Rushcliffe Care Limited

Normanton Village View Nursing Home

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

Summary of findings

Overall summary

The inspection visit took place on 07 June 2016 and was unannounced. This meant the staff and provider did not know we would be visiting.

Normanton Village View provides nursing and residential care for up to 80 people. At the time of our inspection there were 45 people using the service and one person in hospital.

The service had a registered manager in place at the time of our 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 and their relatives had been involved in planning the care and support they received from the service. Their needs had been identified, assessed and reviewed on a regular basis.

People received care in a dignified manner that protected their privacy. People were protected from the risk of abuse as staff understood what constituted potential abuse or poor care and knew how to report concerns.

The CQC is required to monitor the Mental Capacity Act (MCA) 2005 Deprivation of Liberty Safeguards (DoLS) and report on what we find. Mental Capacity Assessments were carried out where key decisions were required and the principles of the MCA had been adhered to. Applications had been made to the supervisory body for consideration under DoLS; however the provider was no able to consistently demonstrate that people were supported to make decisions about their care in accordance with MCA.

People received care and support from staff that had appropriate training and who received regular reviews from the registered manager about their performance.

People were encouraged to undertake activities that interested them and to make choices everyday choices about how they spent their time and what they wanted to eat and drink.

Staff had been employed following recruitment checks. We saw that staff had a police check to ensure they were safe to work with people. However we found in some recruitment records that gaps in employment and references were not verified.

The registered manager and registered provider continuously assessed and monitored the quality of the service and actions plans were in place where areas of improvement had been identified. However these audits did not identify the issues we found during the inspection visit.

Feedback was obtained from people who used the service and their relatives. Records showed that systems for recording and managing complaints, safeguarding concerns and incidents and accidents were managed well. However we found that people's resuscitation records were not correctly completed and people's care plans did not always contain the sufficient and up to date information.

You can see what action we told the provider to take and the end of this report.

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.

Some records did not contain sufficient or most up to date information.

The provider ensured staff that were recruited had undertaken a police check to ensure they were safe to work with people. However gaps in employment and authenticity of references were not explored.

People received their medicines when they needed them.

Staff knew how to recognise signs of abuse and what action they needed to take to protect people from harm.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's resuscitation wishes may not be reflective of their choice.

The provider was not able to consistently demonstrate that people made decisions in relation to their care were protected under the Mental Capacity Act 2005.

People were supported to eat and drink.

People were supported by staff that had appropriate training.

Is the service caring?

Good

The service was caring.

People and their families were happy with the care provided.

Information was available to support people to access advocate services.

People's privacy was promoted and maintained.

Is the service responsive?

Good

The service was responsive.

People received care that was responsive to their needs.

People were supported to participate in meaningful activities.

People were encouraged to raise issues and staff knew what to do if issues arose.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The quality of the service was regularly reviewed; it did not always pick up all areas for improvement.

People were involved in making decisions about how the service was run.

Normanton Village View 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 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.

The inspection visit took place on 7 June 2016 and was unannounced. The inspection team consisted of two inspectors, a specialist advisor on providing nursing care to people living with dementia 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 expert by experience had a history of providing support to people living with dementia.

The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information that the provider had sent to us, which included notifications of significant events that affect the health and safety of people who used the service. We also contacted the commissioners who fund care for some people to obtain their views.

We spoke with one person who used the service and two visiting relatives. We spoke with three carers, two nurses, the cook, cleaner and the registered manager. We reviewed three care records, three staff files and the provider's policies and procedures, accidents and incidents, staff training and supervision records.

Some people living at Normanton Village View were unable to communicate verbally, so we observed how staff interacted and supported people to help assist us in understanding the quality of care they received. 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 to us

Requires Improvement

Is the service safe?

Our findings

We were made aware by a relative that a person had a pressure ulcer which they had identified and brought to the attention of registered manager. We reviewed the care records for this person and there was inconsistent recording of information. We were unable to establish who identified the pressure ulcer and when, as the date of it being recorded did not match with progression of the injury. The registered manager confirmed it was the relative who had identified the injury and staff had failed to report it. However we did see that once the injury had been identified, the necessary referral and involvement from other healthcare professionals had been undertaken.

People were supported by staff that had not undergone a comprehensive recruitment process. We found on occasions that gaps in employment history was not documented and some references were not checked for authenticity. Two files did not contain proof of ID and the staffs right to work. Staff we spoke with told us that as part of the recruitment process, pre-employment checks were completed before they commenced employment. This included completing an application form, attending an interview and they provided proof of identification and undertook a police check. Following our inspection visit, the provider sent us proof of staff identification and their right to work. However no further information was supplied in relation to the references and gaps in employment. This meant that the provider may have employed staff who may have not been suitable to work people using the service.

People were protected from identified risks. For example, we saw that there were people at risk of falling and the provider had put bed rails in place to reduce the risk of falling out of bed. People had individual risk assessments which showed potential risks and what action staff should take to reduce them. We saw that these were reviewed monthly and when people's needs changed. We saw in one person's care record that they had been assessed to be at risk of falling. The assessment identified that a low profile bed should be ordered to minimise the distance should the person fall out bed. We checked the person's room and confirmed the required bed was in place; however their records had not been updated to reflect this.

