Norse Care (Services) Limited

St Nicholas House

Inspection report

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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?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Overall summary

This inspection was unannounced and took place on 15 October 2014.

St Nicholas House is a service that provides accommodation and care to older people and is registered for up to 39 people. There are two units operating at the service, a residential unit and a dementia care unit. On the day of our inspection, there were 31 people living in the residential unit and six people in the dementia care unit.

There was a registered manager working at the service. 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 and associated Regulations about how the service is run.

People felt safe and the staff were kind and caring. Staff treated people with respect and were compassionate towards them and people received their medicines when they needed them.

People's privacy and dignity was respected. People were happy to raise any concerns they had with staff and were

Summary of findings

confident that these would be dealt with. There were enough staff to provide people with assistance within the dementia unit and they had access to activities that they found interesting. However, this was not always the case within the residential unit.

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS) and to report on what we find. We found that the service was meeting the requirements of DoLS.

Staff asked people for their consent when supporting them with tasks. Staff working within the dementia unit understood the principles of the MCA or DoLS. However, staff working on the residential unit did not. Therefore, we could not be sure that people living within the residential unit who lacked capacity to make their own decisions consistently had their rights protected.

The provider did not have effective systems in place to monitor the completion of staff training or the staffing levels required within the residential unit and some people's care records were inaccurate or incomplete.

People received sufficient food and drink to meet their needs and had access to healthcare professionals when they became unwell or required specialist help with an existing medical condition.

The provider had made sure that the premises were well maintained and that the required safety checks had been carried out. Equipment used to assist people to move had been regularly serviced to ensure that it was safe to use.

All of the staff spoken with felt supported by their immediate management team. The management team were approachable where staff could openly raise concerns if they needed to. The provider had learnt from any accidents or incidents that had occurred.

There were some of breaches of the Health and Social Care Act 2008 [Regulated Activities] 2010 and you can see what action we told the provider to take at the back of the full version of the report.

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?

Requires Improvement

The service was not consistently safe.

Staff understood how to keep people safe and the premises and equipment that people used were safe. However, there were not always enough staff within the residential unit to meet people's needs.

People received their medicines when they needed them. However, the temperature at which they were stored had not been consistently monitored to make sure that the medicine was safe to give to people. Staff guidance on when to give certain medicines was not available.Therefore, there was a risk that some people could receive their medication inappropriately.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were supported to maintain good health and were asked for their consent by the staff. Staff working on the dementia unit had a good understanding of their responsibilities under the Mental Capacity Act 2005 or the Deprivation of Liberty Safeguards. However, staff on the residential unit did not. Therefore, we could not be sure that people who lacked capacity to make their own decisions consistently had their rights protected.

Is the service caring?

Good

The service was caring.

Staff were kind and compassionate. People's privacy and dignity was respected. People were involved in making decisions about their care and their independence was encouraged.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

The provider responded appropriately to people's complaints and people's individual needs and preferences had been assessed before they moved into the service. However, the provider was not always responsive to people's individual needs or preferences. There were not always activities on offer to people within the residential until to help them follow their own individual interests.

People were encouraged to maintain and develop relationships with people who were important to them.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Summary of findings

The staff were happy working for the provider and learning occurred from incidents and accidents to improve the care that people received. The management team were open to opinions from the people who lived at the service, staff and outside professionals about how to improve the service. However, some systems that were in place to monitor the quality of the service were not effective and some records were inaccurate or had not been completed correctly. This placed people at risk of unsafe or inappropriate care.

St Nicholas House

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 15 October 2014 and was unannounced. The inspection team consisted of two inspectors.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed any statutory notifications that the provider had sent us. A notification is information about important events which the service is required to send us by law.

On the day we visited the service, we spoke to eight people living at St Nicholas, two visitors, five care staff, the cook, the deputy manager, the registered manager and the quality manager of the provider who was also present. We observed how care and support was provided to people. To do this, we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

The records we looked at included; five care plans, four staff recruitment files, staff training records, records relating to the maintenance of the premises and equipment, four people's medication records and records relating to how the service monitored staffing levels and the quality of the service.

After the inspection, we requested further information regarding staff training, the management of the premises and how the provider calculated the number of staff required to provide care to the people who lived at the service. This was received promptly.

Requires Improvement

Is the service safe?

