Northway House Residential Home Limited

# Northway House Residential Home

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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|---|---|
| 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

We undertook an unannounced inspection of Northway House Residential Home on 7 November 2017. When the service was last inspected in October 2015 no breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Northway House Residential Home is a 'care home'. People in care homes receive accommodation and nursing or 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. The service do not provide nursing care. The service is able to accommodate up to 29 people. At the time of the inspection there were 26 people living at the service.

There was a registered manager in post at the time of this inspection. 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.

During this inspection we identified that improvements were needed in ensuring people were cared for safely. We identified concerns around risk management in relation to choking and requested the registered manager take immediate action to reduce this identified risk. We also noted that risks associated with people being permanently cared for in bed were not well managed. Where people had risks associated with fluid intake and monitoring this was not consistently safe. Where risks were identified in relation to people's weight, actions to monitor their weight increase or decrease had not been completed as required.

Safeguarding systems to ensure people were not safe as referrals had not been made as required and current policies required updating to be in accordance with current legislation and regulations. Medicines management required improving, as we found medicines specific for the use at the end of a person's life were out of date and there was a risk they may have been used. Improvements in relation to infection control practice was required.

The service had not met their responsibilities with regard to the Deprivation of Liberty Safeguards (DoLS). DoLS is a framework to approve the deprivation of liberty for a person when they lack the mental capacity to consent to treatment or care and need protecting from harm. 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 Mental Capacity Act 2005 (MCA). The registered manager had not made any applications for people living at the service and it was not evident they understood current legislation around DoLS applications.

People were not fully supported by the design and decoration of the service. We found that repairs to different areas of the service were needed, for example there was water damage on some ceilings and when it began to rain during the inspection staff used a bucket to catch dripping water. Staff understood the Mental Capacity Act 2005 (MCA) and had been trained in it, however improvements were needed to ensure

that legal records relating to a person's authority to make decisions on behalf of another had been obtained. Improvements were needed to ensure staff received frequent supervision and appraisal.

We found that some practices at the service were not person centred or in line with people's preferences. For example, the service had set 'Bath days' for people and people that wished for more frequent bathing were being told it wasn't possible. Care records did not always evidence how people's physical needs would be met and personalised information about people was not consistent. We received mixed feedback on how involved people and their relatives felt in relation to care planning.

The service had failed to send legal statutory notifications to the Care Quality Commission as required. Governance arrangements were not robust as the shortfalls identified during our inspection relating to risks, safeguarding and medicines had not been identified by current arrangements. We received mixed feedback in relation to the leadership at the service and how involved the registered manager and head of care were in relation to care provision and being visible within the service.

People did tell us they felt safe at the service and were positive about staff. There were systems to support people in the event of an evacuation of the service. In general, positive comments were received about staffing and recruitment was safe. Staff spoke positively about their training at the service and there was an induction for new staff aligned to the Care Certificate. In general, access and referrals to healthcare professionals was timely.

People told us that staff were caring and we made observations to support this. People received information about the service and staff told us their aim was to treat people with respect, dignity and kindness. Staff knew the people they were supporting well and we saw kind and caring interventions between people and staff. People told us they were treated with dignity and visitors were welcomed at the service. People's relatives had sent compliments to the service and given positive feedback on a national website.

Care records showed the service had made efforts to personalise them and risks assessments and associated care plans were reviewed monthly. People had the opportunity to participate in activities. Some community links with the local choir were formed and people were supported to do things they enjoyed before moving to the service. There was a complaints system in operation. The service had discussed end of life wishes with people who wished to and end of life plans were made. There was a system to communicate with people, their relatives and staff through meetings and annual surveys were completed.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In addition, a breach of the Care Quality Commission (Registration) Regulations 2009 was also identified. You can see what action we told the provider to take at the back of the full version of the report.

## 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.

Known risks were not always managed safely and placed people at risk.

Safeguarding systems did not always ensure concerns were raised.

Improvements were needed in medicines management.

We found poor infection control practice in some areas.

People felt safe in the service and with the staff that supported them.

### Is the service effective?

**Requires Improvement**

The service was not fully effective.

The service had not met their responsibilities with the Deprivation of Liberty Safeguards.

The service was not designed and decorated to meet people's need.

Improvements were needed in relation to supervision and appraisal.

Staff felt supported with training.

People had access to healthcare professionals when needed.

### Is the service caring?

**Good**

The service was caring.

People said staff were caring and supported them with dignity.

Staff understood the needs of the people they cared for.

We made kind and caring observations.

People's relatives were welcomed at the service at any time.

Compliments had been received from people's relatives.

## Is the service responsive?

**Requires Improvement**

The service was not always responsive.

Improvements were needed to ensure care was person centred.

People's records did not always evidence how to meet their needs.

We received mixed feedback about involvement in care planning.

People could partake in activities.

There was a system to receive and investigate complaints.

## Is the service well-led?

**Requires Improvement**

The service was not well-led.

