Island Healthcare Limited

Northbrooke House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

The inspection took place on the 7 and 12 November 2018 and was unannounced.

Northbrooke House Nursing Home is registered to provide accommodation for up to 67 older people. There were 58 people living at the home at the time of the inspection. The home is a large extended property and accommodation is arranged over two floors and within two buildings. All bedrooms were for single occupancy and many had ensuite facilities. Bathrooms and toilets were provided on both floors. There was a lift and stairs available to access all the first-floor areas. There was a flat patio area adjacent to the home and lawned garden areas including a paddock housing two donkeys.

Northbrooke House Nursing Home is a 'care home'. People in care homes receive accommodation, nursing and personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. We found the home to be clean and well maintained throughout the inspection.

There were two registered managers, each responsible for different parts of the home and both had an overarching responsibility for the whole of Northbooke House. 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.

There were systems in place to monitor the quality and safety of the service provided and to manage the maintenance of the buildings and equipment. However, these systems were not always effective. They had not identified the areas of concern we found during this inspection in relation to: the inappropriate use of restrictive practices, the safe management of medicines, individual risk management systems, wound care and inconsistencies in care plans and record keeping.

Not all aspects of medicines management were safe. This included the administration of some medicines and ensuring safe storage temperatures.

Individual risks to people were not always managed effectively and the provider's physical intervention policies and procedures were not always being followed.

Staff usually protected people's rights by following the Mental Capacity Act, 2005 (MCA) and were aware of which people were subject to restrictions of their freedom.

Staff demonstrated a good awareness of the individual support needs of people living at the home. However, people's care plans did not always support staff to deliver care in a personalised way and ensure some specific healthcare needs were met in a timely manner.

Staff supported people at the end of their lives to ensure their comfort and their dignity.

People's nutrition and hydration needs were met and people were satisfied with the quality of their meals. Where necessary people received the support they required with eating and drinking.

People were treated in a kind, considerate and compassionate way by staff. Privacy and dignity was maintained and staff used appropriate techniques to communicate effectively with people.

People's individual cultural, sexuality and diversity needs were identified and staff respected these and supported people to meet these and to follow their faith.

Staff encouraged people to be as independent as possible. Relationships with family and friends were encouraged and staff ensured family members were kept up to date with events that had occurred for their relative.

Staff supported people to access a range of activities suited to their individual interests. Positive links with the local community had been developed.

Appropriate recruitment procedures were in place and there were sufficient staff available to meet people's needs. Staff were competent and understood people's needs and were appropriately supported in their role by senior staff and managers.

There were systems in place to protect people from the risk of infection and to respond to emergency situations.

The environment was well maintained and adaptations had been made to the environment to make it supportive of the people who lived there.

People knew how to raise a complaint and when received systems ensured these were investigated and responded to appropriately.

There was an open and transparent culture where visitors were welcomed. The provider sought and welcomed suggestions and feedback from people, relatives and staff. People were satisfied with the way the service was run.

The provider and the registered managers understood their responsibilities and complied with all requirements of the provider's registration.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The provider's physical intervention policies and procedures were not always being followed.

Not all aspects of medicines management were safe. This included the administration of some medicines and ensuring safe storage temperatures.

Individual risks to people were not always managed effectively however risks relating to the environment and the running of the home were managed effectively.

Appropriate recruitment procedures were in place and there were sufficient staff available to meet people's needs.

There were systems in place to protect people from the risk of infection and to respond to emergency situations.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff usually protected people's rights by following the Mental Capacity Act, 2005 (MCA) and were aware of which people were subject to restrictions of their freedom.

Systems in place had not ensured that people always had their specific healthcare needs met in a timely way. There were good links with external healthcare professionals who were positive about the service.

Staff were competent and understood people's needs and were appropriately supported in their role by senior staff and managers.

People's nutrition and hydration needs were met and people were satisfied with the quality of their meals.

Adaptations had been made to the home to help make it suitable for and supportive of the people who lived there.

Is the service caring?

Good

The service was caring.

People were treated in a kind, considerate and compassionate way by staff. People's privacy and dignity was maintained.

Staff used appropriate techniques to communicate effectively with people.

People's individual cultural, sexuality and diversity needs were identified and respected by staff.

Staff encouraged people to be as independent as possible. Relationships with family and friends were encouraged and staff ensured family members were kept up to date with events that had occurred for their relative.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's individual needs were met. However, care plans did not always support staff to deliver care and support in an individual and personalised way.

Staff supported people at the end of their lives to ensure their comfort and their dignity.

Staff supported people to access a range of activities suited to their individual interests. Positive links with the local community had been developed.

People knew how to raise a complaint and when received systems ensured these were investigated and responded to appropriately.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There were systems in place to monitor the quality and safety of the service provided and to manage the maintenance of the buildings and equipment. However, these systems were not always effective and had not identified the concerns raised during the inspection.

