of activities available to them and were able to follow their interests.

People's family members praised the end of life care provided.

People felt confident to make any comments or a complaint should they feel this was necessary.

Is the service well-led?

Requires Improvement

The service was not well-led because not all risks were identified and mitigated, records were not always complete and the service was not always evaluated to improve practice.

Staff were trying hard to do a good job and provide a caring and safe home for people but were not always clear how to do so.

Where practice was identified as needing improvement following our feedback this was undertaken straight away.

There was a strong ethos of wanting to provide a quality service. People said they received a quality service and their views were sought and responded to.

Nynehead 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 checked 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 was a comprehensive, unannounced inspection. It took place on 13 and 15 December 2017.

The inspection team included one adult social care inspector and an expert by experience. An expert by experience is a person who has experience of using, or caring for someone using, this type of service.
.
Prior to the inspection we looked at previous inspection reports. We also reviewed the information we held about the service and notifications we had received. A notification is information about important events which the service is required to send us by law. We used information the provider sent us in the Provider Information Return. 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 received feedback from 14 people using the service, one residing in the extra care housing. During the inspection we also used different methods to give us an insight into people's experience. This included informal observation throughout the inspection. Our observation enabled us to see how staff interacted with people and see how care was provided.

We spoke with five family members and 15 staff members, a visiting therapist, an independent health and social care trainer, a representative of the organisation and the registered manager.

We reviewed five people's care records, two staff files and looked at quality monitoring information relating to the management of the service and safety records. We received feedback from two health and social care professionals.

Requires Improvement

Is the service safe?

Our findings

The service was not always safe.

People had not always taken their medicines and the safety of medicines was not fully promoted. The records of a housekeeping meeting dated November 2017 included, 'Housekeeping staff sometimes find odd tablets either on trays or on the floor and (medicated) sachets unopened...(they are) reminded regarding the procedure to report this to seniors if they find medication not taken'. The registered manager said that it was known when people had not taken their medicines but those medicines were left for housekeeping staff to find and so the care staff administering them could not have known as they would have been removed at the time. This meant people were at risk of not receiving their medicines as prescribed. Staff were informed they should report any medicines found immediately so there could be an investigation.

Medicine were not always kept safely. The first day of the inspection we observed the medicines trolley left open and out of eyesight of the person in charge of it. Medicines could have been removed without them knowing. The second day of the inspection the trolley was locked when left and so the medicines were stored safely.

Professional advice was not always followed up. At pharmacist inspections in September 2017 and March 2017 the service was advised to record and monitor the temperature of medicine storage spaces because medicines must be stored within the manufacturer's guidelines. In one of the three places the records had many days when the temperature was not recorded. The registered manager informed us following the inspection that staff have been reminded of the importance of making those records.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other medicines management was safe. A monitored dosage system was used and, with the exception of a few signature gaps, records were clear and complete. Where a medicine was to be given 'as required' staff had information available to them as to when they could be administered. Staff told us they had received training in how to administer medicines safely.

Not all staff were aware of how to safeguard people from abuse. Staff that provided care were aware of the types of abuse, how to recognise abuse and how to report abuse so as to protect people. Staff who had roles other than providing personal care, such as domestic staff, said they did not receive safeguarding training or had not done so for a long time. They were unable to describe the types of abuse, how to recognise abuse and the procedures for alerting abuse. One staff member said "Abuse would be physical or bullying. I'm not sure". Nynehead Court safeguarding policy states that 'Staff working for and on behalf of Nynehead Care recognise and respond to the main forms of abuse' but not all the staff knew what those were.

Staff were very clear that they would not tolerate anything they saw at the service which worried them and

they knew where to find the service and whistle blowing policies and procedures, which they said they had access to at any time. The service whistle blowing policy had been reviewed in October 2017.

Following our feedback the registered manager said they had put a concentrated effort into ensuring the housekeeping team had received updated training on safeguarding.

Preparations in advance of an emergency situation were not robust because not every person using the service had a personal evacuation plan in place. Following our feedback each person had an individual personal evacuation plan put in place.

Staff were able to describe how they responded to the fire alarm bell and records showed that the alarms were tested weekly and the equipment serviced. Staff had received training in how to evacuate people if necessary.

The premises were kept safe through regular servicing and maintenance.

People told us they felt safe and "Free from harm" and staff were available when they needed their assistance.

People's needs were met in the day time through sufficient numbers of staff. Staff told us they had time to provide the safe care people needed. People felt there were sufficient staff to respond to their needs.

