Contemplation Homes Limited

Northcott House Residential Care and Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 23 and 29 March 2016 and was unannounced.

Northcott House Residential Care and Nursing Home is registered to provide accommodation, nursing and personal care services for up to 55 older people, and people who may be living with dementia, a physical disability or sensory impairment. At the time of our inspection there were 49 people living at the home. Of those, 25 had a residential service and 24 had nursing needs which varied from people who were relatively independent to people with complex care needs. People were accommodated in single rooms with a number of shared areas which included a lounge, a dining area, a conservatory and a smaller sensory lounge.

There was a registered manager in place. 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. The registered manager was on leave during our inspection. We mainly spoke with the deputy manager.

The provider had arrangements in place to protect people from risks to their safety and welfare, including the risks of avoidable harm and abuse. Staffing levels were sufficient to support people safely. Recruitment processes were in place to make sure only workers who were suitable to work in a care setting were employed. Arrangements were in place to store medicines safely.

Staff received appropriate training and supervision to maintain their skills and knowledge. They were aware of the need to gain people's consent to their care and support, and of the principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Staff complied with the principles of the Act where people did not have capacity to make certain decisions.

People were supported to eat and drink enough to maintain their health and welfare. They were able to make choices about their food and drink, and meals were prepared appropriately where people had particular dietary needs and preferences. People were supported to access healthcare services, such as GPs and older people's mental health teams.

People told us they had caring relationships with their care workers. They were encouraged to take part in decisions about their care and support and their views were listened to. Staff respected people's individuality, privacy, and dignity.

Care and support were based on plans which took into account people's needs, conditions, and preferences. Care plans were updated as people's needs changed, and were reviewed regularly. People were able to take part in individual leisure activities which reflected their interests. Shared activities were available if people wished to take part.

The home had an open, friendly atmosphere in which people felt able to make their views and opinions known. Systems were in place to make sure the service was managed efficiently and to monitor and assess the quality of service provided.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were protected against risks to their safety and wellbeing, including the risks of abuse and avoidable harm.

The provider employed sufficient staff and checked they were suitable to work in a care setting.

Processes were in place to make sure medicines were stored and handled safely.

Is the service effective?

Good

The service was effective.

Staff were supported by training and supervision to care for people according to their needs

Staff sought people's consent to their care and support. Where people lacked capacity to make individual decisions, staff complied with the principles of the Mental Capacity Act 2005.

People were supported to maintain a healthy diet and had access to other healthcare services when required.

Is the service caring?

Good

The service was caring.

There were caring relationships between people and their care workers.

People were listened to and were able to participate in decisions affecting their care and support.

People's privacy and dignity were respected.

Is the service responsive?

Good

The service was responsive.

People's care and support were provided in line with plans and assessments which took into account their needs and preferences. Care plans were changed as people's needs changed and were reviewed regularly.

There was a complaints procedure in place and complaints were managed and investigated, but most people said they had no need to complain.

Is the service well-led?

Good

The service was well led.

An effective management system and processes to monitor and assess the quality of service provided were in place.

There was an open, friendly culture in which people were treated as individuals and encouraged to speak up about their care and support.

Northcott House Residential Care and 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 checked whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, looked at the overall quality of the service, and provided a rating for the service under the Care Act 2014.

The inspection took place on 23 March 2016 and 29 March 2016. It was unannounced.

The inspection team consisted of an 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. On this inspection the expert by experience had experience of supporting older people and people living with dementia.

Before the inspection we reviewed information we had about the service, including previous inspection reports and notifications the provider sent to us. A notification is information about important events which the provider is required to tell us about by law.

Before the inspection, the provider completed a Provider Information Return. 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 spoke with 10 people who lived at Northcott House Residential Care and Nursing Home and three people who were visiting relations during our inspection. We observed care and support people received in the shared area of the home.

We spoke with the registered provider, the deputy manager, the head of care and the provider's service quality manager. We spoke with other members of staff, including two care workers, a member of the administration team, two members of the catering team and a cleaner.

