Nottinghamshire County Council

James Hince Court Residential Care Home for Older People

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

We carried out an unannounced inspection of the service on 18 June 2015. James Hince Court Residential Care Home for Older People provides accommodation for persons who require personal care, for up to a maximum of 45 people. Some of the people were living with dementia or other mental health conditions. On the day of our inspection 22 people were using the service.

Summary of findings

On the day of our inspection there was not 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.

An application to become registered had not been received at the time of inspection. The manager in place at the time of the inspection did not work at the home full time. A team leader managed the home in their absence. We have spoken with the provider of this service and have been assured that an application will be submitted as a matter of urgency. We will monitor this until it has been completed.

People did not always have appropriate care plans or risk assessments in place to ensure staff were aware of any risks to people's safety and how they should reduce these. Accidents and incidents were investigated. The environment people lived in and the equipment they used was monitored to reduce the risk to people's safety.

People told us they felt safe. The risk to people experiencing abuse at the home was reduced because the staff had received training on safeguarding of adults, knew how to identify different types of abuse and who to report concerns to. There were enough staff to meet people's needs. People told us staff responded to their requests for support quickly. People's medicines were managed, stored and administered in a safe way, although some care plans did not always reflect the way people currently received their medicines.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. Mental capacity assessments and best interest decisions had been recorded appropriately in some, but not all, cases. Applications for DoLS had been made for the majority of people where required, although there were some examples where the applications had been completed but not submitted to the authorising body.

People were supported by staff who were trained and knowledgeable. However some staff required refresher training in some areas, such as moving and handling. People and their relatives spoke positively about the staff and the food provided. Staff understood how to ensure people received a healthy, balanced diet that met their needs. People were able to access their GP and other external healthcare professionals. External healthcare professionals spoke positively about the care provided by the staff.

People were treated with kindness and respect by the staff. People's dignity was maintained and where people became distressed staff responded to them quickly and offered reassurance.

People were provided with the information they needed to access independent advice from advocacy services. People felt able to make choices about their care. People's privacy and dignity was maintained at all times. There were no restrictions on people's friends or relatives attending the home.

Prior to people attending the home they or their relatives discussed how they would like the care and support to be provided. There were limited activities at the home. Some people felt encouraged to follow the activities that interested them whilst others did not. People's care plans were not always reviewed effectively or in a timely manner. A complaints procedure was available for people and staff responded to complaints raised by people in a timely manner.

People, relatives and staff were encouraged to contribute to the development of the service via meetings and informal discussions although a survey to gain people's views had not been conducted since 2013/14. The risks to people and the service as a whole were discussed with staff and they were aware of how they could contribute to reducing those risks. The manager and the team leaders conducted audits to assess the quality of the service that people received, however they did not identify the issues that were raised within this report.

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.

People did not always have the appropriate care plans or risk assessments in place.

People were supported by staff who had received safeguarding adults training and could identify the types of abuse and how to report it. However, some staff required refresher training.

Accidents and incidents were investigated and the environment people lived in and the equipment they used was regularly reviewed to ensure it was safe.

People's medicines were managed, stored and administered in safe way, although care plans did not always reflect the way people currently took their medicines.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Where people could not make decisions for themselves staff applied the principles of the Mental Capacity Act 2005. The documentation to support these decisions was not always available.

People received support from staff who were trained however some staff required some refresher training.

People spoke positively about the food and were encouraged to follow a healthy and balanced diet.

People could access external healthcare professionals such as their GP's when they needed to.

Is the service caring?

Good

The service was caring.

People were treated with kindness and respect by the staff and their dignity was maintained. People could access independent advice from advocacy services if they wanted to.

People were able to make choices about the care and their privacy was respected.

There were no restrictions on people's friends or relatives attending the home.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Summary of findings

There were limited activities at the home. Some people felt encouraged to follow the activities that interested them whilst others did not.

People's care plans were not always reviewed in a timely manner

Prior to people attending the home people's care was discussed with them and/or their relatives.

People felt able to raise any concerns they had with staff and felt they would be acted on.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There was not a registered manager in place at the service.

Audits to assess the quality of the service that people received had not identified the concerns found on this inspection or had not made sufficient progress to address the issues they were already aware of.

People, relatives and staff were encouraged to contribute to the development of the service although a survey to gain people's views had not been conducted since 2013/14.

The day to day risks to the home and the people that lived there were discussed with staff. Staff were aware of how they could contribute to reducing those risks.

