Bupa Care Homes (CFChomes) Limited

Northlands House Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

At our last inspection of Northlands House Care Home on 1 and 4 November 2016, we rated the service as Good but the Key Question of Safe was rated as Requires Improvement. This was because people gave us mixed feedback about staffing levels. People told us they sometimes had to wait a long time for their call bell to be answered.

We undertook this unannounced focused inspection on 28 and 29 November 2017. The inspection was in response to a number of concerns which were raised with the Care Quality Commission and by the local authority safeguarding team. The team inspected the service against two of the five questions we ask about services: is the service safe and is the service well led?

No risks or concerns were identified in the remaining Key Questions through our ongoing monitoring or during our inspection activity so we did not inspect them. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection.

The inspection was conducted by two inspectors and a nurse specialist advisor.

Northlands House Care 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.

Northlands House is registered to accommodate a maximum of 101 service users. The home is situated in Southampton close to the city centre and provides care to people with physical disabilities and those who may have dementia. The home is over three floors with communal areas on each floor. There were 80 people living in Northlands at the time of our inspection plus a further two who were in hospital.

There was not a registered manager at the service at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At the time of the inspection the manager had submitted an application to register to the Care Quality Commission and was registered between the inspection and our report being finalised.

We found there were not enough staff to meet people's physical care needs. People waited a long time for staff to respond to call bells. People and staff felt there was not any time to talk and chat to people unless they were supporting them with their personal care or eating. Staff said they were stressed and worried about the quality of care they were providing.

The provider did not ensure that all notifiable incidents that affect the health, safety and welfare of people who live at the home were reported to the Commission, which they are required to do by law. When people

died at the home, staff completed the relevant notifications but there was a delay in sending them through. It is important for providers to notify the Commission so that we are kept informed and aware of any issues of concern developing.

The provider had policies and procedures in place designed to protect people from abuse. Risk assessments identified when people were at risk from every day activities. Personal protective equipment, such as aprons and gloves were readily available to ensure the risk of cross infection was minimised. People received their medicines as prescribed by staff who were trained and assessed as competent. Lessons were learnt and improvements made when things went wrong.

The provider promoted an open and transparent culture in the home. People and staff were involved in the everyday running of the home and action was taken to address their ideas or concerns.

There was a quality assurance system of audits in place to monitor and assess the quality and safety of the service provided. The manager and provider worked with the local authority safeguarding team to address any safeguarding concerns.

We identified a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and breaches of the Care Quality Commission (Registration) Regulations 2009.

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.

There were not enough staff to meet people's physical care needs. People waited a long time for staff to respond to call bells.

The provider had policies and procedures in place designed to protect people from abuse.

Risk assessments identified when people were at risk from every day activities. Personal protective equipment, such as aprons and gloves were readily available to ensure the risks of cross infection were minimised.

People received their medicines as prescribed by staff who were trained and assessed as competent.

Lessons were learnt and improvements made when things went wrong

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider did not ensure that notifiable incidents were reported to the Commission or that death notifications were reported without delay.

The provider promoted an open and transparent culture in the home.

People and staff were involved in the every day running of the home.

There was a quality assurance system of audits in place to monitor and assess the quality and safety of the service provided.

The manager and provider worked with the local authority safeguarding team to address any safeguarding concerns.

Northlands House Care 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.

This inspection took place on 28 and 29 November 2017 and unannounced. The inspection was in response to concerns raised to us and by the local authority safeguarding team. The inspection team consisted of two inspectors and a nurse specialist.

During the inspection we spoke with four people living at the home, two visiting relatives, three nurses, four care staff, the administrator and the manager. We looked at a range of records, including care plans for two people, nursing notes for two people, medicines records, three staff recruitment files and audits.

Requires Improvement

Is the service safe?

Our findings

At our previous comprehensive inspection on 1 and 4 November 2016, we rated the safe domain as requires improvement. People gave us mixed feedback about staffing levels and told us they sometimes had to wait a long time for their call bell to be answered by staff. There were not enough pagers available that were linked to the call bells at the time of our inspection which meant that staff without pagers might be nearby but be unaware that someone was waiting to receive support. The registered manager informed us that all staff should have pagers and that new pagers were on order which should see an improvement in response times.

At this inspection, we were told that issues around the number of pagers had continued through the year, as some pagers had been lost and were on order for replacement. However, the situation had been managed and there were now enough pagers. This meant people could use the call bell system and staff would be aware of them calling.