We looked at the care plans and associated records of seven people. We reviewed other records, including the provider's policies and procedures, internal checks and audits, quality assurance survey returns, training and supervision records, staff rotas, and recruitment records for three staff members.

Good

Is the service safe?

Our findings

People told us they felt safe and comfortable at the home. One person said, "Yes, I feel safe here. I have no worries." Another person nodded when we asked if they felt safe. They went on to say, "Once I pressed the emergency bell by mistake. Lots of staff came running to help me."

The provider took steps to protect people from the risk of avoidable harm and abuse. Staff were aware of the types of abuse, the signs and indications of abuse, and how to report them if they had any concerns. None of the staff we spoke with had seen anything which caused them concern, but they were confident any concerns would be handled promptly and effectively by the home's management.

The deputy manager was aware of processes to follow if there was a suspicion or allegation of abuse. Suitable procedures and policies were in place for staff to refer to, including external organisations they could contact if their concerns were not addressed internally. The provider's mandatory training included the awareness of abuse.

The provider identified and assessed risks to people's safety and wellbeing. These included risks associated with people leaving the home unaccompanied, self-neglect, poor nutrition and supporting people to move about. Action plans were in place to reduce the likelihood and impact of risks. For example, a person at risk of poor nutrition had a support plan to address their eating and drinking. People at risk of falls had a sensor mat in their room to alert staff when they moved, had their medicines reviewed, or were encouraged to use a wheeled walking frame or suitable footwear when moving about the home.

Information was available to staff about risk alerts issued for medical devices and other equipment and products, including powder used to thicken people's drinks. One person had a heart pacemaker to help their heart beat regularly. There was information about this and the associated risks in their care plan. The provider had consulted with specialists about managing risks. There was advice from a speech and language therapist for a person at risk of choking, and from a continence specialist where a person was at risk of infections in their urine.

Where people's behaviours could put themselves or others at risk, risk assessments and strategies for responding to them were in place. These were written in general terms with little information about triggers and strategies individual to the person. This meant staff who did not know the person and what might trigger these behaviours, did not have specific instructions how to manage the risk. However we did not find evidence this had affected the support people received.

The provider had identified and assessed risks associated with the building and physical environment in order to identify dangers to people's safety. These included radiators, bed rails, and water temperature. Events such as a garden party and fireworks were assessed for the severity and likelihood of associated risks. Actions to control the risks and information for staff were documented. Personal emergency evacuation plans were in place with information about the individual support people would need in the event of having to leave the building in an emergency.

There were sufficient numbers of suitable staff to support people and keep them safe. People were satisfied there were enough staff to support them when they needed it, although they felt staff were very busy. Staff told us their workload was manageable and allowed them to spend time with people and get to know them. We saw staff were able to go about their duties in a calm, professional manner.

The provider carried out the necessary checks before staff started work. Staff files contained evidence of proof of identity, a criminal record check, employment history, and good conduct in previous employment. Registration dates and numbers were included for registered nurses. Where new employees had training with their previous employer, evidence of this was copied and kept in their files. The provider followed up any questions or anomalies that became evident during the recruitment of new staff.

The deputy manager told us there was some use of agency staff to cover absences. They usually had the same, regular agency staff who were familiar with the home and known to people. The provider had recruited recently to increase the pool of employed staff, and they were waiting for the necessary checks to complete before the new staff started work.

People were satisfied their medicines were looked after safely and that they received them at the right time. Procedures were in place and followed to make sure medicines were stored safely. There was a fridge for medicines which needed to be kept below room temperature. The fridge temperatures were checked daily.

Procedures were in place and followed to make sure medicines were administered according to people's prescriptions. This included prescribed ointments and creams for which there were clear instructions including body maps which showed where the creams should be applied. Records of medicines administered were accurate and complete. Medicines were administered by trained nurses or team leaders following a competency assessment.