There was an open and transparent culture where visitors were welcomed. The provider sought and welcomed suggestions and

feedback from people, relatives and staff. People were satisfied with the way the service was run.

The provider and the registered managers understood their responsibilities and complied with all requirements of the provider's registration.

Northbrooke House

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 inspection took place on 7 and 12 November 2018 and was unannounced.

The inspection was undertaken by two adult social care inspectors, a specialist advisor for the nursing needs of older people 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 service.

Before the inspection we reviewed all information we had received about the service, including previous inspection reports and notifications. Notifications are information about specific important events the service is legally required to send to us. We also considered information the provider sent us in the Provider Information Return. This is information we require providers to send to us at least annually to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with 14 people who used the service and eight family members or friends of people who used the service. We spoke with the provider's nominated individual, two registered managers, the training manager, three registered nurses, eight care staff, an agency care worker, a breakfast assistant, an activities coordinator, two administrative assistants, a maintenance worker, two kitchen staff and three housekeepers. We received feedback from three health or social care professionals who had contact with the service and three visiting volunteer workers.

We looked at care plans and associated records for ten people and records relating to the management of the service, including: duty rosters, staff recruitment files, records of compliments and complaints, accident and incident records, maintenance records and quality assurance records.

We observed care and support being delivered in communal areas of the home. 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.

Requires Improvement

Is the service safe?

Our findings

The provider's physical intervention policies and procedures were not always being followed. We identified that an inappropriate restraint technique was used by a staff member on two occasions to move a person to another part of the home. A registered manager told us they were unaware of the first occasion until we showed them the documentation in the person's care file. They explained the action they had taken following the second occasion, which had involved supervision with the staff member and reviewing the training they had completed. No subsequent similar incidents had occurred following this action indicating that, if appropriate action had occurred following the first use of an inappropriate technique, the second occasion may not have occurred. The person was therefore placed at high risk of harm when an inappropriate restraint procedure was used a second time.

We reviewed other records where physical intervention had been used. Records were incomplete. They were not always dated or include a time of the incident. Records did not provide adequate description of the whole incident to enable patterns and triggers, as well as early warning signs, to be identified. This meant there was inadequate information to plan a proactive approach to supporting the person. Staff had recorded the use of restrictive practices, but there was no information as to what staff had tried to do to diffuse the situation. The outcome of interventions was also not always recorded as per the provider's policy. This meant a full review of incidents could not be undertaken.

We raised this with a registered manager. They took action to review the recording documentation and procedures for monitoring the use of physical intervention.

Staff had completed training to enable them to provide physical support for people should this be required, for example, if a person was behaving in a way that placed themselves or others at risk of harm. Staff were aware of people who were prone to behave in a way that put themselves or others at risk of abuse. They described the action they took to protect people and their property from avoidable harm. For example, a staff member told us, "We keep an eye on [one person] and if they become agitated we [support them on a one-to-one basis]."

People told us they felt safe at Northbrooke House and appeared at ease when interacting with staff. One person told us, "[I feel] very safe here, I have been here for seven months and have not had any problems." When asked if they felt their relative was safe, a family member told us, "[My relative] is very safe here, she doesn't fall over anymore, she has become very calm here."

Staff had received training in safeguarding adults and were confident that any concerns raised would be appropriately dealt with by the management team. Records confirmed that the registered managers had reported concerns promptly and liaised appropriately with the local safeguarding authority.

Not all aspects of medicines management were safe. Whilst reviewing medicine administration records (MARs), we noted that one person had not received their prescribed medicines correctly. Staff we spoke with were aware that there had been confusion over the correct time the medicine should be administered, but

had not followed the provider's medicines error procedures correctly by reporting the error to the registered manager. We informed the registered manager of our findings and they took immediate action to investigate the error and seek medical advice. Although no harm had come to the person staff had not followed the provider's policy to report medicines errors. We also identified that MARs had not always been fully completed and that staff had not acted and followed-up on these gaps, meaning prompt action could not be taken if staff had failed to administer medicines as prescribed.

Where people had been prescribed topical creams, either by health professionals who visited the home or by nursing staff who were employed at the home, systems in place had not ensured these were always applied as required. For example, in one person's bedroom we found a container of topical cream. The person's care plan and MAR contained no reference to the topical cream, which had clearly been used on several occasions. A staff member working in this area of the home was unsure about the application of this topical cream. A similar situation was identified for a second person. Although no harm had come to either person they were placed at risk of skin integrity damage. We raised this with the registered manager who undertook a full audit of topical creams and records relating to them. On the second day of the inspection, we saw MARs were in place and additional information was available to guide care staff as to where and when they should apply topical creams.