The manager told us that staffing levels were decided using Bupa's "Nursing and Care Needs Calculator. This is a tool which helps the management team in the home understand the overall care needs of people in the home and puts them into a 'band'. The bandings were reviewed monthly or sooner if necessary. The manager told us this tool was a basis and that staffing levels were higher than suggested by the banding tool. The staff team was comprised of care staff; senior care staff; nurses and two deputy managers. There was also one senior care worker who were supernumerary to the rota, that is, they were in addition to the number of staff suggested by the banding tool. There were also activities staff, housekeeping staff and maintenance staff.

Although systems were in place to calculate staffing levels, we found there were not enough staff to meet people's physical care needs. People told us staff did not respond to the call bells as quickly as they would like. One person told us it could take a long time for staff to attend and that they had once used the call bell because they were choking. They had been very worried about the length of time it took for staff to respond. One person and their relative both told us there were "not enough" staff to cope with the numbers of people living at the home. They added that at weekends, there did not appear to be enough staff to respond to people and during the last seven to eight months they have appeared particularly short staffed. Another person and their relative said, "It can take a little while, [for staff to respond to the call bell], it varies." They also felt sometimes the wait could be unacceptably long, although staff did, "come eventually." Their relative also felt there were less staff at the weekends.

Staff also said they could not answer the call bells as quickly as they would like. Staff told us they felt stressed when the pagers went off because they were already supporting people with personal care. One staff member said, "If we are hoisting, we don't rush, we don't want to leave people half naked. We are always in a 'situation', [personal care]." Another staff member told us they aimed to answer the call bell within five minutes but could not do so if they were using the hoist to support someone. They said they finished using the hoist safely before going to see the person who was calling.

We asked staff how they supported people with their continence needs, in relation to staffing levels and call bells. One staff member told us, "We encourage them, we tell them, 'buzz and we'll put you on the bed pan' but they say, 'you take too long". Another said, some people were, "bed bound, they use a bed pan or a pad. If they ask we will do it as soon as we can."

The call bell system was monitored to see how long people were calling staff before staff responded to them. The audit took place over the period of an hour, selected at random on a daily basis. The average was noted, along with an individual breakdown of how long each bell took to be answered by staff. Whilst some calls were answered straight away, some calls were not answered for much longer: for example, 19, 27, 28, 40, 57 minutes. On one date in November, there were 22 calls in one hour, averaging a response time of 7.2 minutes, but the individual response time ranged from 0 to 71 minutes.

Staff did not have time to spend talking with people, as they were always focused on supporting people with their personal care. One person told us, "Staff don't 'pop in' unless they are undertaking tasks. I don't see anyone at night." Staff told us they felt they did not have time to spend chatting with people as there was only enough time to support people with their personal care. Comments from staff members included, "When we feed people, [this] is the only time we get to sit and talk with people and the last twenty minutes of the shift" and "Staffing would be better if it was higher. [The middle floor] needs eight carers on rotas but staff phone in sick. Weekends can be all right, it depends on sickness. We don't have time to chat with someone for five minutes."

Staff felt the staffing levels did not meet the needs of people living in the home. One staff member told us, "We are short staffed a lot of the time. It takes a bit longer to get round to everyone to wash them, etc." We saw a written record which stated the number of staff on duty on a particular day and stated that staff had "felt it was not very safe to run floors with these numbers of staff."

Since the last inspection, changes had been made to the staffing structure, which included the introduction of the "senior carer" role. The role of the senior carer was to support nurses and complete some nursing tasks. Care staff felt this meant that care staff were taken "off the floor", meaning that there were fewer care staff to undertake care rather than nursing tasks. One staff member said the rota would show enough staff but there were not enough care staff if the senior had to cover a nurse's absence.

The planned staffing rota showed four to five senior staff over the three floors and of this number, there were between three and five nurses during any shift. Sometimes, nurses were called away to undertake nursing tasks on another floor which depleted the staffing levels on that floor.

Nursing staff also felt under pressure and experienced increased stress levels following the introduction of the senior carer role. Nurses were concerned that they were still responsible overall for the delivery of care on their floor but frequently had to stay on after their shift had finished, to check that information had been recorded properly. Nurses said they remained on duty up to two hours at the end of their shift to complete paperwork. They felt there was not enough time allowed for updating care plans and one said, "It is taking a lot more time to ensure quality". They were all concerned about a compromise on the quality of care delivered. The provider told us staff 'clocked in and out' and that they had not seen any evidence which showed staff had stayed over the end of their shift, other than for emergencies.

The failure to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure that they can meet people's care and treatment needs is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had policies and procedures in place designed to protect people from abuse and staff had completed training in safeguarding people. The manager knew how and when to use safeguarding procedures appropriately and staff told us what action they would take if they suspected or witnessed abuse. The provider had worked with the local authority safeguarding and quality team to investigate and conclude concerns around the care and support provided to people.