One person was receiving crushed medicines because they found them easier to take. There was a letter from the person's doctor authorising that this was a safe way to give them their medicines. The provider had procedures in place for "homely" medicines bought over the counter or provided by people's families. These included checking with the person's doctor that the homely medicines were safe to give in combination with their other prescribed medicines.

Good

Is the service effective?

Our findings

People living at Northcott House and their visitors were satisfied staff had the skills and knowledge to support them according to their needs. One said, "All the staff are good here. I know because I have stayed in other places." They went on to say, "[Staff] are magnificent, out of this world." Another person said the staff were "very good". People and their visitors were confident staff made sure people consented to their care and support.

Staff were satisfied they received appropriate and timely training and had regular supervision meetings, although a senior staff member felt there could be more training specifically on caring for people living with dementia. They told us they had induction training which prepared them to support people according to their needs. The induction was based on the Care Certificate. This certificate has been developed by national health and social care organisations to provide a set of nationally agreed standards for those working in health and social care. There was regular refresher training in subjects the provider considered mandatory such as fire safety, infection control, and moving and handling.

There was an effective system for monitoring staff training, appraisals and supervisions. The provider had an inclusive plan for delivering regular refresher training. The registered manager reported weekly to the provider on completed training and supervisions. There was a "safe to practice" process which showed checks were made that staff, including agency staff, were trained appropriately to meet people's needs. Staff members' individual training records included an induction checklist, care certificate workbooks, supervision records and certificates of training completed. A nurse's training record showed they had received training in wound care, pressure injuries and catheter care.

The Mental Capacity Act 2005 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 the least restrictive possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Act. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards. We checked whether the service was working within the principles of the Act, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff used standard templates supplied by the local council when assessing people's capacity and their risk of being deprived of their liberty. These followed the principles of the Mental Capacity Act 2005. Capacity assessments were for specific decisions, such as agreeing to support with personal care, mobility, medicines, and decisions about nutrition. Where a person had a "do not resuscitate" from in place, a mental capacity assessment showed how this decision was made in their best interests. Although staff completed the templates when assessing people's capacity, the records were not always signed to show who had

carried out the assessment.

Staff assessed people's capacity before applying for Deprivation of Liberty Safeguards. We saw applications which had been sent to the local council and which had been acknowledged, but not yet processed. Where the council had processed an application, no conditions had been suggested.

We saw staff made sure people understood and consented to routine support. Where people were able to, they signed consent to care forms which were filed in their care plans.

People were happy with the quality of the food prepared for them and the menu choices. One person said, "The food varies from good to excellent." Another person told us they enjoyed all the food served. They said, "They do a fine fruit salad with fresh fruit in it." The same person told us they did not like toast and were very pleased the kitchen staff cooked fried bread for them nearly every day. A visitor told us their family member was living with diabetes and staff had discussed healthy food choices with him. They said the food their family member received always looked appetising.

One person said they found the food was repetitive, but they thought that was probably because they had to have soft food. Another person felt that the meals could be presented better, and they did not get the quality of meat they had been used to before they came to live at Northcott House.

The service took into account people's needs and preferences with respect to meals. The chef had records to show where people chose to eat a vegetarian diet or were living with diabetes which affected the choices they could make. The records included those who needed thickened fluids, a soft diet or fortified meals. Information about known allergies was also taken into account. Where people were at risk of not eating or drinking enough, records were kept of their intake.

Staff made meal times a pleasant experience for people. There were clean table cloths and neat cutlery for each person. Some people had adapted cutlery and plate guards to help them eat their meals independently. Drinks of squash and water were available for people.

People were sure they would be able to access other healthcare services if they needed to. One person had seen their GP recently. They said, "I told the nurse I had a problem and she got a doctor to come in and see me. I was happy with that." A visiting relation told us their family member had been living at Northcott House for some time. They said their family member kept well and had not had to see a doctor very often, but they said, "A doctor sees her when required."

Records showed people had access to other healthcare services as they needed to. These included visits by GPs, community nurses, opticians and dentists. People were supported to attend inpatient and outpatient appointments at hospital, and the service made appropriate referrals to services such as the older people's mental health team.

