

Northfield Care Limited

Northfield House

Inspection report

Folly Lane
Uplands
Stroud
Gloucestershire
GL5 1SP

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07 September 2020

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19 October 2020

Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

About the service

Northfield House is a residential care home providing accommodation and personal care to 24 older people who live with dementia at the time of the inspection.

Northfield house can accommodate up to 25 people in one adapted building which has an enclosed garden.

People's experience of using this service and what we found

Fire evacuation procedures were not in place and fire drills had not taken place to test that people could be supported to safely escape if there was a fire. This placed people at risk of harm in the event of a fire.

Whilst some improvements had been made since the last inspection in relation to governance and oversight, systems were still not always effective in identifying and addressing quality concerns. Further improvements were needed in the monitoring of people's care records and fire safety and ensuring identified shortfalls were robustly addressed. We have received some assurances from the provider that they had started taking action to mitigate the risks identified during this inspection.

The monitoring of the medicines management had been effective and had resulted in medicine errors reducing and improved support for staff who administered medicines.

Staff were aware of how to report their concerns in relation to safeguarding and poor care. Concerns raised including about staff's behaviour, were investigated by the provider and actions taken to address any shortfalls. However, in some cases it had taken concerns to be raised for the shortfall to be identified and the provider did not always identify shortfalls such as incomplete records, through their own monitoring systems.

Infection prevention and control processes were in place to protect people and prevent the spread of infection. There was plenty of personal protective equipment (PPE) and improved arrangements to support staffs' use of this in relation to current PPE guidance for COVID-19. Regular COVID-19 testing of staff and people took place, support to socially distance and isolate when needed was provided and support to remain in contact with family members in a safe way.

The views of people and their relatives had been sought and, where it was practicable to do so during the pandemic, these had been considered and acted on to help improve the quality of support and services provided to people.

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 Requires Improvement (report published 6 November 2019) and we

identified one breach of regulation 17 Good Governance. 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 although some improvement was evidenced at this inspection, not enough improvement had been made and the provider remained in breach of regulation 17. We also found a new breach of regulation 12 Safe Care and treatment. The service remains rated Requires Improvement. This service has been rated Requires Improvement for the last three consecutive inspections.

Why we inspected

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. We also 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.

This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

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.

We have found evidence that the provider needs to make further improvements in 'Safe' and 'Well-led' sections. Please see full report for detail.

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 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 a repeated breach in relation to Good Governance as risk and quality had not been monitored effectively and shortfalls, when identified, had not been addressed before they could pose a risk to people's safety. We also found a new breach in relation to Safe Care and Treatment; safe fire evacuation procedures were not in place.

Please see the action we have told the provider to take at the end of this report.

Follow up

We will continue to monitor the information we receive about the service. We will follow up the provider's progress in relation to their compliance with necessary regulations in line with our current regulatory methodology. If we receive further concerning information we will review this and decide on the action we need to take.

We will continue to work alongside the provider, commissioners of the service and the local fire safety team

to monitor progress. We will meet with the provider and ask for an action plan to understand what they will do to improve the standards of quality and safety moving forward.

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 not always well-led.

Details are in our well-led findings below.

Requires Improvement ●

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.

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. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they 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 announced. Due to pressures from COVID-19 we gave the service 72 hours' notice of our visit.

Inspection activity started on 7 September 2020 with a visit to the care home and continued with desk top activity which ended on 11 September 2020.

What we did before the inspection

We reviewed the information we held about the service since the last inspection. We sought feedback from

commissioners of the service. We reviewed information we had requested from the nominated individual (the nominated individual is responsible for supervising the management of the service on behalf of the provider) in relation to the service's infection prevention and control arrangements and pandemic contingency plan. We used all of this information to plan our inspection. 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.

During the inspection

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 with us. We reviewed the arrangements for safe administration and management of people's medicines, including relevant records. We looked around the building and reviewed housekeeping and social distancing arrangements. We observed support given to people at lunchtime. We spoke with the registered manager, deputy manager and five other members of staff; care and housekeeping.

After our site visit

We continued to seek clarification from the registered manager to validate evidence found. We requested, received and reviewed, records relating to people's care, a selection of audits and checks and policies.

We sought and received feedback from two healthcare professionals and a fire safety officer.



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 Requires Improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

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

- People were not always protected from fire related risks. A fire risk assessment had been completed and some actions had been taken by the provider. However, no fire evacuation procedure was in place and staff had not received fire evacuation training. Regular fire safety evacuation drills to test a swift and effective evacuation of people had also not taken place putting people at risk in the event of a fire.