James Hince Court Residential Care Home for Older People

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 18 June 2015 and was unannounced.

The inspection was conducted by three 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.

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. In addition to this, to help us plan our inspection we reviewed previous inspection reports, information received from external stakeholders and statutory notifications. A notification is information about important events which the provider is required to send us by law. We also contacted external healthcare professionals to gain their views of the service provided.

We spoke with ten people who used the service and observed staff supporting people. We also spoke with three relatives, five members of the care staff, two team leaders, the cook and the manager.

We looked at all or parts of the care records for seven who used the service, as well as a range of other records relating to the running of the service such as quality audits and policies and procedures.

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.

Requires Improvement

Is the service safe?

Our findings

People did not always have the appropriate care plan or risk assessments completed within their care records when risks to their safety had been identified. We identified gaps in a person's records who had been identified as at risk of developing pressure sores. No care plan or risk assessment was in place to manage this risk. Gaps were also identified on the supplementary records used to record when a person had been repositioned, which meant we could not be assured that a person was being repositioned at the appropriate intervals to reduce the risk of them developing pressure sores. However we were assured by the manager that people did not have pressure sores.

We also found a care plan was not in place for a person who had been identified as at risk of falling. We spoke with a member of the care staff who described the care plans for people as confusing and said, "The care plans do not always describe people's needs but the staff do understand what people need." We raised these issues with the manager. They told us they were in the process of developing a new care planning process which would include all of the information for staff when managing identified risks to people, however these were not yet in place for all. We asked the manager whether they were confident that people's needs were being met and that people were safe. They told us they were.

However, the examples showed that systems were not working effectively to ensure care needs and risks were assessed and monitored. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Investigations into accidents and incidents that had occurred at the home were conducted by the manager. We saw records that reflected this. We saw recommendations made by the manager to reduce the risk to people had been recorded. However, records did not show whether the manager had checked to see whether their recommendations had been carried out by staff or whether they had been effective in reducing the risk to people's safety. The manager told us they were aware that this needed to be completed and would put the appropriate measures in place to do so.

The manager had ensured the risk to people's safety was reduced by having personal emergency evacuation plans (PEEPs) in place. These plans identified the support people needed if they needed to evacuate the home urgently. An emergency contingency plan was also in place which gave details of how people's safety would be maintained if there was a loss of power, water or other incident that could affect the safe running of the home. The file was accessible for staff in the manager's office.

Regular checks of people's equipment and the environment they lived in were conducted to ensure the risk to people's safety was reduced. External, professionally trained contractors were used to carry out checks on gas boilers, the fire alarm systems and fire detectors.

People told us they felt safe at the home and if they had any concerns about their or others safety they felt able to report it. Information was provided for people who used the service on how they could identify and report abuse. All of the relatives we spoke with told us they felt their family members were safe. An external healthcare professional who we spoke with during the inspection told us they did not have concerns for people's safety.

The risk of abuse to people was reduced because staff could identify the different types of abuse that they could encounter and they knew the procedure for reporting concerns both internally and to external bodies such as the CQC, the local authority or the police. There was a safeguarding adults policy in place and the staff we spoke with told us they had undertaken safeguarding adults training. However, records showed that some of the staff had not completed their annual safeguarding adults training which meant their knowledge of how they could contribute to reducing the risk of abuse to people may not be up to date.

People and their relatives told us they felt there were enough staff available to keep them or their family member's safe. People told us they did not have to wait for long periods of time for staff to attend to them when they needed them. An external professional who we spoke with during the inspection told us there were always staff available when they visited the home. Our observations throughout the inspection supported this.

The manager told us they carried out a regular assessment of people's needs and wherever needed, they increased the number of staff to ensure people's safety. They told us an example of this would be if a person required one to one support from staff at all times to keep them safe. They said

Requires Improvement

Is the service safe?

they would use additional staff and not compromise the safety of others by reducing the numbers of staff in other areas. We spoke to two members of staff who stated that they felt that there were enough staff on duty to meet people's needs.

We checked the recruitment records of two members of staff to establish what checks the provider had carried out before they commenced their role. We saw the provider had carried out the required recruitment checks for these members of staff, including a criminal records check. These checks enabled the provider to make safer recruitment decisions.

People's medicines were stored and administered safely. We observed staff administer medicines to people in a safe way. Staff, who were trained to administer medicines, had their ability to do so assessed on a regular basis. We saw there were daily temperature checks of the room where medicines were stored and of the medicines fridge. This ensured that medicines were stored at the appropriate temperature in order to reduce the risk of them becoming less effective.