Whilst medicines were stored securely, records of the temperature of storage could not confirm that they were always stored at a safe temperature. Daily recording sheets were in place to record the maximum and minimum temperature of medicines storage rooms and medicines fridges. These contained guidance for staff as to the safe temperatures these areas should be maintained at. However, where temperatures were recorded outside of these safe levels, there was no record of any action taken to ensure the safety of the medicines was considered. Action had also not been taken when daily temperature recordings had not been made. We raised this with the registered managers, who agreed that the provider's systems had not been followed to ensure all medicines were safe to use. They took action to review the recording tool and address this with staff responsible for medicines administration. Furthermore, the temperature recording charts had not been included in the monthly medicines audits. Monthly audits had also not identified that some medicines received did not have a use by date and should have been returned to the dispensing pharmacy on arrival into the home.

The failure to ensure the safe and proper management of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Competency assessments were undertaken on all staff who administered medicines as part of their initial training and during annual refresher training. Staff were observed administering medicines competently; they explained what the medicines were for, did not hurry people and remained with them to ensure that the medicine had been taken.

Risk assessments had been completed to identify people who may be at specific individual risk with a view to act on reducing or managing the risk. These included, the risks to people of falling, choking, malnutrition and skin damage. However, procedures had not ensured that the systems for managing all risks were consistently followed. People who were at risk of skin damage used special cushions and pressure relief mattresses to reduce the risk of damage to their skin. Most pressure mattresses need to be adjusted to reflect the weight and position of the person using the mattress to ensure the correct amount of support is provided. In one section of the home three pressure mattresses were required to be set to the person's weight in order to provide the correct amount of support. Two were set incorrectly placing these people at risk of pressure injury.

A senior care staff member told us there was no formal procedure to monitor and ensure these were being used correctly. The registered manager told us these were checked monthly with care plan reviews however, they were not checked on a more regular basis. Although placed at risk of harm the provider subsequently confirmed that neither of the people affected had pressure injuries. Once we identified this to the registered manager, they took action and new procedures were put in place to ensure these mattresses were checked daily, used correctly and ensured the safety of people.

Other risks to individual people were also not managed safely. Some people at risk of skin damage required support to change their position at regular intervals. Care staff were recording when they provided this care however, it did not correlate to information in the person's care plan as to the frequency that the person required to be assisted to reposition. Another person's care plan identified that they may present a risk to other people when in communal areas. Their care plan stated that they should be supervised at all times when in communal areas. We noted on both days of the inspection occasions when no staff were in communal areas to supervise the person. Their care plan also stated that the person should be checked hourly at night however records did not demonstrate that these checks had occurred.

Where an incident or accident had occurred, there was a process in place which enabled the registered managers to identify any actions necessary to help reduce the risk of further incidents. However, where staff identified bruising or other injures that could not be attributed to a specific event, systems did not ensure that they were investigated and reviewed. We noted that care staff had recorded bruising and skin injuries for a person who was cared for in bed at all times. There had not been any investigation into how these injuries could have occurred or action taken to reduce any identified risks. One registered manager confirmed that an investigation did not take place and acknowledged that procedures needed to be improved for these situations.

The failure to ensure all risks to the health and safety of service users were assessed and where possible action taken to mitigate any such risks was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where people had fallen, records showed they were monitored for any head injuries, assessments were completed of all known risk factors and additional measures put in place to protect the person where possible. Specific incidents and accidents were reviewed regularly with the management team to identify any patterns or trends.

The provider had employed a health and safety officer to ensure that risks relating to the environment and the running of the home were identified and managed effectively. These included gas and electrical safety, legionella, fire safety and infection control.

There were appropriate systems in place to protect people by the prevention and control of infection, however we saw a member of staff not following these. At lunch time we observed a staff member serving food using their fingers to push food from a spoon onto plates and then lick their fingers. We also found that systems had not ensured that one piece of equipment was suitably cleaned to ensure it remained safe should the person for whom it was supplied require it's use. The procedure for changing a piece of equipment's tubing and cleaning filters was clearly identified in a person's care plan, but this had not been followed. We informed nursing staff about this and they acted to ensure suitable procedures were followed.

A person told us "The home and equipment are definitely kept clean, they are always cleaning." Another person said, "The home and equipment is kept very clean here." We saw that all areas of the home were clean. Staff had completed infection control training, had access to personal protective equipment (PPE)

and wore this whenever appropriate. Laundry staff described how they processed soiled linen, using special bags that could be put straight into the washing machines in the laundry. The laundry was organised in a way that minimised the risk of cross contamination. Both registered managers were aware of the action they should take should there be an infection concern at the home.

There were sufficient numbers of care and ancillary staff on duty to meet people's needs. People told us staff responded promptly to call bells. One person said, "The staff are always there when I need them, I am not rushed at all." Another person told us, "The staff will do anything for me, they have time to help me and don't rush me." Staffing levels were based on the needs of the people using the service. There was a duty roster system in place, which detailed the planned cover for the home. This provided the opportunity for short term absences, such as those due to staff sickness, to be managed using agency staff and existing staff working additional hours. Care staff felt that staffing levels were suitable to meet people's needs. Staff comments included, "Yes, we have time usually" and "Most days it's all ok."