Risk assessments identified when people were at risk from every day activities, such as moving around the home and detailed what action was taken to minimise those risks and to deliver care and support which met people's needs safely. When people moved into the home, their needs were assessed to identify any risks. This included assessments of their weight; moving and handling needs; a falls risk assessment; an assessment of their skin integrity, and any nutritional risks. An initial 72 hour care plan was completed and monitored to see if any changes were need to better meet people's needs. The assessments were also used to determine which floor the person would be offered a bedroom on as well as whether they wished to attend activities. Staff confirmed that risk assessments were kept in the front of the care plans. One staff member said, "[The risk assessment] lets you know how mobile [the person is, their] risk of falls, what stages of [liquid] thickener they have, whether they have pureed food etc. It is helpful when you go on to a different floor: I always look at the front page."

When completing risk assessments, the least restrictive option was considered, for example, one person liked to access the community independently, so action was taken and the person agreed with the plan, which meant they could continue to do this and staff knew where they were. Another example was that one person wanted to go to church in a taxi but this was not possible, so staff supported them to church in their manual wheelchair.

Equipment was provided when necessary, for example, to assist people moving in bed. Staff confirmed that people had their own slide sheets and hoist slings in their own rooms and that they were appropriate for their needs. Where people were supported to move using a hoist, people told us and staff confirmed that this task was completed by two staff. The risks to people from developing pressure ulcers were assessed and people at high risk had measures in place to manage this risk for them. For example, we saw people were provided with pressure relieving equipment where required. Where people needed to be regularly re-positioned, the required frequency was noted and staff had documented this care had been provided. Records showed evidence of staff supporting people to reposition which corresponded with their care plans. There were also wound care plans in place; photographic evidence of pressure areas and wound assessments. Where necessary, the community tissue viability nurse visited the home and their recommendations were followed.

Each person had a personal emergency evacuation plan which showed the support they would need if they needed to leave the building in the event of an emergency, such as a fire. These were kept in an accessible place together with other information about the home that staff may need in an emergency. Staff had been trained in fire safety, knew what action to take if the fire alarm was activated and took part in regular fire drills. Weekly checks were made of the fire safety systems.

Appropriate recruitment procedures were in place. The provider sought references and completed checks through the Disclosure and Barring Service (DBS) before employing new staff. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

People received their medicines as prescribed by staff who were trained and assessed as competent. Medicines were stored safely and securely. Staff monitored the temperature of the fridge daily to ensure

medicines were stored at the correct temperature. Medication Administration Records were maintained for each person and staff signed to say people had taken their medicine. These records were completed without any gaps. There were care plans in place for medicines which were prescribed as 'when required', such as for pain relief or agitation.

Nurses and senior care staff were trained to give medicines to people. However, more complex medical tasks such as setting up syringe drivers, providing nutrition and medicines through a percutaneous endoscopic gastrostomy (known as a PEG) and the administration of insulin administration were only undertaken by nurses. At the end of shifts, nursing staff completed an audit of the medicines to ensure everyone had received their medicines as prescribed and that the stock count was accurate.

The provider ensured that the premises were kept clean and hygienic so that people were protected from infections that could affect both staff and people using the service. A named staff member had the responsibility of completing infection control audits and a senior housekeeper was responsible for "non-nursing" infection issues. The audits covered a range of topics regarding infection control and identified improvements where needed. Floors were scrubbed and steam cleaned and carpets were replaced when necessary. New staff completed training on the prevention of infection during their induction training. The manager told us what action would be taken if there was an outbreak of an infectious disease. This would include closing the home to visitors and providing support to people in their rooms. The manager was also aware of the need to notify the Care Quality Commission if there should be an outbreak.

Personal protective equipment, such as aprons and gloves were readily available and staff confirmed there was always enough when they needed them. There were two sluice rooms at the home, which were used to clean and disinfect reusable equipment, such as commodes.

During our tour of the home, we saw there did not appear to be many clean sheets relative to the number of beds and the continence needs of people living there. We asked staff if they felt there was enough clean bedding. One staff member felt there was enough but two other staff said this was an issue. One said, "If you need a spare bottom sheet, you check on a different floor or in the laundry, to see if there are any ready [that is, washed and dried]. It makes it difficult if trying to change someone [after an accident]. It's fully stocked in morning, but the bottom sheets go. Dirty pillows are not washed but thrown away and replaced. Another staff member said, "There are generally enough, but sometimes not enough in the morning, they're all in the laundry. We have to go down: we work as a team so one [staff member] stays and one goes down."

Lessons were learnt and improvements made when things went wrong. Investigations were undertaken in response to concerns which had been raised around, for example, how people were positioned, the use of topical medicines and providing consistency of the records around the delivery of care.

