Mrs Sally Roberts & Mr Jeremy Walsh

Northleach Court Care Home with Nursing

Inspection report

High Street
Northleach
Gloucestershire, GL54 3PQ
Tel: 01451861784
Website: blanchworth.co.uk

Date of inspection visit: 29 July 2015
Date of publication: 15/10/2015

Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	
Is the service caring?	
Is the service responsive?	
Is the service well-led?	Requires improvement

Overall summary

We carried out an unannounced comprehensive inspection on 12 and 13 November 2014. At which three breaches of legal requirements were found. This was because the registered person had not notified the local authority Safeguarding team and the Care Quality Commission (CQC) without delay of abuse or allegations of abuse in relation to people using the service. Also the monitoring of accidents and incidents was incomplete.

After the comprehensive inspection the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches. We completed a focused inspection on 29 July 2015 to check that they had followed their plan and to confirm they now met the legal requirements.

This report only covers our findings in relation to the legal requirements. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Northleach Court on our website at www.cqc.org.uk.

Summary of findings

Northleach Court Care Home provides accommodation and personal care for up to 55 people. The home accommodates people living with dementia and provides nursing care and end of life care.

There was a registered manager. 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.

At our focused inspection on 29 July 2015 the provider had followed their action plan which they told us would be completed by 31 March 2015 with regard to recording and monitoring all accidents. Most safeguarding incidents had been reported to the local Gloucestershire safeguarding team. This meant two Regulations were met.

One regulation had not been met as CQC had not been notified of safeguarding incidents. Improvements had been made since our visit on 29 July, however a requirement remains to ensure this is sustained. You can see what action we have asked them to take at the back of the full version of this report.

Summary of findings

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 safe.

All bruises and injuries were recorded and the appropriate action was taken. Most incidents had been reported to the local safeguarding team.

Monitoring of accidents and incidents had been completed. Preventative measures were identified and healthcare professionals supported people when required.

Good

Is the service effective?

Is the service caring?

Is the service responsive?

Is the service well-led?
The service was not consistently well led.

Allegations of abuse between people who used the service were not reported to the Care Quality Commission (CQC) as required. Some improvements had been made and they need to be sustained.

Requires improvement

Northleach Court Care Home with Nursing

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 focused inspection took place on 29 July 2015 and was unannounced. We checked that the improvements planned after our comprehensive inspection on 12 and 13 November 2014 had been made. We inspected the service against two of the five questions we ask about services: is the service safe and is the service well-led. This is because the service was not meeting legal requirements in relation to these questions.

Before our inspection we reviewed the information we held about the service. This included the provider's action plan, which set out the actions they would take to meet legal requirements and notifications submitted by the provider. Providers tell us about important events relating to the service they provide using a notification. The unannounced inspection was completed by one inspector.

During the visit we spoke with a representative of the provider and the deputy manager and reviewed the accidents, incidents and safeguarding records. The registered manager was contacted after the inspection to verify information we looked at during the visit.

Good

Is the service safe?

Our findings

At our comprehensive inspection on 12 and 13 November 2014 the registered person had not notified the local safeguarding team when people that used the service had unexplained bruises. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

At our focused inspection on 29 July the deputy manager had informed the local safeguarding team about an incident between two people that used the service which had happened the day before. The risk assessments for both people were updated and the action taken was recorded.

We looked at four other incident records where people had sustained bruising or minor injuries. Photographs had been taken of the injuries and the appropriate action had been taken to include informing the GP and relatives. Two of the incidents had not been reported to the local safeguarding team. Communication between the registered persons was unclear which led to staff not always reporting incidents to the local safeguarding team. This meant that the regulation remained unmet. However since our visit on the 29 July we spoke with the registered manager who was clear when the safeguarding team must be informed. We have been able to check the local safeguarding team were informed on the notifications forms sent to us since the inspection on 29 July 2015.

At our comprehensive inspection on 12 and 13 November 2014 the registered person had not fully protected people who used the service against accidents as monitoring of accidents and incidents was incomplete. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010.

At our focused inspection on 29 July 2015 the registered manager had followed the action plan they had written to meet the shortfalls in relation to the requirements of Regulation 10 described above. They had completed a review of all accidents and a monthly audit to look at trends. This meant that the regulation was met.

We checked the accident and incident records for two months May and June 2015. All accidents and incidents had been recorded correctly and monitored by the registered manager. A representative of the provider had also checked all March 2015 accidents when a quality review of the service was completed. Actions taken after the accidents were recorded and included referral to the occupational therapist where required. The registered manager checked peoples risk assessments had been updated after an accident. Completed monthly audit of accidents identified any themes or where additional preventative measures might be required.

Is the service effective?

Our findings

When we visited the service in November 2014, we found the service was effective. We have not reviewed the rating we gave at that time. Comments we received from staff members did not give us cause to review this key question.

You can read what we wrote about this section in the comprehensive report by selecting the 'All reports' link for Northleach Court on our website at www.cqc.org.uk.

Is the service caring?

Our findings

When we visited the service in November 2014, we found the service was caring. We have not reviewed the rating we gave at that time. Comments we received from staff members did not give us cause to review this key question.

You can read what we wrote about this section in the comprehensive report by selecting the 'All reports' link for Northleach Court on our website at www.cqc.org.uk.

Is the service responsive?

Our findings

When we visited the service in November 2014, we found the service was responsive. We have not reviewed the rating we gave at that time. Comments we received from staff members did not give us cause to review this key question.

You can read what we wrote about this section in the comprehensive report by selecting the 'All reports' link for Northleach Court on our website at www.cqc.org.uk.

Requires improvement

Is the service well-led?

Our findings

At our comprehensive inspection on 12 and 13 November 2014 the registered person had not notified the Commission without delay of abuse or allegations of abuse in relation to people that used the service. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009.

At our focused inspection on 29 July we looked at four safeguarding incident records and none had been sent to CQQ to notify us of a safeguarding event. Communication between the registered persons was unclear which lead to staff not notifying CQC when required. This meant that the regulation remained unmet.

We spoke with the registered manager after our unannounced visit on 29 July, as they were not available on the day. The registered manager was now clear about when to send us safeguarding notifications. Since our visit on the 29 July they have sent all safeguarding notifications to us retrospectively and continued to keep us fully informed of all incidents with detailed notifications. This is an improvement and needs to be sustained to ensure people are fully protected against the risks associated with abuse and allegations of abuse.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents How the regulation was not being met: People who use services and others were not fully protected against the risks associated with abuse and allegations of abuse as the Commission was not notified of all incidents. Regulation 18 - (1) (2) (e).