The provider had a recruitment process in place to help ensure that staff they recruited were suitable to work with the people they supported. All of the appropriate checks, such as references and Disclosure and Barring Service (DBS) checks were completed for all staff. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. However, the application forms used to support the recruitment process were out of date and did not meet current requirements regarding people's employment history. We pointed this out to the provider, who immediately changed the forms to ensure they were up to date and met the current requirements. New staff confirmed that comprehensive recruitment procedures had been followed and all pre-employment checks were completed before they commenced working at the home.

There were clear emergency procedures in place. Staff knew what action to take if the fire alarm sounded, completed regular fire drills and had been trained in fire safety and the use of evacuation equipment. Staff had undertaken first aid training and a call bell system was located within all areas of the home, which staff told us included an emergency button, meaning staff could get prompt support in an emergency. Emergency suction and resuscitation equipment was available should this be required.

Requires Improvement

Is the service effective?

Our findings

Staff usually protected people's rights by following the Mental Capacity Act, 2005 (MCA). The 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. Many of the people living at the home lacked capacity to make some or all decisions relating to their care needs. Where this this was the case, staff had assessed the person's capacity using an appropriate tool, consulted with people close to the person and made best interest decisions on their behalf.

One person's consent was not sought before staff provided them with care and support. At lunch time, we saw a staff member approach a person and tell them they needed to have their eye drops. The person said, "No, I am eating my dinner!" The staff member responded that they would be quick and proceeded to administer the eye drops. This action failed to ensure that care was always provided with the person's consent. Otherwise, we saw staff seeking verbal consent from people before providing care and staff described how they always acted in the best interests of the people they were supporting.

There was a procedure in place for the covert administration of medicines, Covert medicines administration is when essential medicines are hidden in small amounts of food or drink and given to people. We identified that procedures in use followed the principles of the MCA and protected people's legal rights. They also ensured that all relevant people including GP's, dispensing pharmacists and relatives were involved in the decision to administer medicines covertly.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). The service was working within the principles of the MCA. Where necessary DoLS authorisations had been made, staff knew which people were subject to DoLS and there were processes in place to monitor the expiry dates of the DoLS and to submit renewal applications in good time.

Systems in place had not ensured people always had their specific healthcare needs met in a timely way. Where people had wounds, photographs including a ruler measure had not been taken of wounds. These help subsequent staff to reassess the wound and identify if healing is occurring or if a change in the wound management plan is required. We also found that wounds were not always being reassessed and redressed in a timely way. We found one person had sustained a six-cm skin tear to their lower leg following an accident whilst out of the home. At the time, the wound had been cleaned and dressed by nursing staff. However, there were no further records to show the wound had been reviewed by nurses and redressed for nine days. A registered manager and a senior nurse were unable to explain why the wound had not been redressed during this time. Some people required a urinary catheter (which is a tube which takes urine from the bladder). We found one person's catheter had not always being been changed in line with the manufacturer's guidance. Staff had documented that the catheter should be changed on a specific date 12 weeks after it's insertion. However, records showed that this had not occurred until two weeks after the

change due date. A registered manager was unable to explain why this had not occurred at or around the correct date. Once we identified this to the registered manager, they introduced new systems to ensure nursing staff were made more aware of when dressings and catheter changes were due.

The failure to ensure care and treatment were provided in a safe way for service users was a breach of Regulation 12 of the health and Social Care Act (Regulated Activities) Regulations 2014.

Staff worked collaboratively with other healthcare providers. People told us that when necessary, doctors or other healthcare professionals were consulted. One person said, "I use the doctor that visits the home, sometimes I am taken by transport to the doctor." A visitor said, "My [relative] uses the local visiting GP if she needs one." A visiting dental healthcare professional was positive about the way the home supported people to manage their oral care. Both registered managers were aware of how to contact external healthcare professionals such as dentists and opticians should people require these services. When people transferred to hospital or to another care setting, staff ensure all key information about the person's needs was passed on. The registered managers confirmed that prior to people returning from hospital, they completed a reassessment or spoke with the hospital to help identify any changes in the person's needs and ensure they home could continue to meet these. These arrangements helped ensure continuity of care for the person.

One section of the home provided care for people living with dementia. All staff, including ancillary staff, told us they had undertaken dementia training which they felt had provided them with a good understanding of the condition and how this affected people accommodated at Northbrooke House. This section of the home was organised to enable people to have their needs met at the various stages of the disease with support from nurses in the adjoining unit should this be required. Family members were all positive about the way people living with dementia had their needs met.

Northbrooke House had been designed or adapted to support the needs of people living there. Passenger lifts gave access to all above ground floor areas and bedrooms had en-suite facilities. There were handrails throughout the communal areas, which were of a contrasting colour to the surrounding walls making them easy for people to spot and therefore more likely to use. Bathrooms and toilets were easily identifiable with suitable signage and colour schemes. There was level access to the home and outside patio and garden areas, providing pleasant places to sit in warmer weather. Various lounges and communal areas were available providing people with options as to where they could spend their time. There were systems in place to monitor the safety of the environment and to ensure redecoration occurred when required.