Care staff were well supported by housekeeping, activity, maintenance, catering and administrative staff. Staffing numbers were decided through reviewing people's needs on a regular basis and staff were deployed to ensure a skill and experience mix. Staffing was staggered in the evening with four care workers until 10pm and three after 10pm. Staff said that all people using the service, except two, would be in bed by 10pm although two people would sometimes be awake at night. Two of the four evening care staff provided personal care to people in the Extra Care housing between 9 and 9.30pm. To do so they would leave the Nynehead Court building. They said that, provided there were four staff on duty at that time, people in Nynehead Court were safe with the two remaining staff. These staffing arrangements were in place.

The registered manager said they would sleep at the service if people's changing needs, such as end of life care, meant additional staff were required. They said existing staff would meet any staffing shortfalls and agency staffing had not been required. This happened during the inspection.

There were recruitment processes in place. These included pre-employment checks including references from previous employers and Disclosure and Barring Service (DBS) checks. A DBS checks helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with certain groups of people. Staff confirmed that they did not work at the service until all checks had been completed.

People were protected from infection and the premises were clean and fresh. The service used a coloured coded system for mops and food preparation boards and staff had personal protective equipment, such as gloves, to reduce any possibility of cross contamination. Laundry equipment was suitable for the needs of people using the service. For example, washing machines had a sluicing and hot wash cycle. There was an infection control policy and the staff received training in infection control, and food hygiene, where necessary.

Accidents were recorded and monitored. Where there was a risk to the person if they tried to mobilise

without assistance, a pressure mat was in place to alert staff to their movement. People had individual risk assessments in place, for example, with regard to pressure damage, falls and nutrition. A district nurse said that staff had followed their advice in preventing pressure damage which showed that the service worked to improve people's care.

Requires Improvement

Is the service effective?

Our findings

The service was not effective because staff did not fully understand how to work in accordance with the Mental Capacity Act 2005 (MCA)

Staff had received training in the Mental Capacity Act 2005 and since the inspection the registered manager has arranged for senior care staff to receive additional training.

Some people using the service had capacity to make all necessary decisions relating to their care and support and some did not. The MCA provides a legal framework for making 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 found that people had a capacity assessment relating to 'personal care' and to 'restrictive practices'. Restrictive practices were listed as: taking a photograph of the person, the use of a pressure (monitoring) mat and the use of bed rails. We were told by a senior care worker that the inclusion of the pressure mat and use of bed rails was "In case" these were needed. The use of pressure mats and bed rails can potentially restrict a person's movement and freedom.

Capacity assessments have to be time and decision specific so that the person is given the best opportunity to make the decision themselves, which is the underlying principle of the Act. This was not happening at the service. If people lack capacity to consent to potentially restrictive practices relevant persons must be consulted to make the decision in the person's best interests. People's family members told us this happened. In addition, records showed that when requesting an authorisation for Deprivation of Liberty from the local authority, staff had ticked to say a capacity assessment was completed, but it was not.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interest and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). No person using the service had a legal authorisation in place to deprive them of their liberty but applications had been made, and followed up, for eight people who were not free to come and go as they might want and required constant supervision for their safety. One person had actively tried to leave the service and had left the premises but not the grounds. Staff had correctly made an application to deprive them of their liberty.

People were happy with the care and support they received. They told us "Staff are excellent". A person's family member said "(The person) has much improved since they've been here. Their mobility has improved

and they have put on weight". A health care professional said, "(The staff) are very good and over all I have no major concerns".

A health care professional said that staff were very open to advice; very good at phoning if they have any concerns and comply with what they ask them to do. This showed that staff were committed to providing the health care support people needed to maintain their health and welfare. People confirmed that their health care needs were met through contact with external health care professionals. Records showed contact with, for example, GP, district nursing service, dental services, speech and language and staff had acted very quickly when they recognised an emergency situation. The registered manager said, "We enable residents to attend appointments at the GP surgery and accompany them on hospital visits as needed".

Staff induction started before their first duty and included the culture of the organisation and the philosophy and principles of care.

Staff described their induction as "Brilliant" and "Very well organised, but a whole day and a lot to take in". They said they were instructed about everything they needed to know, such as moving people safely and the use of protective equipment. We were told that staff new to care were able to take the nationally recognised Care Certificate. The Care Certificate is an identified set of induction standards that health and social care workers should adhere to when performing their roles.

The service used, for example, Social Care television and seminars for staff training. Some training was face to face, such as fire safety. The training had included: first aid, pressure care, hand hygiene, health and safety and developing as a worker. They also took advice and instruction from the district nursing service. An independent health and social care trainer said the service "Actively encouraged (staff) to progress" through qualifications in care and that many staff had achieved those qualifications.

