Mr & Mrs F Ruhomutally

Northgate House (Norwich)

Inspection report

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Date of inspection visit:
07 March 2018

Date of publication:
26 March 2019

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Northgate House is a residential care home providing accommodation and care for up to 22 older people, some living with dementia, in one adapted building across two floors. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. At the time of this inspection, three people were using the service.

This service has a history of non-compliance with continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Seven inspections of this service had taken place since December 2014, three of these inspections with an overall rating of 'Inadequate' and four rated 'Requires Improvement'.

This unannounced inspection took place on 10 September 2018. At this inspection, we found that there were four continued breaches relating to safe care and treatment, staffing, mental capacity and governance. There was one further breach of a regulation relating to safeguarding people.

We took enforcement action following an inspection of the service on 19 April 2017 where the service was given an overall rating of 'Requires Improvement' as we found the registered provider had continued to be in breach of four regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We placed conditions on the registered provider's registration to submit monthly reports to us setting out how they would assess, monitor and where required, take action to improve the quality and safety of the care and support provided to people living at Northgate House.

At the last inspection carried out on 7 March 2018, we found that there were continued serious concerns in relation to the quality and safety monitoring of the service. There was a continued failure to ensure people were protected from the risks associated with improper operation and management of the service including the premises. The service was in breach of seven regulations, which were Regulations 9, 11, 12, 14, 17, 18 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not provided with safe care. Oversight and management of the service was chaotic and disorganised. There continued to be insufficient governance arrangements in the service and therefore was still not effective in mitigating the risks to people's health, welfare and safety.

Following our comprehensive inspection on 7 March 2018, we formally notified the provider of our escalating and significant concerns. We asked the provider to inform us immediately of the urgent actions they would take with immediate effect to protect people and raise standards. We received a response to the urgent action letter on 12 March 2018, followed by an action plan addressing the concerns on 13 March 2018. This contained a basic action plan. We placed conditions on the provider's registration to restrict admissions to the service. In response to our findings we notified the local safeguarding authority. Since our last inspection, the local authority has supported people who they commissioned care for to move to other locations.

At this unannounced inspection on 10 September 2018, we continued to have major concerns regarding the lack of action taken by the provider to ensure a safe service was provided. There was a continued lack of effective leadership and we found the provider continued not to have effective systems in place to provide safe, good quality care. There were three continued breaches and one further breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which we found, relating to safeguarding people. In addition, there was a breach of Regulation 18 of CQC Registration Regulations 2009.

The service continued to operate without a registered manager in post, and there had not been a registered manager for two years. 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. The operations manager was currently acting as home manager and had submitted an application to register with CQC as the home manager. This application remains pending with CQC. For the purpose of the report we have referred to this person as the 'manager' throughout. There was a new deputy manager, who was not working on the day we inspected.

Risks to people's safety and wellbeing had not always been identified and those that had been identified were not always mitigated. There remained concerns around medicines administration with no records around people's prescribed topical creams and no guidance provided for staff for the administration of PRN (as required) medicines. Other medicines were given as prescribed.

Recent visits from environmental health inspectors and external auditors such as fire safety experts and a health and safety management auditor highlighted a number of areas where action was required by the provider to improve the safety of the environment and protect people from the risk of harm. Whilst the manager told us they had rectified these shortfalls, we found this was not always the case.

Staff had some knowledge of safeguarding from training, however people were not always properly safeguarded from the risk of abuse.

Accurate records of staffing available to meet people's needs were not maintained. We were unable to ascertain exactly what hours staff had worked and when because the staffing was not accurately reflected in the rota. It was not clear from records maintained that all staff responsible for delivering personal care and support with mobilising people safely were competent in their roles. Staff received some training relevant to their role, however there was not always evidence of sufficient training for all staff delivering personal care. It was unclear whether there was consistent staffing at night to meet people's welfare and safety needs.

The manager lacked understanding in their roles and responsibilities in relation to the Mental Capacity Act 2005. Best interests' decisions were not always made when they were needed, and there remained a lack of understanding around consent. It was not clear how assessments of people's capacity to consent to care were made.

Accurate, contemporaneous records of people's care were not always kept because records did not reflect actual care delivered.

There continued to be poor leadership with a lack of effective oversight and governance of the service. The manager presented in a manner that lacked openness and transparency in carrying out the regulated activity. Health and safety checks were lacking and action had not been taken when external auditors had identified areas of risk to people's safety.

There continued to be a high turnover of staff which did not provide continuity of care for people who used the service. There had been a further change of two managers since our last inspection. There were recruitment checks carried out to ensure that staff were suitable for the work they were employed to perform. However, the manager did not always maintain and record an oversight of staffs' competency to ensure that staff remained suitably qualified to care for people in a safe way.

Care plans contained information about people's hobbies, interests and social history. However, there was mixed feedback as to regularity of activities and the quality of support provided.

