The Abbeyfield (Maidenhead) Society Limited

Nicholas House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Nicholas House is a care home providing personal care to 13 people. The service provides care to adults, some of whom may live with dementia. The service can support up to 30 people. The building has three floors, and each person had their own bedroom. There were shared facilities such as bathrooms and showers, lounge and dining areas as well as staff stations and offices.

People's experience of using this service and what we found
The prevention and management of trips, slips and falls had improved. Actions were taken to mitigate risks including regular updates of the risk assessments, care plans, working with the physiotherapist, reporting of accidents and incidents, and completion of follow up investigations. Infection prevention and control had improved, however further action was required to ensure correct use of personal protective equipment . There were sufficient staff deployed and personnel files contained the information required by the regulation. Although service users received their medicines, improvement was required to the documentation, for example 'as required' protocols and guidance for high risk medicines.

There was positive feedback about the home manager. Oversight of the service at local and trustee level had improved with the changes in the management team. Auditing of care documentation was taking place, and there was evidence of follow up by the management team. There were related action plans, with the actions being tracked for progress on each one. The home manager understood the duty of candour process and had applied it to notifiable safety incidents, for example serious injuries. Statutory notifications required by law were being submitted without delay.

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

Rating at last inspection and update
The last rating for this service was inadequate (published 31 July 2021) and there were multiple breaches of regulations. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements were made and the provider was no longer in breach of some regulations.

This service has been in Special Measures since 11 March 2020. During this inspection the provider demonstrated that improvements have been made. The service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

Why we inspected
This was a planned inspection based on the previous rating.

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

service can respond to COVID-19 and other infection outbreaks effectively.

We carried out an unannounced comprehensive inspection of this service on 18 May 2021 and 19 May 2021. Breaches of legal requirements were found. We issued a warning notice and the provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment, good governance, duty of candour and notifying CQC of certain events.

We undertook this focused inspection to check they had complied with the warning notice and followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the key questions Safe and Well-led which contain those breaches of regulations.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has changed from inadequate to requires improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Nicholas House on our website at www.cqc.org.uk.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service well-led? The service was well-led. Details are in our well-led findings below.	**Good**

Nicholas House

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection was completed by two 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.

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

At the time of the site visit, the home manager had applied to register as the manager with the CQC. At the time of the inspection report, our registration team had completed the assessment of the manager's application and added them to the CQC's register.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we held and had received about the service since the time of the last inspection. We sought feedback from the local authority, safeguarding team and other professionals who work with the service. We checked information held by Companies House, the Food Standards Agency and the

Information Commissioner's Office. We checked for any online reviews and relevant social media, and we looked at the content of the provider's website. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
The site visit took place on 16 December 2021. We made telephone calls to relatives on 22 December 2021. We spoke with two people and 12 relatives about their experience of care and support provided by the service. Some people were not able to participate in a conversation with us. We spoke with the nominated individual about their oversight of the service. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We spoke with the home manager, deputy manager, two senior care workers, a care worker, two housekeepers, a laundry worker and the maintenance person. We also spoke with a physiotherapist who works with people at the home. We reviewed a range of records. This included three people's care records, three staff personnel files and three people's medicines administration records. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We requested and received further care documentation, quality assurance documents, and were provided with a variety of additional evidence for consideration.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as inadequate. At this inspection this key question has now improved to requires improvement. This meant some aspects of the service were not always safe and continued changes to safety process were ongoing. There was a lesser risk that people could be harmed.

Assessing risk, safety monitoring and management
At the inspection on 9, 10 and 13 January 2020, there was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people were at risk of, and sustained injuries from falls. At the inspection on 18 and 19 May 2021, there was a continued breach of Regulation 12. Robust systems to prevent and manage falls were not in place.

Enough improvement was made and the provider was no longer in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 at this inspection .

