Mr & Mrs F Ruhomutally

Northgate House (Norwich)

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

This inspection took place on 30 November 2016 and was unannounced. Our previous inspection of this service took place on 06 June 2016 and identified one breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to the management of medicines.

This November 2016 inspection found that these concerns had been remedied, but different concerns had been identified in relation to the same regulation. These related to safe care and treatment. In addition, we found that the provider was in breach of three further regulations in relation to safeguarding, consent and the governance of the service.

Northgate House is a residential home providing accommodation and care for up to 22 older people. At the time of this inspection 14 people were living in the home.

There was a registered manager in post. 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.

Some risks to individuals' welfare had not been appropriately acted upon. We had particular concerns with regards to how people were supported with behaviour that challenged. We also found that staff did not always identify and respond to the impact this behaviour had upon other people. Safeguarding referrals in relation to this had not been made when appropriate.

Improvements were required to ensure that staff understood how to implement the Mental Capacity Act 2005 and the related Deprivation of Liberty Safeguards into every day practice.

The provider oversight was focused on the environmental side of the service and improvements had been made here. However, they had limited oversight of the provision of care. The manager had delegated some responsibilities to a care co-ordinator but had not adequately overseen their duties. Some service audits were not effective.

Improvements had been made in the management of people's medicines and people received their medicines as prescribed.

Staff received training in most areas. However, service users could have been better supported if staff had received training in managing behaviour that challenged. There was a lack of understanding in this area. People had enough to eat and drink and enjoyed their meals. People received support from healthcare professionals when any needs or concerns arose.

Staff were caring and people were treated with respect and dignity. People's physical needs were attended

to promptly. The provider had a complaints system in place and people, their representatives and other visitors to the service were encouraged to raise concerns.

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 consistently safe.

Some risks to individuals and risks in relation to the environment were not safely managed.

The necessary action was not always taken when incidents occurred that required a referral to the local authority's safeguarding team.

Medicines were managed and administered safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Improvements were still required to ensure that staff understood how to implement the Mental Capacity Act 2005 and the related Deprivation of Liberty Safeguards into every day practice.

Whilst staff training was up to date staff had not been supported with training in how to respond to challenging behaviour. Supervisions were taking place, but these required improvement to make sure they were objective.

People had good access to healthcare professionals.

Is the service caring?

Good

The service was caring.

People were cared for by kind and caring staff.

People were treated with respect and dignity and their views and preferences about their care were respected.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's physical needs were met, but there was sometimes a lack of response to people's emotional or psychological needs.

People knew how to make a complaint or raise a concern and were encouraged to do so.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The provider had limited oversight of the care that people received.

The systems to assess the quality of the service provided were not always effective. Action was not always taken when areas for improvement had been identified.

Northgate House (Norwich)

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 of Northgate House was carried out on 30 November 2016 and was unannounced. The inspection team consisted of one inspector and an inspection manager.

Prior to this inspection we reviewed information we held about the service. Before the inspection, the provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed statutory notifications we had received from the service. Providers are required to notify us about events and incidents that occur in the home including deaths, serious injuries sustained and safeguarding matters.

During the inspection we spoke with three people living in the home and representatives of five people. We made general observations of the care and support people received at the service. We also spoke with the manager, the operational manager and four care staff.

We reviewed four people's care records and the medication records of seven people. We viewed records relating to staff recruitment as well as training, induction and supervision records. We also reviewed a range of maintenance records and documentation monitoring the quality of the service.

Requires Improvement

Is the service safe?

Our findings

Our previous inspection in June 2016 found that the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to concerns with the management of people's medicines. This inspection found that these concerns had been remedied, but other concerns were identified in relation to this regulation.

One person, who was cared for bed, needed the assistance of staff to eat meals. When we went into their room they were alone. They were partly sat up in bed and were trying to swallow food in their mouth. They were having some difficulty with this and were coughing slightly. They had been left alone with food still in their mouth and had not been sat up at a safe angle to aid swallowing and digestion. This had put the person at risk of choking.

Since our previous inspection the service had admitted two people with complex needs and behaviours that could put themselves or others at risk. Records showed that one person had a tendency to throw objects at people. However, there had been no analysis to identify whether situational or environmental factors increased the likeliness of their behaviour in order to implement a strategy to reduce the risks. Staff told us that they had not received training in responding to challenging behaviour but had discussed between them how to support the person by using distraction techniques.