Relatives told us they could approach staff with any concerns, but they were not always resolved quickly. The provider had received some compliments.

There was a choice of meals available and people received enough to eat and drink. Staff supported people to access healthcare professionals and appointments.

On 13 March 2018, CQC used its urgent powers to restrict admissions to the service. This means that it can no longer admit people to live in the home. On 19 July 2018, CQC sent a Notice of Decision to cancel the provider's registration of this location.

The provider appealed against this decision to the First Tier Tribunal (Care Standards) under section 32 (1) (b) of the Health and Social Care Act 2008. The appeal hearing was due to be held on 11 February 2019. The provider withdrew their decision to appeal and therefore the Notice of Decision was upheld. The location is no longer registered with CQC, and is no longer able to provide a regulated activity.

Other stakeholders including the local authority supported people and relatives to find other homes or alternative care arrangements.

Full information about CQC's regulatory response to any concerns found during inspection is added to reports after any representations and appeals have been concluded. You can see the enforcement action we took at the end of this 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?

Inadequate

The service continued not to be safe.

People continued not to be safeguarded from risks to their health, welfare and safety. Risks to people's safety associated with improper operation of the premises had not always been identified and action taken to reduce these risks.

There was not always sufficient numbers of staff to meet people's assessed needs.

The provider did not practice safe recruitment procedures.

Medicines were poorly managed. People did not always receive their medicines as prescribed form suitably qualified and regularly assessed as competent staff.

Is the service effective?

Inadequate

The service continued not to be effective.

Staff had not been provided with regular supervision and had not received all of the relevant training to support them in their roles.

Staff sought consent from people before providing support. However, people's capacity to make decisions had not been consistently assessed.

People had access to health care professionals when needed.

Is the service caring?

Inadequate

The service was not consistently caring.

Whilst we observed staff to be kind and caring towards people, further work was needed to imbed a culture of caring throughout the service.

Widespread significant shortfalls in the service meant that people's health, safety and welfare was not upheld. Care and support plans for people living with dementia, contained a lack of information to guide staff in meeting their social and

emotional needs.

People and their representatives were not consistently involved in the planning and review of their care.

Is the service responsive?

Inadequate

The service was not responsive.

The care provided did not always meet people's individual needs and preferences, including the provision of activities.

Care records did not provide sufficient guidance to staff to help ensure the care provided was safe, effective and personalised.

The provider failed to operate a system to regularly seek people's views and used these to improve the quality of care.

Is the service well-led?

Inadequate

The service continued not to be well led.

Oversight and management of the service was chaotic and disorganised. Overall governance systems continued to be ineffective and did not ensure the safety and quality of the service was maintained.

The provider did not demonstrate they had systems in place to continuously learn, improve, innovate and ensure sustainability.

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.

Prior to the inspection, we reviewed information we had received about the service such as notifications. This is information about important events, which the provider is required to send us by law. We also looked at information sent to us by the provider and from other stakeholders, for example the local authority and health care professionals.

We also used the information the provider had sent us in their action plans and management monitoring reports sent to us following our last comprehensive inspection in April 2017. This included what action they had taken to address shortfalls, and how improvements were being implemented, monitored and maintained.

This inspection was unannounced and carried out by two Inspectors.

During the inspection, we spoke to four people who used the service. Some people could not tell us their views about the care and support they received, as they were unable to communicate with us verbally, therefore we spent time observing interactions between people and the staff who were supporting them. We also observed the care and support provided to people and the interaction between staff and people throughout our inspection.

We spoke with the registered provider, operations manager, the supporting manager, four care staff, two senior care staff, and the cook. We also spoke with three relatives.

To help us assess how people's care and support needs were being met we reviewed the care records of six people who used the service including risk assessments, management of their medicines and monitoring charts in relation to care support provided. We also looked at medicines management, staff recruitment files, staff training records and systems for assessing and monitoring the quality and safety of the service.

Inadequate

Is the service safe?

Our findings

Our inspection of the service in April 2017 found significant shortfalls in the safety of the service provided for people and we rated the service 'Requires Improvement' in 'Safe'. During this inspection, we identified serious shortfalls and found people continued not to be safe in the service. We found a continued breach of Regulations 11, 12, and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and have rated this service as 'Inadequate.

Lessons had not been learnt to help reduce the reoccurrence of incidents, identify themes and trends and areas that posed a risk. This was because of continued ineffective management oversight and governance of the service to protect people from the risks to their health, welfare and safety. For example, we found recent works to update the heating system left people at risk of scalding from exposed hot water pipes located along the full length of one corridor and in five people's bedrooms. Two people residing in these rooms had been identified as at high risk of falls and following recent falls had been admitted to hospital. Both falls were not witnessed by anyone. No one had identified or assessed the risk and vulnerability of these people.