- People's risk assessments and care plans were more detailed to ensure the risk of falls was prevented.
- Staff had a better knowledge of people who were at high risk of falls.
- Factors leading to falls such as medicines, mobility, eyesight and environmental risks were examined and measures put in place to mitigate risk.
- The privately-employed physiotherapist worked closely with people, to re-able them to mobilise safely and be as independent as possible. They ensured their safety, for example by providing the right mobility aid to people to reduce the risk of falls.
- Staff received specific training about falls, for example what led to falls and how to respond if someone sustained a fall.
- The rate of falls had significantly reduced. Feedback from the local authority confirmed that progress was effectively made to protect people from falls.
- Other risks related to day-to-day support of people such as malnutrition, dehydration, skin integrity and continence were assessed appropriately. Care plans were in place to inform and guide staff how to provide safe care to people, based on their individual risks.
- The premises and equipment were appropriately maintained to reduce the risk of harm to people, visitors and staff. Checks were completed such as fire safety, prevention of Legionella, lifting equipment operation, lighting and electrical items and window restrictors. Staff regularly reported any defective items via a communication book, which the maintenance person promptly responded to.

Preventing and controlling infection
At the inspection on 18 and 19 May 2021, there was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement was made and the provider was no longer in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 at this inspection. However, we were not

assured about several systems to prevent and control infections at the location.

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were somewhat assured that the provider was using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.
● During the inspection, we identified two members of staff not wearing PPE appropriately. This was raised to the home manager who took immediate action.
● We have also signposted the provider to resources to develop their approach.

Using medicines safely
● People received their medicines in a timely way, and the ordering, storage and disposal of medicines was safe.
● Documentation pertaining to some aspects of medicines required improvement.
● People did not always have individual instructions for 'when required' (PRN) medicines that were prescribed for them. This meant staff did not have instructions on the use and administration of prescribed PRN medicines for individuals, potentially placing people at some risk of harm.
● When the service had not received printed MARs from the pharmacy for newly prescribed medicines, staff wrote instructions by hand on the existing MAR sheets. However, in two MAR sheets, the signature of the person transcribing was missed. Where a staff member had added their signature, the transcription had not always been witnessed and signed by a second member of staff.
● Where creams were prescribed for people, body maps to demonstrate staff where to put the cream were not always in place.
● People did not always have a care plan in place when prescribed high risk medicines such as anticoagulants.
● We provided our feedback at the site visit to the home manager and nominated individual about the documentation of medicines. They accepted our findings. They provided assurances that the management team would review the findings, and take action to address the areas for improvement. This was added to their existing action plan.
● At the last inspection, we recommended the provider take action to ensure the medicines policy was based on national guidance and best practice. At this inspection, the provider had made improvements to the medicines policy.

Staffing and recruitment
● We reviewed three staff recruitment records. One staff file did not include verification of reason for leaving their previous role within health and social care. When this was raised to the home manager, they were able to provide evidence of contacting the previous employer to verify reason for leaving.
● All other staff files contained all the necessary evidence including employment history and relevant qualifications and were in line with legal requirements. There were safe staff recruitment procedures in

place. We found job applications showed full employment histories, satisfactory references and Disclosure and Barring Service checks (DBS). A DBS is a criminal record check. This meant the service only recruited staff who were suitable to meet people's care and support needs.

● There were enough staff deployed to support people. Staff told us they felt there were enough staff per shift and one commented there was a, "…good mixture of people's knowledge." Another staff member told us, "There is low turnover of staff; residents like it because they know the staff well."

● People also felt there were enough staff. One person said, "They [staff] come if I call them. I never have to wait long."

Learning lessons when things go wrong

● There were improvements in how accidents and incidents were assessed and managed.

● Staff reported all accidents and incidents appropriately. The home manager or deputy manager completed satisfactory investigations into the matters.

● Thorough documentation of accidents and incidents was maintained. This included reviews of risk assessments, care plans, daily notes and staff accounts of what happened.

● The home manager reported the frequency of accidents to the provider's trustees via manager meetings. This ensured the nominated individual and provider's representatives were aware of incidents at the service.

Systems and processes to safeguard people from the risk of abuse

● People were protected from harm, neglect and discrimination.