People were supported to have a high standard of dining experience. People had a varied and nutritious diet available to them. There were two dining rooms and some people chose to have their meals in their room. People receiving personal care had their meal taken to their home in the Extra Care bungalows.

People spoke positively about the food, menu and assistance they received. Their comments included: "The food is delicious", "There's plenty of food", and "I'm not good at chewing so staff will mash any food for me". People were encouraged with menu choices by visual aids and were encouraged to eat. The dining rooms were beautifully laid and people were able to use meal times as an opportunity to socialise. Sherry or wine was available.

Menu choices always included a vegetarian option. The chef said that they always ensured people had what they wanted. Menu choices included, for lunch: Roast Chicken Supreme, apple stuffing, cauliflower, buttered swede, roast potatoes, ginger and fruit roulade with cream and fresh fruit salad. The supper menu included: broccoli and red lentil soup with bread and butter and gammon steak, egg and chips.

Each person had a nutritional risk assessment in place and records of their preferences and any intolerances or allergies. One person, who had not really touched their squash, was offered a hot drink which was accepted more readily. This showed that staff worked to meet the needs of the individual.

The service decided, based on people's needs and in consultation with them, which part of the building their needs could be best met. For example, The Mulberry Wing was designed to provide a safe and effective living area for people living with dementia. Throughout the building information was displayed in the written word and in pictorial form. For example, the dining room tables had a colourful 'what's on today'

leaflet on the tables and a sign showed where the shop was and when it was open.

There was level access to each floor via vertical lifts and stair lifts. People could access the extensive gardens independently and enjoy them using a wheelchair or 'buggy', as necessary. Provision was made that people would not be disadvantaged and they could access meaningful activities.

Good

Is the service caring?

Our findings

The service continued to be caring.

People said they felt well cared for. Their comments include, "The girls are splendid, kind and caring", "They are kind and gentle and have time for me" and "I like a laugh". Interaction between staff and people using the service was kind and respectful.

People said they were treated respectfully by staff and each interaction between staff and people using the service demonstrated this. For example, staff were observed using great care to assist a person to eat who was being cared for in bed. The staff member even advised on how thick the stuffing was. They were fully engaged in helping the person, using thoughtfulness and kindness.

People's privacy was upheld. Each person had an en-suite bathroom and, when personal care was being delivered, a 'care in progress' sign was displayed on the door. Staff were observed knocking before entering people's rooms.

People's views helped to shape the service. People's views were sought and responded to on a daily basis, for example, some people were shown their meal options so they could decide what meal appealed to them. People said, "I am asked what I want to wear", "The staff know I have a little nap in the afternoon" and "I have all I want really".

The registered manager said they were not currently seeking people's formal opinion of the service because people became tired of completing questionnaires, but "We have a discerning group of residents and families and we are in regular dialogue with them to ensure that on-going or changing needs are met". There were residents' meetings. These included subjects such as activities and Christmas arrangements. Staff recruitment had been discussed and it was proposed that people using the service could be involved in the process. People also received a monthly list of activities and diary dates to keep them informed.

People's family were welcomed at Nynehead Court and praised the staff for the caring attitude.

Good

Is the service responsive?

Our findings

The service was responsive to people's needs but this was not demonstrated in care planning.

Care plans should inform staff about people's needs and wishes and how they wished their care to be delivered. Some care plans included a lot of detail but some used standard phrases, which did not show a person centred approach to the care. One did not include important details relevant to the person's care. For example, they had a pressure relieving mattress in situ but their plan said they still required one. Nor was there information about any necessary repositioning toward managing the risk from pressure damage. A member of staff said the person's care plan should have been reviewed the week before and described it as "very sketchy". However, care staff were able to describe the care needed, said that care was being delivered and records showed there health care professional involvement.

Another person's care plan merely said 'Clean glasses daily' and 'Administer eye drops…' although they were partially sighted from a chronic eye disease. This information did not demonstrate a person centred approach to meeting their needs.

We recommend a comprehensive review of care planning at the service.

Some care files included 'This is me' information, which informed staff about the person's history, interests and what was important to them. A health care professional said, "The staff really do know the residents".

People, or people who had authority to act on their behalf, were involved in developing people's care plan based on an initial, and ongoing assessment of their needs and wishes. People had signed to consent to the care plans where they were able.

Staff had received training in Equalities and Diversity and understood how to ensure people were not disadvantaged by their age, disability or other protected characteristics. For example, people with poor mobility could use a 'buggy' to be driven around the gardens and people were supported to meet their faith needs. The service benefitted from a church in the grounds. A dementia friendly carol service was advertised.