The staff levels based around the dependency levels of people who used the service. This was regularly assessed using a 'dependency tool' to measure the staffing hours needed. We saw the most recent dependency tool and this demonstrated that that the number of staff increased or decreased depending on people's needs and how many people were living at Normanton Village View.

One person we spoke with told us they felt safe living at the home because staff understood what they should do to protect from abuse. Staff confirmed that they had attended training in safeguarding and they could tell us what actions they would take if they had any concerns for the safety of people. Staff were aware of the provider's whistleblowing policy that enabled them to report concerns anonymously. They were aware they could contact external organisations such as the local authority and us. We saw that the provider's safeguarding and whistleblowing policies displayed within the home.

People had personal emergency evacuation plans (p.e.e.p.) in place and staff we spoke with knew how to support people during an emergency. The p.e.e.p. provided information on the level of the support a person

needed in an event of a fire.

People received their medicines regularly. We saw that nurses sat with people and explained what they were being given. One person told us, "I get my tablets when I need them. I have three in the morning, one at dinner and three at night." When people were prescribed medicines on an 'as and when required' basis, such as for pain relief, we heard staff checking with people to see if they were in discomfort and needed medicine. We observed one nurse giving people their medicine. One person had declined to have their medicine and we saw the nurse went back to the person and they were encouraged take it. We saw that the arrangements for medicine storage and stock control were managed by nurses and recording of medicines was accurate. This demonstrated that people received their prescribed medicines in a safe way to maintain their health and wellbeing.

Requires Improvement

Is the service effective?

Our findings

People weren't always effectively supported in making decisions regarding their care.

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 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.

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 MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the provider was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

People's care records contained a general risk assessment for using call bells. Where people had been assessed as not being able to summon assistance by using a call bell, the person had bed rails put in place to prevent them from getting out of bed and placed under regular observation to check their safety. However the risk assessment did not document how the decision had been made and what other interventions had been considered to demonstrate this was the least restrictive option and in the person's best interests where they lacked capacity.

People's resuscitation wishes known as 'Do Not attempt Cardiopulmonary Resuscitation' (DNACPR) were incomplete or inaccurate. One DNACPR had a person's incorrect personal details. Another DNACPR had sections which had not been completed. We saw that a person's end of life wishes were discussed with them and it was recorded that they wished to be resuscitated. However the care record contained a DNACPR and there were no information available to confirm that the person had been consulted with other than a note to say their relative had been told and agreed. We saw no evidence to confirm that the relative had Power of Attorney for Care and Welfare. This meant that people, who might not be authorised to do so, were making decisions on the person's behalf.

We brought these issues to the registered manager's attention during the inspection visit and they assured us these would be reviewed as a priority.

This was a breach of Regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported by staff that received appropriate supervision and appraisal. A staff member told us, "The registered manager or the nurse does my supervision. I am asked how I am getting on and have discussions around my training needs." Another member of staff said, "I feel I get the support I need from the

manager." A member of staff told us they undertook a three day induction at the provider's head office that covered essential training. They commented, "The training has helped me a lot, especially the moving and handling, so that I can move and support people safely." We saw that staff assisted people to move around the home in a safe and effective manner in line with their training. Staff were also supported to undertake qualifications in care. Records we saw showed that inductions, training and supervision were undertaken in line with the provider's policy.

People were supported to eat and drink enough. One person told us they could choose what to have for breakfast which included "toast, cereals or an omelette," and if they didn't like anything on the menu the staff would prepare something else. We saw that the food menu was available in written and pictorial format which enabled people to make choices, this was important as some people were unable to communicate verbally.

People's nutrition needs had been assessed and people who were at risk of not eating or drinking enough, referrals had been made to external health professionals such as the dietician. We saw that people who required specialist's diets, this information had been communicated to staff and the cooks. The cook had a list of people's dietary needs and food allergies and they were able to explain how people's meals should be prepared. For example some people required soft or pureed diets and needed their drinks to be thickened to minimise the risk of choking. We observed at lunch time that people were given food and drink appropriate to their diet. We also saw that drinks and snack were available throughout the day. This meant that people were supported to maintain a balanced diet.

People were supported maintain good health and had access to healthcare services and appropriate referrals were made when there were changes to people's needs. For instance, we reviewed the care record for a person who had difficulties in swallowing food which placed them at risk of choking. We saw a referral was made to the Speech and Language Therapist (SALT). We also saw records that confirmed people were supported with their day to day healthcare needs such as seeing a GP and Optician.

Good

Is the service caring?

Our findings

We saw people were at ease with staff. People and their relatives said they were happy with the care provided. A relative had said, "My dad is happy here and I am happy and staff communicate with him well and he enjoys the banter with the carers."

