The Retired Nurses National Home

Retired Nurses National 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

This comprehensive inspection took place on 18 and 21 April 2017. The first day was unannounced.

At the last inspection in January 2016, we told the provider to take action to improve care planning and to comply with the requirements of the Mental Capacity Act 2005. This action has been completed in order to meet the regulations, although improvement is ongoing.

The Retired Nurses National Home is a care home for up to 52 older people. Nursing care is not provided. There were 28 people living there or staying there short term when we inspected. Some people were living with mild or moderate dementia. The service was located in a 1930s purpose-built building. People had individual bedrooms on the ground and first floors, the first floor being accessed by two lifts and three staircases. Communal facilities, such as a lounge, dining room and chapel were located downstairs. There were neatly kept open garden areas to the front and rear of the building, and car parking spaces at the front.

There are eight independent living flats on site and people who live in those are able to participate in activities in the home and have meals. These flats did not form part of our inspection as the service does not provide personal care to people living in them.

As required by the conditions of its registration, the service had a registered manager, who had started in post around the time of the last inspection. 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.

People received care and support that met their individual needs. Their independence was promoted. People, and where appropriate their relatives, were involved in decisions about their care.

Staff treated people with compassion and respect, upholding their dignity.

People consented to their care, unless they did not have the mental capacity to give consent. Where they lacked mental capacity in relation to aspects of their care, a best interests decision was made. This took into account the person's known preferences and there was consultation with the appropriate people, such as relatives and healthcare professionals.

Medicines were managed safely.

People's nutritional needs were met. There was a choice of meals and snacks were available around the clock. Specialist advice was sought from healthcare professionals where there were concerns about weight loss or swallowing difficulties.

The service had an activities coordinator, who organised a range of group and individual activities for people to take part in if they chose. They had found out about people's hobbies and interests in order to design the activities programme.

People were protected against the risk of potential abuse because staff understood their responsibility for safeguarding adults.

The premises were regularly maintained, and key checks were undertaken. However, we identified some environmental hazards, which we drew to the attention of the registered manager. Where able to, they took immediate action. Following the inspection the registered manager confirmed that remedial works had been authorised and were being arranged.

People involved in accidents and incidents were supported to remain safe. There were arrangements in place to keep people safe in an emergency. We have made a recommendation regarding the system for identifying treads and patterns in accidents and incidents.

Safe recruitment practices were followed before new staff were employed to work with people. People were supported by sufficient staff with the right skills and knowledge to meet their individual needs. However, a few people said they thought call bells could be answered more quickly, whereas others were satisfied with the response.

People were positive about staff ability to provide the care and support they needed. Staff were supported through supervision and training.

People and staff were confident to raise any concerns with the management team.

There were regular meetings for people and relatives, and for staff, to discuss what was happening at the service and to contribute to improvements.

People's experience of care was monitored through annual quality assurance surveys to people, relatives and other stakeholders. Information was gathered by an external organisation to be fed back to people and actioned as necessary.

The service worked in partnership with community organisations to improve the experiences of people living at the home.

There were regular internal audits to monitor the quality of the service being delivered. The regional director also visited most months.

Learning from safeguarding investigations and from internal audits had led to changes in practice. The provider had linked with a national organisation that promotes good, evidence-based practice in social care, to provide a dedicated safeguarding telephone line. The provider had also piloted a project to promote dignity in care.

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 from abuse and harm.

Recruitment systems were robust and staffing levels were reviewed and adapted to people's changing needs.

Medicines were managed consistently and safely.

Is the service effective?

Good

The service was effective.

Staff had training and supervision to enable them to carry out their roles effectively.

People were asked for their consent to their care. Where people lacked the capacity to consent, staff ensured decisions were taken in their best interests and involved the right professionals.

People were supported to manage their health, and their nutrition and hydration needs were met.

Is the service caring?

Good

The service was caring.

People received care and support from staff who knew and understood them.

Staff treated people with kindness and compassion, upholding their dignity.

Is the service responsive?

Good

The service was responsive.

People received care that met their individual needs. They were

involved in decisions about their care.

People were enabled to take part in group and individual activities within the service and sometimes in the local community.

People were encouraged to maintain their independence as far as possible.

Is the service well-led?

Good

The service was well led.

People expressed confidence in the way the service was run.

People and staff were confident to approach the management team for guidance and support.