People's nutrition and hydration needs were met and people were satisfied with the quality of the meals. A person told us, "I like the food here, they [kitchen staff] sometimes make me a special meal if I want it." Another person said, "I do like the food here, there is a choice and we do get snacks mid-morning and in the afternoon every day." A visitor said, "My [relative] eats all her food, she likes it here, drinks are always available."

Each person had a nutritional assessment to identify their dietary needs. Some people needed a special diet or needed their meals and drinks prepared in a certain way to meet their individual needs and we saw these were provided consistently. Staff monitored the nutritional intake for people at risk of malnutrition or dehydration using food and fluid charts. They also monitored people's weight and acted when people started to lose unplanned weight. For example, they fortified people's meals with additional calories or referred people to dieticians. When people needed support to eat, this was provided in a dignified way on a one-to-one basis. Coloured plates and plates with higher sides were also provided where required and supported people to eat independently.

Staff received appropriate training and an effective induction into their role, which enabled them to meet the needs of the people they were supporting. Each member of staff had undertaken an induction programme, including a period of shadowing a more experienced member of staff who assessed their suitability to work on their own. New staff were supported during their induction by a designated mentor to provide a point of contact and support. Staff who were new to care, received an induction and training, which followed the principles of the Care Certificate. The Care Certificate is a set of standards that health and social care workers adhere to in their daily working life.

The provider had a system to record the training that staff had completed and to identify when training needed to be updated. This included essential training, such as medicines training, safeguarding adults, fire safety and infection control. Staff had access to other training which focused on the specific needs of people using the service, such as, dementia awareness, oral health care, falls prevention, pressure care management and end of life care. Staff were supported to undertake a vocational qualification in care and demonstrated an understanding of the training they had received and how to apply it. For example, we saw staff using equipment to assist people to move correctly.

Staff had regular supervisions and staff who had been at the service for longer than 12 months also received an annual appraisal. Supervisions provide an opportunity for management team to meet with staff, feedback on their performance, identify any concerns, offer support, assurances and identify learning opportunities to help them develop. Each staff member had a dedicated note book which contained the records of each of their supervisions. This enabled both the management team and the staff member to review their supervision history and identify their personal development trajectory and any further training and development needs. Staff said they felt supported by the management team and senior staff. There was an open-door policy to managers and staff said they could raise any concerns straight away.

Staff made appropriate use of technology to support people. For example, movement alert equipment was used to alert staff of the need to support people when they moved to unsafe positions. An electronic call bell system allowed people to call for assistance when needed. The service had internet access and equipment was available to enable people to keep in contact with relatives via electronic systems. A large tablet computer was also available which could be used for individual or group activities.

Good

Is the service caring?

Our findings

People consistently told us they were treated in a kind and compassionate way by staff. One person said, "The staff are brilliant here, they have time for me, they are very caring." Another person said, "The staff will do anything for me." A family member told us, "When we visit, the staff are very kind to my relative and have time for her."

We observed positive interactions between staff and people living at Northbrooke House. For example, while supporting people to eat, staff engaged with people and gave supportive prompts. When a person spilt their drink at lunchtime, a staff member calmly cleared it up, brought the person a fresh drink and sat with them to help them drink it. Staff were considerate of people's individual likes and dislikes. For example, a staff member knew which biscuits were a person's favourites and commented to the person, "I had to dig to the bottom of the [biscuit] box, but found you your favourite." Ancillary staff also knew people well and we saw them using people and visitor's names appropriately. For example, we overheard the receptionist having a conversation with a person. Although the person was unable to have a coherent conversation, the staff member knelt to their level and actively listened, making it a valued interaction for the person. When people returned from a community lunch event, staff asked them if they had enjoyed their lunch demonstrating an interest in the people and their experience. On another occasion, a person had been in hospital and was returning to the home. Staff had put a 'welcome home' banner in the person's bedroom. These examples show how staff valued people as individuals regardless of their level of mental or physical disability.

People were encouraged to view Northbrooke House as their home. For example, people could visit the home prior to moving in and where possible choose between available bedrooms. They could personalise their bedroom by bringing in their own furniture and possessions to make their room feel more homely. We saw family members bringing in some items of furniture for a new person during the inspection. We were told the home's maintenance person would also collect furniture if family members were unable to arrange or transport this. The home had been adapted to support the needs of people living there. One of the registered managers told us that a person who was living with dementia was due to move into the home. However, the person found it difficult to live in a residential home environment and mix with the other people. In consultation with the person and their family, the provider had arranged for their room to be adapted to provide external access, which meant they would not have to go through the home. This approach would allow staff to support them in a way that met their personalised needs and maintained their independence while keeping them safe. During the inspection, the registered manager showed us this room which was nearing completion.

