Ings House Care Limited

Ings House Nursing Home

Inspection report

350 Bradford Road
Liversedge
West Yorkshire
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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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

Ings House Nursing Home is a registered nursing home in a quiet residential area of Liversedge. It provides accommodation, personal and/or nursing care for up to 32 people. The home was built in the early 1800s and has been extensively renovated and refurbished. Accommodation is provided over two floors, which can be accessed using a passenger lift or a stair lift. On the day of inspection there were 27 people living at the home.

At our last inspection we rated the service Good. At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and on-going monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

At this inspection we found the service remained Good.

The manager and staff understood how to keep people safe. There were clear policies and procedures to follow for staff to raise concerns and staff were aware of these.

Risk assessments were in place for aspects of people's care and support and these were updated regularly to protect people from harm. People were supported to have choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Staff were trained to give medicines safely, all training was monitored, competencies were checked and staff received regular support from the manager through supervision and appraisals.

People had a choice of what to eat and where they ate their meals. People were supported to eat when appropriate and their nutritional intake was monitored. People were regularly weighed to make sure they were healthy. We observed staff were caring and told people what they were doing at all times, we observed that people were treated with dignity and respect. We saw in people's care plans what is important to them and how these needs were met. People are supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice.

Some mental capacity assessments were in place. We have made a recommendation about decision specific capacity assessments for consent to care and support.

The manager was visible and spent time each week working alongside the staff. Meetings with staff were inclusive with staff describing the manager as approachable. Systems and processes for ensuring the quality of the service were securely and effectively in place.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Requires Improvement.	**Requires Improvement**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

Ings House 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.

This was a comprehensive inspection. This inspection took place on 11 May 2018 and was unannounced. The inspection team consisted of two adult social care inspectors and one 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 our inspection visit we reviewed the service's inspection history, current registration status and other notifications the registered person is required to tell us about. Notifications are when registered providers send us information about certain changes, events or incidents that occur within the service. We contacted commissioners of the service, safeguarding and Healthwatch to find whether they held any information about the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. This information was used to assist the planning of our inspection and inform our judgements about the service.

We used a number of different methods to help us understand the experiences of people who lived in the home. We spoke to four people and five relatives of people who lived at the home. We spoke with the registered provider, the registered manager, one nurse, two staff members and the cook. We reviewed three staff files, three people's support records and a variety of documents which related to the management and governance of the home. We also spoke to a visiting health care professional. We looked around the building and saw the kitchen, people's bedrooms and the communal areas.

Requires Improvement

Is the service safe?

Our findings

At the last inspection we found the registered provider had breached the regulations regarding the safe management of medicines as there were concerns about the storage of liquid medicines in terms of temperature and security. At the last inspection we also found the medication rounds took some time, although this was because the process was being led by people's own routine and the nurse was interrupted on a number of occasions between administrations. At this inspection we found sufficient improvements had been made which meant the registered provider was meeting this regulation.

Since the last inspection, an early morning medicine round had been introduced to ensure people received time specific medicines as prescribed. We found the medication round finished mid-morning and whilst the person administering medicines did get interrupted, the impact was minimal. The room and fridge temperatures were routinely recorded on a daily basis. Medicine trolleys were kept in one of the lounge areas. We noted the temperature on the day of our inspection was 25 degrees Celsius. We discussed this with the registered manager and nominated individual as some medicines can become less effective or spoil if they are stored over 25 degrees Celsius. The nominated individual told us they were in the process of reviewing storage arrangements for medicines and would consider purchasing an air conditioning unit.

We looked at refrigerated medicines and found these were appropriately stored. The opening date and expiry date was listed on all the items we looked at which meant staff responsible for medicines knew when these should be disposed of. Controlled drugs are medicines which are liable to misuse. We looked at the management of these medicines and found this was safe as they were securely stored and each administration was signed by two staff members. Where people had patches for pain relief applied, the records showed when the patch was applied and removed, as well as where it was positioned on the person's body. This is to ensure the placement of the patch is rotated and not used in the same place twice. This follows national guidelines.

For the recording of the administration of medicines, medicine administration records (MARs) were used. People's MARs contained an up-to-date photographic record for each person, GP and pharmacy details and allergy information. Most medication was administered via a monitored dosage system supplied directly from a pharmacy. This meant the medicines for each person for each time of day had been dispensed by the pharmacist into individual trays in separate compartments. We checked the physical stock of controlled drugs as well as other medicines and found this consistently matched the records we looked at.

