Randomlight Limited

St Nicholas Care Home

Inspection report

21 St. Nicholas Drive
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
St Nicholas Care Home is owned and operated by Randomlight Limited. The home provides nursing and personal care for up to 176 people over six separate units. At the time of the inspection 2 of the units were not operating. Of the 4 houses operating, 1 provided general nursing care, 1 provided nursing care to people who have a learning disability, 1 nursing care for people living with dementia and 1 unit provided residential personal care to people with dementia. There were 73 people accommodated at the time of the inspection.

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

Right Support: On Brocklebank house the service was not able to demonstrate how they were meeting some of the underpinning principles of 'Right support, right care, right culture'. The house was bigger than most domestic style properties. It was registered for the support of up to 28 people with a learning disability.

People were supported to have maximum choice and control of their lives and staff supported /did them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Right Care: On Brocklebank house there was a strong commitment to good practice in line with promoting an individualised approach to care. There was good information around how to preserve dignity and respect, and people were clearly encouraged to go into the community and do activities which were meaningful for them. Care was person-centred and promoted people's dignity, privacy and human rights

Right Culture: We found any negative impact on people was mitigated by the fact the building was separate from the other houses on site.

Medication was not always managed safely. Due to some recording issues with the electronic system we could not always be sure if people had had their medicines or not. There were no 'as and when required' (PRN) protocols in place for staff to follow. Incidents and accidents were recorded, however over all analysis was poor and we could not tell what processes had been put in place to prevent further reoccurrence. Some risk assessments lacked sufficient detail with regards to how to keep people safe from harm. The home was clean and tidy, and people told us they felt safe living at the home. There was enough staff on shift to be able to support people safely. Staff were recruited and selected safely.

Governance systems were in place and had highlighted some but not all of the concerns we found during

our inspection in relation to poor risk assessments. However not all governance systems had been efficient with regards to picking up the medication concerns and the incident and accident oversight. This led to one serious incident not being reported correctly.

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

Rating at last inspection
The last rating for this service was good (published 11/11/21).

Why we inspected
The inspection was prompted in part due to concerns received about pressure area management, and person to person injury. A decision was made for us to inspect and examine those risks.

You can see what action we have asked the provider to take at the end of this full report.

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

The provider was responsive during and after our inspection to ensure any concerns were promptly dealt with.

Enforcement and Recommendations
We have identified breaches in relation to risk management, medications, records and governance.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe,

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

St Nicholas Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by 4 inspectors 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. The second day of the inspection was carried out by 2 inspectors who looked at records off site remotely.

Service and service type
St Nicholas is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. St Nicholas is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

At the time of our inspection there was not a registered manager in post, however there was a manager who had started their registration processes.

Notice of inspection

This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since their last inspection. We sought feedback from the local authority and professionals who work with the service. We used all of this information to plan our inspection.

The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection
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.

We spoke with 8 relatives about their experience of the care provided and 4 people who lived at the home. We spoke with 5 members of staff including the manager, nurses, senior care workers and care workers.

We reviewed a range of records. This included 7 people's care records, and multiple medication records. We looked at 4 staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

- Some risks were not always effectively assessed or mitigated. This meant people were exposed to unnecessary harm.
- Choking risk assessments were not detailed and did not contain enough information to mitigate the risk of choking occurring. For example, 1 person's choking risk assessment had action for staff to 'find the nurse in charge.' There were no other actions documented in their risk assessment. Another person, who was at risk of choking, did not have any details in their choking risk assessment, such as how to support them to eat to minimise the risk of choking.
- Some people were prescribed thickener in their drinks as they were at risk of choking and aspiration, however records showed people were not always getting the correct amount of thickener. For example, 1 person required 2 scoops of thicker per 200ml of fluid, however, there were numerous entries in their daily notes which stated they had only been given 1.
- Some people at the home required 1 to 1 support to ensure they had a safe level of assistance due to them expressing themselves unsafely. Risk assessments did not contain enough detail about how to support people when they were experiencing these heightened levels of anxieties such as how to interact with them. Where people experienced increased distress during support with personal care, there was not always enough information available to staff to support them safely.
- Some people had pressure wounds and had wound care plans and risk assessments in place, however there were not always photographs of the wound at each dressing stage. This meant the progression and healing of the wound could not always be monitored or evidenced.
- Where some people required a repositioning regime of 2 hourly turns, these were not always being completed, and there were some considerable gaps in people's reposition records. This meant people were at risk of further pressure area breakdown.