Our findings

We received mixed views from people who lived on the residential unit as to whether there were enough staff available to help them when they needed assistance. Three people told us that staff assisted them promptly. However, three other people said that they often had to wait for assistance to get up in the morning or to go to bed and that staff sometimes took a long time to answer their call bell. One person told us, "I sometimes cannot go to bed when I want to and have to wait for staff to help me. I wanted to go to bed at 9pm last night but had to wait until 10pm." Another person told us, "I don't think that there are enough staff to help in the morning as I cannot always get up when I want to."

Three of the staff we spoke with who worked on the residential unit told us that they did not think there were enough staff to help people when they needed it. They said that this was due to an increase in the number of people requiring two staff to support them with their care.

Our observations confirmed that there were not always enough staff available to help people when they needed it within the residential unit. We saw one person ring their call bell but this was not answered. This person told us, "I feel that sometimes staff forget me." We had to alert staff that this person required some assistance. During lunchtime, six people had to wait for over 30 minutes in the dining room before they received their meal. We spoke to one of these people who told us that they often had to wait for their meal. They said "They [the staff] have so many people to deal with. It is not convenient for those of us who are in pain when we have to sit and wait." This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We asked the registered manager how they ensured that there were enough staff working on each shift to provide people with support when they needed it. They told us that each person on the residential and dementia units had been allocated a set number of hours of care each week. The provider had not assessed the required staffing levels based on people's individual needs. Therefore, there was a risk that they did not have an accurate picture of how much individual care each person required.

The registered manager advised us that an extra 30 hours had recently been made available by the provider for staff to give care. The best way to allocate these hours was being trialled within the residential unit.

On the dementia care unit, we saw that there were enough staff to meet people's needs and to keep them safe. The two staff we spoke with who worked on this unit confirmed this. We observed that there were always two staff available to provide help and assistance to the six people living on the dementia unit.

People's medicines were stored securely and they received them when they needed them. The temperature of the room where the medicines were kept on the day of the inspection was within an acceptable limit to make sure that the medicines were safe to give to people. However, the temperature had not been monitored everyday as was expected by the provider. Records showed that there were some days in September 2014 when the temperature had not been recorded and there were no records available for October 2014. Medicines that needed to be stored at a low temperature were kept in the fridge and the temperature of the fridge was regularly monitored to make sure these medicines were safe to give to people.

We reviewed four people's medication records. We looked to see what supporting information was available to assist staff to help them give people their medicines safely. Each person's medication record contained their photograph to aide staff with their identification and included information about any allergies and medicine sensitivities they had. The records also stated how people liked to take their medicines. However, how and when medicines prescribed for occasional administration (PRN) should be given was not documented. Therefore there was a risk that people could receive their medication inappropriately.

The registered manager confirmed they had recently been asked by the provider to produce supporting documentation regarding the administration of PRN medication which they were currently working on.

We asked four people if they felt safe living at St Nicholas. All of them told us they felt safe and that they did not feel they were discriminated against. They also told us that if they were worried about their safety they would feel comfortable talking to members of staff about this.

Requires Improvement

Is the service safe?

The staff we spoke with demonstrated that they understood what abuse was and told us what steps they would take to report any concerns. Staff told us they had received training in this subject and the training records we viewed confirmed this.

We were advised by staff that some people at the service had on occasions, displayed behaviour that may challenge others. We checked the care record of one person regarding this and saw there were clear instructions for staff to follow. We read what might trigger the behaviour and what staff could do to support the person to keep them and others who lived at the service safe. During our conversations with staff, they told us what actions they took to try to distract a person when they became upset. These matched what we had read in the person's care record. Where the service had been unable to prevent these incidents from re-occurring, they had sought advice from an outside specialist team who they were working closely with to enable them to provide extra support to the person.

All of the people we spoke with told us that they did not feel that their freedom was restricted in any way. Risks to people's safety had been assessed by the provider. These had been tailored to the individual person and covered areas such as assisting the person to move, malnutrition, pressure care and falls. The staff we spoke to had a good understanding of how to support people to manage these risks and we saw that action had been taken to protect people from harm. For example, one person who was at risk of falling out of bed had a bed that was low to the floor and a crash mat beside it to help prevent them from injuring themselves.