Statutory notifications had not been sent as required.

Governance arrangements were not robust.

We received mixed feedback about leadership and management.

There were methods to communicate with people, their relatives and staff.

Annual quality assurance surveys were completed.

# Northway House Residential Home

**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 checked 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 October 2017 and was unannounced. This inspection was carried out by two inspectors and an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service. When the service was last inspected in October 2015 no breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that the provider completes to give some key information about the service, they tell us what they feel service does well and the improvements they planned to make. We also reviewed the information that we had about the service including safeguarding records, complaints and statutory notifications. Notifications are information about specific important events the service is legally required to send to us.

Some people in the service were living with dementia and were not able to tell us about their experiences. We used a number of different methods such as undertaking observations to help us understand people's experiences. We spoke with 16 people who used the service and three people's relatives. We also spoke with 10 members of staff. This included the registered manager, the head of care, care staff and activities staff. Following the inspection we also contacted the local authority to obtain information about the service.

During the inspection, we looked at 9 people's care and support records. We also reviewed records associated with people's care provision such as medicine records and daily care records relating to fluid consumption. We reviewed records relating to the management of the service such as the staffing rotas, policies, incident and accident records, recruitment and training records, meeting minutes and audit

reports.

Requires Improvement

# Is the service safe?

## Our findings

Although generally people told us they felt safe, some areas of practice within the service were not safe and placed people at risk. For example, we observed lunch during our inspection. During the lunch service, one person who was eating unsupervised got into difficulty swallowing their food. They began to have difficulty swallowing. The person regurgitated their food and the staff member removed their plate. As a result of this incident, we reviewed the person's care records and spoke with staff.

Senior staff at the service told us that a referral to a Speech and Language Therapist (SALT) had recently been made. We reviewed the current and historical information relating to this person's choke risk. On reviewing the person's records, we identified the first episode of choking was recorded on 08/09/2017. During lunch on this day, the person got into difficulty and choked on a fish bone. This required staff to perform back slaps and three abdominal thrusts to clear the obstruction. Despite this incident, no referral was made to the SALT and no modifications to the person's current meal consistency was discussed with them or implemented.

A further review of the person's records showed that on 26/10/2017 they suffered a further choking episode. This incident was at night during a medication round. The person got into difficulty swallowing a tablet when being administered their medicines and required immediate staff intervention. This again involved back slaps which were unsuccessful and abdominal thrusts were required to remove the tablet obstructing the person's airway. Paramedics were also called to attend this incident. We reviewed the person's records. This further showed no referral to a SALT was made and 12 hours later the person was given cereal, eggs and toast for breakfast with no assessment of any on-going risk being completed.

We reviewed the person's nutritional care plan that was created on 14/07/2017. There was a section that questioned if the person had swallowing difficulties which was incomplete. There was no information relating to any choke or swallow risk in the plan of support and the only information for staff was the person didn't eat a specific meat. The nutritional plan was shown as being reviewed on 28/09/2017 [after the first choking incident] and stated, "No change."

We spoke with the head of care. They told us the person was referred to the SALT following difficulty swallowing porridge on 31/10/2017. This was five days after the second choking incident. We spoke with the head of care who told us that as an interim arrangement the person was on a, "Softer diet." There was no record of this within the person's records, and when we spoke with a cook they were unaware the person may need any modified consistency food and there was no record within the kitchen. The person was not served soft food on the day of the inspection when they experienced swallowing difficulties.

At the conclusion of the inspection, we requested that the registered manager and head of care address this matter with urgency and discuss interim safety measures with the person pending the SALT assessment. This was completed and the day following the inspection we received a copy of an interim care plan to reduce the choking risk. In addition to this, the registered manager had created an action plan evidencing previous and future action taken in response to this risk. This did not evidence that there were effective

systems in operation to manage and monitor risks appropriately.

It was not evident that appropriate arrangements were in place to manage risks and records were not maintained to evidence and ensure effective risk management. For example, we observed one person who was nursed in bed because they were immobile. From reviewing the care provision and management of risks associated with people who were cared for in bed, we identified this person did not have a turn/repositioning chart. This meant that there was a risk of pressure ulcer or moisture lesion development as it was not being recorded that the person was being repositioned on a frequent basis for observation and recording of their skin integrity. It was not clear how frequently staff were repositioning the person, nor would it be clear to staff how frequently or when their colleagues had supported the person to turn. This further evidenced that mitigation of known risks was not effectively managed or monitored. We highlighted this to senior management who were prompt in providing a repositioning chart for the person and for staff to complete.

Risks associated with malnutrition, obesity and dehydration were not always effectively managed. We observed that fluid balance charts that were being used to observe adequate hydration did not have the total 24 hour intake and output identified. The target amount of fluid required by people that they should be encouraged and supported to consume was not recorded. This meant that although a risk was identified, the risk was not appropriately managed. The absence of a total fluid intake requirement meant there was no reference to establish if a person had achieved a positive or negative fluid balance or if escalation to a relevant healthcare professional was required. This placed the person at risk.