Older people can have poor skin integrity, loss of feeling and poor mobility which can leave them unable to independently move away from a heat source they could lean or fall on/near. People did not always receive their medicines as prescribed and these were poorly managed. We found excess stock of medicines and/or medication, which remained in their containers, where staff had signed to say they had administered them. There were gaps in records where it could not be determined if people had received their medication or not. This included pain relieving and antipsychotic medicines.

There were also gaps in records for application of creams which protect people against risks of pressure ulcers. We could not be sure these people had received their medicines as prescribed. Where risks had been identified, insufficient action had been taken to manage and mitigate the risk of any further harm.

There were gaps in recording where staff had not confirmed a thickening agent had been added to drinks as prescribed to reduce risks of choking. The lack of risk assessment also meant staff could not tell us what they would do if someone choked. A container of thickener had the pharmacy name/instruction sticker removed. Staff told us who it had been prescribed for, but without the label to guide them, staff were unable to determine if they were preparing drinks to the correct consistency. One person's care plan explained they had major problems chewing and swallowing, but there was no further information about how they should be supported with this, if there a thickening agent was prescribed or if they should have a soft diet. A senior care worker confirmed the person required this but the information was not included in their care plan. Whilst it is not possible to prevent all episodes of choking, the provider had not taken all reasonable action to improve the safety of individuals identified as being at risk from swallowing/eating difficulties (dysphagia) and at risk of choking because oversight of risk assessment, care planning and staff knowledge was not robust enough.

One person had been prescribed a Ventolin inhaler prescribed to treat the symptoms of asthma and breathing difficulties, which they kept in their handbag to self-administer. Their care plan stated that they

were not safe to take their own medicines. This had been recently reviewed on 28 February 2018 where it had been added, '[Person] is unable to safely administer [person's] own medication'. There was no risk assessment or guidance for staff in relation to the person's inhaler. Their care plan stated the inhaler was prescribed 'as required' (PRN) medicine but there was no protocol attached to this, so staff were not aware of when and how it should be taken by the person. We were concerned that staff may not understand or recognize when, how or if the person was safe to do this independently as per the prescription requirements.

One person had two half-full bottles of cough medicine in their room. Their care plan contained no information or risk assessment of homely remedies of this kind. The person had been diagnosed with dementia and presented with confusion. Their care plan stated, 'trained staff should always administer their medicines'. The person had unrestricted access to the medicine, which could have been taken inappropriately, unknowingly or impacted on their wellbeing because no one had seen them take it. As the medicines had been left unsecured in the person's room, there was also a risk that other people could access these and become unwell.

Supporting information was not always available alongside medication administration record charts to assist staff when administering medicines to individual people. For some people there was no personal identification such as photographs to help ensure medicines were being administered to the right person. This did not mitigate risks of medicines being administered to the wrong person and does not reflect best practice in medicine administration.

We observed staff using unsafe moving and handling techniques. Staff did not always follow moving and handling care plans to ensure people were moved safely. Staff did not support one person in accordance to the guidance specified by a healthcare professional who had assessed the person on 21 September 2017. This put the person at risk of harm or injury. We saw three people being transported in their wheelchairs by staff without footplates. This also put people at risk of injury and no risk assessments were in place to demonstrate if this was the choice of the person or if the risks had been considered. Not everyone who needed it had a moving and handling plan in place to guide staff on moving them safely. For example, a risk assessment and plan did not specify the type of hoist, the type and size of sling or correct loop on the sling for staff to use to ensure each person was supported to move safely. Using the wrong equipment or using it incorrectly can put people at serious risk injury, it can also be uncomfortable and undignified.

Health professionals were treating one person who had a pressure ulcer. The person's care records recommended two hourly changes of position, however their repositioning records did not demonstrate that this was always taking place. Staff could not demonstrate the person was being repositioned as advised. If not being followed this put them at risk of existing pressure areas worsening and/or new ones developing. Another person assessed as high risk of developing pressure ulcers had two pressure cushions to help maintain their skin integrity. They sat all day in the same chair in their room without any pressure cushion in place. The manager confirmed that the pressure cushion should have been in place and their care plan also confirmed this.

The Malnourishment Universal Screening Tool (MUST) was used to identify individuals at risk of inadequate nutrition and losing weight. However, not all staff had been trained in the use of this tool. People had been identified as having lost significant amounts of weight but the tool was not always correctly completed and people not always referred for specialist advice. One person who had lost 14kg within the last three months had been incorrectly assessed as low risk. No action had been taken to refer for specialist advice or in the interim explore the reasons for it. This did not take into account best practice and staff were not recognizing the significant risks or understand the interventions that could be put in place to support the person regain

weight and be healthy.

Risks to people's safety associated with improper operation of the premises had not always been identified and action taken to reduce these risks. We found prescribed creams unsecured in people's rooms throughout the day, as well as other hazardous substances in unlocked rooms used by staff to store their belongings. For example, eight paracetamol tablets were found on a low shelf where people could access as well as aerosol cans, a glue gun and hand wash chemicals. This meant people were exposed to potential risk of harm through inappropriate use of these substances.