Four activities workers were employed with a view to providing meaningful activities to people and reduce any likelihood of isolation. They had received training relevant to their work. One described how they spent time with people who preferred to stay in their room. One person told us "I often have opportunity to get involved (in activities). "Sometimes I don't want to though".

People had the opportunity to take part in a wide variety of activities. These included: an arts exhibition, craft work, exercise classes, shopping in Taunton, visits to places of interest and visiting entertainment. A shop was available part of the week for people to purchase everyday items, such as toiletries. There was a sensory garden. We observed staff assisting one person with a jigsaw of Europe. People had newspapers and books available to them. There was a black cat called 'Tommy' who resided at the service and chickens in parts of the gardens.

The service worked to provide fulfilling, individual opportunities for people. One person had an artist's studio in the building; one had a workshop and a person was playing a piano with expertise.

People's family members were very happy with the end of life care provided at the service. People's family members spoke of the kindness when their relative had received end of life care at Nynehead Court. Their comments included: "It was very good care. Everybody knew (the person) and me. The registered manager would come in or, if she was not available, the Director. They were very, very supportive to family and friends as well".

When a GP felt a person was in the 'dying phase' of their life a care plan was adjusted to meet those needs. For example, 'just in case' medicines were available toward pain relief. Advanced care wishes were sought and taken into account.

The service had arranged a 'Memorial Afternoon' which was held in the Orangery. Families of people who had ended their life at the service were invited to come and spend time meeting others and for 'a quiet time of reflection'. This was non-religious so that it was totally inclusive.

The registered manager reported that they had two complaints in the previous 12 months. Both had been investigated and concluded. A complaints procedure and forms were available in the entrance to the service. People and their family members said they felt comfortable enough to raise a complaint if and when necessary.

The Care Quality Commission had received no complaints about the service.

Requires Improvement

Is the service well-led?

Our findings

The service had not continued to be well led because people were not fully protected from the risks of unsafe or inappropriate care and treatment. Audits did not always identify where safety needed to be reviewed, for example, audits of care plans and records.

Fluid monitoring records were not consistent and, although a person's diet was poor, there were gaps of days in the records. This meant the true level of any concern might not be identified.

People's capacity to make decisions was not assessed in line with the Mental Capacity Act 2005 (MCA) in that assessments were not always decision specific and time related. This meant that their legal rights might not be upheld. This had not been identified by the registered manager who believed the service was acting in accordance with the MCA.

Good practice was not always followed, for example, staff left a medicines trolley unattended and temperature records of storage areas were not complete. The service policies and procedures were not always followed. An example was non care staff not receiving instruction which enabled them to identify and correctly report safeguarding concerns. When medicines had been found on the floor or in people's beds this was not always reported at the time. Staff had been reminded to report any medicines found straight away.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a registered manager but, due to circumstances outside of their control, they had not been able to be in day to day control of the service consistently. They had identified staff to work as "leads" for identified areas, such as capacity assessments, dementia care, and infection control. Those staff had been supported to attend specialist courses. However, they did not always understand how to complete their role competently, for example, completing capacity assessments.

The registered manager was supported by one of the Directors of the organisation, who was present for the inspection. During 2017 an independent quality assurance audit had been undertaken. This showed the intention to run a quality service.

Staff spoke of Nynehead Court being a "Home from home". One said "I've only been here two months and I've been well supported". Staff received formal supervision of their work and had staff meetings. All staff expressed their strong desire to provide very good care and they were conscientious. Some staff showed a lack of confidence. One was upset because they had not had time to keep up to date with a person's care plan review. Another was asking the inspector how to complete some paperwork because they were unsure. The staff member leaving the medicine cabinet open did so with the inspection team watching; they had not recognised the risk and did not accept the risk following our feedback. Staff referred to "being sick and so not up to date" and "being on leave and so not up to date" or "I work at the other end of the home and so I

don't know". We understood that staff, being allocated to work at different ends of the premises, might not always have information about people in other parts of the premises.

There was a very clear ethos of providing a quality service and people told us they received a quality service. People had their views heard and taken into account.

The registered manager understood their duty of candour responsibilities and notified the Care Quality Commission as required.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered person was failing to act in accordance with the Mental Capacity Act 2005. Regulation 11 (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered manager was failing to ensure the proper and safe management of medicines. Regulation 12 (2) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good governance. The registered person was failing to assess, monitor and mitigate risks, maintain accurate and complete records and evaluate and improve practice. Regulation 17 (1) (2)(b)(c)(f)