Contemplation Homes Limited

Northcott House Residential Care and Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 4 and 5 June 2018 and was unannounced.

Northcott House Residential Care and Nursing 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. Northcott House provides nursing and personal care. It provides support for up to 55 older people, some of whom live with dementia. At the time of our inspection there were 41 people living at the home. Accommodation is in a very large building with long corridors and over two floors.

At our last inspection in September and October 2017 we found multiple breaches of the legal requirements. People did not receive safe care and treatment and the management of medicines was unsafe. This was a breach of Regulation 12. The deployment of staff was not appropriate to meet the needs of people and staff had not received appropriate support and training in order to deliver their role effectively. This was a breach of Regulation 18. Care was not always planned or delivered in a person centred way and this was a breach of regulation 9. People's consent was not always sought and where it was needed the Mental Capacity Act 2005 had not been applied. This was a breach of Regulation 11. Whilst the provider had systems in place to monitor and assess the safety of the service, these had been ineffective in identifying concerns and driving improvement. This was a breach of Regulation 17. The service was rated as inadequate in each key question and overall. It was placed into Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection, the service demonstrated to us that improvements had been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures.

Since our last inspection a new manager had been appointed and had applied to become registered with CQC. 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. Since this inspection visit they had become the registered manager. Throughout the report we have referred to them as the manager.

Whilst improvements had been made to the assessment and management of risks to people's safety, further work was needed to ensure this approach was consistently applied.

Medicines were now managed safely. Staffing levels had improved and were now appropriate to meet the needs of people. Staff training had been enhanced and competency assessments were taking place regularly. Staff felt supported and were receiving supervisions to support them in their roles.

Care planning and delivery was improving and we observed staff mostly responded promptly to changes in

people's needs, although this was work that needed further embedding into the service to ensure consistency. Where applicable, mental capacity assessments had been undertaken and we consistently saw and were told that people's permission was sought before staff provided care.

People were protected against abuse because staff had received training and understood their responsibility to safeguard people. Concerns were reported and investigated. The provider's recruitment process ensured appropriate checks were undertaken to ensure staff suitability to work in the home. People and their relatives felt the home was always clean and well maintained. Equipment was managed in a way that supported people to stay safe and people were supported to maintain good health and had access to appropriate healthcare services.

There was a process in place to deal with any complaints or concerns if they were raised. People told us they knew how to complain and we saw complaints were investigated and outcomes shared with people and staff.

Prior to people moving into the home, assessments were undertaken to ensure the home and staff could meet the person's needs. Staff were aware of the need to treat people as individuals and ensure care reflected their individual needs. People were supported to ensure they received adequate nutrition and hydration. Staff worked well as a team and people were supported to maintain good health and had access to appropriate healthcare services.

People and their relatives provided positive feedback about staff. Observations reflected people were comfortable and relaxed in staff's company. People were cared for with kindness and compassion. People's privacy and dignity was respected and they were encouraged to be involved in making decisions about their care.

Communication and team working had improved. The registered manager had reinforced staff roles and was open to suggestions and feedback. Staff felt supported by the registered manager and able to raise concerns at any time. They were confident these would be addressed. People and their relatives were confident to raise concerns if they needed to and spoke positively about the registered manager's approach. People, their families and staff had the opportunity to become involved in developing the service. Systems and processes to monitor the service had improved although further work was needed to develop and embed these.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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 always safe.

Whilst improvements had been made to the assessment and management of risks to people's safety, further work was needed to ensure this approach was consistently applied. Medicines were now managed safely.

Staffing levels had improved and were now appropriate to meet the needs of people. The provider's recruitment process ensured appropriate checks were undertaken to ensure staff suitability to work in the home.

People were protected against abuse by staff who understood their responsibility to safeguard people. People and their relatives felt the home was always clean and well maintained. Equipment was managed in a way that supported people to stay safe.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff training had been enhanced and competency assessments were taking place regularly. Staff felt supported and were receiving supervisions to support them in their roles.

Where applicable mental capacity assessments had been undertaken, although this needed to be fully embedded. We consistently saw and were told they people's permission was sought before staff provided care. Prior to people moving into the home, assessments were undertaken to ensure the home and staff could meet the person's needs.

People were supported to ensure they received adequate nutrition and hydration. Staff worked well as a team and people were supported to maintain good health and had access to appropriate healthcare services.

Is the service caring?

Good

The service was caring.

Observations reflected people were comfortable and relaxed in staff's company.

People were cared for with kindness and compassion.

People's privacy and dignity was respected and they were encouraged to be involved in making decisions about their care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care planning and delivery was improving and we observed staff mostly responded promptly to changes in people's needs, although this was work that needed further embedding into the service to ensure consistency.

There was a process in place to deal with any complaints or concerns if they were raised. People told us they knew how to complain and we saw complaints were investigated and outcomes shared with people and staff.

Is the service well-led?

Requires Improvement

The service was not always well led.

Significant improvements had been made since the last inspection. The systems in place to monitor the safety and quality of the service had improved but further work was needed on these.