Staff understood what action they needed to take in an emergency situation to keep people safe. The fire exits were clear and well sign posted to assist people to leave the building if they needed to. Staff confirmed to us they had received training in fire safety and that testing of the fire alarm occurred regularly. The provider had contingency plans in place should the service need to be evacuated in the event of emergency so that people would continue to receive support with their care.

We saw that a gas safety check had been carried within the last 12 months and that equipment such as hoists and stand aids that were used to assist people with moving had been regularly serviced. This demonstrated that the provider made sure that the premises and equipment were safe.

The recruitment records of staff working at the service showed that the correct checks had been made by the provider to make sure that the staff they employed were suitable and of good character.

Requires Improvement

Is the service effective?

Our findings

The registered manager and the provider were aware of the recent Supreme Court judgement that had affected the interpretation of a deprivation of someone's liberty and the provider had arranged a meeting to discuss this subject imminently. The Mental Capacity Act 2005 (MCA), Deprivation of Liberty Safeguards (DoLS) requires the provider to submit applications to a 'Supervisory body' for authority to deprive someone of their liberty. The registered manager had identified that they were possibly depriving someone of their liberty in their best interest and had sought guidance on this from the local authority. An urgent application for a DoLS was being made following specialist advice. Therefore the service was meeting the requirements of DoLS.

The provider had assessed people's ability to make a decision about their care or treatment where it was felt they may lack capacity. The two staff working on the dementia unit were able to demonstrate a good understanding of how to apply the principles of the MCA and DoLS into their day to day work. However, none of the staff spoken with on the residential unit were aware of their duties under this Act and did not understand that any decisions they made for people who lacked capacity had to be in their best interests. The staff confirmed to us that there were people living within the residential unit who lacked capacity to make their own decisions. They were also not able to demonstrate a good knowledge of the Deprivation of Liberty safeguards (DoLS).

The provider's training records indicated that staff on the dementia unit had received training in MCA and DoLS but that the majority who worked on the residential unit had not. Therefore, we could not be sure that people who lived within the residential unit who lacked capacity to make their own decisions, always had their rights protected.

We queried the lack of training for staff on the residential unit in MCA and DoLS with the registered manager. They confirmed that all staff working on the residential unit would receive training in this subject, some of which was planned for November 2014.

All of the staff we spoke with told us they had received enough training to meet the needs of the people who lived at the service. We observed staff using correct techniques when assisting people to move. A member of staff who had received training in dementia had been seconded into the home from another service to coach the staff how to support people with dementia effectively. The staff told us that this had helped them to develop their skills in how to assist people who had dementia and to provide them with good quality care.

Staff told us they were happy with the supervision they received from their manager. They said they could raise any issues they had and discuss their performance and any training and development that they required.

We asked four people if staff asked for their consent and they all confirmed that they did. One person said, "They [the staff] always ask permission." Our observations confirmed this. For example, one staff member asked someone if they were happy to be moved with the hoist and another staff member asked someone if they wanted to wear some protective clothing whilst eating their meal.

All of the people we spoke with told us that they enjoyed the food. One person said, "The food is good." The provider had asked people what foods they liked and staff were aware of people's individual dietary needs. For example, some people preferred to have a vegetarian diet and this was catered for. The kitchen staff told us that they were aware of people's individual dietary requirements and that they received this information from the care staff in a timely manner so they could ensure they met the person's dietary needs.

People told us they could have food when they wanted it and that if they didn't like something on the daily menu, that staff would provide them with an alternative that they preferred. There was fresh fruit and cold drinks in the dining room for people to help themselves to and there were also jugs of drink in people's rooms. This meant that the provider had made sure that people had access to adequate food and drink.

Where people required assistance with their meals, this was given by the staff. People's health in respect of nutrition was monitored regularly and where concerns were found, specialist advice from dieticians or the person's GP was sought.

We asked four people if they were able to see their GP when they needed to. All of them confirmed that they could. One person told us, "They [the staff] send for the GP

Requires Improvement

Is the service effective?

in good time." Records confirmed that the staff contacted the GP and other healthcare professionals such as dentists and opticians where necessary for their advice. This meant that staff supported people to maintain their health.

Good

Is the service caring?

Our findings

All of the people we spoke with told us that staff treated them with kindness and compassion. One person said "They are a good lot of girls. They are not clock-watches. They do a lot of hours." They went on to tell us how one staff member had stayed with them beyond their contracted time the previous night to make sure that they were alright. Another person told us, "They [the staff] are all perfect." A visiting relative told us that they were 'very happy' with the care that was being given to their family member.