One unlocked room on the first floor contained several tins of paint and tools. The paint had not been stored behind a fire door. On the ground floor store cupboards and linen cupboards were unlocked. These unlocked rooms could pose risks for people who were mobile and living with dementia or mental health conditions. For example, there was a risk that people could fall and not be found promptly. There had also been concerns about one person smoking in the house which posed further risks given the contents of these unsecured rooms.

The water system had been tested for legionella in October 2016 and the results had been negative. However, the risk assessment and maintenance control measures in place were not robust. For example, there had been no inspection or assessment of the home's water system to determine of the level of risk from the legionella bacteria. There was no plan in place to show how potential sources of risks in the water system could be prevented or controlled.

These concerns meant that the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were plans in place to protect people against identified risks. For example there were risk assessments for falls, pressure area care and nutritional risks. These identified the potential risks to each person and described the measures in place to manage and minimise these risks.

We were told by one person living in the home and relatives of two further people that one person had a tendency to throw things at people, including cutlery and food. The manager told us that a person who was

living with mental health issues sometimes shouted at other people living in the home. Some instances of challenging behaviour should have been referred to the local authority as safeguarding referrals. As this had not been done the local authority had not been able to independently investigate if necessary or provide support and guidance to staff to help reduce the risk of harm to people. We could not be confident that safeguarding referrals were made when necessary.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's medicines were being managed appropriately. We looked at the medication records of seven people which indicated that people received their medicines as prescribed. We found that ongoing medicine stock levels were routinely checked against records, all of which we found to be in order. If people required variable doses of prescribed medicines, records showed how much was administered and why. Guidance for the administration of 'as required' medicines was in place. Medicines were securely stored at suitable temperatures.

The manager told us that they had assessed the service as requiring three care staff during the day and two overnight. Most days there was an activities staff member on duty as well. These staff had received training in care and they were able to provide additional support when necessary. At the time of our inspection there were 14 people living in the home, one of whom was in hospital.

Whilst there were enough staff to meet the needs of most people, further consideration needed to be given to the resourcing required or deployment of staff to effectively meet the needs of one person who was living with dementia. On the day of our visit the person had required substantial emotional support or interaction with staff. When they received this, they were settled and engaged. When they were not occupied their behaviour could become challenging. The manager told us that the person had had a particularly 'bad' day on the day of our visit. They explained that the person often preferred to be in a separate lounge, but the separate lounge had been otherwise in use.

We reviewed the recruitment records for two recently employed staff members. The systems in place were robust and included criminal records checks, identity checks and references were obtained. This meant that the risk of employing unsuitable staff had been minimised as far as was possible.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

Our June 2016 visit found that whilst training in the MCA and DoLS had been underway that there was limited understanding in this area. This November 2016 visit found that staff training in this area had been completed. However, improvements were still needed in this area. We observed that staff didn't always seek the consent of people they were supporting. One person was ushered into another room without any discussion taking place.

Whilst mental capacity assessments were in place some of the information was conflicting or incorrect. For example, one person had been deemed not to have capacity to make any day to day decisions due to them having dementia. Their records stated that they did not have capacity to make their own decisions in relation to personal care. Another section referred to the person having agreed for staff to support them with their personal care. The person's records stated that a relative held power of attorney for 'health and finance'. However, when we spoke with the person's relative we were told it was in relation to their finances only. The person's records did not contain evidence that the Lasting Power of Attorney had been checked.

Whilst the service had made some applications to the local authority for authorisation to restrict some people's freedoms, which were in order, not all instances of where this may have been required were considered.

On the day of our visit we observed that one person wished to move freely about the home. However, we observed that staff repeatedly escorted them back to the main lounge to sit down. There had been no assessment to determine whether not allowing the person to move about the home freely was in the person's best interests. There had been no consideration of whether a DoLS application was required because the service had needed to restrict the person's freedoms in order to keep them safe.

These concerns constituted a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On arrival at the home we saw that the day's menu was available on tables in the dining area. This showed

that choices were available. One person told us, "I get a choice of food here which is all very nice." Another person's relative told us, "The food is fine. [Family member] never has any complaints about it." The manager told us that other than one person requiring a diabetic diet, no other people living in the home required a special diet.