Good

Is the service caring?

Our findings

There were caring relationships between people and staff who supported them. One person said their care workers were "wonderful". Another person told us they found their care workers were always cheerful, and that made a difference to them. They said, "I like to tease the carers. They laugh with me." Another person told us they liked their care workers and thought they did a good job. They had helped her get used to being supported by people whose first language was not English, which they had found difficult at first because they had not experienced it before. She told us she was now accustomed to this and thought everybody looked after her well. A care worker said, "We love our residents."

Thank-you cards and other compliments were on display. One read, "[Name] could not have been in better hands with such friendly and capable people looking after him. In recent months as his health and spirit declined, you treated him with the utmost love, care and respect."

Staff used people's names and talked with them in a pleasant way. They made eye contact with people while they talked with them. There was a calm, unrushed atmosphere while staff supported people. Staff had friendly chats with people and their visitors. One member of staff stopped what they were doing to chat with a person who was leaving to go to hospital, checking that they were all right. On another occasion a staff member checked that a person was getting ointment for a sore eye. The registered provider took a person's arm to guide them about the home safely, and took the opportunity to check they were being looked after. Staff were aware of people's needs and checked they were being met.

Staff supported people to express their choices and take part in decisions about their care and support. At lunchtime they offered people choices and where they needed support to eat, this was done in a sensitive way. If people wanted a late breakfast, their choice was accommodated.

People and their visitors told us how they were involved in choices and decisions about their care. One person's visitor told us their family member preferred to stay in their room. Staff respected this, and reviewed their decision regularly to check this was still what the person wanted. Another person told us how they liked to go for a walk in their wheelchair, and staff tried to support them with this in the early afternoon when things were a bit quieter. Staff asked people about choices such as where they wanted to sit.

Staff respected people's dignity and privacy. One visitor told us staff always found a quiet place where they could sit with their family member, and always brought them a hot drink. Another person said they found it difficult when they first needed support with their personal care, but they were used to it now. They said the care workers' practical and caring attitude had helped them maintain their dignity.

A member of staff had been nominated "dignity champion", which meant there was a contact point for people and staff if they had questions or concerns about dignity. Information about dignity in care was available for people to know what they could expect. The registered manager had recently carried out a dignity audit to check that people's dignity was given proper consideration in all aspects of their care.

Staff told us nobody living at the home had particular needs or preferences arising from their religious or cultural background. The care assessment process was designed to identify if the person had relevant needs or preferences in this area. Staff were aware of some of the adjustments to people's support that could arise from this. Equality and diversity was included in the provider's regular training programme.

Good

Is the service responsive?

Our findings

People received assistance with their personal care that met their needs and took into account their preferences and wishes. One person told us they thought the care was "faultless". Other people described themselves as "very happy" with the care and support they received.

People's care plans were based on pre-admission assessments designed to identify people's needs and preferences. They included their relevant medical history and information about the person as an individual, including elements of their life history. Choices, such as people's preferred name, were recorded. Support plans were individual to the person concerned and included a residential support plan which identified where people needed support with activities of daily living. Where people had made advance decisions about care in the future, this was recorded. Specific care plans were in place for individual medical conditions, such as for a person who was living with rheumatoid arthritis. Wound care plans were in place for people who had damaged skin.

People's care and treatment plans were reviewed regularly and changes were made if required. There were monthly checks on people's weight, pulse, temperature and blood pressure. Staff used standard screening tools to assess people's risk of poor nutrition or of developing a pressure injury. Staff contacted people's GPs to review people's care plans where appropriate, for instance if the checks showed they were losing weight or their blood pressure was high. Staff told us the care plans contained the information they needed to support people according to their needs and preferences.

Staff supported people in line with their agreed plans. The support people received was recorded in their daily progress records. Staff kept other records where people's care plans showed their welfare should be checked at night, or regularly during the day. If people were at risk of poor skin condition, staff kept records to show they checked their pressure areas regularly and supported them to turn in bed or reposition themselves.