A fire safety risk assessment carried out by an external contractor in January 2017 identified a number of recommendations to bring the environment up to the required safe standard to protect people from related risks. For example, work was needed on fire doors to make sure they met the right safety standard and an external fire escape was also noted not to be in good condition. This work had not been done at the time of this inspection.

People with limited capacity had access to a fire door leading to an external staircase. This had not been recognized as a potential risk and therefore had not been assessed. Despite requests to the operations manager, we did not receive the responses required to assure us that action had been taken to carry out the works required. Following our inspection we informed the local fire authority of our concerns.

We were so concerned about all of the above that we wrote to the provider to urgently respond and tell us what action they were taking to reduce urgent risks including the hot water pipes, moving and handling and medication. They provided an action plan to us which included building work and training to take place the following week of the inspection. However, we remain seriously concerned the provider had not independently recognized these matters and we have taken action to ensure people's safe care and treatment.

All of the above demonstrated a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not protected from being cared for by unsuitable staff because robust recruitment procedures were not in place. Three staff started work prior to references having been obtained from their most recent employer and none of them had Disclosure and Barring Service (DBS) checks carried out to check they were safe to work with people who by virtue of their circumstances were vulnerable.

This demonstrated a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not receive care and support from sufficient numbers of suitably qualified, competent, skilled and experienced staff in order to meet their assessed needs. On the day of our inspection there were sufficient staff numbers on duty. However, a review of rotas, discussions with staff, people and their relatives showed us this was not always the case.

There was no system to ensure the skill mix and deployment of staff had been considered against the needs of people living in the service. The provider did not have a robust system in place to assess the competence of staff before they worked unsupervised in their role. Not all newly appointed staff had been provided with the opportunity to shadow other more experienced staff before being placed on the staffing rota to work unsupervised.

People told us staff did not always respond to people's needs in a timely manner. For example, one person told us, "If I need help to get undressed I just call the bell. But sometimes it takes up to an hour." The same person told us there was not always sufficient staff available to support them to return to their room from the lounge if they wanted to, and they had waited up to 30 minutes and sometimes more, as they required support to mobilise.

There has been a significant turnover of staff including three managers. People and staff told us this had resulted in a lack of consistent care and support. One person told us, "I don't know the names of staff, they come and they go, I've lost track of who's who. Staff don't always have time, we just sit here all day with little to do other than watch TV." A relative told us, "There has been a number of staff who are no longer here. Managers come and go. We are not informed of the changes or even what people do, we don't know their job title."

The manager and care staff told us there was no agency staff usage as staff shortages were managed from within the team of staff. Despite this approach staffing rotas over the previous last eight weeks prior to inspection showed significant shortfalls in staff working against the numbers needed to ensure that people's needs were being met.

A senior care worker told us the lounge was supervised at all times. We saw staff meeting minutes confirming this lounge should be monitored with one member of staff at all times. However, we observed this was not always the case as the lounge was left without staff presence on several occasions throughout the day of our visit. We observed people in this lounge who had limited mobility and did not have access to call bells to alert staff if they required support. This left them at risk of falls from attempting to move independently as they had no other way of alerting staff.

Staffing rotas and discussions with staff showed the manager and the senior staff member had been unable complete medicines audits because they had filled in on shifts to cover shortages. This directly impacted on their ability to carry out quality and safety management monitoring or to implement the changes required to improve the quality of the service.

The operations manager told us they were actively recruiting for an activities role within the service. However, they had been unsuccessful in identifying the right person for this role. We observed people sitting for long periods throughout the day with little meaningful occupation and interaction from staff. Care staff were task focused, attending to people's personal care needs, serving meals and attending to laundry. There had been no consideration of any interim arrangements whilst the activities role was recruited to. The provider/manager had not considered or explored how many staff they needed against all the needs (including social) of those in their care.

This demonstrated a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a failure to take opportunities for learning from incidents to help improvement. One senior member of staff told us that following a recent audit they had identified staff who had made mistakes in the management of people's medicines. They also confirmed that no action had been taken by the provider to assess if they were competent to continue to administer medications or if further training and oversight was needed to mitigate the risk of further errors. Mistakes were not recorded as incidents and there was no record of investigation or actions to mitigate future risks/reoccurrence.

Despite breaches of regulation and poor practice being identified at previous inspections the provider had

not ensured that these areas were robustly addressed, lessons learnt and used to improve the service and the limit risks or exposure to the risks for those living there. There was a lack of systems in place to ensure this happened so the provider could demonstrate the service is being managed effectively, safely and to a good quality.