People who chose to stay in their rooms, as well as those in communal areas, had drinks available to them. The food served at lunch and tea time looked appetising and people were asked whether they wanted an alternative if they weren't eating it or a second helping. We observed one person being patiently and effectively supported by a staff member to eat their lunch.

Staff training was up to date and all staff had achieved either level 2 or level 3 diplomas in social care. Some staff had undertaken more detailed training in certain areas to help with specialised roles in the home, for example around infection control. The provider's representative told us that the service intended to specialise in dementia. However staff had not received any training in this area. We saw that all staff received regular supervisions. However, the quality of these was poor. They contained little meaningful reflection on performance and where issues were raised there were no details of how these were to be resolved or of any support provided for staff.

One person told us, "They soon get the doctor here if you're not well." Records showed that people received support with their health care. For example, we saw that people had access to GPs, district nurses, dentists, opticians and chiropodists.

Good

Is the service caring?

Our findings

People were positive about the staff that supported them. One person told us, "There's a good feeling here, I knew as soon as I came in the door. Some of the staff bring their children in to see me, which I really enjoy." Another person told us, "Staff are kind here." A third person stated, "The staff are wonderful."

Four of the five people's representatives were also positive about the staff. One of them told us, "The staff are really nice, they do a good job." Another representative stated, "The staff are always friendly and helpful." A third said, "All staff seem kind. We've never had any problems." The fifth person told us, "I don't think some of the staff have the right attitude."

People's preferences and wishes were taken into account in how their care was delivered. For example the times people preferred to get up and go to bed were recorded in their care records and staff were mindful of this. However, they still checked to make sure this was what people wanted on a day to day basis rather than assume.

The staff and management team had developed good relationships with people. A number of staff had worked in the home for several years and knew the people who lived there well. They were knowledgeable about people's individual personalities and were aware of people's likes and dislikes.

People were respected. They and their representatives were encouraged to make their views about the home and how it was run, known. Minutes from residents and representatives meetings showed that people were kept informed about events affecting the home such as staff changes and re-decoration plans and their observations and suggestions were sought. Posters throughout the home of upcoming events and health professional visitors were also utilised to help remind or encourage people's participation.

Throughout our visit we observed staff showing kindness and consideration to people. When staff went into communal areas where people were they were acknowledged. Staff had a good rapport with people and were seen to be friendly. As people came into the lounge in the morning they were helped into their chairs with patience and respect.

People and their representatives commented on the improvements to the environment. One person told us, "They have done a good job inside, it's a different place." Outside areas had been tidied. Internally, a process of re-decoration and refurbishment was ongoing. Improved lighting had been installed in some areas and the home was painted in bright and cheerful colours. A hair dressing salon area had been established. Pictures of events that had taken place were on the walls and information leaflets were available to people in communal areas. These improvements helped people to feel cared about.

Staff had a kind, caring approach. We saw they always knocked on doors and checked people were not receiving personal care before they went in. One person who chose to stay in their room told us, "I am never lonely or miserable. Staff are always popping in and out and they know to let me sleep in the day. Staff are always about. If I ring the bell someone will come." People's rooms were personalised with people's

belongings, such as furniture, photographs and ornaments to help them feel at home. The person told us, "I have my own bits and pieces. It's a little bit of home. This is my home now."

Requires Improvement

Is the service responsive?

Our findings

Whilst staff were caring we found that the service did not respond consistently to people's needs, particularly those of an emotional or psychological nature. We saw instances where staff were not always observant of people's behaviours or mood and did not identify when their intervention might have been required.

We observed that when one person exhibited challenging behaviour that adversely affected another person staff did not take effective action. One person had repeatedly tapped the arm of another person sitting next to them which caused this person some distress. Staff were aware of the tapping and distracted the person doing the tapping for a few moments before going back to their duties. The person then resumed the tapping. This had left the second person upset. This pattern re-occurred several times.

The person doing the tapping needed more engagement from staff to meet their needs than they received. When a visiting group from a local church attended the home during the afternoon of our visit and played scrabble with the person they were settled and content.

One person's care records stated that they didn't recognise themselves in the mirror and this resulted in them becoming frightened and distressed. The care records stated there should not be any mirrors in the person's room. However, there were two mirrors in their room.

Arrangements were in place for dedicated staff support for people to engage with their interests. We saw that a variety of activities took place, some with groups and some individually. Some people had been involved with preparations for Christmas. During our visit we observed staff looking at photographs with people of places and persons of interest to them. People were enjoying this. Representatives of two people we spoke with felt that some of the activities could be more adult orientated.