During a review of another record, we noted that a person who was identified as at risk of weight loss had not had their weight recorded monthly as identified on the risk assessment. There was a period of two months that had passed without this person having been weighed to assess if they had lost further weight. A further care record we reviewed showed within the nutritional plan they should be weighed monthly. The supporting weight records showed they had been weighed in July and September 2017 and the person had not suffered a significant weight variance. However, the failure to complete the required weight monitoring in August 2017 meant any significant weight loss would not have been identified meaning any required risk management measures would not have been implemented.

The above evidence amounts to a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes for safeguarding were not fully effective and did not fully protect people from exposure to risk. Although staff understood how to report safeguarding and felt confident the registered manager or senior staff would take action, we found referrals had not been made when required. For example, following our inspection we communicated with the local authority. They advised us that there were four safeguarding investigations reported to them by third party agencies since January 2016. None of these were reported by the service. In addition to this, when reviewing evidence we obtained at the inspection, it was evident the registered manager had identified an incident of alleged neglect and had failed to report this.

We reviewed a staff meeting agenda from a meeting held in October 2017. In the minutes, the registered manager made reference to the alleged neglect of one person. The meeting minutes showed that the person had a target fluid intake of 1400 – 1600 millilitres a day. The minutes evidence that over an eight day period the person averaged 828 millilitres. The person then had a fall and was noted to be dehydrated by paramedics. Despite identification of this potential neglect, no alert was raised with the local authority. We made a safeguarding referral to the local authority on identifying this evidence.

During a review of the provider's policy in relation to adult protection and prevention of abuse, it stated that CQC should be notified of abuse or allegations of abuse. We also identified that the policy, despite showing it had been reviewed in 2017, made reference to historical legislation and regulations and was not current. We also noted that there was no whistleblowing policy to guide staff on how to report concerns in confidence to third party agencies. When we spoke with staff they explained they had received training in whistleblowing and knew the agencies they could speak with for support.

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

During the inspection, we saw evidence of poor infection control practice. For example, during our initial walk around the service with the registered manager we identified that within a currently empty room the mattress did not have a protector on and had apparent bodily fluid stains with the appearance of blood, vomit or urine. We highlighted this to the registered manager who told us the mattress would not be used and would likely be replaced as opposed to cleaned. Later in the day, our inspection team observed this bed had been made by staff with sheets and fresh bedding placed directly on top of the soiled mattress with no protector. We brought this to the attention of the registered manager. We also saw in one person's bedroom their overnight catheter bag full of urine was on their bedside table. In addition to this, we noted that handwashing facilities in the medication storage room lacked any soap. Effective handwashing is necessary in preventing cross infection.

We identified that some areas of improvement were required in relation to the safe management of medicines. The service had a medicine policy that had been written in 2010 and reviewed by the registered manager on 06/09/2016. The policy was overdue for its annual review. Policy reviews are important as they can identify and result in changes and amendments that reflect current best practice.

No covert medications were being administered at the time of our visit and the service had not had any medication errors in the previous six months. We noted that the temperature of the medication storage room and medication fridge had been taken and recorded on a daily basis. This ensured that medicines were stored at the optimum temperature. A master signature list was maintained that included the signature of the newest member of staff. The reason for a master signature list is that in the event of a medicines error the responsible member of staff can be promptly identified.

We observed that bottles of medicines had been labelled with the date they had been opened; this ensured that liquid medicines that had an expiration period following being opened were not used when past this date. Staff told us that medication reviews were held on an annual basis. The service used a blister pack system and we checked a sample of blister packs against the Medicine Administration Records (MAR) and found them to be correct.

We saw that all people had a current photograph on their MAR. A copy of this photograph and the date it was taken was held in the care plans. An accurate and current photograph helps when agency staff are dispensing medication and do not know people individually. Medicines were only dispensed by senior staff who underwent a series of 'shadowing' and observed practice until both they and the senior member of staff/head of care were satisfied that they were safe and competent to administer medicines. Dispensing staff had regular six monthly competency assessments.

Medication audits were conducted by an external pharmacist on a six monthly basis and in house audits in between the pharmacist visits. Medication audits are a way of ensuring that best practice was being followed and checks storage, dispensing, disposal and stock levels. At the time of our visit two people

managed their own medicines. We saw risk assessments that were reviewed on a monthly basis to ensure people's safety in continuing to self-medicate.

We checked the storage and stock levels of medicines that required additional storage measures had been put in place. We found during this check that end of life medication used to control pain and anxiety at the end of life of a person's life had expired. The storage of expired medicines should have been identified during a previous audit. The storage of these medicines past the manufacturers recommended retention date presented a risk of the medicines being administered them.