The provider supported the registered manager and staff to bring about improvements.

Retired Nurses National 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 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 comprehensive inspection took place on 18 and 21 April 2017. The first day was unannounced. The inspection was undertaken by two inspectors and an expert-by-experience on the first day, with the lead inspector returning on the second day. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we reviewed information we held about the service, including notifications we had received from the service since the last inspection. Notifications are information about significant events that the service is required to send us by law. We also obtained feedback from the local authority social services contract monitoring team.

During the inspection we spoke with 19 people and three relatives about their experiences of the service. We made observations around the home, including observing care and support in communal areas. We also spoke with the registered manager, two care staff, two other staff and a visiting healthcare professional. We reviewed records including five people's care records and medicines records, four staff files and other records relating to the management of the service.

Good

Is the service safe?

Our findings

Everyone we spoke with said they felt safe at the service.

People were protected against the risks of potential abuse. Information about abuse and how to deal with it was displayed for people and staff to refer to. The registered manager told us, "I want residents to feel safe". Staff had undertaken training in safeguarding adults and were confident about identifying and reporting safeguarding concerns.

We identified some environmental hazards, which we drew to the attention of the registered manager. Where able to, they took immediate action. Following the inspection the registered manager wrote to us, advising that remedial works had been authorised and were being arranged.

People involved in accidents and incidents were supported to stay safe. Investigations were undertaken and action had been taken to prevent further injury or harm. However, there was not a robust system in place to enable the registered manager to identify and act upon trends or patterns of accidents and incidents.

We recommend the provider reviews their system for collating and monitoring information to enable staff to identify and act upon trends and patterns of accidents and incidents.

There were dedicated maintenance staff who told us they generally had enough time and the right equipment to carry out their role. They described the registered manager as, "Very supportive". Staff and people living at the home used a communication book to request repairs or maintenance and we could see their requests had been completed. Key maintenance and testing included gas safety, portable appliance testing, electrical hardwiring, and the inspection and servicing of equipment including hoists, bath hoists and fire detection equipment. There were also ongoing daily or weekly checks of matters such as water temperatures and health and safety checks around the building.

There were arrangements in place to keep people safe in an emergency. People had personal evacuation plans recorded within their care plans. The service's current list of residents was colour coded red, amber or green to reflect the level of support each person would need to evacuate the premises in an emergency. This would be provided to emergency services personnel.

People were supported by sufficient staff with the right skills and knowledge to meet their individual needs. People gave varied feedback about how quickly call bells were answered. Comments included: "It depends on how busy they are. Sometimes they come quickly, more often they don't", "There's a bad time when they're having their lunch, but it's usually OK. I don't wait that long" and "If it's urgent they'll come". The registered manager completed dependency assessments each month to make sure they were able to meet people's needs responsively, and confirmed this by talking with staff, people and auditing call bell response times. There were five to six care workers on duty during the daytime and three waking care workers during the night. In addition, there were catering, housekeeping, administration and maintenance staff.

Safe recruitment practices were followed before new staff were employed to work with people. Checks were made to ensure staff were of good character and suitable for their role, including criminal records checks with the Disclosure and Barring Service. Staff files included application forms, full employment history since leaving education, records of interview and appropriate references.

Risk assessments were in place for areas that can affect older people, such as malnutrition, falls, the development of pressure ulcers, and moving and handling. These included recognised risk assessment tools, such as the Malnutrition Universal Screening Tool. Risks were reviewed regularly and those seen were up to date. Where risks were identified, these were addressed through the person's care plan.

Peoples' medicines were managed and administered safely. Medicines were stored securely, in an organised fashion. Some people were able to administer their own medicines; the risks this presented had been assessed and managed. Staff who administered medicines were trained to do so and had been observed and assessed as competent in handling medicines safely. People received their medicines as prescribed, whether regularly or as required. Where people had medicines on an as required basis, there were clear guidelines for staff as to when the medicines would be needed, how often they could be given and the maximum dose in 24 hours. Medicines and medicine administration records (MAR) were audited regularly to ensure sufficient medicines were in stock, that all stocks of medicines were accounted for, that MAR contained the required information and that medicines were properly recorded.