These shortfalls demonstrated a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were aware of their responsibilities with regard to safeguarding people from abuse. However, they did not recognise or understand the wider aspects of safeguarding people from the risks we identified at this inspection or the impact of neglect from not having enough staff to meet people's needs. The breaches in this section demonstrate that people were not being safeguarded from the operation of the service overall.

Some areas of the service were found to be clean but there were also areas that needed attention. We found raised toilet seats and commode chairs stained with a sticky substance underneath and in need of thorough cleaning. We were concerned people were not always protected from the risk of cross infection.

Inadequate

Is the service effective?

Our findings

At our last inspection in April 2017 we rated the service Requires Improvement in 'effective'. We identified that improvements were needed to ensure the provider acted in accordance with the Mental Capacity Act 2005 (MCA), Deprivation of Liberty Safeguards (DoLS) practices and staff training. At this inspection, we found that there was continued non-compliance and further improvements were required. The rating in this key question is now 'inadequate'.

Staff had not been provided with regular supervision and had not received all of the relevant training to support them in their roles. For example, robust induction for new staff, training in understanding their roles and responsibilities in relation to the Mental Capacity Act 2005, pressure ulcer prevention and meeting the needs of people at risk of inadequate food and fluid intake.

Staff received training in the main from the operations manager and administrator. Some staff received support from an external training provider in working towards the Quality Care Framework (QCF) diploma at levels two, three and five. However, the number of concerns identified regarding the care and support provided throughout our inspection meant we could not be confident that the training provided was effective, took in to account best practice, and was imbedded into staff practice. Poor practice in moving and handling, medicines, risk assessment, dementia care and mental capacity impacted on the quality of care being provided and a learning culture was not being promoted.

Staff told us they did not always receive regular supervision support to enable them to discuss their performance and plan for their training needs. Reviews of rotas showed newly appointed staff had been placed on the rota without opportunities to shadow other more experienced staff. Staff gave examples where they had worked unsupervised and without adequate time made available for them to read care plans and get to know the needs of people or how to provide their care and support. For example, one newly employed member of staff was allocated three long working days of double shifts in their first week of employment, without shadowing support when the rota was already understaffed. The provider could not demonstrate that the new staff member had the competence to carry out their role unsupervised and safely.

This demonstrated a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Nutrition and hydration needs of people were not always appropriately assessed, with robust planning to guide staff in meeting people's needs. Where people received support there were no systems used to monitor if they received enough fluid to mitigate any associated health risks. This is especially important because people using the service were identified as at risk because they were prescribed thickeners to avoid the risk of choking and/or were not able to communicate if they were thirsty or recognise if they were dehydrated.

We received mixed views about the food, one person describing it as, "Sometimes good, sometimes

terrible." Two people told us they were not made aware of what was for supper before serving. Another told us, "Tea is always soup and sandwiches."

People told us they were not always consulted about meals. One person said, "You eat what you get. I'm not complaining as the food is ok. " Another told us, "If you ask you can have something different, it just depends whose cooking." A relative told us, "[Relative] does not complain about the food, I don't think they get much choice. What we see, it looks ok to us."

The cook told that there was an option of two meals provided daily for the midday meal but also confirmed there were no menus produced and meals were planned on an ad hoc basis. During our visit we observed everyone to eat the same midday meal of turkey and vegetables. However, for the teatime meal we did observe a choice of cheese and potato pie, sandwiches and soup. Staff were not able to demonstrate that the food available had been planned against the nutritional needs and best practice guidance for older people.

One of the partner providers had been allocated as cook on the day we visited. They told us there was one person who needed a specialised diet. However, we found there were two additional people who had been assessed as requiring soft diets due to swallowing difficulties and also people who required specialist diets due to their diagnoses of diabetes. The provider could not demonstrate these needs were being met.

This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff did not take opportunities to make meals into a socially stimulating engagement. For example, we saw one person who had their midday meal in front of them whilst sat in a lounge armchair. They had not begun to eat their meal of their own accord. After a period of at least 10 minutes, a member of staff came and sat with them and supported them to eat as they had not touched their meal. However, the food may have cooled down by this time and not be at its' best. We saw two staff supporting people to eat their meals in the lounge with very little interaction.

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.

Staff explained how they tried to give people choices and options and support their decisions. However, where some care plans recorded that people lacked capacity to make decisions, it was not always clear how this conclusion had been reached. People's capacity to make decisions had not been consistently assessed. Some mental capacity assessments had been carried out, but these were not for specific decisions. Therefore, people's consent to care was not always determined and best interest decisions were not always made properly.

One person's care plan stated they had 'changeable' capacity to make decisions. Their assessment of need did not explain what decisions the person required support with, and how. For example, in relation to personal care, medicines administration and any restriction on their freedom of movement. There were no best interests decisions documented for any of the care plans we reviewed for people who lacked capacity. We were therefore not assured that people had been given the opportunity to make some decisions for themselves, and what they were if they are able.