People had a named nurse who oversaw their care. The named nurse was responsible for reviewing their needs and support and ensure the person and their family were involved. Staff were able to explain how people preferred to be supported and what assistance they required. This helped with the continuity of care and promoted positive relationships between staff and people living at the home. We saw where people and their relatives had been involved; this was recorded in the person's care plan.

People were supported to make decisions and choices about their care. We observed staff giving people options and choices for example, if they wanted to take part in activities or what choice of meal or drink they wanted.

We saw there was information available to people about using advocacy services. An advocate is someone who can support people to express their views and wishes to assist with making decisions. The information was displayed within the home and easily accessible. This meant that should people require assistance there was an independent service that could help.

People were able to make choices about how and where they spent their time. We observed staff knock on people's bedroom doors before entering. We also saw when staff were attending to people they closed the door. People were encouraged to develop and maintain relationships with the important people in their lives. Relatives told us that they felt welcomed and they could visit at any time. We observed when visitors arrived that they were able to sit with the person in the communal area or go to their room should they wish. That meant staff recognised and maintained people's privacy and dignity.

Good

Is the service responsive?

Our findings

People's care needs were assessed prior to them receiving care. We saw that the provider undertook an admission assessment which gave a picture about people's medical history as well as the person's current care and support needs. This helped the provider to assess whether it could respond to those needs prior to the person using the service.

People's care was reviewed monthly by the provider to ensure that the care they received was reflective of their current needs and preferences. Reviews of care gave people and their relatives the opportunity to be involved and give input in how care was delivered. Visiting relatives told us that they were involved in planning and reviewing the relations care. One relative told us, "I have seen my dad's care plan and I was able to be involved." For example, when we spoke to staff about one person's care needs, they were able to provide an overview of their current care needs and also commented that the person preferred baths instead of shower. This was reflective of the person's care plan.

People were supported to take part in social activities. One person told us that they enjoy doing things on their own such as, "Crocheting and watching the television" and that staff respected their choice not to participate in group activities. One visiting relative told us that their relation took part in activities that interested them. For instance they told us, "Dad enjoys the baking, church service and the parachute game. He wants to join in everything." We spoke with the activities coordinator who told us they have a range of activities planned which included supporting people to go out in the garden and play ball games, listen to music to sing along to and do exercises.

People knew what to do if they had concerns or complaints. One person told us, "I have nothing to complain about but if I did, I would speak to the carers." We saw that the complaints procedure was displayed within the corridors of the home and this was easily accessible. A system was in place to record complaints received by the service, this ensured the action taken and outcome was recorded. We looked at a sample of complaints records which showed that these were investigated and responded to appropriately.

Requires Improvement

Is the service well-led?

Our findings

The quality, safety and effectiveness of the service were checked by the registered manager but also by members of the management team and the registered provider. Quality audits covered all aspects of the service. The registered provider and registered manager evaluated these audits and action plans were written where areas of improvements were identified. Progress was then evaluated. However we identified concerns with the risk assessments for call bells and DNACPRs which were not picked up during their audits. This meant that the quality audits were ineffective in identifying areas for improvement.

A relative we spoke with commented positively on the care that their relation received. There was a registered manager in post and they had responsibility for the day to day running of the service. We observed the registered manager interacting with people and we saw she knew people well and engaged with them in an open and inclusive way. People we spoke felt it was well run. One relative had said, "I think the manager is lovely, hardworking and passionate about raising standards."

People who used the service were supported to have a say in how it was run through regular meetings and reviews of their care and support. Relatives were also supported to be involved via attending review meetings and by completing annual surveys. The provider had completed a recent Satisfaction Survey in July 2015 and they were in the process of conducting the survey for 2016. Actions from the surveys were put in to an action plan which the registered completed. For example, the survey identified that some relatives had previously not been involved in reviewing their relatives care. As a result, the registered manager wrote to all family members to invite them in and copies of the letters were retained.

There was a suggestion box available near the entrance of the home. People using the service and visitors were able to make comments and suggestions and place them in the box. This also gave people the opportunity to raise issues and to remain anonymous should they wish. The comments were then reviewed by the registered manager and any improvement ideas were placed in the action plan.

People were kept informed about changes in the home as the provider had a 'You said. We did' display in the entrance to the home. This had key themes and issues that had been identified through audits and surveys along with a caption about what action the provider had taken to address them. This demonstrated that the provider had an open and person-centred culture.

The registered manager had been at the home for many years and it was clear that they knew the needs of the people and their staff well. Services that provide health and social care to people are required to inform us of important events that happen in the service. The registered provider had informed us of significant events in a timely way. This meant we could check that appropriate action had been taken. The registered manager was knowledgeable about these requirements and was transparent in ensuring we were kept up to date with any notifiable events.

There were regular staff meetings and this was confirmed by staff members we spoke with. Staff told us what they discussed and that they found them useful. We looked at the records from the recent staff

meeting and saw relevant topics had been discussed. Staff told us they had regular supervision by management and were given feedback on their performance and underwent competency checks. This helped to ensure they were performing well and providing appropriate care to the people who used the service.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent This was because the provider was not able to demonstrate that they acted in accordance with the requirements of the Mental Capacity Act 2005.