Action for Care Limited

Northfield House

Inspection report

Stockton Road
Knayton
Thirsk
North Yorkshire
YO7 4AN

Tel: 01845537964
Website: www.action4care.org

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Northfield House is a residential care home for up to eight younger adults living with a learning disability and/or autism. At the time of the inspection, eight people were living at the service.

Northfield House is a detached property. Bedrooms are across two floors with en-suite facilities and shared communal spaces and bathroom.

People's experience of using this service and what we found
Risks to people were not identified and managed to prevent avoidable harm. Accidents and incidents were inconsistently documented by staff and not reviewed by management. There was a lack of action taken to safeguard people. Medicines were not managed safely, and there was a lack of learning when things went wrong. One relative told us, "I'm not happy, its difficult handing your precious child over to someone, you want to trust them."

The environment was unclean and in a poor state of repair. Communal areas were not therapeutically beneficial to the people living at the service due to noise levels and design. Guidance around COVID-19 was not always adhered to by staff which put people at risk.

Staff had not received appropriate training, supervision and support despite working in a challenging environment. We made a recommendation about safe recruitment checks and practices.

Communication with external professionals and agencies was poor and they told us they had concerns about the service. People were not actively supported to be involved or to improve their independence. One staff member told us, "Care could be better from some staff, there could be more interaction with people, getting them to do more for themselves and not de-skilling them. People are capable but not encouraged."

The provider did not have effective quality monitoring systems in place that identified all issues and ensured these were addressed in a timely manner. Management and leadership were inconsistent. An interim manager from another service has supported the service whilst awaiting a recruitment of a new manager.

People were not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. We have made a recommendation around the use of the mental capacity act.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the guidance CQC follows to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

Based on our inspection of the safe, effective and well-led domains the service was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture. People were not always encouraged to be independent where they were able. The environment did not meet the needs of the people and at times impacted on their well-being. Care was not always person-centred or appropriate to meet people's needs, taking into consideration their preferences. More could be done to include and empower the people using the service. The management of the service did not ensure people were at the centre of the service. The culture and shortfalls in the service did not lead to safe and effective care of people. The management team recognised and had identified actions needed to address shortfalls. Since the inspection, they have started to work with partner agencies to improve the care provided.

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

Rating at last inspection
The last rating for this service was good (published 23 May 2019).

Why we inspected
The inspection was prompted due to concerns received about medicines, staffing and management of risk and incidents. A decision was made for us to carry out a focused inspection to inspect and examine those risks.

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 coronavirus and other infection outbreaks effectively.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection.

You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to person-centred care, good governance, staffing, safeguarding, care and treatment and the environment at this inspection. Please see the action we have told the provider to take at the end of this report.

During the inspection we sent the provider a letter of concern which outlined the areas of concern. They responded to this letter.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures.' This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Northfield 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 carried out by one inspector over three days.

Service and service type
Northfield house is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with CQC at the time of the inspection. It is a legal requirement to have a registered manager. The registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. 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 used all this information to plan our inspection.

During the inspection
We spoke with one person who used the service and three relatives about their experience of the care provided. We spoke with nine members of staff including the nominated individual, area manager, manager, deputy manager, and five support workers.

The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included seven people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. 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 looked at training data and quality assurance records. We spoke with professionals who regularly visit the service including the community learning disability team.

Inadequate

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 good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Risk assessments and guidance for staff were not always in place or up to date. They did not contain relevant information to keep people safe. They were not reviewed following an incident or change in a person's support needs.
- People did not receive the level of support and supervision they needed to keep them safe. For example, one person who had regular seizures was not monitored effectively resulting in unwitnessed seizures. This placed them at risk of avoidable harm.
- A hoist in the service had not had an essential safety check carried out. This was not in use at the time of the inspection. However, there was nothing to indicate to staff that this could not be used.
- Environmental checks were not robust or effective in managing fire safety. Staff had not always received appropriate training or practised fire evacuations.
- Lessons were not learnt following accidents and incidents. There was no analysis of patterns or trends to identify themes.
- Investigations had not always taken place when required and those completed were insufficient.

The provider failed to assess and mitigate the risk to health and safety of people. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider took action to service the hoist when this was identified during the inspection.