Improvements were required in relation to the infection control practice within the service. The service employed cleaning staff to undertake the cleaning within the service. Whilst an environmental audit was conducted, the supporting records produced to us by the registered manager did not evidence an ongoing system to ensure frequent checks of infection control practice and cross infection risks were completed. An 'environment' and 'body fluids and sharps' audit tool had been completed in July 2015. The remainder of the record just indicated they had been 'reviewed' annually not evidencing an audit had been completed.

People and their relatives told us they felt safe at the service and with the staff that supported them. One person we spoke with said, "I feel safe and I am not going to be kicked out." Another comment was, "I feel very safe here." A relative we spoke with told us they felt the person living at Northway House was safe and staff did their best to stop him falling.

There were personal evacuation plans for people in the event of an emergency. These showed individual people's mobility and support requirements during an evacuation and also a nominated place of safety for people to go. Individual plans were colour coded red, amber or green to indicate to staff or the emergency services the complexity of the person's individual requirements. Records indicated that regular fire alarm and emergency lighting testing was completed and annual inspections and tests were carried out by external specialists. Regular servicing was completed of mobility equipment and aids to ensure they were safe and serviceable. An external provider completed this servicing, and records showed equipment such as hoists, bathing equipment and commodes underwent periodic testing.

In general people commented there was sufficient staff on duty. Staff commented that there was normally sufficient staff on duty to support people and meet their needs. They commented this would sometimes change depending on unplanned sickness but other staff may cover this. Most of the people we spoke with told us that there was sufficient staff to support them and we made observations to this effect. One person however told us, "Sometimes the girls [staff] are pushed and cannot spend time like two years ago." There appeared enough staff on duty to meet people's needs, however at lunch time in the dining room there were 13 people sat at the tables and only one member of staff to serve lunch and clear the tables. This appeared to make the lunch period excessive in time and it took one hour for a group of three people to have their meal. This also resulted in very limited interaction between the staff member and people during lunch. At the end of lunch, the staff member collected the dishes without much interaction with people who then just left the dining area. In addition to this, when the person began choking, as described above, there were no additional staff members present to support the member of staff promptly in the dining room.

The provider operated safe recruitment procedures and ensured all pre-employment requirements were completed. Staff files had completed initial application forms together with the staff member's previous employment history and employment or character references. Photographic proof of the staff member's identity and address had been obtained. An enhanced Disclosure and Barring Service (DBS) check that ensured the applicant was not barred from working with certain groups such as vulnerable adults had been completed.

Requires Improvement

# Is the service effective?

## Our findings

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 application procedure for this in care services is called the Deprivation of Liberty Safeguards (DoLS). We checked whether the home was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

The provider had not met their legal responsibilities in relation to the DoLS. At the outset of the inspection, the registered manager told us that no applications had been made for any person at the service to be deprived of their liberty. They told us that all of the people at the service were free to leave and all had the capacity to do so. During the inspection when speaking with people, all of the inspection team noted that some people within the service were confused as to where they were and why they were there. This did not evidence people had the capacity to consent to care or treatment and also to consent to remain at the service. Staff we spoke with also told us they did not believe several people in the service currently had capacity.

During feedback, this was highlighted to the registered manager. If it was evident there was a limited knowledge and understanding of the current DoLS legislation and the Supreme Court ruling in 2014 which set the 'Acid Test' to be undertaken in relation to establishing if an application should be made. The provider's policy was out of date and related to old regulations and Primary Care Trusts (PCTs) which no longer exist. The registered manager advised the inspection team they would seek to enhance their knowledge through training and external professionals to ensure the relevant legislation was met. This absence of knowledge placed people at risk of being unlawfully deprived of their liberty.

This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not currently being supported in an environment where the adaptation and design evidenced the provider responded promptly when required. We found that some areas of the service were in need of repair and restoration and it was apparent this had been required for some time. In addition to this, areas of the service were cluttered with equipment which restricted the use of potential communal areas for people and their families. In relation to damage and restoration within the service, the inspection team observed areas in need of repair.

For example, the ceiling in the main dining area had suffered water damage and was brown. Holes had been drilled to release water. Staff we spoke with could not remember exactly when this happened but stated it had been, "Some time." During the inspection there was heavy rain, and one area of the service was leaking and required a used plastic container to catch the dripping water. The water damage around the area the water was dripping from indicated this had been the case for a period of time. At various points throughout the service the carpet was stained or worn, in a downstairs bathroom there were dead spiders and cobwebs behind a secondary glazing sheet which was dirty. Walls were scratched and areas or paintwork around

radiators and skirting boards needed attention. We were also told by some staff the extractor fan in the kitchen had not worked for around 12 months and this caused excessive heat and headaches amongst staff.

Other areas of the service had not been maintained in a way they could be used by people or staff. A downstairs communal lounge area had been used as a storage area and was unusable. Staff we spoke with told us this used to be a, "Quiet room" and was previously used by people and their relatives. When we looked within this room, it was used as a storage area for unused mobility equipment, unused pressure relieving cushions, a hoover, a fan, hairdressing equipment, bed bases, tools and wheelchairs. Some staff we spoke with told us the service, whilst not evidently unsafe, did not promote a good environment for people. One staff member told us some areas of the service were, "Embarrassing" and told us that at times priority was taken for storage as opposed to using areas for people at the service.