A lack of reasonably practicable action, in relation to fire safety procedures and staff training, puts people at risk of not receiving the support they require in the event of a fire. This is a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The service was linked to an alarm monitoring company, who in the event of the fire alarm sounding, would contact the fire service aiding staff response time. Fire alarm points in the building were tested weekly. Staff had completed a 'fire walk' during their induction training which made them aware of fire exits, fire equipment and where to meet if the fire alarm sounded. Mobile communication devices had been purchased so that staff could communicate with each other if in different areas of the building, in the event of the fire alarm sounding.

Following our inspection, the provider and registered manager confirmed action was being taken to ensure fire safety concerns were addressed, which included implementing fire evacuation procedure and staff training.

- Staff we spoke with understood the action they needed to take to ensure people remained safe in other areas of their care.
- People's care records however, did not always include up to date or comprehensive information about the support people needed to stay safe. One person's mobility had changed and they were using a hoist and another person's falls risk had increased but all their care records had not been updated with this information. Another person's malnutrition assessment score was incorrect. Staff and health professionals might therefore not always have the information they needed to support people appropriately.

People's records were not always, accurate or complete. This is a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing

- The pandemic had produced challenges in maintaining enough staff to meet people's needs. Some tasks

such as cleaning could not be fully completed as planned. However, staff had worked together and flexibly to cover staff absences. Some staff had worked additional hours to ensure people's needs were met and the staff collectively kept the home clean.

- The service continued to recruit new staff.

Using medicines safely

- People's medicines were stored and administered safely. Where there had been a medicine error (person was not harmed) action had been taken immediately to review this person's health with their GP and to prevent this from happening again. Recording errors (omission of staff signature following administration) were monitored closely and had reduced in number.
- People were supported to take their prescribed medicines and 'as required' medicines, such as pain relief. Medicines prescribed for occasional use and for anxiety or distressed behaviours, were used only when other support measures had failed.
- Staff were trained to administer medicines by a member of staff who was competent to do this. Staff competencies in the administration of medicines were also reviewed regularly.

Preventing and controlling infection

- The provider's infection prevention and control policy was up to date and infection prevention and control processes were in place to protect people and prevent the spread of infection. There was plenty of personal protective equipment (PPE) and improved arrangements to support staffs' use of this in relation to current PPE guidance for COVID-19.
- Regular COVID-19 testing of staff and people took place, support to socially distance and isolate when needed was provided and support to remain in contact with family members in a safe way
- We were assured that the provider was making sure infection outbreaks could be effectively prevented or managed. At the time of our inspection the service had not experienced a COVID-19 outbreak. However, during the inspection week several people presented with short lived gastrointestinal symptoms which were appropriately reported and managed.

Systems and processes to safeguard people from the risk of abuse

- People were protected from potential abuse. Staff knew how to recognise and report potential abuse. Staff reported changes in people's behaviour and unexplained marks on people's skin and these reports were followed up by senior care staff or managers.

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 Requires Improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders had not created a culture where improvement was consistently achieved and sustained.

At our last inspection on 28 August 2019 we identified that the provider had continued to fail to operate effective governance and quality monitoring systems to identify shortfalls in quality and safety and drive improvement. This was a repeated breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although some improvement was evidenced at this inspection, not enough improvement had been made and the provider remained in breach of Regulation 17.

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

- The provider and registered manager had not taken effective action to improve the service when systems identified risks and shortfalls in the service. Our last inspection found improvements were needed in the monitoring of fire drills and staff evacuation training to ensure people remained safe. The provider had commissioned an independent Fire Risk Assessment which identified the need to ensure fire evacuation procedures were in place. At the time of our inspection robust action had not been taken to address this shortfall and measures had not been put in place to reduce the risk to people until a fire evacuation procedure was in place. The service's own quality and risk monitoring systems had also not identified, although some action had been taken, sufficient progress had not been made against the Fire Risk Assessment action plan and that people remained at risk.
- Effective systems were still not in place to monitor whether service users' care records, including risk assessments and care plans, were accurate and complete. The registered manager told us that quality checks of service users' care records had been completed. No records relating to these checks/audits were available to show what shortfalls in service users' records had been identified and how progress had been monitored until improvements had been made. We found shortfalls in people's care records during this inspection and the checks completed had not been effective in identifying and addressing these shortfalls.
- The completion of kitchen tasks had been checked for weeks commencing 3 August 2020, 10 August 2020, 17 August 2020, 24 August 2020 and 31 August 2020 and identified a lack of steam cleaning of the kitchen, reminding staff this needed to be completed. There was no record of action taken to address this continued shortfall and the internal quality checks did not lead on to timely action being taken to drive improvement.
- The views of people's relatives were sought last through a satisfaction survey, completed earlier in 2020. The collated information forwarded to us showed mostly positive comments from those who responded, but no detail or actions relating to the small percentage of areas which were recorded as 'requires improvement' or 'inadequate' were noted to show how this information was being used to improve the

service.