Some people had prescribed skin creams and ointments administered by staff. Instructions, body maps showing where the cream should be applied and a recording chart, were kept in people's rooms and therefore readily available to staff. The registered manager had identified that on occasions staff had not recorded on creams charts when they had administered creams and was working to address this. This is an area for improvement.

The service's medication policy required a pharmacist's involvement in best interests decisions about covert medication (administering medicines in a disguised format without the person's knowledge or consent, which is only likely to be appropriate if they actively refuse their medicine but lack the mental capacity to understand the consequences of this). However, on the first day of the inspection we saw someone's GP had authorised certain tablets to be crushed, in line with the person's wishes (hence not covert medication). Administering medicines in food or drink can significantly alter their therapeutic properties and effects, and pharmacist advice is necessary. A member of staff said a pharmacist had been consulted and had supplied a crusher device, but there was no record of pharmacist involvement on file. By the second day, this had been obtained.

We recommend the provider reviews their medicines policies to address how they involve a pharmacist in decisions about non-covert administration of medicines in food and drink, or otherwise altering the format of the medicine.

Good

Is the service effective?

Our findings

People's rights were protected because the staff acted in accordance with the Mental Capacity Act 2005 (MCA). The 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 Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

At our last inspection in January 2016, we found that records of mental capacity assessments were incomplete and were not always referenced in people's care plans. Records of best interests decisions did not include the people consulted. There was insufficient information about the type of power of attorney held on one person's care records. These omissions were a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found that action had been taken to meet Regulation 11. The registered manager and staff had had training about the MCA. The staff we spoke with understood their responsibilities in relation to the MCA.

Where possible, people or their legal representatives were involved in care planning and their consent was sought to confirm they agreed with the care and support provided. Where there were concerns about someone's ability to give consent, a mental capacity assessment was recorded in a way that reflected the requirements of the MCA. If someone was assessed as lacking the mental capacity to give consent to a particular aspect of care, staff made a best interests decision on their behalf, in consultation with relevant people such as family members and professionals. The person's known preferences, beliefs and values were taken into account. For example, someone was unable to consent to assistance with personal care but actively refused staff assistance. A decision had been made in the person's best interests that they should receive personal care in the least restrictive way possible. A health professional had advised as to what was the minimum level of essential care, and how staff could approach the person in a way they would find more acceptable and so co-operate with. Staff we spoke with had a good understanding of how to do this.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager understood when DoLS applications would be required and had made appropriate applications.

People were positive about staff ability to provide the care and support they needed. Comments included: "They are always very good, not always very efficient; they try their best", "The carers are very good", and "The staff are all very helpful".

People were supported by staff who had the skills, knowledge and understanding needed to carry out their roles. Staff confirmed they had the training they needed when they started working at the home, and were supported to refresh their training. Training completed by staff at induction and at intervals thereafter

included moving and handling, medicines management, food safety and hygiene, first aid awareness, health and safety, infection control and fire safety. New staff were expected to obtain the Care Certificate, a nationally-recognised qualification for staff new to health and social care. Staff were supported to further increase their understanding in specific areas through training provided by specialist healthcare workers such as a Parkinson's nurse, and dementia specialist workers.

Staff had one-to-one supervision meetings with their line manager. The supervision matrix showed staff had received regular supervision meetings and records showed these enabled staff to discuss their work and their professional development needs. Staff confirmed that supervision meetings happened regularly and enabled them to discuss any training needs or concerns they had.

People told us they had a choice of food and most were complimentary. Comments included: "The food's wonderful… really first class", "The food is excellent and I mean excellent", "Good choice", "There are very good meals, there's a choice of two meals for lunchtime and evening meal. Some go down for the evening meal. I have it in my room. We all get the same, whether in your room or the dining room" and, "Smashing, lovely. I'm 85 and I know about food". Two people said they found their soft or pureed food bland.

Meal services were calm and organised, and snacks were available around the clock for people who wanted them. People came for lunch when they were ready, there was no fixed time when it was served. Staff welcomed residents, reassured them they were not late and ensured they were seated. The dining room was very attractive and there were numerous photos of residents displayed. Easter table decorations were on the tables. Music was playing quietly. The atmosphere was very friendly and relaxed. People had soup and the meal they had chosen. They had individual gravy boats so could add gravy to their meal if they wished. One person who changed their mind was quickly provided with the other meal option without comment. Residents chatted amongst themselves. One staff member assisted a resident to eat and conversed with them and others at the table.