● Staff received training in safeguarding adults at risk. They confirmed they knew the different types of abuse and how to report it.

● At the last inspection, we recommended the provider updated their safeguarding policy. A new policy, based on the current approach to protecting adults at risk, was in place at the service. This reflected best practice and national as well as local resources.

● There was a whistleblowing policy and staff said they knew how to raise concerns about care practices.

● The home manager reported allegations of abuse or neglect to the local authority, so they could be investigated if needed.

● The service informed us of any incidents where potential or actual abuse had occurred.

● Relatives said care was safe. Comments included, "Yes, it is safe…the physical environment, everything is clean and easy to navigate for the frail. They look after [the person] well", "[The person has] been there 2 years and is definitely safe. I have been happy with everything" and, "[The person] is safe there. In terms of [COVID-19] they are abiding by the rules. I have to do a lateral flow test. They keep me informed. [The person] is perfectly safe, and the staff are doing all they can."

Good

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as inadequate. At this inspection this key question has now improved to good. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
At the inspection on 9, 10 and 13 January 2020, there was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because quality monitoring systems were ineffective and did not protect people from inappropriate or unsafe care. At the inspection on 18 and 19 May 2021, there was a continued breach of Regulation 17. The provider failed to operate effective systems in place to ensure the health, safety and welfare of people was assessed and monitored. We issued a warning notice against the provider.

Enough improvement was made and the provider was no longer in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 at this inspection.

● Significant improvements were made since the last inspection to ensure that a satisfactory governance system was in place at the service.
● There was a new home manager and deputy manager in post. They were observed to work well together and expressed their commitment and responsibility to ensure the safety of people who used the service.
● The new home manager had applied to the CQC to register. Their application was being assessed by our registration team at the time of the site visit.
● The home manager was knowledgeable, experienced and skilled in adult social care. They understood their role in the operation of the service, and that they would be legally accountable for safe care once registered as the manager by the CQC.
● At the time of this inspection report, the home manager is now registered. This means they are legally responsible for ensuring that the service maintains high quality of care and meets all of the applicable regulations.
● There were appropriate action plans in place following our prior inspection and enforcement. These were detailed, were kept up to date and clearly demonstrated changes and actions that were taken. Where an action was still ongoing, this was clearly demonstrated and progress was regularly evaluated.
● The provider had engaged a compliance consultancy company to conduct an audit of the service on 26 and 27 October 2021. An extensive report was provided to the management team. They created an action plan to address areas for improvement. At the time of our inspection, almost all quality improvement initiatives were in place.
● Audits and checks were carried out to ensure good governance at the service. These checks included people's risk assessments and care plans, medicines management including staff competencies, staff

training, safeguarding and complaints.
● The provider's oversight of the service had also improved and increased. Trustees had completed their own audit of the service in September 2021. The report stated, "As Trustees we were very happy with the general environment, the management manner was respectful, considerate and willing to share information."
● The nominated individual shared the executive committee meeting minutes from 2021. These showed oversight of the service from the provider's representatives and how they communicated with the home manager and nominated individual. One set of minutes reported, "On a brighter note we still have an incredibly dedicated management [and] staff without whom we would be struggling to survive in these difficult times…a big thank you to all of you."
● Relatives said, "Present manager been there a while and is thoughtful. Both her and the last manager really like the residents and they know us well", "The new manager is personable and conversational. I can ask questions and queries, and they will respond to me", " [We] saw the social worker the other day and the manager came and she mixes with the relatives" and, "New manager…spoken to her on the phone once, seen her but not had a sit down with her. She seems very efficient and very good…is always kind and good hearted."

At the inspection on 18 and 19 May 2021, there was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. The provider had failed to notify us of all the events it was legally required to.

Enough improvement was made and the provider was no longer in breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 at this inspection.

● Since the last inspection, the management team had sent notifications to us pertaining to events where they were legally required to submit the information.
● Clear records were kept at the service of the notifications. This included supporting information that accompanied the respective notification.
● The home manager and nominated individual provided further information to us about the notifications when we requested it.
● The home manager understood the events that required notifications. They were knowledgeable about notifications, understood the reason for them and able to tell us how they used the content of them to help drive improvements at the service.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
At the inspection on 18 and 19 May 2021, there was a continued breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not always act in an open and transparent when things went wrong.