Using medicines safely

- Medicines were not managed safely. Responsibilities for medicine administration and documentation was not clear and communication was poor. This had led to medication errors and gaps in recording.
- Medicines were not stored safely or disposed of correctly. Creams and ointments were found in the communal bathroom, tablets were found in a disposable paper medicines pot that could not be identified. Temperature checks were not documented.
- Best practice guidance in relation to non-prescribed or 'over the counter medication' was not included in the provider's policy or being followed.
- The provider's compliance audit identified several failings in relation to the overall management of medicines. However, the service had no meaningful quality assurance processes in place, such as audits. Neither the service or provider had identified specific medicine errors or other shortfalls around the safe administration of medicines.

The provider failed to ensure proper and safe management of medicines. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had identified that medicines were not safely managed and had an action plan in place to address this.

Preventing and controlling infection
● Government guidance in relation to infection prevention and control (IPC) and COVID-19 was not followed. Staff wore personal protective equipment (PPE) incorrectly. Visitors did not always have their temperature checked, and screening questionnaires were not always completed.
● The service was visibly unclean and regular cleaning of communal areas and people's bedrooms was not always completed as staff didn't have time. Clinical waste bins were not always available or were broken.
● Not all staff had IPC and food hygiene training. Risk assessments around risk of COVID-19 were not in place when required.

The provider failed to manage the risk of preventing, detecting and controlling infection. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider took action to schedule training for those staff who had not completed it.
● Following feedback from the inspection the provider took action to have an external contractor complete a deep clean of the service.

Systems and processes to safeguard people from the risk of abuse
● Systems and process were not effective in addressing safeguarding concerns to ensure people were protected from the risk of harm and abuse.
● Staff did not always recognise abuse and take action to address concerns where there was a risk to people. Procedures were not followed in relation to informing the local authority of safeguarding concerns.
● Staff had not always completed or reviewed safeguarding training as per the provider's policy.

The provider failed to safeguard people from the risks of abuse. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Staff were not effectively deployed to ensure they had the appropriate skills and competency to meet the needs of the people they were supporting.
● There were insufficient staff on a night to safely evacuate in the event of a fire and the service did not have a plan in place. Staffing had reduced to one waking and one sleeping staff member, from two waking night staff due to lack of staff availability.
● Staff told us, "It's pretty horrible really, one person can need observing all night, and then there is personal cares, we can't do other tasks like cleaning as there isn't time."

The provider failed to deploy sufficient and suitably qualified staff. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider did not always operate a safe recruitment process.
● Staff's right to work was not always checked and evidenced. Staff risk assessments were not adequate and

had not been reviewed to reflect current risk.

We recommend the provider consults current guidance and legal requirements to ensure appropriate recruitment checks are carried out as standard practice for all staff.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
- People were admitted to the service without full consideration of their support needs. Technology was not used to promote independence and minimise restrictions.
- Best practice guidance for people displaying behaviours that challenge was not followed. Positive behavioural support plans developed by the community learning disability team were not available for staff to follow and implement.
- Communication aids were not used to support effective communication when people were not able to verbally communicate.

The provider failed to do all that was reasonably practicable to mitigate risk. This is a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
- Most staff had not received appropriate training in multiple areas. This included training to effectively support people living with learning disabilities and/or autism.
- The provider's training and development plan was not followed. It was not clear from records kept which staff were required to complete the care certificate (an agreed set of standards for health and social care workers). The majority of staff had not completed the 'care certificate' within the first three months of employment.
- Staff on 'shadow shifts' (observing experienced staff) we're often left providing 1:1 care or without adequate support.
- Staff did not receive regular supervisions. They were not always provided with support following incidents which may have resulted in injury or impacted their well-being. One staff member told us, "It's a new staff team who are inexperienced, the way we react can cause behaviours due to inconsistencies."

The provider failed to ensure staff were competent, skilled and experienced. This is a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
- People's risk in relation to poor nutrition and hydration were not managed or monitored effectively.
- People were not always supported appropriately. For example, one person did not receive one-to-one support when eating. This was required to manage the risk of choking.
- People were offered regular food and drinks, but they could not independently access these. Cupboards

and the fridge were locked due to one person needing restrictions as a result of allergies.
● People were not given a choice of evening meal and one person told us, "Staff choose."

The provider failed to assess the risk to health and safety of service users. This is a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some people's likes and dislikes were documented. We observed people offered a choice at breakfast and lunchtime.

Adapting service, design, decoration to meet people's needs
● The service was poorly maintained, and repairs and redecoration were required throughout the service. Issues had been identified by the provider but there were no time frames identified for works to be completed.
● For example, there was visible mould in the bathroom due to poor ventilation and carpets on the stairs were worn.
● The design of the service was not therapeutically beneficial to the people living there. Design and decoration of the service had not ensured that the environment was autism friendly.
● The environment was very busy with high numbers gathering in communal areas. The service was noisy due to doors banging and echoes throughout. External professionals described the service as "chaotic."