Systems were not in place to ensure care records and assessments included and informed staff about the arrangements for independent support for people who had no one acting on their behalf (were assessed as needed). Where people had a lasting power of attorney (LPA) appointed to act on their behalf, this was not recorded in their care plan. A LPA is a legal document that lets people appoint one or more people to help them make decisions on their behalf. For example, in relation to their health, welfare and finances.

This demonstrated a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service caring?

Our findings

At our last inspection in April 2017, the service was rated 'Good' in 'Caring'. During this inspection, we identified shortfalls and found the service was not consistently caring.

We identified widespread failings in the oversight and management of the service provided, which meant that people did not always receive the care and support they required to uphold their health, dignity, safety and welfare. The management team had failed to independently identify these failings and take action to improve the quality of the care people received. This meant that the management team did not promote a culture focused on providing safe, personalised care.

Whilst we observed some positive caring interactions between people and staff, further work was needed to imbed a culture of caring throughout the service. One person told us, "The [staff] are all very good." Another said, "They are all very busy, most are kind." A workplace-training assessor told us they had always observed staff to be polite. However, other people told us, "I don't always get the help I would like, like having a regular bath, I know they are very busy and understand they do not always have the time."

People and their relatives told us they were not involved in the planning of their care. One person said, "I don't know what my care plan looks like. What is it?" Another told us, "No I don't know about any care plans." Care records we reviewed did not evidence that people had been involved in the planning and review of their care and their views were not documented.

Care and support plans for people who had little or no verbal communication due living with dementia, contained a lack of information to guide staff in meeting their social and emotional needs. For example, guidance which would instruct staff to look for body language that would indicate pain or to interpret facial expressions for assessing people's responses in promoting their rights to choice.

A shortage of staff meant that people were not always able to receive personal care, to use the toilet or access baths or showers at the time they wished. A staff member told us that recent staff shortages had meant people had to wait, "Too long at times" to receive support from staff to access the bathroom. They described this as having a, "Negative psychological impact" on people and impacted on their dignity.

People did not always receive personal care according to their individual needs and preferences, which could have a significant impact on their well-being, dignity and self-respect. We saw in one person's care plan that they wished to have a shower twice a week. A review of their care records and discussions with staff showed us that support with regular showers had not been provided as requested. We were unable to determine when this person had last been supported with a shower.

We observed CCTV cameras to be in use within two communal areas of the service. The operations manager told us these were website cameras and were used to monitor staff and check people were safe. We requested from the operations manager their policy on the use of these cameras and information as to how people had been informed of their use and issues of people's privacy and consent considered. However,

despite repeated requests we did not receive the requested information.

This demonstrated a continued breach of Regulation 17 of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

At our last inspection, we rated the service as 'Good' in 'Responsive'. At this inspection, we identified deterioration and found the service 'Requires Improvement' in this key question as we found people did not always receive personalised care that met their individual needs.

The content of care plans was confused at times with conflicting information. Since our last inspection, the provider had revised care plans and was in the process of updating them to an electronic system. Reviewed care plans contained incorrect and/or lacked relevant information and effective care planning strategies. This included a lack of correct information in relation to people with diagnoses of dementia, those at risk of malnutrition, the management of people's medicines and people at risk of insufficient nutrition and hydration. Staff therefore did not have sufficient guidance to ensure people's rights are being protected, their safety and welfare is robustly assessed and monitored to ensure needs are met and changes are recognised, explored and actioned to safeguard the person's wellbeing.

Staff told us they learned of changes in people's needs through their daily handovers. They said they did not look at people's care plans, and solely communicated verbally with colleagues about people's needs. This presented a risk if staff had periods of absence that recommendations and updates may not be communicated effectively and important information in relation to risks could be provided inconsistently or not at all.

Care records did not include specific information on how to care for people who had diagnosed conditions such as stroke, diabetes, asthma and epilepsy. There was limited information about people's personal life history and preferences. The care plans reviewed contained very limited information regarding people's personal interests, hobbies and how they wished to spend their day and life at the service. People were not always protected from the risk of social isolation or loneliness. One person who sat alone in their room all day told us, "I am lonely." Other comments included, "There's nothing to do. I don't want to be inside all the time, I don't like it." Another person who was independent in their ability to engage with some activities on their own, told us, "I enjoy reading and watching television but it would be good to have more choice and activities to join in with."

All of the staff we spoke with, as well as relatives told us there were limited opportunities for people to engage in organised activities. One member of staff said they took the time to sit and chat with people, but two other staff said they did not ever have the time to carry out anything other than personal care related tasks. One said, "We don't have any activities going on at the moment as we have lost our activities organiser and we don't have the time." The lack of staffing and recruitment to the activities role did not help limit the impact of this. There were no plans for increasing staff or for any arrangements to meet these needs in the interim.
Although no one living at the service was in receipt of palliative care, care plans did not evidence that people had been supported to express their views as to how they wished to be cared for at the end of life. We found there was no record of any discussions around this having taken place. Staff were not aware of people's choices, wishes and preferences. The provider had not explored best practice guidance around end of life

care, which can include care up to 12 months prior to death. Given the frailty and vulnerability of all people using the service we are concerned that this aspect of people's care has not been robustly explored.