A new manager was in post who had clearly defined staff roles and their responsibilities. They had provided a clearer structure in the home and staff team. Communication was more effective and staff and people felt well supported and encouraged to make suggestions.

Incidents which required reporting to CQC were being reported.

Northcott House Residential Care and Nursing 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 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.

The inspection took place on 4 and 5 June 2018 and was unannounced.

The inspection team consisted of two adult social care inspectors, a specialist nurse advisor and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the service including notifications the provider had made to us. This helped to inform what areas we would focus on as part of our inspection. We also reviewed the previous inspection report and the provider information return (PIR) sent to us before this inspection; this is a form that asks the provider to give us some key information about the service, what the service does well and improvements. Before the inspection we sought feedback from the local authority and an external health professional.

During the inspection we spoke to 15 people and eight relatives. We spoke to 15 staff, including registered nurses, care staff, kitchen staff, activity staff, the manager and a senior manager. We also spoke with a visiting professional. Due to the nature of people's illnesses we were not always able to communicate with them so we spent time observing the interactions between people and staff, in public areas of the home, in order to help us understand people's experiences.

We looked at the care records for 10 people who used the service and the personnel files for seven staff members. We also looked at a range of records relating to how the service was managed. These included training records, complaints, quality assurance systems and policies and procedures.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at Northcott. One person said "Yes I'm safe and happy here". A second person said "Oh yes, very safe. The day they moved me in here I slept for 7 hours straight off. I was stuck in the bath at home for a long time and afterwards I was frightened of being on my own" and "I am so glad I came here, I feel safer" and "I thank God every day that I came here" and "My friend now lives here, they bring her in to see me. I thank God she'll be safe now too".

At the last inspection we found serious concerns about the safety of the service. People were placed at risk of harm because appropriate measures had not been implemented to identify and assess risks. In addition, measures had not been taken to ensure that risks for people were minimised and medicines were not always safely managed. Staff lacked knowledge of those at risk of choking and measures were not in place to minimise this risk. The environment had not been assessed and made safe against any risk of choking this may pose. One qualified staff member was unaware of how to use the suction machine and no records were kept to show this was maintained. Skin integrity was poorly managed which placed people at risk of injures. Bed rails were inappropriately used and not used in line with risks assessments. Risk of health complications such as urinary tract infections (UTI's) had not been assessed when they were a known risk. Care records lacked assessment/risk assessments of specific health conditions such as diabetes and for behaviours which posed risks. Clinical observations which could indicate health concerns were not understood and acted upon. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This had improved at this inspection although further work was required in some area's of risk management.

At the last inspection people were not protected against the risk of skin damage. We found that this still needed some improvements. For example, we found that the records showed the support for people at risk of skin damage to reposition regularly were not always in line with their care plans. One person's records showed this did not take place every four hours as instructed whilst another person showed they were regularly supported to move their position. In addition, on the first day of our inspection we found three air mattresses (specialist mattresses used to reduce the risk of skin breakdown for people) were set incorrectly and one had been turned off at the plug. Whilst staff told us these were checked, records did not reflect these mattresses were being checked by staff to ensure they were set correctly. The manager took immediate action to address these and placed alerts on the electronic care system used by all staff. This alerted staff to the need to check the setting of these mattresses if this had not been completed.

At the last inspection we found that people who lived with health conditions were placed at risk because care records lacked information staff would need, staff did not always take action when risks were presenting and at times staff lacked knowledge of how to monitor for these risks. This had improved at this inspection and staff knowledge of people, the risks their health conditions posed and how they could reduce and manage these risks had improved. However, as the provider was implementing an electronic system of care planning, some records still needed developing. For one person, whilst staff understood the risks their health condition posed and could clearly tell us about this, their care records provided no guidance to staff about how the condition affected the person and the specific actions staff could take to

reduce these risks. We could see that the person had developed an ulcer as a result of this condition and staff were taking appropriate action to manage this and were involving other professionals in this. For a second person, we saw they had suffered a fall whilst unwell, which resulted in an injury. Whilst the reason for them being unwell was being treated and staff told us they were aware of the risks of this person falling, no assessment of this risk had been undertaken and no plan implemented to reduce the risk. This person's care records had not been reviewed since the fall had occurred. The lack of assessment and review could place this person at further risk of injury as a result of falls. We discussed this with the manager who took immediate action to address this.

The increased awareness and knowledge of staff lowered the impact of these issues of concern for people but the lack evidence of clear assessment of risk and planning to reduce risk meant that people may not always receive safe care and treatment. This remained a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found for some people the information to show risks to them had been clearly assessed and plans implemented to mitigate these. For a third person living with a health condition that affected their breathing, clear information was contained in their records to identify this condition, the risks this presented for the person, how staff would identify a deterioration of this and how they would manage this. For a fourth person recently admitted to the home, whilst care plans were being developed, there was comprehensive information in place to guide staff about their need for enteral feeding. In addition, staff had been trained and deemed competent by external health professionals to care and manage this, therefore reducing any risks this could pose for them.