The provider has failed to ensure the premises were clean, properly maintained and suitable for purpose. This is a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People were not always supported to access healthcare services in a timely manner. Annual health assessments by their GP and other regular health checks had not taken place. Whilst this has undoubtedly been impacted by the recent pandemic there was a lack of assurance around involvement from external health professionals and how the risk were being managed during this time.
● Guidance provided from external professionals was not always understood by staff or followed. Information shared with other professionals was not always timely or was inadequate.
● People's movement between services was not well managed. There was a lack of communication around how people needed to be supported to ensure safe and effective care.

The provider failed to address and meet people's care and treatment needs through collaborative working with others. This was a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance
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. In care homes, and some hospitals, this is usually through MCA

application procedures called the Deprivation of Liberty Safeguards (DoLS).

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

- Staff understood the MCA and best interest decisions. However, in practice best interest decisions did not always involve people, their family members or external professionals.
- People's capacity to make decisions and decisions made were not regularly reviewed when there were changes and it was not always clear that less restrictive alternatives had been considered.
- People had DoLS authorisations requested or in place and these were monitored by management.

We recommend the provider considers current guidance and best practice on implementing the Mental Capacity Act 2005; taking action to improve their practice accordingly.

Inadequate

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 good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture of the service did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Staff did not always feel supported by the manager and did not seek support to deal with issues and concerns when needed. This resulted in poor outcomes for people.
- The culture of the service was not open, and staff were not comfortable addressing issues with colleagues which negatively impacted the service. Families were asked to escalate concerns on behalf of staff members.
- The service had experienced a high turnover of staff and change in management which impacted on morale. Staff had not received adequate support and communication around changes within the service had not been effective.

The provider failed to improve the quality of the service impacting on the experience of the service user. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; 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

- Quality assurance processes were not in place or effective. There were limited audits carried out by the service and those that were in place were inadequate.
- The provider's audits did not address issues relating to the care received by people. For example, issues relating to care plans, observations, medication errors and incidents had not been identified.
- Families and external agencies such as the local authority were not always informed following an incident or safeguarding concern.
- There was no manager currently registered with CQC. The current manager has made an application which was currently being reviewed.

The provider failed to operate effective systems and processes. This was a breach regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care

- There was no oversight or review of accidents and incidents resulting in risks not being identified and addressed. Where new systems had been put in place to address concerns these had not been used by staff

or checked for effectiveness.
● The providers time frames for actions were not always proportionate to the risk identified and action had not been taken to mitigate immediate known risks. For example, night staff continuing to work without having appropriate training.

The provider had failed to assess, monitor and mitigate the risk relating to health, safety and welfare. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● People, their relatives and professionals supporting the service had not been asked for their feedback. Professionals working with the service felt the service was not well-led and had limited input with the new manager.
● Families felt communication could be improved and there were concerns that care was not pro-active or responsive to people's changing needs.
● One relative told us, "I tend to sort things out myself, I raised concerns with [the service], there was a series of mistakes makes with medication and they are still happening." Another relative told us, "I get no regular updates, I want to be rung once a week for update, I went five weeks without one. I don't know who the manager is."

The provider failed to seek and act on feedback to improve the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The new manager had recently held a staff meeting and started to implement changes such as a suggestions box to encourage feedback from staff.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to address and meet people's care and treatment needs through collaborative working with others. Regulation 9 (3)(a)(f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to deliver care and treatment in a safe way by ensuring risk was assessed and mitigated. The provider failed to ensure proper and safe use of medicines. The provider failed to assess the risk of preventing, detecting and controlling the spread of infections. Regulation 12(1)(2)(a)(b)(g)(h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to safeguard people from the risks of abuse.

Regulation 13(2)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider failed to ensure the premises were clean, properly maintained and suitable for purpose. Regulation 15(1)(b)(c)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure staff were competent, skilled and experienced The provider failed to deploy sufficient and suitably qualified staff. Regulation 18(1)(2)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to establish effective governance systems and processes. The provider had failed to assess and monitor the service to mitigate risks to the health, safety and welfare of service users. The provider failed assess, monitor and improve the quality and safety of the service provided in the carrying on of the regulated activity. The provider failed to maintain accurate, complete and contemporaneous records in respect of each service user or keep accurate records of person's employed. The provider failed to evaluate and improve practice and the practice of those in employment.

The enforcement action we took:

A warning notice has been issued.