We asked people and their relatives whether they had any concerns with the way medicines were administered. People spoke positively about this. One person said, "I take a lot of different medicines and can't recall what they are all for. However staff are very good at making sure I take them when I need to."

We looked at people's medicine administration records, used to record when people have taken or refused their medicines. We saw these were recorded appropriately and the stock of medicines recorded for each person tallied with their records.

There were processes in place to protect people when 'as needed' medicines were administered. 'As needed' medicines are administered not as part of a regular daily dose or at specific times. We saw the reasons these medicines were administered was recorded on people's records with guidance for staff to follow before they administered them. However, we did find a small number of examples where this guidance was not in place and therefore there was an increased risk of staff administering these medicines inconsistently. The manager assured us that people received their medicines safely and rectified this during the inspection.

People's care plans did not always reflect the current procedure for administering their medicines. For example one person's care plan stated that they were having their medicine administered covertly. This usually involves disguising medicines by administering it in food and drink. As a result, the person is unknowingly taking their medicines. However when we spoke with the staff and with the manager they told us this was not correct. The incorrect information within this person's care plan could result in them receiving their medicines in a way that was not appropriate. The manager assured us they received their medicines in a safe way and would ensure their care plan was updated to reflect this.

Requires Improvement

Is the service effective?

Our findings

People told us they felt they received the support they needed from the staff. One person told us, "The staff are very nice." All of the relatives we spoke with told us they had no concerns about the ability of staff to care for their family members and that they had the right skills and competency to do so.

People were supported by staff who received an induction prior to commencing their role. The manager told us the induction provided the staff with the appropriate skills to carry out their role effectively. The manager showed us details of the induction process new staff received. This included current guidance for new workers in adult social care.

We spoke with two members of staff and asked them how often they received supervision of their work to ensure they carried out their role effectively. One of them told us, "There has been a bit of a gap in supervision over the last year." Another member of staff told us. "I had a group supervision a month ago but nothing before that for a year." The records we looked at showed that whilst supervisions had taken place for staff, the frequency of these varied. We raised this with the manager. They told us they had identified this as an area where improvement was needed when they became manager of the home. They told us they were putting in plans for the supervisions to be carried out much more frequently to ensure people received consistent and effective care from all staff.

People were supported by staff who received training in core areas such as moving and handling and safeguarding of adults. However, records showed that some of the staff some of the staff had not completed refresher courses in areas such as moving and handling and mental capacity to ensure their knowledge was up to date. The manager told us they were aware of the need to address this and were in the process of booking courses for staff where required.

We reviewed the care plans of seven people. We checked to see, where appropriate, an assessment of their capacity to make and understand decisions relating to their care had been undertaken, as required by the Mental Capacity Act 2005 (MCA). The MCA is legislation used to protect people who might not be able to make informed decisions on their own about the care and support they received.

We saw examples of the MCA being used to determine people's ability to make decisions. However we did find a small number of examples where the best interest documentation, used to support the decisions made for people, had not been completed. This meant that the appropriate legal process may not have always been followed when decisions were made for people.

The registered manager could explain the processes they followed when they applied for authorisation for Deprivation of Liberty Safeguards (DoLS) to be implemented to protect the people within the service. DoLS aim to make sure that people are looked after in a way that does not inappropriately restrict their freedom. Records showed that applications had been made for the majority of people who needed these safeguards. However, we did find two examples where the documentation had not yet been sent to the authorising body which could mean these people's liberty was being unlawfully restricted. Records showed that all staff had received MCA and DoLS training although some staff required refresher training due to the length of time that had passed since they had last completed it.

The records that we looked at showed people's wishes to not have life-saving treatment if it were to have a detrimental effect on their on-going health were recorded on their care plans. The appropriate documentation was fully completed, however we did find one person's documentation had not been. The manager told us they were reviewing all of these to ensure they were completed correctly and appropriately represented people's wishes.

All of the people we spoke with told us they were happy with the food and drink that was provided for them. One person we spoke with told us, "There is plenty to eat and drink." They also said, "If you don't like what is on the menu you can ask for something else like a jacket potato or salad." Our observations of the lunch time experience supported this. We spoke with the cook and asked them how they ensured people were able to choose what they wanted to eat. They told us people were asked to complete a form which they could state their choices of food they would like for the day.