This was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 we spoke with did not raise concerns with us. One person we spoke with told us, "The staff give people choice and they are attentive."

Staff we spoke with had an understanding of the MCA and how it was applied in the work. People were observed being offered choice in their daily lives and were involved in decisions with the support of staff. Within care records we saw that capacity assessments for some people had been completed but additional assessments may be required when reviewing people's DoLS status. We found improvements were needed in ensuring legal documentation was obtained and retained when a third party had lawful authority to make decisions on behalf of someone living at Northway House. For example, where a Lasting Power of Attorney (LPA) was in place, a record of this was not always held at the service. The registered manager immediately made arrangements to rectify this following the inspection.

Staff spoke positively about their training, and told us they felt supported in relation to the training they received that consisted of both mandatory internal training and additional nationally recognised qualifications. However, in addition to training, there is a requirement for the service to ensure that staff received appropriate supervision and appraisal and improvements were needed in this area. The current training records showed that staff completed training in key areas such as first aid and basic life support, health and safety, infection control, safeguarding adults, moving and handling and dementia.

There was an internal induction programme. For staff new to care the induction was aligned to the Care Certificate. The Care Certificate is an identified set of induction standards that health and social care workers should adhere to when performing their roles. There was a system to ensure staff received performance supervision and an annual appraisal where performance and learning objectives for the coming year could be set. Some staff we spoke with told us they had completed the Care Certificate and we saw an example of a new staff member's Care Certificate workbook being completed.

We found that improvements were needed in the supervision and appraisal of staff. We reviewed the current supervision and appraisal records and spoke with staff. We received less that positive feedback about the delivery of supervision and appraisal by the registered manager, however most staff felt well supported in their role. One staff member told us, "I have not had an appraisal in [number of years worked at service]

years but I will be having one next week. I have never had a one to one supervision. Training is good." Another said, "I have worked here [number of years worked at service] years in that time, I have only had two or three supervisions. I was due to have an appraisal this week but it was cancelled but I have had one appraisal."

Supervision and appraisal records did not show frequent bi-monthly supervisions had been completed as shown on the records as being required. For example, the record showed that no supervisions had been completed in January, March, June or October 2017. Other parts of the record showed that some staff had not received supervision for six or seven months. Additionally, there was nothing on the record that showed either the registered manager or head of care had received supervision from their line manager during 2017. When we spoke with the head of care they confirmed this and told us, "I have worked here two years and I have had appraisals but not supervision."

We found that people's nutrition and hydration needs were met. People we spoke with about the food served at the service were generally positive. People told us there was plenty to eat and drink and that they never went hungry. One person told us, "I could have cooked breakfast everyday if I wanted. You can ask for something different from the menu." Another said, "We have mince far too often, but if you ask for an omelette you get one. The alternative is usually vegetarian which I don't like." A person's relative explained how since arriving at the service their relative's weight had improved. The relative told us they were invited to eat at Northway House and said, "I am happy with the food [relative's name] receives, can't fault it."

People had the access they required to external healthcare professionals when requested by them or the service. People's care records had a recording sheet that detailed external professional visits and referrals. These records evidenced staff had been prompt in requesting external professional advice and guidance. Records showed people had been referred to and seen by their GP, the district nursing team, a dietician and optician when needed.  We noted in a care record for one person who had recently fallen they had expressed the desire to see a physiotherapist to assist in developing confidence following the fall. A timely referral had been made and the person told us they were happy about this as they were eager to maintain maximum independence.

Good

# Is the service caring?

## Our findings

People spoke positively about the staff that provided their care. All of the people spoken with commented positively on the staff and told us they had a good relationship with them. People used positive words to describe the staff. For example, people described the staff as "Kind", "Happy", "Jolly" and, "Reassuring." One person commented, "I feel cared for, staff will sit and have a chat." Relatives we spoke with gave similar feedback and did not raise any concerns about the care provided by staff.

People received information about the service. The service ensured that people received the "Statement of Purpose" and "Service User Guide." This ensured people and their representatives received key information about the service. For example, the documentation communicated information such as the aims and objectives of the service, the philosophy of care, key personnel within the service, quality standards and how to raise concerns or complaints. This ensured key information was available to people and their families about the standards and quality of care and support people should receive.

Staff told us they always aimed to ensure people were treated with kindness. One staff member we spoke with told us about the registered manager's approach to care told us, "It's his big thing – to always promote dignity." This was in keeping with the provider's "Statement of Purpose" which listed one of its aims as, "To help residents maintain their independence, mobility, well-being and dignity." A staff member told us they felt everyone was looked after well, and described this as a, "Staff priority."