People told us that the staff knew them well. The staff we spoke with were able to demonstrate that they knew the people they cared for. They understood people's individual preferences such as what time they liked to get up in the morning, what they liked to eat and what hobbies and interests they had.

Staff respected and supported people's cultural needs. For example, one person was supported to attend church regularly so that they could continue to practice their chosen religion.

We observed the lunchtime meal in the dementia care unit. People looked happy and were laughing regularly. They were relaxed with the staff who were supporting them and were talking openly with them about their past lives and what their plans were for the rest of the day.

People told us that they felt listened to and involved in their own care. They said that they had been asked about the care they had wanted to receive. The registered manager told us that people were consulted about their care on a regular basis and that their care plan was then developed following these conversations.

The dementia unit had recently opened and people had been involved in choosing names for the bedrooms and the colour scheme. People were also given a choice about where to spend their day, what they wanted to do and what food to eat and drink. We saw one person enjoying a glass of wine with their lunch.

Staff treated people with respect. Where people wanted to have a lie in during the morning, staff returned later to see if they wanted to get up. We heard staff talking to people in a polite manner. They also knocked on the doors of people's rooms before entering. Our conversations with people who used the service confirmed that staff were respectful. One person told us, "Yes, the staff are respectful and are hard-working."

Staff encouraged people to participate in tasks that helped them to remain independent. We saw people helping out with daily activities such as setting the table for lunchtime, washing and drying dishes and tidying their own rooms.

There were facilities available so people could talk to visitors in private. We saw that a GP had been called as one person felt unwell. They were escorted into a private room so that their conversation could be conducted in private. This demonstrated that the provider respected people's right to privacy.

Requires Improvement

Is the service responsive?

Our findings

We observed that staff were responsive to people's needs all of the time in the dementia unit. For example, assisting people with personal care, taking one person out to see their GP or providing them with food and drink when requested. However, three people within the residential unit told us that staff were not always responsive to their needs and that their preferences were not always met. These included them not being able to get up or go to bed when they wanted to.

For most of the inspection, we saw that staff on both units were responsive to people's needs. However, we saw one example of staff within the residential unit not being responsive to a person's request to go outside in the morning. We heard the person ask a member of the domestic staff team for assistance to go outside. They were told that a carer would be asked to assist them. The person was still waiting to go outside over 20 minutes later and eventually gave up waiting and went into the dining room for lunch. This showed that staff were not always responsive to this person's needs.

Four people within the residential unit were asked whether they were able to follow their interests. Three of people told us they were satisfied with the level of activities on offer. One person said, "We always have fun." They went on to tell us about how they enjoyed playing bingo and having a sing-a-long. However one person said, "There is not a lot to do since the person who did the activities was laid off."

Two staff who worked on the residential unit told us that they felt there was little stimulation for people. We asked the registered manager about this. They said that the activities co-ordinator role had been replaced with staff providing extra care hours and that the emphasis was on staff making sure that opportunities to participate in daily living activities were offered to people on an individual basis. However, staff told us that they did not have time to offer people these opportunities. We did not see any activities taking place within the residential unit on the day of our inspection. People spent most of their time either watching the television, staring around the room or quietly chatting to each other. It was therefore unclear, how activities had been tailored to meet people's individual interests.

Within the dementia unit we saw that people participated in activities such as knitting, baking, reminiscence and making bird feeders. These were listed in some people's care records as activities that interested them. Therefore the provider had made sure that people in the dementia unit could take part in activities that they enjoyed.

People told us that they often had visitors to come and see them and that they could go out into the community if they wanted to. The visitors we spoke with said that they were always made to feel welcome and were encouraged to visit the service regularly. The registered manager confirmed that visitors were encouraged. The provider also had a room available for relatives to stay in overnight it they chose to be near their family member.

The care records that we checked demonstrated that the service had conducted a full assessment of people's individual needs to determine whether or not they could provide them with the support that they required. This assessment took into account people's preferences such as the time they wanted to get up, go to bed, the food they liked and whether they wanted a bath or shower. There was also information for staff regarding people's life history to help them talk to people about their past lives. People and the visitors we spoke with told us that they had been asked about what care they wanted before they started living at the service.