At the last inspection we found people were placed at serious risk of harm because staff lacked knowledge of those who were at risk of choking, assessments of this risk were not completed, care planning lacked information to guide staff about the reduction of this risk, information within the home about choking risks was inconsistent and the environment was not kept safe from the risks of choking. This had improved at this inspection. The provider had introduced an electronic care planning and recording system. All staff carried a hand held device which they could use to access the information to understand the needs of the people they were supporting. We saw that an alert message scrolled across the top of people's records which told staff what the risks for people were. Where people were at risk of choking, this continually ran across the top of the persons records. The electronic system used a risk assessment tool to identify the risk and a senior manager for the provider told us they were working with the developer to improve this assessment further. Care plans were in place which provided guidance to staff about the risk of choking for people and the support they needed to reduce this risk. Guidance from external health professionals had been used where needed to inform these plans. All staff had received additional training about the management of choking risks and this training had been followed by competency based assessments. The management of meals times had been improved by the clear allocation of staff. People at risk of choking were provided their meals on red plates to ensure all staff were aware of the need to observe them and not leave people unsupported. Information in the home about who was at risk of choking was consistent and clear. Where people were at risk, information was contained in their rooms about the signs of choking and the first aid management of this. Appropriate staff had been trained to use the suction equipment which was checked regularly. The environment had been cleared of potential choking hazards and these were stored safely.

At the last inspection we found people were not always safe because bed rails were inappropriately used. This had improved at this inspection. Everyone who was using bed rails had been assessed to ensure this was safe. Bed rail bumpers were in place which would reduce the risk of injury from bed rails. Where bed rails had been deemed unsafe for people, alternative support had been implemented including lowering beds to the lowest level, using sensor mats to alert staff to people's movement and using crash mats to

reduce any risk should people fall out of bed.

At the last inspection we could not be confident people always received their medicines as prescribed. Where covert medicines were being used, pharmacy input not always sourced. The medicines trolley was left unattended and unlocked in public areas. PRN protocols were not up to date with current prescribed medicines and Topical Medication Administration Records were poorly completed, so it was not possible to be sure that these creams were applied correctly and when needed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This had improved at this inspection and was no longer a breach, although we did find further improvements were needed to improve staff knowledge of the medicines they were administering and the early identification of medicines errors.

At the last inspection medicines prescribed on an 'as required' (PRN) basis had protocols in place which were not always up to date with current prescribed medicines. At this inspection we found for some people these records had been changed since our last inspection but had since become out of date and were not accurate. The manager took immediate action to address this and confirmed the day after our visit that these had all been checked and updated.

At our last inspection we found medicines trolleys were often left unattended and unlocked. Throughout this inspection we observed the medicines being administered and found that practice followed guidance from the Royal Pharmaceutical Society. Staff did not leave the medicines trolley unlocked when unsupervised. Staff checked the records before administering the medicines and then signed for these once the person had taken them. However, when checking medicines stock we found on one occasion, for one person a medicine had been signed as being given but remained in the blister pack. For a second person two medicines had been signed as being given on two occasions but remained in the blister pack. This meant the practice of signing once medicines had been taken was not consistently applied.

At the last inspection we found no input from a pharmacist had been sought when medicines were administered covertly (hidden). This meant if the medicine was mixed with food or drink that it was not compatible with it could become ineffective. At this inspection the manager and nursing staff confirmed this had taken place. We found records confirmed this for one person but not for a second. The manager took immediate action and confirmed with the pharmacist the following day.

The planned monthly audits had yet to be completed and the manager was confident that these medicines errors would have been identified during the audit but did agree that they should have been identified sooner. They told us they would look into this and the day after our inspection advised us that they had arranged a staff meeting to discuss this and, in the interim, were meeting with individual staff. In addition, an interim audit would take place in the following two weeks. In addition, the manager was reviewing the audit to ensure this also covered "blister pack popping, PRN protocols and covert protocols".

Of four staff we spoke with, two had a good knowledge of commonly used medicines and their side effects, whilst one was unable to tell us this and a fourth was not able to tell us when one medicine should be given.

Medicines continued to be stored in locked trolleys, rooms and fridges. The checking of the temperature of medicines storage was undertaken daily. Where people required their fluids to be thickened to enable them to take their medicines safely this was done. The recording of cream application had improved and was now recorded electronically with alerts to ensure staff remembered to do this.

At the last inspection we found staffing levels varied throughout the inspection and there was no system to ensure these levels met people's needs. Call bell response times were poor and people's comments

indicated staffing levels may not be appropriate to meet their needs. Call bells rang almost continually. Due to the length of time it was taking for call bells to be answered, the system frequently moved to emergency alarm. There was no system to determine staffing levels and they were not effectively deployed. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This had improved at this inspection and was no longer a breach of regulation.