During conversations with staff, it was evident they knew people's needs well and could describe these to us. For example, staff explained people's backgrounds and some history about their lives. This demonstrated staff had ensured they knew the people they were supporting in an individually approached way. Staff we spoke with knew people's mobility care needs and risks; we observed this in practice when staff were supporting people in mobilising and moving around the service. We saw that this knowledge supported staff in providing personalised care to people and people were observed at ease when with staff.

We made observations that showed staff were kind and caring. During our observations we saw that staff spoke appropriately with people, in a tone and speed people understood. It was evident staff understood people's communication abilities, as they adjusted the way they communicated with certain people, for example by speaking louder. Staff clearly knew people well and there was an unhurried and calm atmosphere within the service. Where people were independent with mobility but needed to move slowly, staff were patient with this and ensured the support was given at an appropriate pace. This demonstrated staff ensured people could be independent where possible.

People told us that the staff were attentive, kind and treated them with dignity. We saw that when bedroom doors were shut, staff always knocked on the person's door before entering. One person we spoke with commented, "We are treated with respect and dignity and if I wasn't I would know who to talk to and confident something would be done." Another person we spoke with told us, "They do their best to respect my dignity. Regular staff know me." All of the interactions we saw were respectful and dignified.

People could be visited by their friends and relatives at any time of day. There were no restrictions on people's relatives or friends visiting the service and relatives were welcomed. This meant that people living in the service were not isolated from those closest to them. During our inspection, several visitors came to the service to see people and there was a busy social atmosphere in the communal areas and people's bedrooms. It was clear that staff knew the visitors well when we heard them speaking with them. Relatives we spoke with were all very positive about the way they were treated and felt comfortable visiting at any time of the day. They told us they were offered drinks during their visits and we observed this happening.

The service sought the views of people and their relatives using a national website. Since our last inspection, four reviews had been left on a public website. All of these reviews were positive about all aspects of the care provided at the service with all stating they were, "Extremely likely" to recommend the service to others. One of the reviews on the website read, "Over the last two years, my brother-in-law has been a resident at the care home mentioned above, in that time he has been very happy. Enjoyed the food and activities and has said many times it's a home from home. He has always been clean and smart, and well presented. A credit to the staff. I only hope that I would be looked after so well should the circumstances arrive."

We reviewed a selection of the compliments the service had received. These had been received from relatives and visitors of people at the service. An example of the written compliments and thanks included, "Please accept our heartfelt thanks, and thanks for the wonderful care given to [person's name]." Another read, Our thanks to you all for the kindness and care shown to [person's name] over the last few years." Another message said, "The [family surname] family would like to express their thanks and gratitude for your compassionate care."

Requires Improvement

# Is the service responsive?

## Our findings

People commented that in general they received personalised care that met their needs. However, we found practice that did not evidence a consistently person centred approach to care. For example, during a conversation with one person they told us they would like to have a shower every two days. The person then told us, "My bath day is Saturday." They then commented that on the Saturday prior to the inspection, they had been unwell and had not had their bath. This meant that on the day of the inspection, the person had not had a bath for 10 days despite their desire to bathe twice a week.

The person told us they had asked staff about increased baths. We reviewed the records relating to this person which evidenced this request had been recorded. During a review of the person's daily records an entry was made three days before the inspection. The entry read, "[Person's name] would like to have more baths but explained there is a list of who has baths and we will try our best to give more when we can." This further evidenced that basic personal care such as bathing was not provided at the request of people and was completed by use of a schedule, which is institutional practice.

During a conversation with the relative of a person, similar concerns were raised. The relative told us they had previously requested that additional personal care was provided as they felt their relative living in the service needed it. The relative stated they believed there were, "Set days" for baths and hair washing. This again did not evidence a person centred approach to meeting people's care needs and was not consistent with the providers "Statement of Purpose." This read, "Residents may bath or shower as often as they wish."

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care records did not always evidence that care plans fully reflected people's physical needs. For example, we reviewed the records for people who were cared for in bed and who had an electric pressure relieving mattress in operation. This mattress was designed to support people by reducing the risks of people developing pressure ulcers due to immobility. In order to be effective, the mattress must be set correctly and in accordance with the person's weight. Incorrect setting of these mattresses may have an adverse effect. We observed two mattresses in operation and reviewed the relevant care records. There was no detail of the correct setting of the mattress or who was responsible for checking that they were at the correct setting and fully functioning. There was also no system in place for reviewing mattress settings were correct. We highlighted the risks of this to the registered manager and head of care and that this presented a risk of the person's needs not being met and to their health and well-being. They responded immediately by reviewing current arrangements.

When reviewing care records, it was evident that efforts had been made to personalise the care plans and we noted that instructions to staff were generally detailed. Staff seemed responsive to changing levels of need and care records evidenced staff were normally prompt to secure external professional advice and input where needed. However, in the 'Safe' section of this report we have highlighted when a referral for an evident choke risk was not escalated quickly. The care plans included an assessment of current need and

the aim and outcome of interventions.