People's dietary needs and preferences were documented and known by the chef and staff. The chef kept a record of people's needs, likes and dislikes. Where people had difficulty swallowing placing them at risk of choking, a referral was sought for a swallowing assessment by a speech and language therapist in order to devise a safe swallow plan.

People's weights and risks of malnutrition were monitored at least monthly and in most cases the appropriate action was taken, including more frequent monitoring, a diet fortified with high calorie foods and, if necessary, getting the GP to refer the person to a dietician. However, we found one instance where weight loss had not been referred to the GP as it should have been. We drew this to the registered manager's attention, and they took immediate action to ensure the referral was made. Following the inspection they wrote to us confirming the action they had taken to reduce the risk of this happening in future.

People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals. People told us they saw a health care professional if needed. Comments included: "I don't see the doctor very often. I see the district nurse if there's something wrong. They take my blood pressure every week since my tablets were changed" and "They rang my doctor to get my pills sorted". People's care records showed relevant health and social care professionals were involved with their care.

Good

Is the service caring?

Our findings

People and relatives spoke positively about the caring approach of the staff. For example, someone told us staff were always kind and patient, saying, "We only ever meet with kindness and compassion". Another person described staff as, "Very nice, helpful", and someone else described staff as, "Perfect, couldn't be better. They are always friendly and always helpful".

People were treated with kindness and compassion. We observed this throughout the inspection. Staff supported people in a calm and unhurried manner. They showed concern for people's wellbeing in a caring and meaningful way, and responded to their needs quickly if they were showing signs of discomfort or distress. Someone told us about how the chef took time to play cards with them, which they welcomed. Two people commented that they wished staff could spend more time chatting with them, although we did see instances of staff spending time talking with people.

Staff respected people's privacy and dignity. Assistance with personal care was offered discreetly and given behind closed doors. People were able to choose where they spent their time, whether in their rooms or in communal areas.

People received care and support from staff who knew them or were getting to know them. Someone who had previous experience of the service told us they knew one or two staff from before, and that both they and the staff were pleased to meet each other again. The registered manager and staff we spoke with were able to tell us about people and their preferences. People's records included information about their life stories and how they wished to be supported. However, two people commented that staff put sugar in their tea when they preferred their drinks unsweetened. We advised the registered manager of this area for improvement.

People's bedrooms were arranged and decorated to their taste, as far as it was safe to do so. Some people had brought items of furniture from home. For example, someone who did not need a specialist bed used the bed they had brought with them from home.

Good

Is the service responsive?

Our findings

People and their relatives spoke positively about the way people's needs were met. Someone told us about how they were looked after properly. Other comments included: "They take such great care of them", "I just have to ring that bell and they'll come to me for anything" and "If there is a problem it is dealt with straight away".

At our last inspection in January 2016, we found that care plans were not personalised, did not always accurately reflect people's assessed needs and that care planning could be more responsive to people's needs. This constituted a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found action had been taken to meet Regulation 9. People had care plans that clearly explained how they would like to receive their care, treatment and support. People, and where appropriate their relatives, were involved in developing these. People's needs and care plans were reviewed regularly and if necessary updated. Staff had a good understanding of people's care plans and were able to explain the care that people needed.

Before they came to stay, people's needs were assessed to make sure the service would be able to provide the care required. Information had been sought from the person, their relatives and other professionals involved in their care. This had informed the plan of care.

Where people required support with their personal care they were able to make choices and be as independent as possible. People told us they got the help they needed, staff enabling them to do what they could do for themselves. For example, someone told us about how staff helped them with washing and dressing when they were ill.

People were supported to follow their interests, take part in social activities and on occasion go on trips out. Comments from people and relatives included: "The activities officer... is exceptional", "There's always something going on - cake-making or arranging flowers. Once a week he takes out one elderly person for a run. They go to the golf course for the view and for tea and cake. I've been out twice since I've been here" and, "She enjoyed the llama coming in. [Activities coordinator] works hard to involve them all. He keeps asking, even if they keep saying no". The activities coordinator, who organised a range of group and individual activities, told us they worked to a good budget. They were supported by a volunteer, who organised the bingo and told us about activities such as crafts, making cakes, pickling onions, quizzes, entertainers visiting the home and animals being brought in. People were able to choose what activities they took part in and suggest other activities they would like to complete. There were notices displayed about forthcoming activities, events and trips out. Events since the last inspection had included a celebration of the Queen's 90th birthday, a summer fete, a party to celebrate the local air show and Christmas events.