We asked people if they were confident to raise any concerns or complaints if they were unhappy with anything. They told us that they were happy and did not have any complaints, but that they would speak to the staff if they needed to. Information about how to complain was displayed around the service and was given to people when they moved into St Nicholas.

The service had received 11 complaints within the last 12 months. We tracked one of these complaints to make sure that it had been dealt with. The complaint had been recorded, investigated and responded to. We were therefore satisfied that people's complaints were responded to appropriately.

Requires Improvement

Is the service well-led?

Our findings

We found that some people's care records contained inaccurate information or that records were not being completed as intended. Therefore, people were at risk of receiving unsafe or inappropriate care as staff who may not be familiar with the person's needs, would not have access to accurate written information about them. For example, one person's care record stated that they had the mental capacity to make their own decisions. However, we were told by the registered manager and staff that an assessment had recently been completed by an outside team that deemed the person's capacity fluctuated. Therefore the document within their care record was incorrect.

Another person's mobility care plan stated that they walked with a frame but a staff member told us that they had needed to use a hoist that day to assist them into a chair. The mobility care plan was therefore inaccurate and the moving and handling risk assessment required updating.

A pressure care risk assessment in another person's care record was undated so it was unclear whether it was being regularly reviewed. This person had a pressure ulcer. There was not a plan of care in place to guide staff on what care they needed to provide to reduce the risk of this person's pressure ulcer from deteriorating. We also found inconsistencies around the signing of records within the care plans. Some people or their relatives had signed documents to show that they consented to the care that was provided but others had not. The temperature of the room where people's medicines were stored had also not been recorded each day as was required by the provider. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) 2010.

The provider carried out a number of audits to monitor the quality of the service. However, we found that a number of people's records held inaccurate information, that staffing levels on the residential unit were not sufficient to always meet people's needs and that staff training had not been monitored closely to make sure that staff had current up to date knowledge to enable them to provide safe care. For example, excluding new staff, ten staff had not received safeguarding training and 25 had not received food hygiene training. Other staff required refresher training in moving and handling and fire safety that was overdue. Therefore the systems in place to monitor these areas were not always effective. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2010.

There was a registered manager in post who also managed another service for the provider within the local area. A deputy manager managed the service in her absence to make sure that there was always someone available to provide leadership to the staffing team.

The staff told us that they felt supported and listened to by the immediate management team and that the management were approachable. They confirmed that they felt comfortable to raise concerns if needed. They also told us that action was taken in response to these concerns and that they felt the immediate management team led the service well.

We saw minutes of recent meetings that confirmed the management team held regular meetings with staff and people who lived at the service to gain their opinions on how to develop the service. People, their relatives, friends or representatives and staff were also asked for their opinions regarding the quality of care that was delivered every year. The last survey was in October 2013 and the responses had been analysed. The registered manager had developed an action plan following the survey and some changes had been implemented. These included each person being allocated a keyworker with pictures of them in people's rooms to help people and their relatives to know who to talk to if they had any issues.

Staff and managers were clear about the visions and values of the service and their own individual roles. We asked staff about whistleblowing. Whistleblowing is a term used where staff alert the service or outside agencies when they are concerned about care practice. They all told us that they would feel confident to whistle blow if there was a need to.

Accidents, incidents and complaints were all recorded and investigated by the registered manager. This information was then passed to the provider to analyse for any patterns so they could determine if any learning or improvements could be made. The registered manager told us that they also carried out their own internal analysis on incidents such as falls. If deemed necessary, action was taken such as discussing the incident with staff, re-assessing the person's care needs and involving specialist professionals for their advice. We were made aware of a recent

Requires Improvement

Is the service well-led?

communication that had come from the provider to the registered manager regarding how the service could improve the management of people's medicines. Incidents and complaints were also discussed with staff in staff meetings. This demonstrated that the provider had a system in place to learn from incidents and complaints.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers People who use services and others were not protected against the risks associated with unsafe or inappropriate care due to ineffective systems to monitor the accuracy and completion of records and the monitoring of the completion of staff training. Regulation 10 (1) (a) (b) and 2 (b) (iii).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records Some people's care records contained inaccurate information. Some records had not been completed as required by the provider. Regulation 20 (1) (a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing There were not enough staff available on the residential unit to meet people's needs.