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

The operations manager told us they had not received any complaints since the last inspection. People and their relatives said they had not been provided with any information to guide them should they wish to make a formal complaint. They did however tell us they were confident to approach the operations manager or senior staff with any concerns they might have. The manager told us they held regular meetings with people to assess their views. When we requested copies of minutes from these meetings, we were only provided with one residents and relatives meeting agenda for January 2018. We were unable to determine if people had attended this planned meeting and what views were expressed and any action taken in response. The provider could not demonstrate they were routinely providing with opportunities to express their views, or consulted in the planning of their care, menu choices and activities. We were therefore not assured that people's views were listened and responded to and used to improve the quality of care provided.

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

Inadequate

Is the service well-led?

Our findings

Our inspection of the service on 7 March 2018 found significant shortfalls in the way the service was run, and we rated the service 'Inadequate' in 'Well-led'. The inspection on 7 March 2018 found the provider demonstrated that they continued to lack effective oversight and governance of the service. The service was in continued breach of Regulations 11, 12, and 17 of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014. There were also further breaches of Regulations 9, 14,18 and 19 in relation to fit and proper persons employed, insufficient staffing, nutrition and hydration and person-centred care. The provider had continued to be in breach of some Regulations over the previous six inspections since 2014.

Seven inspections of this service had taken place since December 2014, with three of these leading to an overall rating of 'Inadequate' and four rated 'Requires Improvement'. Following an inspection in April 2017, we had serious concerns and we informed the provider in writing of these. We placed additional conditions on their registration requiring them to submit monthly reports to us setting out how they would assess, monitor and, where required, take action to improve the quality and safety of the care and support provided to people living at Northgate House (Norwich). The provider had relied on the manager to submit regular progress reports, which have been submitted as requested since that time. However, these have demonstrated a continued lack of understanding as they did not reflect what we found when we inspected, in either our last inspection on 7 March 2018, or this inspection of 10 September 2018.

At this inspection on 10 September 2018 we found that the provider remained in breach of Regulations 17, 12, 11 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There was a further breach of Regulation 13 of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014. There was also a further breach of Regulation 18 of CQC Registration Regulations 2009 relating to notifications.

Many issues, including the findings from the environmental health officer, as well as the checks not being carried out or fire safety issues, identified in the health and safety report carried out in April 2018, were again later identified as remaining concerns. This was in an audit carried out by a consultant on 6 June 2018, and still no action had been taken before our inspection on 10 September 2018. This demonstrated that despite continuing support from external quality assurance colleagues, no actions were taken to improve the service. We asked the manager for these audits and reports during the inspection, as they told us they had employed a consultant to support them to improve the service. However, they told us they did not have access to any of these so could not provide them. A week after our inspection visit, the consultant provided their audits to us.

The manager had not added items to their action plan to improve the service when external auditors had identified areas associated with health and safety which required improvements. When we raised the questions around the lack of actions following these issues identified, for example around fire safety, the manager said the previous manager was responsible for this. However, the manager was the named responsible person according to the provider's own health and safety policy. They had not acted to respond to the issues identified. For example, risks associated with not checking bed rails had been identified by an

external auditor in April 2018. Another external auditor had inspected fire safety in April 2018, and actions from this, such as implementing fire drills and installing a smoke detector in one area, had still not been completed.

The manager told us they had been working with a compliance consultant to improve the service. However, they were unable to produce any records of any work that had been completed with this person, such as reports, audits or action plans.

Medicines audits still failed to identify gaps or concerns. Despite previous input from the local authority and CQC inspection findings, medicines administration remained problematic. Nobody had monitored the appropriate administration of PRN medicines or topical creams, and recording around these remained absent or inconsistent.

There were no further audits carried out by either of the partners in the provider's organisation, although one regularly visited the service. Staff confirmed that they saw them regularly and we saw them briefly twice on the day of the inspection. They did not initiate any discussion with us or provide any information about the running of their service.

There was poor leadership in place. Management remained chaotic and disorganised, and one member of staff described management as, "A shambles." We remain concerned that with a low number of people now living in the service, there remained significant shortfalls in the oversight and management of the home. The manager had not developed and sustained effective quality assurance systems. This demonstrated that the providers are unable to make sufficient improvements and sustain a service of a reasonable standard.

Staff confirmed that although the manager was regularly in the home, they turned up at different times, rather than according to the time they were in according to the rota. One staff member said if they felt if there was an issue, for example with staff conduct, they would go to the member of staff themselves to try and rectify it. They said if they went to the manager, they doubted anything would be done. Another member of staff told us if they raised a concern they felt they would, "Get shut down straight away." This demonstrated that staff did not always feel that they could raise and resolve concerns.