People's physical needs were met. We saw that when someone asked for a snack between meals, this was promptly provided. Staff responded to people's requests for assistance promptly. One person's representative told us how their family member had recently informed staff that something was wrong with their ankle. Staff had assisted the person to their room, carried out some preliminary checks and had determined the best course of action to take.

The manager or care co-ordinator assessed people's needs before they moved in to the home. Assessments contained information about people's health, background and preferences. People's care records had guidance for staff on how to provide people's support and to enable them to be as independent as possible. One person told us, "They put the toothpaste on the brush for me, but I brush my own teeth."

People knew how to make a complaint. There were posters on walls encouraging people to speak with the manager or the provider's representative. The service had a complaints procedure for people, relatives and visitors to raise concerns. Written complaints were well managed. We found that the manager had responded in a timely and even handed manner, had apologised and made appropriate changes to

people's care if this had been necessary.

However, some verbal concerns were not responded to appropriately. We observed one person bring an issue to the attention of a staff member. Once the staff member had finished listening they carried on with what they had been doing and took no corrective action.

Requires Improvement

Is the service well-led?

Our findings

The registered manager reported to the operations manager. The operations manager, who represented the provider, had oversight of the home in relation to the refurbishment of the premises and the business side of the home. However, there were no systems in place for them to assure themselves of the quality of the service that people received. Their focus was not sufficiently directed towards the care that people received.

A new role had been created for a care co-ordinator. The provider's PIR stated that this new role was about monitoring the quality of care that people received. The care co-ordinator was responsible for undertaking audits and the quality of the care plans. However, there was little effective oversight of this role or operational support for this role by the manager. The manager's most recent supervision of the care co-ordinator had not identified the issues we had found during this inspection.

An infection control audit had not been carried out with a high degree of scrutiny. For example the infection control audit had 'achieved' recorded beside almost all of the 140 checks. Some of the issues recorded as 'achieved' were not relevant to the home's situation. Others which required staff to be verbally tested on their understanding had no record to show this had been done. There was no record of any sampling within the home to substantiate the assertions of achievement made within the audit. The audit had not been reviewed or signed off by the manager or provider. Where 'not achieved' had been recorded, there were no details of what remedy was to be sought or when the issue would be rectified by.

The service was using the auditing templates within their computerised care record system. These had last been completed on 7 November 2016 in relation to health and safety, maintenance and grounds and a care overview. The care overview audit stated that repositioning, food and fluid charts had been completed, but sometimes in the wrong part of the computerised system. There was no corrective action recorded for this.

We found poor recording in relation to two people's repositioning records. One person required repositioning every two hours. On three consecutive days we found gaps between recorded repositioning of five hours, ten hours and four hours. A second person required repositioning every four hours. On one of the same three days there was no record that they had been repositioned after 9am.

The recording of people's fluid intake was also variable. Some charts indicated that people had only drank in multiples of 100 mls. Others were more realistic and recorded smaller amounts and sips. The last record drink for one person on one day had been at 10am. Staff were not recording whether people who required assistance to drink had been offered drinks and had declined. There were no systems in place to ensure that recording charts were adequately completed. Consequently the provider could not assure themselves that people were receiving appropriate care and support.

These concerns meant that the provider was in breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The operations manager told us that it was envisaged that the service would look to specialise in the care of

people living with dementia. However, the provider had not ensured that staff had the right training, skills or experience to provide a service for people living with dementia.

Accountability and responsibility for some aspects of the service were not at the appropriate level. The changes in the management structure had resulted in confusion and, on occasion, complacency.

The care co-ordinator told us that they were responsible for carrying out audits, completion of care plans and the day to day organisation of staffing shifts and supervising the senior care staff. However, senior care staff we spoke with told us that they were responsible for the organisation of the shift. As a result of the change in the management structure some staff found themselves carrying out supervisions for friends or those they shared accommodation with. This had caused some tensions in the staff team.

People living in the home were positive about the management of the home. One person told us that, "The home has done good since the new manager came." Three of the five people's representatives we spoke with were positive about the home's management. One of these commented, "The manager has got a lot more things in place. It's more organised and disciplined." However the representatives for two people expressed concerns that the standard of the management in the home could be starting to decline.