Staff told us that care plans were reviewed on a monthly basis and amended if necessary. When reviewing the care records, it was evident these reviews had been completed by staffing related to needs and risks associated with people. The care plans contained some social history about people that described people's previous life experience and occupation. During our observations around the service, we noted staff had developed laminated information sheets for a number of people that had been pinned onto their bedroom doors. This contained key information from within the person's care records and detailed information such as the person's life history and communication needs. This information can be helpful when initiating a conversation with people. It was however noted that this was not consistent throughout the service with several people not having this information on their door.

We received mixed feedback from relatives we spoke with about their involvement in care indicating that a more consistent approach was required. For example, we spoke with one relative who was the person's Lasting Power of Attorney (LPA), meaning they could lawfully make health and welfare decisions on the person's behalf when in their best interests. They were positive and told us they had been involved with care decisions from day one. They told us they were invited to see the person's GP to discuss care provision. They also told us they saw the registered manager or head of care when they visited and there was always someone to go to if they had concerns. However, during a discussion with another relative this was not evident, the relative said, "I don't always feel involved in decisions that are made." This did not evidence an inclusive, consistent approach to care provision.

People had the opportunity to participate in activities. During the inspection we observed that staff had time to sit with people and complete individual activities. The service had dedicated activities staff who provided activities every weekday and on a Saturday every two weeks. We spent time speaking with the activity co-ordinators. They told us they always tried to encourage maximum participation in a wide range of activities. The activities staff knew people well, for example their likes and dislikes. They had a good understanding of individual people's type of dementia. They knew which people liked to stay in their rooms for an activity such as cards or dominoes and who liked group activities. The activity staff met regularly to plan a month ahead. There was a notice board with activities for the week.

We saw the activities on offer included cards, dominoes, reading the papers, cake making, colouring books and nail painting. In addition to this, organised external entertainment was provided two to three times a month. This included singers, musical instruments, flashback-themed sessions and petting animals. The activities staff said that they felt well supported by the registered manager through funding for materials and training for activities.

We also saw that some community links were evident through the local school choir attending the service and frequent communion being held for people that wished to partake. We saw in one person's room they had a photo of themselves decorating fairy cakes. We saw an example of where the service had promoted a person to continue previous activities they had enjoyed before moving to Northway House. During a review of a person's care plan we noted that it was recorded the person enjoyed making things with clay. We saw they had been given the opportunity to do so and the results were proudly displayed by the person.

There was a complaints policy in place for people. This was available to them in both the "Statement of Purpose" and "Service User Guide" they received. In addition to this, a copy of the complaints policy was displayed within a communal area. The complaints procedure gave information on how to make a complaint, how the complaint would be investigated and how the complainant could escalate matters to the local authority and ombudsman should they wish. We reviewed the complaints received during 2017

and two separate people had made complaints to the service. One matter had been concluded and a second matter was currently being investigated and pending conclusion. All of the people we spoke with felt able to raise issues or concerns with staff and management in the service. One person told us how in the past they had raised issues and felt the service had tried to help him in resolving them.

We spoke with the registered manager and head of care in relation to end of life care. We also reviewed care records to ascertain if records had been completed in relation to people's end of life care wishes and preferences. Care records we reviewed were variable in content and detail. Some care records were completed, showing things such as if people wanted to be resuscitated or if they wanted to be admitted to hospital. Other records did not show this. When speaking with the service management, they explained that they always spoke with people in relation to their end of life wishes, however responses from people were variable. They told us that when people had been willing to discuss future wishes as they approached the end of their life this had been documented. They also told us some people did not want to have the conversation due to it making them upset or distressed, and that their decisions on whether to have these conversations was respected.

Requires Improvement

# Is the service well-led?

## Our findings

The service had failed to send notifications to the Care Quality Commission (CQC) as required. Statutory notifications are information about specific important events the service is legally required to send to us. They help the CQC in monitoring aspects of the service including the safety and the wellbeing of people. During the inspection, we found that the service had failed to send us statutory notifications relating to serious injuries sustained by people, safeguarding concerns and an incident involving a person being found by police in the community after they had left the service unwitnessed.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Governance arrangements had not consistently identified shortfalls within the service. We reviewed the current governance arrangements to ascertain how risks to people's health, safety and welfare were identified and managed. We found that whilst provider level audits were completed, internal systems used by the registered manager and head of care had not consistently identified concerns. In relation to provider visits, we saw records that showed regular visits to the service were undertaken. These visits included speaking with people, staff and the registered manager about the service. The records we reviewed showed that positive feedback was received from people about the care they received.