People were asked their opinion and supported to make choices about aspects of their care. For example, meals were served by care staff from heated trolleys, meaning people could see the food and make a choice at the time of service. In addition, the nominated individual told us they were looking at how they could further increase choice around meals with the use of sample plates to support people living with dementia with making choices. Information was included within people's care plans which gave staff an insight into the person's interests, background and relationships that were important to them. When we spoke with staff, we found they had a good understanding of people's histories and gave examples of how they used

the information to support people.

Staff used appropriate techniques to communicate effectively with people according to their individual needs. For example, when speaking with people with hearing loss, they faced the person and spoke clearly; when communicating with people living with dementia, they used short, simple phrases and gave the person time to process the information. When a person became anxious and confused, we observed a staff member bent down to the person's eye level, held their hand and spoke with them gently. Staff were happy to provide physical contact including hugs where people wanted this.

Staff respected and promoted independence by encouraging people to do as much as possible for themselves. People's care plans included information as to what support they needed and what parts of personal care, such as washing their own face, they could do independently. At lunch time, we saw a range of adapted crockery and cups were provided when necessary, meaning people could continue to eat independently. Should people wish to participate in light house work, this was also possible. We saw one person washing up some cups after lunch. This provided the person with a worthwhile activity and promoted their self-esteem and feelings of self-worth.

Staff understood the importance of protecting people's privacy and dignity. A person said, "The staff are very respectful, they knock on my door before they enter." They added, "The staff do look after my dignity, they are very nice." All bedrooms were for single occupancy with ensuite facilities, which helped to ensure privacy and dignity was maintained when personal care was provided. Staff described how they kept people covered as much as possible when providing personal care. One staff member said, "We [staff] keep them covered as far as possible." Some people had asked to receive personal care from staff of a specific gender only. Staff were aware of these wishes and told us they always respected any such requests.

One registered manager told us how they explored other aspects of people's cultural, sexuality and diversity needs during ongoing discussions with people about their backgrounds, interests and beliefs. Further information about people's individual life and cultural choices was included in a 'This is me' document, which gave staff an insight into the person's interests, background and relationships that were important to them. The issue of identifying and meeting people's diversity and sexuality needs had been discussed at a senior staff meeting. This included ideas as to how the home could improve the support for, and raise awareness of, older LGBT (lesbian, gay, bisexual and transgender) people. As a result, a LGBT rainbow symbol had been purchased to go on the main building door to show people and visitors that the service was supportive of people from the LGBT community.

People were supported to follow their faith and religious needs. During the inspection, we saw some visitors from a local church were providing a service for a person. The registered manager was aware of how to contact various religious or faith leaders should people request this. When we spoke with staff, we found they had a good understanding of people's histories and gave examples of how they used the information to support people. Staff had completed diversity training.

People's relationships with family and friends were encouraged and staff ensured family members were kept up to date with events that had occurred for their relative. One relative told us how staff always welcomed them when they visited and offered them a refreshment. We saw staff knew visitors by name and welcomed them on their arrival. Visiting, including with pets, was unrestricted. Where relatives were unable to visit on a regular basis, staff r used computer technology to either enable the person to keep in contact or provided updates for family members via emails. Due to the fact there was no longer a direct bus route to the home, the provider told us they could also collect visitors from nearby towns if they lacked personal transport. This would help ensure family members could continue visiting.

Confidential information, such as care records, were kept in secure offices and only accessed by staff authorised to view them. Any information which was kept on the computer was also secure and password protected.

Requires Improvement

Is the service responsive?

Our findings

Assessments of people's needs were completed by one of the registered managers before people moved to the home. This information was then used to develop an appropriate care plan in consultation with the person and their relatives, where appropriate. People and their relatives were aware of their care plans and confirmed they had been involved in discussions as to how their care needs should be met. One person told us, "I have been involved in my care plan and so have my family."

We found the quality of care plans varied with many being very individual and person focused whilst others contained contradicting information. For example, one care plan contained a lot of individual detail, especially around how a person liked to be cared for at night. This included specific information such as the person liked a low light left on and their bed positioned so they could see where the toilet was, with the ensuite bathroom door left open. This also promoted the person's independence as they would be able to make their own way to the toilet if required at night.

However, other care plans provided contradictory information. Two plans specified different information as to the frequency that a person required repositioning when they were in bed and others lacked information as to where and when topical creams should be applied. Some care plans contained vague statements and detailed care that was no longer relevant. For example, one plan for a person who was cared for in bed at all times, stated that they were not to be left alone at any time especially if they were upset. We visited the person on several occasions in their bedroom during the inspection and they were alone with no staff present. We discussed this with one registered manager who agreed this section of the person's care plan required reviewing as it was no longer relevant due to a change in their needs and risks. The person's care plan also stated they were on a normal diet, however, we saw a note on a large board in the care office saying the person should receive a high calorie diet. The provider has now informed us they have updated this care plan.