Staffing levels had increased at this inspection and the structure of staff had changed. Two nurses, one of which was a senior nurse, were on duty throughout the day. They were supported by 12 care staff in the morning and 11 in the afternoon. There were senior care staff on each shift. In addition, activity staff, housekeeping staff and kitchen staff were available as well as the manager and deputy manager.

Staff told us that the staffing levels were ok and there were enough staff to keep people safe. One staff member told us "In a perfect world every home would have more staff than they need. If you work as a team, communicate well, it's better". Staff confirmed and we saw that the allocation and deployment of staff across the service had improved and one member of staff told us their roles were "now much clearer since matron came in". they said that staff morale improved "massively", "[staff] have purpose and clarity".

The senior management team were auditing the emergency calls alarms each month and we could see that the number of emergency calls had reduced and the response times had improved. People we spoke with raised concerns about the length of time that their calls bells were answered and we saw this was a common cause for complaint in the home. One person told us when we asked if there were enough staff "No, I don't think there is" and "I detest it when I buzz and no one comes for ages-it's not their fault there's not enough of them". A second said "No-that's a problem. I need two people to help me so it's not always swift" and a third said "Depends, sometimes it takes a long time [for staff to answer call bells], but night time is fine". Whereas a fourth said "They are very good but rushed off their feet. I'm not keen on having too many agency staff, they don't know you as well as the others" and on call bells "I have a call bell. I seldom wait too long".

On two occasions on the first day of our inspection we observed that it took over six minutes for staff to respond to call alarms during the morning, which staff told us was a busy time of day. We discussed this with the manager and senior manager who told us the provider intended to link the call bell system to the electronic care planning system. Staff would be alerted to calls on a handheld device they all carried and would be able to communicate using this device to other staff if they were unable to answer a call bell in their allocated areas. The hope was that this would improve the communication when staff were busy with other people, so staff who were free in other areas of the home could respond.

In addition, the provider aimed for this change to the call bell system to link up with dependency assessments and use all the information they gathered to inform their staffing levels.

Apart from the first morning of our inspection our observations demonstrated that staff allocation was much clearer, staff responded promptly to people's requests for support and undertook regular checks of those people unable to use their call alarm.

Safe recruitment processes were in place. Application forms had been completed and recorded the applicant's employment history, the names of two employment referees and any relevant training. There was also a statement that confirmed the person did not have any criminal convictions that might make them unsuitable for the post. A Disclosure and Barring Service (DBS) check had been obtained by the provider before people commenced work. The Disclosure and Barring Service carry out checks on individuals who intend to work with vulnerable children and adults, to help employers make safer

recruitment decisions.

People told us they felt that Northcott House was clean and tidy which we observed throughout our visit. We did not detect any malodours. All areas, both communal and clinical, were clean and tidy. There were ample hand hygiene stations throughout the home. All hand basins contained hot running water, soap and disposable towels. Bathrooms and toilets were clean and free of litter or debris. Staff received training in infection control. Infection control audits were completed to monitor the cleanliness of the service. There was adequate provision of personal protective equipment (PPE) for staff, such as gowns and gloves, which we observed were used appropriately.

People were protected from the risk of abuse because staff understood how to identify and report it. Staff had access to guidance to help them identify abuse and respond in line with the provider's policy and procedures if it occurred. They told us they had received training in keeping people safe from abuse and this was confirmed in the staff training records. In addition, competency based discussions took place with staff about their knowledge of safeguarding. Staff told us they would have no hesitation in reporting abuse and were confident that management would act on their concerns. We saw where staff had identified potential safeguarding concerns, all bar one, had been reported to the local authority safeguarding team and investigated. The manager was not aware of the one potential safeguarding issue when we discussed this and took immediate action to begin investigating this during our inspection, including addressing the failure to alert the manager, with staff involved. For all other potential safeguarding issues, there was evidence that any required actions were considered and carried out.

A system was in place to record all incidents and accidents. The manager audited all of these on a monthly basis. These audits looked for patterns and trends as well as recording any individual actions that had been taken for people.

Requires Improvement

Is the service effective?

Our findings

People told us they felt staff were knowledgeable of their needs and had the skills to support them. One person said "Yes, some take a bit longer than others to get to know you, but the ones who've been here longest know what to do".

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA 2005. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA 2005, and whether any conditions on authorisations to deprive a person of their liberty were being met.

At the last inspection we found people's consent was not always sought and the Mental Capacity Act 2005 was not always followed. Bed rails were used with no consent sought or capacity assessed and there was a lack of capacity assessments when covert medicines being used. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection this had improved and was no longer a breach but further improvements were needed.

Whilst we were confident consent was being sought, the records confirming people's consent to their care plans had not been signed. People told us they had been asked for their permission to use bed rails and that they were always asked for their permission before staff provided any care. One person told us "A couple of days now I've felt rotten. They say don't worry I'll come back later and see if you are up for a wash" a second said "Yes, I remember. They've got our pictures on their phones" (referring to the handheld devices used by staff to document the care provided to people). A third said "I remember they asked permission to photograph my leg". During the inspection we heard staff asking permission to enter rooms, to assist people with their meals and to support them to transfer to chairs.