There were good pastoral links and the service promoted non-denominational worship for people living

there. Services were held in the chapel, for those who chose to go. There were links with local clergy and a priest visited someone for communion. The activities coordinator told us about how they and one of the people living at the service cleaned the silverware in the chapel together.

People's concerns and complaints were encouraged, investigated and responded to in good time. The complaints policy was displayed in a communal area. There was a log in place. We looked at the complaints received by the service in the 12 months up to the inspection; these had been investigated and resolved in accordance with the policy. There was a thoughtful approach to people's concerns including considering different ways of working and alternative solutions. Someone told us how their complaint had been acted upon, and they now had more frequent baths as a result.

Good

Is the service well-led?

Our findings

At our inspection in January 2016, the home had been going through a period of great change with a new organisation taking over management of the service in September 2015. There had been a lot of changes of staff, with a new manager and periods of high use of agency staff. The changes continued to have repercussions in the months following that inspection. The registered manager remained in post, and a new staff team was subsequently established. At the time of the current inspection, staff vacancies had been filled and the use of agency staff had diminished.

People and staff had confidence the management team would listen to their concerns, which would be received openly and dealt with appropriately. One person told us they knew and liked the registered manager. Other comments from people and relatives included, "I'd complain to the manager, they come round every now and again" and, "I'd complain to the higher manager or senior staff nurse. I don't really know the manager; they see me every so often. See I'm alright". Staff told us the registered manager had an open door policy, one commenting, "She's very intelligent, approachable and open" and that they felt comfortable to raise any problems with her.

Quarterly meetings enabled people and their relatives to contribute to the improvement of the service. A person who lived there told us about the residents meetings and said they were listened to and their suggestions were acted upon where possible. The registered manager told us about some of the changes they had made as a result of people's feedback. These included the reintroduction of mealtime tablecloths, and developing individual key workers to further support people.

People's experience of care was monitored through annual quality assurance surveys to people, relatives and other stakeholders. Information was gathered by an external organisation to be fed back to people and actioned as necessary.

The service worked in partnership with community organisations to improve the experiences of people living at the home. Local schools had taken part in arts and crafts projects with people, and a local nursery school had visited at Christmas time for carol singing. At Christmas staff had offered a table to local residents who may have been alone on the day to have Christmas lunch with people living at the home. The registered manager told us they hoped to publicise this more successfully in future years.

Staff meetings were held bi-monthly and enabled staff to discuss service projects, training needs, and the health and safety of the buildings. Staff could also discuss concerns relating to people such as call bell response times and any accidents or incidents. A member of staff mentioned they did not always get to see minutes of staff meetings they attended. The registered manager had also introduced daily 'ten at ten' meetings to discuss what was happening that day and what was coming up. These involved the chef, the domestic supervisor, the activity coordinator, the shift leader, the maintenance supervisor and the administrator, as well as the registered manager.

Internal learning from, for example, safeguarding investigations had led to changes in practice. Following a

safeguarding investigation, the provider had linked with a national organisation that promotes good, evidence-based practice in social care, to provide a dedicated safeguarding telephone line. The provider had also piloted a project at the service to promote dignity in care. The medicines management system had been reviewed and changed as a result of an issue with a person's medicines. People's assessments of need, particularly on admission, had significantly changed. This was following an incident where it was identified that staff did not have the information they required when one person had become unwell. The registered manager told us, "We learned a lot" and explained about admission packs that were "as user friendly as possible" and included a checklist to make sure all the information required was gathered. This made sure staff understood people's needs quickly. A member of staff commented that they would like more detailed feedback from investigations into complaints, including the response to the complainant.

The quality assurance system included regular internal audits to monitor the quality of the service being delivered. Where internal audits had identified shortfalls, action had been taken to bring about improvements. The provider's most recent internal audit report was dated February 2017 and covered matters including care plans and risk assessments, pressure mattress checks, medicines, meals, activities, cleaning, and maintenance of the premises. The regional director also visited most months.

The management team were aware of the requirement to notify CQC about significant events such as serious injury. CQC uses such information to monitor the service and ensure they respond appropriately to keep people safe.