People were supported to eat healthily and to maintain a balanced diet. Care plans were in place to assist staff in understanding people's likes and dislikes and the most appropriate way they could encourage people to eat and drink sufficient amounts. We saw specific guidance for staff

Requires Improvement

Is the service effective?

to follow to support people with a healthy diet when they were living with diabetes. We spoke with the cook about a person who had arrived at the home on the day of the inspection. They had a clear understanding of their dietary needs and told us they would ensure these were met immediately to ensure they received the appropriate food and drink.

The fridges and freezers were well stocked and their temperature was regularly checked and recorded in order to ensure food was stored at an appropriate temperature. There was also a good stock of dry foods.

People's day to day health needs were met by the staff and external professionals. If people required access to their GP or dentist then they were supported by staff to visit these. One person told us; "I am able to ask to see the GP when I feel ill." We observed the staff throughout the inspection to see whether they identified any areas of people's health or welfare that required assistance. For example we saw a member of staff speak with a person and realised they did not have their hearing aid in place. They immediately dealt with this and went to get it for them. This meant the staff provided effective care for people.

An external healthcare professional told us they felt the staff dealt with changes to people's health well. Another told us the staff were quick to call them if they had any concerns about people's care such as the development of pressure sores.

People were provided with information about their care and who they could contact if they wished to discuss it. Leaflets and other sources of information were available for people to read and we observed staff explaining aspects of the care and support they were providing for people throughout the inspection.

Good

Is the service caring?

Our findings

People spoke positively about the staff. One person said, “They are wonderful, the staff can’t do enough for you.” Another said, “The staff are very nice.” All of the relatives spoke positively about the staff and felt they treated their family members with respect.

People were treated with kindness and compassion. A person who used the service told us, “I like it here, they [staff] look after you.” Staff interacted and provided care and support for people throughout the inspection. We saw staff supporting people with their mobility needs around the home but did so in a reassuring way; talking with them and explaining what they were doing. We observed staff lower themselves to people’s eye level and ensured they gave people their full attention when talking with them. This showed they were interested in what people had to say, made people feel as though what they were saying was important and that their views mattered.

A member of staff told us they felt that the service was very caring and was impressed with the way that all members of the staff team spoke to residents in a caring way. The staff we spoke with had an understanding of people’s diverse needs, including their cultural and religious preferences and could explain how they would support people if they required support to follow these preferences.

People were supported by staff who understood their backgrounds and preferences. The staff we spoke with could describe people’s likes and dislikes and were knowledgeable about how to support them. In one of the care plans that we looked at we saw information had been recorded about the person’s interests. We observed staff interact with this person in a way that showed they were knowledgeable about this information.

In two of the care plan records we looked at people had given their views on how they liked to be supported when personal care was provided. When we spoke with people about this and asked them about how involved they were with decisions about their care we received mixed feedback. Some people told us they were not involved with the planning of their care but they did make decisions such as whether they would like a bath or shower.

People had been provided with information about how they could access and receive support from an independent advocate to make major decisions where needed. Advocates support and represent people who do not have family or friends to advocate for them at times when important decisions are being made about their health or social care.

People were supported by staff who spoke respectfully to them. We observed the handover between shifts where the team leaders discussed people’s needs. They spoke respectfully and compassionately and gave clear information about people’s needs.

The manager had ensured people were provided with information about ensuring they were treated with dignity. Information was also provided for the staff. There were dignity champions in place. A dignity champion is a person who promotes the importance of people being treated with dignity at all times. A member of staff told us, “The staff are kind to the people who live here.”

People were able to have the privacy they needed and the staff respected their wishes. We observed staff knock on people’s bedrooms doors and wait for permission to enter before doing so. There was plenty of space throughout the home for people to sit alone or to speak with family and friends if they wanted to. The registered manager told us there were no restrictions on people’s friends or relatives attending the home to see their family members.

Requires Improvement

Is the service responsive?

Our findings

Prior to people attending the home an assessment of their needs had been conducted and discussions had been held with them and or their relatives to ensure the care provided met their needs. People's ability to do things for themselves was also assessed. We asked people if they were supported to be as independent as they wanted to be. Two of the people we spoke with told us they tried to do as much as possible for themselves but they felt the staff helped them when they needed extra support.

People's care planning documentation contained information about people's likes and dislikes and what was important to them. We spoke with staff and they could explain the things that were important to the people they were supporting. The care plans contained information about people's personal history although we did find two examples where this had not been completed.