Staff understood the importance of always assuming a person can make their own decisions. Mental capacity assessments had mostly been completed where needed, although we did find one person was having their medicines administered covertly and staff were unable to find the records of the capacity assessment. The manager confirmed the day after the inspection that the assessment had been redone. Staff and the registered manager understood their responsibilities with DoLS and had received training from the provider. Where DoLS had been applied for mental capacity assessments had been completed. The manager had a system in place to track the expiry dates of these and any conditions that were required to be met. We saw they had been working with social services to meet the conditions for one person.

At the last inspection, staff did not always receive effective support, supervision or training. We identified a number of concerns about the competency and skills of some staff including their understanding of clinical observations and the use of emergency equipment. No assessments to ensure staff's competence in these areas had been completed. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection this had improved and was no longer a breach.

Since our last inspection, further training had been delivered to staff and staff told us they had done lots of training which helped them in the roles. Staff were required to complete mandatory training such as safeguarding and moving and handing. Additional subjects were also available for staff to complete. This included the Mental Capacity Act 2005, Deprivation of Liberty Safeguards, falls awareness and dementia. At our last inspection, we had raised significant concerns about the management of people who were at risk of choking. Staff had received training and competency assessments had been completed in regards to managing the risk of choking and Dysphagia (the medical term for difficulty in swallowing). Champion roles were being introduced such as end of life care champions and additional training and support was being provided to these staff who were also being encouraged and supported to make links with other organisations and professionals.

The new manager had completed supervisions with all staff as a means to get to know them, develop an understanding of their expectations of the manager and be clear about the expectations and roles of staff. Ongoing supervisions with staff were planned and the manager was working on a plan to delegate these to other senior members of staff.

At the last inspection feedback was mixed about food. Observations of lunch showed this was disorganised and chaotic. Staff found it difficult to seat everyone and people were not supported safely. Where people had lost weight, this had not been explored and records of monitoring people's intake was poor. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection this had improved and was no longer a breach.

At this inspection people said "I couldn't fault it seeing as they are cooking for a lot of people here. Today I didn't fancy a cooked meal so had cheese and biscuits and a pudding, it was lovely", a second said "the food is wonderful here" and a third said "there's a lot of things I don't like, it's my fault not theirs. They make a lovely salad here. Every few weeks my son brings in fish and chips for a treat". Pointing to a member of staff, a fourth person told us "She's very nice. She makes me a cup of tea just the way I like it with honey added" and "I'm going to have 2 fried eggs on toast for tea".

Since the last inspection staff had received training to ensure that they were able to meet people's nutritional needs appropriately and provide meal time support safely. The information available to staff was accurate in relation to people's needs and the kitchen staff had a good knowledge of people's needs. The deployment of staff at meals times supported this to be a smooth and comfortable experience for people.

The risk of malnutrition for people was assessed on a regular basis and where concerns were identified such as unexplained weight loss, action was taken to address this. The kitchen staff were kept informed and ensured that where needed people's meals were prepared to ensure a high calorie intake. The monitoring of food intake had improved. The record of people's weight was audited each month and the nursing staff told us this enabled them to check action had been taken where needed. We observed that the audits did not make clear the action that had been taken or was to be taken. The manager was aware that some recording still required further work and needed to be fully embedded. They were working on this with staff.

At the last inspection whilst we saw people were supported to access other health professionals, we were

not confident referrals took place promptly and at the time a need was identified. Health professionals had made recommendations about a person's hand care which we were not confident was taking place. In addition, we were not confident staff always recognised when a health professional may be needed. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection this had improved and was no longer a breach.

Feedback from people was positive and they all felt they were supported to see a doctor if they needed to. Prior to the inspection, we received concerns that one person may not have been supported to a medical appointment due to not having the equipment available. We were assured the person attended the appointment and equipment was available. The manager had been aware of these concerns and had implemented a system to ensure regular checks and ordering of this equipment was in place.

Handovers between staff took place to ensure they were kept up to date about everyone's needs. The manager felt they had developed good working relationships with other professionals to enable clear communication. A health care professional told us that they felt improvements had been made and that "Northcott have made more timely referrals to us". They also advised staff were now working more proactively with an external health team in implementing champion roles to monitor people more closely. Records confirmed that people were supported to access other professionals when needed. For example, one person had been referred to an appropriate professional to consider the management of a wound.

Prior to moving into the service, pre admission assessments including risk assessments were completed. These followed relevant evidence based guidelines such as NICE and were nationally recognised assessment tools including Waterlow (used to assess risk of skin breakdown) and MUST (used to assess risk of malnutrition). This enabled staff to identify any specialist requirements or equipment people may need, including pressure relieving, moving & handling equipment, wound management, nutrition and hydration requirements. Following these processes care plans were developed to enable staff to deliver the care people needed. The manager planned to introduce further evidence based tools to aid staff in the delivery of care such as a fluid intake matrix which would guide staff to a person's ideal fluid intake and prevention of dehydration, when used.