Enough improvement was made and the provider was no longer in breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 at this inspection.

● Improvements were made to ensure that the service was open, honest, transparent and informed the relevant people of notifiable safety incidents. A notifiable safety incident is a serious injury or harm that occurs during, or as a result of care.
● The home manager displayed a good understanding of the elements of candour. They expressed this as acknowledging any failings, apologising or expressing remorse and acting to ensure that appropriate

information is provided about what went wrong.
● Two notifiable safety incidents were reviewed. Improvements were required to the first example, and the home manager acknowledged steps that could have been improved. However, in a more recent incident, all steps and documentation were completed in line with the requirements of the regulation.
● The provider displayed their rating of 'inadequate' on their website, and the ratings 'poster' was clearly on display in the reception area of the building. People, relatives, staff and community health and social care professionals knew about the prior inspection rating. The service was honest that improvements were required. The management team acknowledged further improvements were also ongoing.
● Relatives said, "[The person] is safe, the care is good, it is a good place for [the person] to be. I have not been in recently but anything I need to know I am updated regularly", "They called me this morning as [the person] has just gone into hospital. They phoned me immediately. It has always been consistent and it feels that they respond as quick as any of us would" and, "They are doing their level best and doing what is suggested and responding to comments."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● There was a positive workplace culture. Staff expressed how changes in management had improved their emotional wellbeing.
● Staff were committed to caring for people in the right way. They demonstrated they knew the people who lived at Nicholas House well, and acted in their best interest. Interactions between staff and people were positive.
● The environment within the building was clean, bright and had relevant information posted throughout. This encouraged people, staff and relatives to view and read the information. Posters included the information about how the service was performing in relation to health and safety. There was also information that people needed to live their best life, for example about activities and social events.
● The physiotherapist we spoke with provided positive feedback. They said staff were passionate about care, and had worked with them extensively. They described staff as eager to learn and that care workers only wanted the best for people. The physiotherapist said staff sought out more learning and wanted to participate in improving care.
● The service had an appropriate statement of purpose. This clearly set out the aims, objectives and ethos of the service. The statement of purpose was available for anyone to access and read.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The service had attempted to gain feedback from people, relatives and staff during 2021. There were very limited responses, and workforce pressure from the pandemic meant further surveys were delayed.
● There was a robust plan to attempt gaining feedback again in January 2022.
● Less formal methods were also used to listen to and document people's and relatives' opinions. These included telephone calls and e-mails to the management team.
● We observed a relative call the home manager during the site visit. They enquired about visiting restrictions. The home manager was confident in their response, and knew the government guidance in place at the time. They attempted to ensure that the relative and the person's human rights were appropriately considered.
● During lockdowns, the staff ensured people had contact with their relatives and friends. This included via video calls so that they could see each other. This helped prevent social isolation, as many people who were supported could not understand the pandemic and why relatives did not visit for parts of 2021.
● Relatives said, "I think it is managed well. I have got no complaints and am happy [the person] is there. They send reports saying what the residents have been doing with photos. It was inspiring that they had

hen's eggs and an incubator to hatch chicks, which [the person] loved".

Continuous learning and improving care
● There were improvements to how the service used information to learn and grow.
● The data from all accidents and incidents was used to determine whether any themes or patterns were apparent. There were no themes in the accident data, and the number of incidents had decreased significantly across 2021.
● Incident and accident information was openly shared with staff. It was also displayed on the ground floor on a monthly basis.
● The home manager was able to confidently explain how changes to care processes were made if an analysis of an incident report indicated learning from a prior event was required.

Working in partnership with others
● The service continued to work with health and social care workers to ensure the best health outcomes for people.
● In the home manager's report to the trustees dated November 2021, there was evidence of how the service worked with stakeholders such as the local authority, to ensure people and staff were protected during the COVID-19 pandemic.