Detailed protocols for the use of 'as required' medicines were in place. The administration of medicines was safe as the responsible staff member ensured people had taken their medicines before signing the MAR to state they had been given. The staff member washed their hands with an alcohol gel between administrations which demonstrated good practice regarding infection control. We looked at the management of topical creams and found the application of these items was recorded by care staff who applied them.

We asked the staff member responsible for the administration of medicines to review the PRN protocol for

two people's paracetamol. This stated they could have up to eight administrations in a 24 hour period, although this also stated administrations should be every four to six hours, which would mean a maximum of six administrations in a 24-hour period. There had been no overdose of this medicine and both protocols were amended during the inspection. Staff responsible for administering medicines had received training in this area and also had an up-to-date assessment of their competency.

People and their relatives told us they felt safe at Ings House Nursing Home. One person said "I feel safe because it's very nice here. Everybody is happy, there's no animosity about anything, no one wanting to be nasty to you," and another person said "I feel safe because someone is always there." A relative said "My relative is safe and content because the staff are interested in them and are trying to help them."

The staff we spoke with demonstrated they understood how to ensure people were safeguarded against abuse and were able to describe the signs to look out for which would indicate a person was being abused. A staff member explained, "It might be the way a client acts with you or reacts to family and friends, their mood might change."

People and relatives told us risks were managed with due regard to people's choice and independence as far as was possible for individuals. We observed staff assisting one person to move from a sit to stand position and saw staff supporting the person by holding them under their arms, which can be unsafe. However, when the person returned they were appropriately assisted. We discussed this example with the registered manager who told us they would address this. All other examples of staff assisting people to move were seen to be safe.

We saw risk assessments had been completed in relation to falls, nutrition, infection control, the use of emollients, bed rails risk and for people who were unable to use their call bell. However, one of the care plans we looked at stated the person had a risk of choking and there was no risk assessment for this. We raised this with the registered manager who told us they did not have choking risk assessments in place. They said they would address this immediately. We noted the person's care plan for dietary needs dated February 2018 contained information about the risk and the action staff should take to lower the level of this risk and confirmed staff and the cook knew about the risk.

Regular safety checks took place throughout the home to help ensure premises and equipment were safe. On the day of inspection we identified the gas certificate had expired. This was brought to the attention of the registered provider and registered manager and was rectified by the end of the day. We further identified people did not have personal emergency evacuation plans (PEEPs) in place. This was brought to the attention of the registered provider who was aware of this and had made plans to put these in place. This was remedied the day after the inspection and we were then assured that all the people had PEEPs in place.

We reviewed the staff rota which showed sufficient numbers of staff were deployed to support people safely. Some staff felt there were not enough staff during the afternoon but two people we spoke to told us there was enough staff to cater for people's needs. One person said, "There's enough staff but they are overworked." A relative said, "They call in every half hour to check on my relative because my relative is unable to use the call bell."

All areas of the home were clean. One person said, "The cleanliness is second to none," and staff we spoke with were able to explain the procedures for infection control. At the time of the inspection one person required separate cleaning and laundry procedures and these requirements were clearly documented in cleaning and laundry records and by a symbol on the door to alert all staff.

Records of audits showed where the registered provider had implemented new ways of working. In one instance a different audit sheet had been devised to better capture actions and accurately track their completion. Meeting minutes showed audits were reviewed and discussed with staff to implement areas of learning from the audits.

Good

Is the service effective?

Our findings

All the people and relatives we spoke to told us staff knew what they were doing and had the skills and experience to administer people's care. One relative commented, "I am happy, I wouldn't want my relative anywhere else."

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager had appropriately referred to the local authority for authorisations and notified the Care Quality Commission about the people who live at Ings House Nursing Home and have DoLS authorisations in place.

We asked the registered manager whether they kept a register of power of attorney for health and/or welfare and finances. They told us they had recently contacted relatives to ask for this information. This meant that at the time of inspection we were unable to check whether family members who had signed consent forms on behalf of their relatives had the legal right to do so.

We saw mental capacity assessments which covered consent to care and treatment and the use of bed rails. We looked at the care plan for one person who was unable to make a decision about what they wanted to wear. We saw their care plan for personal care dated February 2018 referred to a specific type of clothing with the note added 'They need to be of a stretchy material as this makes it easier for staff to dress [name of person]. However, there was no mental capacity assessment and best interest decision to support them wearing these items. We recommended to the registered manager and nominated individual that decision specific capacity assessments be introduced for consent to individual aspects of people's care and support.