People were cared for in an environment where some adaptations had been made to meet their needs but further work could be done to develop this further. Northcott House has a large footprint with several corridors on the ground floor. Flooring helped to reduce the risk of falls and most communal areas were well lit, although the long corridors did at times appear quite dark. There were some picture signs showing where the dining room and lounges are but these were not always clear and you could easily find yourself feeling lost in the corridors. While not entirely maintained in a dementia friendly style (e.g. using differing colours to distinguish areas, items and clear signage) efforts had been made to add interest for the people living there. People were able to personalise their rooms. In several areas large boards were covered with photographs of people enjoying activities and special occasions. There are three large sea side scenes murals on the walls which staff use as a discussion/reminiscence opportunity. At the foot of the main staircase is another sitting area which also has a large fish tank and two budgies in cages which people can stop and talk to.

Good

Is the service caring?

Our findings

At the last inspection we rated caring as Inadequate. This was because the service could not be considered as caring due to the other issues of concern we found. At the last inspection we found lots of concerns which placed people at risk or harm such as poor management of people at risk of choking and a lack of response to emergency call bells. A service that was caring would not place people at risk of harm. Although some further work was needed to ensure the improvements to the safety of the service were fully embedded, the service had significantly improved and were able to demonstrate a staff team that were caring in their individual approaches as well as an organisation committed to ensuring people were cared for well.

At the last inspection we found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered persons had failed to ensure a person received the care that they required to reduce any risks associated with their contractures. This had improved at this inspection and was no longer a breach. We observed the care plan for one person living with severe contractures gave guidance to staff about exercises to help with these. Staff told us how this was supported and we saw that records mostly reflected these exercises taking place.

Feedback from people had changed at this inspection and they consistently described staff as kind, caring and supporting them well. One person told us "They're lovely. They treat you like one of the family. I can't think of anything bad to tell you". A second person said "They're smashing, it's a pity there's not more of them then the ones we know and love could sit and talk to me". Another person said "Yes, the staff are good, we can have a conversation. There's a new one who's just started, she pops her head round the door to see if I'm ok" and a fourth said "I'm happy here. The staff are very kind, they know I can't see very well so they help me". People's relatives also said they felt staff were caring. One told us "I think they're caring from what I've seen. Thinking back there have been occasions in the past when some might not have been but that was addressed at the time and that's history-there's lots of improvements been made". A second said "I've got no problems with any of them. I can ask them anything. I asked them to accompany mum to the toilet and they put it on their phones".

Our observations at the last inspection showed that staff were very task orientated in their approaches. However, throughout this inspection our observations showed that staff supported people with kindness, respect and in a person centred way. On one occasion, a person with dementia walked into the dining room at 8.55am and thought it was lunchtime. A member of staff gently told the person the time and reminded them that they had had breakfast recently. The member of staff asked if the person was still hungry and the person said yes. The member of staff asked if the person would like their favourite snack of bananas and cream. The person nodded and a bowl of sliced banana and cream was quickly produced. On a third occasion, one person kept calling out during breakfast. They were comforted by a member of staff who asked what the matter was and offered to take them back to bed. The person indicated that they wanted to stay downstairs at first then wanted to go back to bed. The person hadn't eaten breakfast so the member of staff had toast and tea taken to the person's room. We observed people being supported to be as independent as possible.

Prior to people moving into the home, assessments were undertaken to ensure the home and staff could meet the person's needs. Most people couldn't remember details of their admission to Northcott House, but some who did told us they were involved in a pre admission assessment and that staff met them and their family beforehand. One relative told us "Yes, someone came up to the old home with me". The preadmission assessment process identified the areas of support people needed in relation to their health, their social needs and their personal needs. Whilst most people could not recall their care plans, relatives confirmed that they and their loved ones had been involved in the initial development of these and that they had been reviewed.

People told us they felt listened to. One person said "I'd like to have music from downstairs piped upstairs but I don't think it would be possible". We observed a member of staff make arrangements for music to be played in this person's room via a phone.

The manager held meetings with relatives and residents to share updates to the service and again feedback. The manager described how with the involvement of people, a lunch club had been introduced with the local school, whereby some of the children shared lunch with people living at the home. We were advised this was enjoyed by all involved.

Staff were aware of the need to treat people as individuals and respect their beliefs and lifestyle choices. Staff were provided with training in dignity and respect; person centred care and equality and diversity to aid staff's understanding. The manager was clear that discrimination would not be tolerated and was confident any human rights or equality needs people had would be met. People were supported to maintain their independence. We observed people were provided with the appropriate equipment they needed to eat their meals independently including adapted cutlery and crockery. People mobilised freely around the home and one person was supported to visit people outside of the home.

People said their privacy and dignity was maintained. One person told us "They close the door when I'm getting more dressed or washed". An external health professional visited the service while we were there. We observed the member of staff ask the person if she would like some privacy and helped her to the treatment room. Records were held securely and confidentially.