We found documentation, including records of care people had received were not always fully completed. For example, records of hourly checks at night had not been recorded and repositioning records also did not evidence that people had been supported to change their position as per their care plans. Some people living with dementia behaved in a way that could place themselves or others at risk. Where these incidents were recorded, we identified that the quality of recording was insufficient to enable a comprehensive analysis of the person's behaviours. Good recording would help staff to understand and develop a plan to support the person with a view to reducing the incidents. Records did not detail all proceeding situations which may have helped understand what had led to the incident. The registered manager confirmed that formal monitoring and incident analysis was not being used to understand the purpose of behaviours which were placing people at risk. The registered manager reviewed the documentation during the inspection to ensure more information about specific incidents was recorded.

In respect of meeting some healthcare needs, care plans contained insufficient detail. One person was receiving some of their fluid intake via a tube directly into their stomach. They had previously also been receiving nutritional supplements via this tube. The reason why the nutritional supplement had been

discontinued was not readily available in the care plan meaning that non-permanent staff may not have been able to locate this information and be unaware as to how the person's needs should be met. This placed the person at risk of not receiving the correct nutritional and fluid intake. One person was prescribed three different forms of pain relief. Their care plan contained no information to inform staff as to when each should be administered, meaning these may not be consistently administered.

Some people were living with diabetes. This was documented in their care plans and nursing staff were monitoring blood sugar levels. Records viewed indicated that different nursing staff took different action for the same person dependant on these results. This included not administering insulin on some occasions, whereas for the same reading other nursing staff had administered insulin. Care plans did not specify clearly the action staff should take. We raised this with the registered manager who explained that in addition to the test results the nurses would also use clinical judgment taking into account other symptoms and factors to decide on what action to take. By the second day of the inspection, the registered manager had updated these care plans to provide comprehensive information as to the actions staff should take in various situations. This would help ensure a consistent approach to the management of each person's diabetes.

We were told that care files were reviewed monthly by heads of care and every three months by care planners. We were also told that senior staff reviewed records of care provided for people daily and prior to filing on a Sunday night. However, these procedures had not identified the inconsistencies and inaccurate information we found and had failed to ensure all care plans provided comprehensive and up to date information. The provider explained that they were in the process of updating all care plans with a view to moving to an electronic system within the next few months

We joined nursing staff for a handover between the morning and afternoon shift and saw that appropriate information was passed onto the next staff team. Care staff told us that if they had a few days off or new people were admitted to the home, they were given additional information to ensure they were updated about people's needs. Staff were allocated to work in specific parts of the home, meaning they could get to know people and understand their needs.

At the end of their lives, people were supported to have a comfortable, dignified and pain free death. However advanced planning had not been completed meaning staff may be unaware of people's specific wishes as they approached this time of their life. One registered manager told us they were reviewing how this information could be included in a meaningful way within care plans and related documentation. This would also include a leaflet for family members and include additional information about people's individual later life wishes. The registered managers, nursing and care staff described how they supported family members and people as they approached the end of their lives. These discussions showed that people would be treated with kindness, compassion and that staff would ensure they were as comfortable as possible. External health professionals would be involved to help ensure people received appropriate care to manage any symptoms.

Opportunities for mental and physical stimulation were provided everyday by activities staff and visiting activities providers. One person told us, "I do like the activities here, I like crossword puzzles and other things." Another person said, "I do go down and join in the Men's Club that they run in this home, it is very good, I like it." Most activities took place within the communal lounge areas, however activities staff told us they also offered a range of activities to people who remained in their own bedrooms either by choice or due to their care needs. Activities were developed to suit the abilities and needs of people within the various areas of the home. Activities staff also encouraged community participation. For example, on the first day of the inspection, several people had been supported to attend a local community lunch and they later told us this was a regular event. The local community was also welcomed into the home. On the second day of the

inspection, local mothers had been invited to bring their babies and young children to the home for a weekly social event. We saw people were joining in and appeared to be very much enjoying their small visitors. Volunteers were also available and they told us they spent time especially with people who did not have regular visitors. People were encouraged to interact together during activities and activities staff demonstrated a good understanding of people's likes, dislikes and approaches to encourage engagement.

People felt able to raise issues or complaints should the need arise. One person said, "I would talk to the manager If I had a problem." A relative told us, "If [my relative] had a problem, we would talk to the manager." They added, "We only had a few small concerns and they were dealt with." One of the registered managers told us that minor day to day issues were dealt with straight away and recorded in person's file. The provider had a policy and arrangements in place to deal with complaints. These provided detailed information on the action people could take if they were not satisfied with the service being provided. One of the registered managers told us they had received one complaint in the previous 12 months. We reviewed this complaint and saw the registered manager had fully investigated the concern, dealing robustly with the issues identified and providing a written response to the person who made the complaint.