The provider's governance and quality monitoring systems were still not always identifying quality and risk concerns and driving necessary improvement where it was needed. This is a repeated breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Improvement was evidenced in the quality monitoring of the medicines system. This had resulted in improved administration practice and a reduction in medicine recording errors.

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

- People received care which was personalised to their needs and staff were committed to supporting people to live well with dementia. One member of staff told us the staff team worked in a flexible way to meet people's needs at times it suited the person. Feedback provided by relatives on a website designed for this purpose confirmed their satisfaction with the care provided.
- Informal discussions were held with people in small groups or on a one to basis to support inclusiveness in decisions made about food, drink and social activities.
- Staff spoken with told us they felt empowered and encouraged to provide feedback and to make suggestions in meetings.

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

- When responding to a request to investigate a concern or incident involving a service user the nominated individual has confirmed that staff have been open and honest in their account of what had happened and what had been reported to the person's relative or representative.
- Prior to the inspection we had received several pieces of information of concern which also stated, that managers were not always open to or acted on concerns reported to them. We had shared each piece of information of concern we had received with the nominated individual for investigation. They responded each time, and where they had identified areas of shortfall, they had been open in sharing these with us and took action to address these. Although some shortfalls had been identified these had not impacted on the personalised care people had received.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People were supported to express their views and preferences and engage in conversation according to their individual communication and cognitive abilities. Staff were aware of people's differing protected characteristics and knew what made people happy and what might upset them. Some people had expressed a wish to get more involved with meaningful daily tasks, such as laying dining room tables and folding tablecloths, so the staff supported those who wanted to get involved in these activities.
- Team meetings and staff handover meetings took place to support effective communication between managers, senior staff and the rest of the staff team. One member of staff told us what had been discussed in the last team meeting a week prior to this inspection. This had included clarification and updates on infection, prevention and control arrangements and reminders for staff to wash their hands frequently. This had followed the completion of practice observations in relation to handwashing.
- One member of staff told us the registered manager was "supportive" and "approachable".

Continuous learning and improving care

- Improved monitoring of the medicines system had led to the implementation of a 'Reminder/ Action form.

This helped a senior member of staff track actions taken in response to medicine recording errors. These could be further reviewed with the member of staff later when their progress and learning was reviewed with them. This process had led to senior staff considering one staff member's protected characteristics when they were considering how to support their further development and practice in safe administration of medicines.

- When considering areas for continued improvement in staff learning during the pandemic the provider had purchased an ultra-violet light box to support improved awareness of effective handwashing procedures.

Working in partnership with others

- Managers had worked closely with local commissioners to support safe admissions to the care home during the pandemic.
- Managers linked into the local authority's safeguarding team to support the appropriate management of safeguarding concerns.
- Staff worked in partnership with a mixture of external professionals and agencies to support joined up assessment and care for people. Some improvement was needed to ensure referrals to health and social care professionals were always done in a timely manner.
- During the pandemic there had been limited working in partnership with the wider community as the care home adhered to relevant guidance to reduce people's contact with members of the wider community.

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	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The provider had not done all that was reasonably practicable to mitigate risk to the health and safety of those receiving support. They had failed to establish and operate effective fire safety processes to ensure service users could safely escape if there was a fire; placing them at risk of harm in the event of a fire.</p> <p>Regulation 12, (1), (2) (a) (b) (c)</p>

The enforcement action we took:

We issued a warning notice in respect of action not taken to produce fire evacuation procedures, train staff to be able to implement these procedures and complete fire drills to evaluate and monitor the effectiveness of the evacuation procedures and staffs' implementation of these.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The provider had continued to fail to ensure the quality of the care and service provided was regularly monitored, assessed and steps taken to improve the quality and safety of the services provided in the carrying on of regulated activity.</p> <p>Regulation 17 (1), (2), (a), (b), (c)</p>

The enforcement action we took:

We issued a warning notice in respect of continued shortfalls in the provider's governance and quality monitoring systems to be able to effectively assess, monitor and take action to drive improvement.