We could not be assured that the manager had a transparent approach. The manager was not transparent with us when we requested information. We asked the manager, who had overseen any recruitment following our last inspection on 7 March 2018, if there were any new staff since our last inspection. They told us they did not. It transpired, however, that there were at least six new staff members who had started since our last inspection. This in fact made up the majority of the care staff team at Northgate, despite the manager reiterating to us that they had retained all their staff. The staff we spoke with, and recruitment records, confirmed to us when they had started working in the service.

When we asked the manager if they had taken action on the findings of external audits they said they had. On several occasions throughout our inspection we asked for information and found that what we were told was not the case. When we looked around the home to check that actions had been taken they had not been completed. Two members of staff we spoke with referred to the manager as being dishonest.

During the inspection the manager told us that the consultant they employed was working with them in the home three days a week, but they were currently on holiday at the time of our visit. We spoke with the consultant a week later, and they confirmed to us that they had finished working with the service on 22 August 2018, and that prior to this they had visited one day a week for the time that there were only three people living there. They said prior to this they worked with the home two days a week.

A staff member told us about a staff member being sent home for a disciplinary issue during a shift and they told us this had left some people without their medicines as this had occurred in the middle of a medicines round. This occurrence was later confirmed by the external consultant the provider was working with. When we asked the manager about some staff who no longer appeared to be working in the service, they demonstrated a lack of understanding around employment management and law.

One member of staff told us they had been told what to say to CQC, so they did not feel that all staff felt confident to talk openly.

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

The provider had failed to notify us of all incidents within the service reported to safeguarding authorities.

This meant the service was in breach of Regulation 18 of CQC Registration Regulations 2009.

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 9 HSCA RA Regulations 2014 Person-centred care Person-centred Care The planning for the care and treatment of people did not always meet their needs and reflect their preferences. There was not adequate provision for people to engage in activities. There were insufficient systems in place to ensure the nutritional and hydration needs of people, having regard to the service users' wellbeing and provided in line with preferences and choices.

The enforcement action we took:

We issued an NoD to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Person-centred Care The planning for the care and treatment of people did not always meet their needs and reflect their preferences. There was not adequate provision for people to engage in activities. There were insufficient systems in place to ensure the nutritional and hydration needs of people, having regard to the service users' wellbeing and provided in line with preferences and choices.

The enforcement action we took:

We issued an urgent NOD to restrict admissions to the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Need for consent The provider continued not to act in accordance with the Mental Capacity Act 2005.

The enforcement action we took:

We issued an NOD to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Need for consent The provider continued not to act in accordance with the Mental Capacity Act 2005.

The enforcement action we took:

We issued an urgent NOD to restrict admissions to the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Safe care and treatment There was a continued failure to assess, protect and mitigate risks to people's health, welfare and safety. There was improper and unsafe management of people's medicines.

The enforcement action we took:

We issued an NoD to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Safe care and treatment There was a continued failure to assess, protect and mitigate risks to people's health, welfare and safety. There was improper and unsafe management of

people's medicines.

The enforcement action we took:

We issued an urgent NOD to restrict admissions to the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The nutritional and hydration needs of people to maintain their health and wellbeing were not met.

The enforcement action we took:

We issued an NoD to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The nutritional and hydration needs of people to maintain their health and wellbeing were not met.

The enforcement action we took:

We issued an urgent NOD to restrict admissions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Good governance The provider continued not to operate effectively, to assess and monitor the safety and quality of the service people received. Risks to people's safety associated with improper operation of the premises had always been identified and action taken to reduce these risks.

The enforcement action we took:

We issued an NOD to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Good governance The provider continued not to operate effectively, to assess and monitor the safety and quality of the service people received.

	Risks to people's safety associated with improper operation of the premises had always been identified and action taken to reduce these risks.

The enforcement action we took:

We issued an urgent NOD to restrict admissions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Fit and proper persons employed Recruitment procedures were not operated effectively to ensure that persons employed were of good character prior to their starting work at the service.

The enforcement action we took:

We issued an NoD to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Fit and proper persons employed Recruitment procedures were not operated effectively to ensure that persons employed were of good character prior to their starting work at the service.

The enforcement action we took:

We issued an urgent NOD to restrict admissions to the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing The provider did not ensure that there were sufficient numbers of staff made available at all times, suitably qualified, competent, skilled and experienced persons in order to meet people's needs.

The enforcement action we took:

We issued an NoD to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 18 HSCA RA Regulations 2014 Staffing

personal care	Staffing The provider did not ensure that there were sufficient numbers of staff made available at all times, suitably qualified, competent, skilled and experienced persons in order to meet people's needs.

The enforcement action we took:

We issued an urgent NOD to restrict admissions to the service.