The provider and registered manager were aware of the Accessible Information Standard (AIS). This was introduced in August 2016 and applies to people using the service who have information or communication needs relating to a disability, impairment or sensory loss. It covers the needs of people who are blind, deaf, and/or who have a learning disability. Plus, people who have aphasia, autism or a mental health condition which affects their ability to communicate. The registered manager told us that if needed any information could be provided to people in large print. Picture menus were provided as needed. They told us that staff members had been supported with some training courses through the use of yellow paper, where this has been needed, to support their dyslexia. They also advised how a relative had had an operation which affected their ability to speak so to support them and their loved one, they ensured the tools needed for writing were available and used email as the preferred communication tool. The manager advised that this was always going to be work in progress and that they aimed to ensure the assessment process identified any specific communication aids people may need.

Requires Improvement

Is the service responsive?

Our findings

People spoke positively about living at Northcott House and felt staff responded well to their needs.

At the last inspection we found that whilst a feedback survey was used to gain people's feedback and an action plan was developed following this, the action plan provided no timescales for the action and we found that some areas which required improvement remained a concern during our inspection. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. This had improved and was no longer a breach.

At this inspection the provider had undertaken an analysis of feedback surveys sent since the last inspection and planned a further analysis of additional surveys received between January 2018 and June 2018 in the near future. Following this the action plan would be developed and shared with the manager. However, in the interim the manager had reviewed the surveys that had been returned to the home. Where concerns had been raised, they had acted upon these, although the recording of these actions could improve. For example, one person raised concerns about the food. Staff and the manager told us of the actions taken including, reviewing menus and sharing the information with the kitchen staff however this had not been clearly documented. In addition, we observed the new manager had also carried on with the previous action plan aiming to ensure all actions were completed.

At the last inspection we found a breach of Regulation 9 of the Health and Social Care Act 2014 because a person centred approach was not taken at the end of a person's life. This topic area was under the key question of caring in the previous assessment framework, but was moved to this key question when the framework was reviewed and refined. At this inspection this had improved and was no longer a breach, although the manager recognised the need to develop formalised care plans.

At this inspection staff were able to tell us how they would support the end of life care for people. We were told the home operated the six steps planning for end of life care. This is a nationally recognised system for planning and delivering care to a person at the end of their life. The manager told us how two staff had been appointed as champions to take this forward in the home and had been given additional training to do so. The manager was aware of the need to start developing people's care plans but staff were aware of what would be involved. This included identifying when a person was deteriorating and possibly entering the end phase of their life; involving the medical team early and sourcing appropriate medicines to ensure they were pain free; ensuring any spiritual, cultural and religious needs were understood and supported as well as involving the person's family if this was the person's choice.

At the last inspection we found staff did not respond to incidents which reflected a change in a person's needs. A failure to respond to a change in a person's condition and ensure that risks associated with their needs had been effectively assessed, plans developed and delivered to mitigate the risks was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2017. This had mostly improved although further improvements were needed.

We did find one example where a person's clinical observations had indicated they were unwell. This person had previously been unwell and had finished a course of treatment for this. We were concerned that staff had taken no action regarding the observations and contacted the GP. This person was well at the time of our inspection, however we discussed the potential risk of this with the manager. The manager took immediate action to raise this concern with the staff involved. On a second occasion we noted a bruise had been found on a person's arm and the cause of this had not been followed up. The manager had not been made aware of this, however we would expect that a registered nurse would explore this. The manager told us they would take action to address this.

We found other examples where staff were very responsive to people's needs. One person who wished to remain as independent as possible chose to go out daily. This person's medical condition meant they were at risk. Staff had worked proactively with others to respond to this person's needs and minimise the risks. They ensured appropriate clothing was worn, assisted with arranging taxis, ensured the person carried a charged mobile phone and laminated card with their address and phone number on should they become disorientated or need assistance.

We found good examples of person centred care planning. One person's care plans described how this person was sometimes reluctant to take their medicines in the morning but with a clear explanation from staff and ensuring a drink was available would usually take this. Since the last inspection, there had been a real focus on ensuring that care plans included the risks for people and the manager was aware that further work was needed to ensure that all people's care plans were fully reflective of people's likes and preferences also.

The providers had a policy and arrangements in place to deal with complaints. They provided information on the action people could take if they were not satisfied with the service being provided. All of the people we spoke with told us they knew how to complain and were confident to speak to both staff and the registered manager. The registered manager told us that when concerns were raised they dealt with them straight away in line with the provider's policy. Records reflected complaints were investigated and the outcome and learning shared with the person and staff.

Requires Improvement

Is the service well-led?