We found no evidence people had been harmed. However, these examples are a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We fed these concerns back to the provider on the day of our inspection and they took immediate and appropriate action to ensure these risks to people were addressed.

- People said they felt safe living in the home. Comments included "I am very happy here and always feel safe." A relative of a person living at the home told us "[Family members name] is in a secure, safe environment. I have never seen anything untoward."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

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

Using medicines safely
● There was an electronic system for recording medication (E-MAR) in place at the home. We found however, the system was not always being used correctly by staff, and it was not always easy to tell if people had their medications or not.
● There were numerous occasions on people's E-MAR where staff had recorded incorrect codes when administering medications. For example, 1 person who was prescribed metformin, according to their E-MAR had missed 13 doses of this medication.
● There were no protocols in place for medicines that were prescribed as and when required. These are known as (PRN) medicines. This meant people were at risk of not receiving their medicines when they needed them to help manage pain or anxiety.

We found no evidence people had been harmed. However, these examples are a further breach of regulation 12 of the health and social care act 2008 (Regulated Activities) Regulations 2014.

The provider took action immediately to rectify these concerns. They have since provided us with assurances around medication administration.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● We could not be certain that learning was being taken from accidents and incidents that occurred within the home.
● Following a choking incident that resulted in staff administering first aid, there were no records completed to show whether any learning had been taken from the incident to prevent a similar incident occurring.
● There was a lack or review and analysis of other incidents, such as falls, to look for patterns and trends. This meant there may be missed opportunities to prevent these incidents from occurring in the future.
● We received verbal reassurances from the manager that action had been taken and patterns had been identified, however these had not always been recorded.

These examples are a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Staffing and recruitment
● There was enough staff on duty to make sure people's needs were met. Most relatives told us there was enough staff. One relative said "Always seem enough staff around when I visit. They are always kind, caring and never rush." However, another relative told us "I feel that some days there are not enough staff about.

However, after I say this, I have always witnessed the staff being kind and patient."

● Recruitment procedures were safe. New staff were only offered positions in the home after checks were undertaken on their character and suitably to work, including references and Disclosure and Baring Service (DBS) checks. (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Preventing and controlling infection

● Infection prevention and control procedures were effectively managed.
● Staff understood the need to use PPE when required.
● The home was visibly clean.
●The provider was safely facilitating visiting for people and there were no restrictions on visiting.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Despite some risk analysis and audits being completed, they had not highlighted some of the concerns we found during our inspection. For example, some risk assessments lacked detail around how to mitigate risks.
- Information in people's care plans, monitoring charts and daily notes was not always being checked to ensure people were getting the correct care and support which met their needs. For example, some peoples wound care charts had not been completed accurately and incident and accident analysis was not clear. There were also gaps in peoples reposition charts which had not been highlighted through some audits.

This was a breach of regulation 17 of the health and social care act 2008 (Regulated Activities) Regulations 2014.

- The home did have a manager when we inspected, however they had not yet submitted their application to CQC.
- The provider had notified CQC of any reportable occurrences.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- People did not always achieve good outcomes due some to the shortfalls we found in relation to the safety of people at the home.
- The manager was honest and transparent throughout the inspection and had a positive attitude regarding feedback and improvement. They were responsive between day 1 and 2 of the inspection in terms of gathering information for CQC to provide assurances around some of the risks to people's health and well-being and medication administration.
- The manager understood their obligations around duty of candour. There was a policy and procedure in place to support this practice.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- Referrals were made to other agencies when needed, such as diabetic specialists.
- Staff felt the morale on the units was good. Some said they had not got to know the new manager yet.

● Staff meetings and relative's meetings took place and there were minutes circulated for staff and relatives to view.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Procedures for recording medicine administration were not always robust. PRN protocols were not in place. Some risk assessments lacked enough detail for staff to follow to keep people safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Systems in place to review and analyse accidents and incidents were not always used effectively. Governance systems were not always robust. Some audits did not identify shortfalls in service provision. Some records were not always completed accurately or in full.