Requires Improvement

Is the service well-led?

Our findings

The provider did not ensure that all notifiable incidents were reported to the Commission. We found that in September, two people had sustained injuries at the home, which should have been notified to us. The manager, on returning to the home, was aware that notifications had not always been completed but said they had to focus initially on safeguarding concerns.

The failure to notify the Care Quality Commission of all incidents that affect the health, safety and welfare of people who use services was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Staff did send death notifications as required, but they were not all completed as soon as possible. Typically, the forms were completed between five days and two weeks after the person had died.

The failure to notify the Care Quality Commission without delay the death of a service user was a breach of regulation 16 of the Care Quality Commission (Registration) Regulations 2009.

It is important for providers to notify the Commission so that we are kept informed and aware of any issues of concern developing.

There was not a registered manager in place at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the home is run. The registered manager had left the service in April 2017 due to personal circumstances and subsequently deregistered. The provider ensured there was management cover but there had been three different managers during that time. The previous registered manager had returned to the service at the beginning of November 2017 and is now registered with the Care Quality Commission.

The provider promoted an open and transparent culture in the home. The previous inspection report and rating was displayed prominently in the reception area. The manager told us their door was always open for anyone to come and talk to them. One staff member said, "The home is managed very well, [the manager] is very approachable. Any issues, you can knock on the door and ask. Everyone is very nice." They went on to say that if they made a mistake, they would feel confident to, "own up, it's better than trying to hide it." Another staff member said the home was, "well managed and all the carers get on well."

People and staff were involved in the everyday running of the home, for example, people decided the layout of the dining rooms, which was different for each floor. The manager told us, "I walk around the home every morning, see how the night went, see people at breakfast, talk to the staff and nurses." Monthly meetings were held which were attended by people and their relatives. The manager gave us an example of changing practice in response to concerns raised by families regarding not knowing who individual staff were. Staff were all given name badges and asked to ensure they wore them so people and their families could identify

them. Another example was regarding some people had complained that the food was cold when it was served. An action plan was put into place which included asking staff to ensure the meals were hot and to reheat them if requested. A 'dining experience' audit was subsequently carried out by senior staff and the issue discussed at the next 'resident's meeting'. There were no further complaints about cold food.

There was also a monthly survey which was given to a sample of ten percent of people living at the home. People were supported to complete the survey when appropriate. There was also a monthly newsletter distributed to people and their families which included news and information about environmental issues and catering.

Staff meetings were held and these were used to discuss safeguarding issues and learning from incidents. The manager said the meetings were transparent and that staff came up with ideas and made suggestions to improve people's lives, for example, suggesting a room change to a room which would suit their needs better.

There was a quality assurance system of audits in place to monitor and assess the quality and safety of the service provided. Audits included monitoring the reasons and identifying any patterns when people fell; care plan reviews; who was nursed in bed, what mattresses they were using, whether they had bed rails and whether there was consent for them; pressure ulcers; nutrition and medicines. To ensure the safety of the building, there were quarterly health and safety audits, monthly legionella testing, weekly and monthly home improvement plans. These plans were action plans which senior management reviewed to ensure the necessary action was taken. Certificates were in place which showed the boiler, electrics, lighting and fire equipment had been tested and considered safe. There was a business continuity plan in place should there be any unforeseen incidents affecting the provision of the service. However, although call bells were monitored to see how long people waited for staff to respond, we were told that the audits had been taking place since the end of August. A staff member said, "We will now be able to analyse [the data]."

There was a clear management structure, which consisted of a manager, a deputy manager, heads of departments, nursing staff, senior care staff and the area director. The manager was supported through regular visits from the area manager and the quality manager. Their role was look at the quality of the service provided in the home and where issues or concerns were identified an action plan was created and managed through regular meetings with the manager. The manager attended monthly meetings with other care home managers and there were weekly meetings where all the heads of departments attended.

There was a whistleblowing policy in place and the provider ensured staff were aware of what action staff should take to report concerns. Whistleblowing is where a member of staff can report concerns to a senior manager in the organisation, or directly to external organisations. Staff were aware of the 'whistleblowing policy' and there were 'Speak up; Speak out' posters around the home, which acted as a visual reminder to reinforce the policy.

The manager and provider worked with the local authority safeguarding and quality team both in response to concerns raised and when raising their own concerns.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 Registration Regulations 2009 Notification of death of a person who uses services The provider failed to notify the Care Quality Commission without delay following the death of service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider failed to notify the Care Quality Commission of all incidents that affect the health, safety and welfare of people who use services.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure that they can meet people's care and treatment needs