Additional internal governance systems were either not in place or had not been effective. The current governance arrangements had not identified the significant shortfalls associated with a person's choke risk we have reported on. For example, there was no system to ensure that people nursed in bed using an air mattress were being cared for on correctly inflated equipment. No staff were aware of the correct setting. This was rectified prior to us leaving the service. As identified in the 'Safe' section of this report, although fluid charts were used they were not monitored effectively. There was no system in operation to ensure these were regularly checked to monitor risk. It was further evident that governance arrangements for the safe use of medicines were not effective as we identified in regard of important out of date medicines in the service.

The current governance arrangements in relation to auditing did not evidence routine auditing was completed. When requested, we received audits that monitored the outside areas, the kitchen, the environment, body fluids and sharps, fire safety risk tool and disposal of waste tools. All of these audits were dated as being completed in May 2015. They were then shown as being 'reviewed' in June 2016 and July 2017 but a further audit was not completed. This did not evidence that regular auditing was completed. In addition to this, a records audit tool showed that the care records for people were audited in May 2015 and then subsequently reviewed in June 2016 and July 2017. A more frequent and accurate audit would identify the concerns we found in relation to nutritional records and weight monitoring.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Feedback we received from staff about the leadership and management of the service was mixed and we

received some less than positive comments. Some staff were positive, with one comment being, "I get supervision every month and I have just had my appraisal. I got feedback on my job. I enjoy the training and it helps me do the job. Everything is done by the book and they stop and check out our knowledge. The managers have been supportive and accessible and I would feel comfortable talking to them." Another member of staff said, "I like coming to work, most days it doesn't feel like a job. I have got all the equipment I need and the managers are responsive if I ask for anything. I have never seen anything to concern me and if I did I would go to a senior. I feel the manager is supportive and listens."

Less positive comments related to the visibility and 'hands on' support staff received from the registered manager and head of care. One staff member said, "The head of care is not hands on with care, they are always in the office doing paperwork. Neither of them [registered manager and head of care] are out on the floor." Another comment was, The manager is quick to tell you when something is wrong but barely ever praises. The manager and head of care spend a lot of time in the office. I rarely ever see the head of care on the floor. We get lots of training and that helps. I haven't ever seen anything that concerns me here. I like to think residents are well looked after. This is not a happy place to work." A further bit of feedback from a different staff member was, "Managers do occasionally come out of the office and if we need them they are approachable and supportive. I think residents are safe here and well looked after. Everyone is friendly and I'm happy working here."

The registered manager held meetings with staff, however during a review of the previous meeting agenda for the meeting held in October 2017 we saw less than positive comments. The registered manager explained to us during the inspection the meeting was to 'shock' staff as performance levels were poor and they said it had worked. Extracts from the minutes stated, "If they [CQC] inspected now, it would be a rubbish report, and rightly so. So why don't I fix it? Because it's a group of people who conspire and manipulate situations and cover each other's back." The minutes also focussed on attendance, poor care provision, poor record keeping and poor work ethic. Additionally, the registered manager stated, "I have never known it to be as bad as this" when describing the service during the meeting.

We spoke to people and their relatives about the leadership of the service. One person we spoke with was less than positive and told us, "I think the home is going downhill. We are afraid to speak." However, in contrast we received complimentary feedback from people. For example, one comment we received was, "I am very pleased at the way it goes on here, very comfortable here." Another person we spoke with told us, "I have lived here [number of years living at service], very good as far as I am concerned." People's relatives did not raise any concerns about the management. The only area of concern raised was that one relative wasn't aware resident and relative meetings were held.

There were systems to seek the views and opinions of people or their representatives. An annual quality assurance survey was sent out to people. The report was focussed on different areas of the service. For example, the survey asked for views on matters such as the food quality, privacy and dignity, care and assistance provided and accommodation. The most recent survey was completed in June 2017. In order to assist learning and improving, the survey results were judged against the previous year. The most recent survey had not identified significant change, however where improvements were identified an action plan was created. For example, the service identified people wanted improvements with their GP and this was actioned to speak with them. The water damaged ceiling in the dining room was identified as an action requiring attending by the end of September 2017 but this had not been done at the time of our inspection.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 Registration Regulations 2009 Notifications of other incidents<br><br>Notifications had not been sent as required.<br><br>Regulation 18. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>The care and treatment of people was not always person centred and met their needs and preferences.<br><br>Regulation 9(1)(b)(c) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>People risked being unlawfully deprived of their liberty as the service had not complied with the 2005 Act.<br><br>Regulation 11(3) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>Systems and processes to investigate allegations of abuse were not effective. |

Regulation 13(1) and 13(3)

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 15 HSCA RA Regulations 2014 Premises and equipment<br><br>The premises were not appropriately maintained.<br><br>Regulation 15(1)(e) |

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider had not ensured systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users were effective and robust.<br><br>Regulation 17(1) and 17(2)(b). |

This section is primarily information for the provider

# Enforcement actions

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Risk management was not safe and risk mitigation was not consistent to fully protect people.<br><br>Regulation 12 (1) and 12(2)(a)(b) |

**The enforcement action we took:**

We served a Warning Notice.