People had been asked about their interests, hobbies and how they would like to spend their time and this was recorded for staff. We received mixed feedback from people when we asked them about their interests. Some of the people we spoke with did not feel they were actively encouraged to follow their hobbies or interests. However, two people did speak positively about the activities they took part in. One person told us they enjoyed singing and we observed staff encourage this person to do this. Another person showed us examples of craft activities that they had been involved with and told us, "There is lots of arts and crafts here which I like."

A part time activities coordinator was employed to support people with activities. We saw a noticeboard which contained information about activities that took place on a daily basis. However, the majority of these only took place in the evening. We observed staff talking to people about their hobbies and interests during the day although we did not see any activities taking place.

People's care plans were reviewed monthly to establish whether people's needs had changed. However, some care plans in people's records had not been reviewed since March 2015. We also saw examples where reviews had been conducted but not identified or recorded recent changes in people's care and support needs. For example the care plan for one person who was living with diabetes stated the person required regular weighing. However, the person had not been weighed for three months and this had not been identified during the review. We also saw a person who had been diagnosed with diabetes did not have a care plan in place for staff to manage this. This had also not been identified during their care plan review. We raised this with the manager during the inspection and the care plan was amended.

People living with dementia were provided with the appropriate support to maintain their independence. People's bedroom doors were personalised and there was signage around the service to help people find the toilets and other communal areas. Each bedroom door had a key safe on the outside. Records showed discussions had been held with people or their relatives as to whether they would wish for the bedroom door to be locked when they were not in it. There was plenty of space around the home for people to move around independently of staff. We observed staff support people who used walking aids but did so in a non-restrictive way; encouraging them to do as much for themselves as they could.

All of the people and the relatives that we spoke with felt able to raise a concern or a complaint if they needed to. Staff could explain the process they would follow if a person raised a complaint or concern with them. The manager kept a log of any complaints received and responded to them in a timely manner. A complaints procedure was made available for people who used the service in a format they could understand.

Requires Improvement

Is the service well-led?

Our findings

The previous manager of this service left in March 2015 and a permanent replacement was not in place. The manager in post at the time of the inspection split their time between this and another service. At the time of this inspection no application had been received for them to become registered. We were told by the manager that a team leader provided management cover when the manager was not at the home.

The manager had an auditing process in place that assessed the quality of the service people received. Audits were conducted in areas such as the environment, staffing, quality of the food and health and safety. However, these audits had not worked effectively to assure the quality of the service. They had either not identified the concerns found on this inspection or had not made sufficient progress to address the issues they were already aware of. For example, they had not identified that some people did not have specific care plans or risk assessments in place when risks to their health and safety had been identified. The new care planning process which was being implemented at the time of the inspection has not progressed quickly enough to reduce the risk to people's safety. The systems in place to record people's information were not effective and had led to documents going missing, or not being completed at all. The manager told us they would address the concerns raised during the inspection.

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

People, their relatives and staff were encouraged to give feedback on their views of the quality of the service provided in order to drive improvement and develop the service. One person we spoke with told us, "I have nothing to criticise or grumble about." We saw a survey had been completed by people for the business year 2013/14 however one had not been completed after this. The manager told us they obtained people's feedback on the service in a number of ways such as resident and relative meetings and informal chats with people, but did state that they were planning on carrying out another survey soon. The relatives we spoke with told us they found the meetings they attended informative.

People were supported by staff who enjoyed their job. One staff member told us, "I love my job, it's great to be able to have fun with the people who live here and to help them as much as I can." Another staff member told us, "I love working with the people and helping people." Staff felt able to raise any concerns they had to the manager. Staff told us they felt the manager was approachable and would act on any concerns they had. One staff member said, "If you have a problem you can go and see her. She is a great listener." An external healthcare professional told us, "The manager is always available and approachable."

The service was led by a manager who understood their roles and responsibilities. They ensured the CQC and other agencies such as the local authority safeguarding team were notified of any issues that could affect the running of the service or the person who used the service.

Records showed that regular staff meetings were carried out to ensure staff were informed of the risks to the service and how they could contribute to reducing these risks. The manager told us they also held weekly risk management meetings to discuss and prioritise the risks people could face. They told us they ensured the staff were aware of the responsibilities and were accountable for their actions. They also told, "I have given the team leaders more responsibility. They are accountable for ensuring that mental capacity assessments and care plans are up to date. I meet with them regularly."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 17 HSCA (RA) Regulations 2014 Good governance The manager did not always assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); The manager did not always assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. The manager did not always maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and provided to the service user and of decisions taken in relation to the care and treatment provided. Regulation 17 (2) (a) (b) (c)