We found staff were well-trained and had their competencies in all aspects of care checked regularly. Their monthly supervisions took place over a full day when they were shadowed by a senior member of staff. The registered manager regularly delivered refresher training for small groups of staff.

We spoke to the cook who had a good knowledge of people's dietary needs and their preferences. There was a list of dietary requirements which included details of those people who needed assistance to eat. Staff were allocated to individuals on a daily basis so people were given appropriate support.

The relative of one person with a sensory impairment told us staff supported their family member to ensure their living environment was safe and without obstructions. They told us staff ensured their relative was aware of where drinks were placed and they provided assistance to support the person's nutrition during mealtimes. They also said their relative was given drinks in a beaker with a lid which restricted any spillage

Staff were able to describe the handover process and had a good understanding of people's individual needs. One relative said, "Staff know [people] well and they communicate what is going on and they all know everything."

One health professional said, "I'm able to reiterate that the home are doing the right thing, they are responsive and welcomed my input." Care records we looked at demonstrated staff worked with a range of health professionals such as GPs, opticians, chiropodists, best interest assessors for DoLS and nurse practitioners. The home was providing support for residents who needed reablement and work with healthcare professionals in the service.

We found at this inspection that Ings House was homely and welcoming. People had individual ornaments and pictures in their rooms. The lighting was dementia friendly but there was no appropriate signage to support people living with a diagnosis of dementia in their orientation at the home. We discussed this with the registered provider who felt the client group within the home was primarily people who were not able to mobilise independently if they were living with dementia, but following discussion was keen to explore other options for making the home environment more suitable for people living with dementia.

Good

Is the service caring?

Our findings

People and relatives we spoke to were very positive about the staff. One person commented, "Staff are very good, they all come and speak to you, use your name and want to help you." A relative said, "Staff are warm, friendly, kind, capable, efficient angels. They respect my relative's privacy."

During our inspection there was a calm atmosphere throughout the home and we observed staff being very attentive to, and patient with people. Staff were able to demonstrate they knew people on first name terms and we witnessed good-natured humour between people and staff. One staff member said, "The best thing about working here is definitely the [people], it's like being part of a big family."

Staff were able to explain how they communicate with people to make sure the person's views were met and relatives told us staff gave people sufficient time to absorb information. One relative told us about their family member who had a sight impairment and informed us staff took time to describe each item of clothing so the person could choose what to wear because it was important for them that their clothes matched.

During our inspection we overheard staff members routinely giving people choice. For example, one staff member asked a person, "What would you like for breakfast this morning [name of person]?" Another staff member asked, "[Name of person], would you like fish and chips for your dinner?" The staff member acknowledged the person only wanted a small portion. At lunchtime people were asked where they wanted to sit and we overheard a staff member ask one person who had just received their meal, "Do you want me to put the tomato sauce on or do you want to?" This meant people were supported to retain their independent living skills. One person who did not have much to eat was asked if they wanted an alternative such as soup and sandwiches. We observed a staff member brought them a sandwich which the person had requested.

Care plans were concise and person-centred as they reflected people's personal preferences in their daily routines. For example, the personal care plan for one person stated '[Name of person] washes their own hands and face, but then staff have to assist with washing their back and abdomen etc. If [name of person] chooses to have a shower, they prefer to have it later in the day as on a morning they like to be up and out of bed quite early, as soon as they wake up'. This demonstrated care plans promoted individualised care as well as supporting people to remain as independent as possible.

People told us their doors were open by choice and staff respected their privacy. Staff were able to describe how they made sure people's dignity was respected. One staff member said, "I always ask visitors to step out of the room if I need to support someone with their personal cares and cover [the person] up while I get anything." We observed staff knocking on people's doors before entering.

People's religious beliefs were recorded as part of their assessment of needs. However, we saw one person's nursing information sheet dated March 2018 recorded they were not religious, although the same person's life history sheet dated March 2018 stated they had a religious belief. It was not clear which information was

correct and if the person held a religious belief, whether staff needed to support this person in meeting this need. The registered manager clarified this during our inspection and amended the documentation.

Good

Is the service responsive?

Our findings

None of the people we spoke to were aware they had a care plan. However relatives were able to describe their involvement in their relative's care plan and two of the relatives we spoke to had been involved in recent reviews of these.