Our findings

Since our last inspection a new manager had been appointed and had applied to become registered with CQC. Since this inspection visit they had become the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People spoke positively about the new registered manager and felt that Northcott House was managed well. One person said "[manager's] lovely you can talk to her about anything". A second person said "I want to tell you how good [manager] the matron is. I've been here 9 years now. She came here last year and has made some changes. She's made sure everything has a good clean and she's told me there's going to be a poster up in my room telling people about me and what I like and don't like." Relatives told us the manager was "very approachable" and had "made changes for the better". Staff spoke positively about the manager and changes that had been made since the last inspection. One member of staff said "I have seen much improvement over the last six months. Mainly in how we organise care, and person centred care planning. It feels like the care staff are here because they want to be here. There is good communication." Another member of staff told us "The home's organisation is improving, certainly from a year ago. The chain of command is now very tangible and staff are very clear what their roles and responsibilities are. We are being encouraged to be more innovative (within protocols). There has also been some streamlining which reduces confusion and duplication".

The manager told us how they had spent time getting to know people and staff. They ensured they carried out supervisions with all staff as a means of developing relationships and providing staff support. The manager was visible throughout the inspection and staff said they were always there to provide help if staff needed it. The manager was encouraging staff to reflect on their practice and when things went wrong used this reflection with them to look at what could have happened differently and what they would do next time. For example, the manager had been unaware of an incident that had occurred in the home, we spoke to the member of staff involved who openly told us what they would do differently and how they would ensure the manager was made aware.

The structure of the home and staffing structure had changed since the last inspection and the manager told us this was to ensure clear lines of responsibility and accountability which was lacking at the last inspection. Residential and Nursing areas had been split to ensure clearly defined areas with appropriate staffing. Supervisory roles had been introduced including new senior nurse roles and senior carers to promote more person centred care. More permanent staff had been employed reducing agency usage. The manager was clear that they operated a zero tolerance to poor standards and staff reiterated this telling us the manager was firm but fair.

At the last inspection we found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 because the systems in place to monitor the safety and quality of the service were ineffective. The provider employed a quality assurance manager and we found their audits to be ineffective in

identifying concerns and driving improvement. At this inspection we found this had improved but needed to be embedded fully.

Although the manager had delegated some audits to others, they had oversight of these audits. Multiple audits were in place and the manager was aware of the need to make further improvements to the recording of some of these. For example, whilst people's weight records were audited each month, the audits did not make clear the action that had been taken or was to be taken. The senior management team were auditing the emergency calls alarms each month and told us they would be moving to a more general call bell audit system now they were assured response times had improved. They were working with the developers of the computerised system to aid this work but it had yet to be completed. We did find that some delegated audits such as wounds had not been completed since March 2018 and the manager's report had not identified this. In addition, the audit in March 2018 of wounds was more a report of the current situation rather than an analysis that would aid learning opportunities and improved practice. During the inspection, we found the manager was not aware of three incidents until we told them. They told us this was due to the reporting system used as this did not always support the process to ensure the manager was made aware immediately of those incident which required their action. The provider had recently changed the reporting of these incidents to ensure the information was inputted onto the provider's electronic system. In addition, they were approaching the IT developer to place an alert on the system that would ensure the manager was made aware as soon as a incident record was completed. In addition, moving to electronic reporting would enable the senior management to monitor the service, identify trends and ensure action was taken.

The provider had very recently introduced a report for managers which ensured they reviewed all audits carried out in the service and undertook analysis of these, looking particularly for learning points. The manager explained how they had found five of eight falls had occurred at night and in discussion with the night staff had asked them to consider what takes place at night and how things could be improved upon for people. The manager and a senior manager told us this audit tool was work in progress and was developing further as it was being used. They said that this would also aid them to work with others on their auditing skills.

The provider's quality assurance manager continued to audit the service regularly and we found these had been more successful in identifying issues and driving improvement. For example, we found one audit since our last inspection identified a lack of information in the kitchen about meal types people needed. At this inspection, kitchen staff were very knowledgeable about what people needed and information was in place to guide them. A further audit identified the need to ensure photographs were in place with medicine administration records and we saw this had been done. We were unable to find any care plan specific audits and the manager and senior manager told us they had been reviewing these but needed to develop a tool to support clearer auditing of these. They were aware that the audits had focused on making sure information was transferred onto the computerised system and were aware that they now needed to have a much more person centred approach to these audits to ensure the issues we identified and reported on in Safe and Responsive domains were in place. They were planning on reviewing these tools but had yet to complete this.

The registered manager engaged with other agencies and the local community. An external health professional told us how they home had really "embraced " working with the signposting service, and dying matters. In addition, the registered manager had made links with local schools to build community engagement which they said they wanted to build on further. People, relatives and staff were asked their views in relation to the quality of care on a regular basis. Staff consistently told us the registered manager had really made a difference to the home, in a positive way. There was open communication about the

service, people and staff were encouraged to engage and contribute ideas. Staff told us they were able to make any suggestions and felt they were listened to.

At our last inspection we found a failure to notify CQC of significant events that happened in the service. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. At this inspection we found this was no longer a breach and the manager and provider had ensured incidents that required notifying to CQC had been done so in a timely manner.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment A lack of effective assessment of risk and planning to reduce risk meant that people may not always receive safe care and treatment. Regulation 12.