Requires Improvement

Is the service well-led?

Our findings

There were systems in place to monitor the quality and safety of the service provided and to manage the maintenance of the buildings and equipment. However, these systems were not always effective. They had not identified the areas of concern we found during this inspection in relation to: the inappropriate use of restrictive practices, the safe management of medicines, individual risk management systems, wound care and inconsistencies in care plans and record keeping. The failure to adequately monitor the quality of the service and records held in respect of people and the care they required and received has meant that people have not always received care in a timely way to meet their health and care needs.

The failure to provide good governance to ensure the safety and quality of service provision and that accurate records are maintained is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider carried out their own quality assurance process and provided documentary feedback of their findings to the registered managers. Where issues or areas of development were identified, these were either acted on straight away or formed part of a rolling action plan to ensure all actions were completed appropriately. There was a health and safety lead who carried out regular environmental health and safety, and fire safety checks. The registered managers carried out regular quality assurance checks, which included reviews of care plans, kitchen audits and ad hoc audits. In addition, they carried out an informal inspection of the home during a daily walk round. Where issues or concerns were identified, an action plan was created and managed through regular meeting processes.

People were happy at Northbrooke House Nursing Home. A person told us, "The home runs nicely, it must be well run." Another person said, "The management do ask what I think about things like the food choices." A visitor told us, "We do think the service is well run, always helpful, happy and bright." Visitors including health care professionals said they would recommend the home to others in need of a similar care service and would be happy for their own relative to be admitted to the home.

The providers were fully engaged in running the service and their vision and values continued to be built around valuing individuals and inspiring them to maintain their wellbeing and live a fulfilled life. To support this vision, the provider has divided Northbrooke House into two separate units; Rylands, which provides accommodation for older people living with dementia; and Hazel Lodge, which has a primary focus on providing nursing care to older people, including those living with specific physical disabilities. Each unit had an identified manager, who was registered with CQC and both had an overarching responsibility for the whole of Northbooke House. 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.

Staff were aware of the provider's vision and values and how they related to their work. Regular staff meetings provided potential for the management team to engage with staff and reinforce the provider's

values and vision. They also provided the opportunity for staff to provide feedback and become involved in developing the culture of the service. There was an opportunity for staff to engage with the management team on a one to one basis through supervisions and informal conversations. The provider had suitable arrangements in place to support the registered managers, for example regular meetings, which also formed part of their quality assurance processes. The registered managers told us that support was available to them from the provider. They were also able to raise concerns and discuss issues with the registered managers of other locations owned by the provider.

All staff were positive about the home's management team. One staff member said, "[Nominated individual] is very passionate, she does a great job." Staff said they felt able to make suggestions about the home and that these would be listened to. The provider recognised the importance of engaging with staff in the development of the service. For example, they had recently sponsored a competition to encourage staff to identify "fun recruitment ideas", to encourage the recruitment of new staff. They had also initiated the use of a secure messaging app to enable staff to share ideas on how to improve the service and experiences of people living at the home. For example, one idea adopted by the provider was to create individual 'Red Folders' for people, which contained all of the day to day documents used by staff to record how they had supported people's needs.

There was the opportunity for people and their relatives to comment on the culture of the service and become involved in developing the service through regular feedback opportunities, such as informal interactions with the registered managers. One of the registered managers told us that although they have an open-door policy they also held a 'family clinic' monthly as some families appreciated a more formal process. We found that people and their families were also engaged through regular monthly client forums and through feedback surveys. One relative told us, "I cannot fault [the provider], they listen. I have put in loads of suggestions. If you want to be involved you can be. They listen, I asked for new cushions for outside [to allow my relative to sit in the garden]. They [management] took that on board and brought new furniture and cushions so [my relative] would be comfortable. I asked for a new notice board for upstairs and they got one." The provider also held monthly family forums, which they describe as being similar to an 'Alzheimer's café' where families can enjoy tea and cakes and discuss any concerns and different aspects of dementia care. For example, the last forum focused on 'the three stages of dementia' and the next was on 'what makes a good visit'.

The home had a whistle-blowing policy which provided details of external organisations where staff could raise concerns if they felt unable to raise them internally. Staff were aware of different organisations they could contact to raise concerns. For example, care staff told us they could approach the local authority or the Care Quality Commission (CQC) if they felt it was necessary.

The provider and the registered manager understood their responsibilities and were aware of the need to notify the CQC of significant events in line with the requirements of the provider's registration. The home's previous inspection rating was displayed prominently in the home's entrance halls. There was a duty of candour policy in place, which required staff to act in an open way if people came to harm. The registered managers were clear about how and when it should be used.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person has failed to ensure the safe and proper management of medicines and to ensure that all risks to the health and safety of service users were assessed and where possible action taken to mitigate any such risks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person has failed to ensure good governance systems to monitor and maintain the safety and quality of service provision and that accurate records are maintained.