People told us there were limited activities for them to do in their rooms. One person said, "They take me to the lounge if there is a concert on." Relatives we spoke to had mixed views about activities on offer at the home. One relative said, "They brought some (entertainment) to my relative's room the other day to play the flute." The home has an activities co-ordinator Monday to Friday and the registered manager explained they were recruiting an additional activities co-ordinator so that every day had an activities co-ordinator.

Staff told us how they supported people to have choice and made decisions about their daily life. One member of staff described how people chose when to go to bed and how staff made sure their bed-time routines were individually supported. We observed one person who had a toy dog which they identified with as their pet; this person lived with dementia and felt comforted by their dog. Staff were very supportive of the therapeutic value of the pet dog and when they asked the person if they wanted to go outside they reassured them that their dog could also go.

We looked at three care plans in detail and a further care plan regarding a person's end of life care wishes. Records showed people had their needs assessed before they began to use the service. This ensured the service was able to meet the needs of people they were planning to accommodate and care for. Subsequently, an assessment of need was carried out when people moved into Ings House Nursing Home which was then used to complete a suite of care plans which covered, for example, personal care, mobility, communication, dietary needs, continence and social interests.

We saw a number of people who were at risk of pressure wounds and needed pressure cushions and air flow mattresses. Care plans detailed very clearly what the correct setting for air flow mattresses which was based on people's weight. We found the care plans for helping people to move needed some further detail to record the type of loops carers should use when assisting people to transfer using slings. Moving and handling assessments contained detail around the equipment needed and number of staff, although where the method for correctly assisting the person to transfer should have been written, the care plans we saw stated 'As per training'. We discussed this with the registered manager and nominated individual who told us they would look at this.

Individual care plans were reviewed monthly by a senior staff member and an annual review of care plan with the person or their relatives. This meant people and relatives were able to decide how they wanted their care and support to be provided.

People and relatives were confident to raise any concerns or complaints and were aware of the complaints procedure, although there were no complaints recorded for this year. One person said, "I have nothing to grumble about, I cannot pick fault."

Care plans we looked at in detail did not contain information regarding people's end of life wishes. We discussed this with the registered manager who told us, "I would broach that as they become end of life." They also said they had conversations about end of life wishes with people and their relatives when they moved in to Ings House Nursing Home. However, we found future wishes were not routinely recorded. The registered manager showed us where one person had expressed their wishes and this had been clearly recorded. We discussed the recording of end of life care with the registered manager and nominated individual who told us they would ensure these discussions were recorded and where people preferred not to discuss the subject, this would also be respected and recorded.

Compliments cards showed relatives' thanks to Ings House Nursing Home for providing appropriate end of life care for their relatives who had lived at the home.

Good

Is the service well-led?

Our findings

There was a registered manager in post who had been registered since September 2014. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered manager was very visible in the home and spent one shift per week working as a nurse. The registered manager is supported by a deputy manager. One person said, "The manager pops in to say 'hello'." A relative commented, "The manager is proactive in communicating. There is always someone available. They answer the phone well and get messages to my relative."

A staff member said, "The manager is very approachable, I know any problems will get solved." Another staff member explained how the manager had asked them for their ideas to better support a person because the staff member knew them well. All staff we spoke to thought they would benefit from more regular team meetings.

Staff were able to explain the ethos of the home. All staff received a handbook which includes the home's 'General Philosophy of Care'. We saw from posters displayed throughout the home that 'May is the month for smiling'. All the staff we spoke to made reference to this and said the theme changed each month and focused on the experience of the people living at the home. We saw from meeting minutes the results of the relatives and staff surveys had been discussed with staff and potential solutions for the issues raised had been considered by staff.

There was an annual relative's meeting in January 2018 where relatives were invited to comment on the running of the home. There was an annual relatives' survey, which took place in November 2017. The results from this had been analysed by the registered provider and an action plan produced for improvements. The registered provider was keen to explore better people and relative engagement options.

Regular quality assurance checks and audits took place. The registered manager did a formal monthly walk-round and produced notes and actions from this. The registered provider undertook quarterly walk-round and premises check. Actions were then produced from these observations and subsequently checked for completion.

Staff meeting minutes showed discussions as a result of these audits, for example, the results from the recent fire risk assessment and the recent medication audit.

The registered manager was actively involved in local authority best practice groups and described how they worked in partnership with colleagues from rehabilitation support and hospice. We saw that there were links with a local school church choir who also visited regularly.