Staff responded where checks or observations showed additional care or treatment were needed. One person had problems with their catheter during the morning of our visit and had told staff they were in pain. Staff called the person's GP, and the person told us they were expecting their doctor to arrive later that day. Where people were not able to communicate if they were in pain, staff used a standard tool to assess if they might need pain relief.

People could take part in a variety of activities and entertainments, but if they declined to do so, staff respected their wishes. There were opportunities for arts and crafts which were arranged to be appropriate to the season. On the day of our visit people were making artificial flowers. People could pursue leisure activities according to their interests and choices. These included playing scrabble and singing in a choir. There were raised beds in the garden for people who liked to grow plants from seeds. Paintings by a person who lived at Northcott House were exhibited on the walls in shared areas of the home.

Shared activities were arranged to coincide with events such as Christmas, Comic Relief, Valentine's Day and

Children in Need. They were also linked with charity campaigns such as cancer awareness. Photographs of these activities were on the walls of the home, which helped people remember and reminisce about them.

The provider had a complaints procedure which was clearly displayed near the entrance to the home. Six formal complaints and three minor concerns had been logged by the registered manager. These had all been followed up, investigated and reported back to the person making the complaint.

People were aware they could complain, but said if they had any concerns they would just mention them to a nurse, and they were confident they would be dealt with. Visitors we spoke with said they had never had the need to make a complaint. One said that communications with staff were so good that problems did not arise.

Good

Is the service well-led?

Our findings

There was an open, inclusive atmosphere in the home. Staff described it as "like a big family" or "like a second family" and "homely". They said there were open, two-way communications, which meant they were confident any suggestions they made or concerns they raised would be listened to. They told us the managers were understanding and there was good teamwork. Two visitors were complimentary about how the home was managed and the quality of care their family member received. People living at Northcott House appreciated how it was managed and praised it as a good place to live. One person had responded to a feedback request with, "This home is wonderful." Another person told us they preferred to stay in their room to read and watch television. They appreciated the view from their window and said they kept meaning to compliment the home about the garden. They said, "It is great. There is a female member of staff who is often working out there, making sure it looks nice."

There was an effective management system with regular staff meetings. The registered manager and deputy manager shared supervisions between them. They had recently introduced a staff "champions" scheme which staff were starting to sign up for. This meant there would be nominated staff members who people, their families and other staff members could contact about certain subjects. These included oral health, dementia, falls, dignity, nutrition, continence and first aid. There was information about the dementia friends scheme near the entrance to the home and a number of staff had taken part in the scheme to learn more about how to help people live well with dementia.

The management team was supported by managers' meetings across the provider's organisation. These were consultative events where managers could learn from each other's experiences. The registered manager reported weekly to the provider's operations manager. Their report included incidents, accidents and new applications for Deprivation of Liberty Safeguards. The provider's functional managers, for instance the operations manager and service quality manager, visited the home regularly and reported to the registered manager on any findings.

There was a system for monitoring and improving the quality of service provided. There were internal checks and audits which covered areas such as infection control and medicines management. Where actions were identified in these checks, they were followed up and signed off in the audit reports. The registered manager had recently completed an audit of all care plans. Where these found actions, they were assigned to nurses and care workers to complete. There were also spot checks on medicines storage and records. There were regular checks of beds and mattresses, and food hygiene procedures, and audits of falls and accidents. There had been an external audit of medicines procedures by the provider's pharmacist in July 2015. Where this had identified actions they were followed up.

The provider regularly asked people, their families and visiting professionals for feedback about the quality of service they provided in the form of survey questionnaires. The most recent of these for people who used the service asked them to identify three things they liked about the service and one thing they would change. These surveys had identified improvements which had been carried out. These included the provision of a wider range of soft foods for people who needed a soft diet, and lighter cutlery for people who

found standard cutlery heavy to use, but did not need a specific adaptation.