Mr & Mrs F Ruhomutally

Northgate House

Inspection report

2 Links Avenue
Hellesdon
Norwich
Norfolk
NR6 5PE
Tel: 01603 424900

Date of inspection visit: 8 July 2014
Date of publication: 30/12/2014

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**

Overall summary

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 2012 and to pilot a new inspection process being introduced by the Care Quality Commission (CQC) which looks at the overall quality of the service.

At the previous inspection completed on 4 June 2013 we found a breach of regulation 9 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010. People who used this service were at risk of unsafe care because risk assessments and care plans had not been reviewed or updated for more than three months. Following this inspection the manager sent us an action plan to tell us how they were going to make the improvement. During this inspection on 8 July 2014 we found that improvements had been made. People who lived in the home now had their risk assessments and care plans reviewed monthly.

Summary of findings

During this inspection on 8 July 2014 we found breaches in regulations of the Heath and Social Care Act 2008 (Regulated Activities) Regulations 2010 and a breach of the Care Quality Commission (Registration) Regulation 2009.

This home is a residential care home for up to 22 older people. There is a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

The people living in the home told us they felt safe and that the care and support provided ensured they were safe. However, we found some areas within the building were not safe such as the main kitchen and laundry.

Care staff were able to explain to us about not restricting people's liberties but they had not received the relevant training regarding the Mental Capacity Act 2005 or Deprivation of Liberty Safeguards.

We found that the training and support for staff had not been fully implemented. However the manager had started to act on the concerns and another training provider was about to be introduced.

We were told by people living in the home that the meals were good and that they enjoyed the food. However, risks around nutrition were assessed but not always acted upon. Professional advice was usually sought and followed, although we found this had not occurred on every occasion.

We observed staff interacting with people living in the home in a positive, caring manner. We did not hear call bells ringing for long and people were generally treated respectfully and politely. They told us the staff were kind and caring.

The people we spoke with who lived in this home told us they had the care that they needed but would like more stimulation and activities. They told us this had been an issue for a number of years. The home had not responded well to demands for social activities. The home's quality questionnaires of 2012 completed by people who lived in the home had reported the concern but still no improvements on activities had been provided over the last two years.

During the inspection we found that systems to monitor and audit the service provided were limited and information to improve and develop the service was not evident.

You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not always safe.

We found poor food storage, poor hygiene, poor cleaning practices and unsuitable building extensions.

Although staff had not received comprehensive training they were able to discuss abuse and what signs to look for if they suspected abuse had occurred to ensure people's safety.

People told us they felt safe.

Is the service effective?
The service was not always effective.

The GP had told us that the home staff responded and acted quickly on health concerns.

People told us they did enjoy the meals provided. However, some inconsistencies were noted in records regarding nutrition when decisions were taken without professional advice when weight loss was a concern.

Staff did not always feel they were offered support and training in a timely and efficient manner.

Is the service caring?
The service was caring.

People we spoke with were positive about the care and support they received. They told us staff were caring and courteous.

We observed the interactions and conversations between people who lived in the home and the manager. It was evident that each person was known well and that staff knew people well.

Is the service responsive?
The service was not always responsive.

The manager responded to the previous inspection and rectified the shortfall identified. Care plans were up to date and reviews were completed monthly.

Comprehensive personal histories were recorded. However, there was limited evidence to show how this information had been used to support people's social interests. Therefore the provider did not always respond and provide suitable social activities to meet people's needs.There was a complaints procedure in every bedroom and people spoken with were aware of the procedure.

Is the service well-led?
The service was not always well led.

Monitoring systems to measure effectiveness were not taking place such as the home's cleaning schedules, staff supervisions and training.

Quality monitoring was not acted upon and the systems used to measure the quality was limited.

Staff and relatives meetings were not held to ask their views or assist with the development of the service.

Summary of findings

We had not received any notifiable information from this service over the past four years.

Northgate House

Detailed findings

Background to this inspection

The inspection team consisted of an inspector, an Expert by Experience and a specialist advisor. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. This specialist advisor was an expert in nutrition.

We asked the provider to complete a Provider Information Record (PIR) prior to this inspection. This is information we asked the provider to send us telling us about the standards of care and support they are providing. We looked at other information that we hold about the service, including notifications about issues that the provider is required by law to inform us about. This information helped us to plan our inspection.

During this inspection we talked to seven people who lived in the home, spoke with a health professional and two care staff, one cook and the manager. We observed care and support being provided to people living in the home and looked at records.

We looked at six sets of care plans and looked at other records relating to the management of the home.

Requires Improvement

Is the service safe?

Our findings

On arrival to the home we spent time with the manager looking around the premises. In three of the bedrooms we found stained carpets. One bedroom carpet was badly stained with the carpet tiles lifting to create a potential trip hazard. In another bedroom we found a split in the carpet. The manager was asked how often the carpets were cleaned. We were told, "Regularly". However, when we asked when, we were then told it was eight months prior to this inspection. Two commodes placed in bedrooms had rusty frames under the cushions making them difficult to clean and potentially prone to germs and micro organisms which could promote infections. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

In the kitchen and laundry small extensions had been added to the side of the home to increase the sizes of these two rooms but these had only been partly built. On the day of this inspection a storm occurred. Where the kitchen extension was incomplete dirty rain water spilt into the main kitchen. This extension was already being used for frying and also had vegetables stored in it. This incomplete extension created a potential risk of contamination. In the laundry the floors were not able to be cleaned properly as the surface, in parts, were bare wood. This laundry room had not been improved upon to ensure the area could be cleaned to an acceptable standard. This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The last inspection completed on 4 June 2013 found that risks for people receiving the service had either not been assessed or were not up to date. During this inspection on 7 July 2014 we looked through six sets of care plans. We found that records showed appropriate action had been taken on the risks that had been identified. On talking to staff and people living in the home about the risks they told us that the risks had been acted upon and removed or reduced. For example, suitable methods of assisting a person to transfer safely in a hoist had been reviewed and records had been updated to provide accurate guidance to staff.

During the inspection we observed the care provided to people throughout the morning. We noted the safe methods care staff were using to support people to move from one area to another. An explanation was given to one person, step by step, as they were supported at their own pace to move across the room. We noted another staff member assisting someone to the bathroom. They assisted them slowly and respectfully offering reassurance throughout.

People we spoke with who lived in this home were positive about the way the staff helped them and ensured they were alright. One person said, "I see staff regularly and they always ask me if I am okay." Another three people we spoke with said they felt they were supported safely and that the staff were kind and treated them well.

Due to the concerns found regarding the premises on our arrival to the home we looked at other areas around the home. In the kitchen store cupboard used for dry goods and freezer foods we found paint tools, Christmas decorations, four 'out of date' tins of different foods from 2009 to 2013 and tins of beans had been placed on the floor. Behind the freezer we noted a grey pipe from ceiling to floor with drip lines running down from what appeared to be a previous leak. Each side of this pipe we found packets of cakes and plastic bags containing breakfast cereal. This was a potential hazard of contamination.

The home had been visited by an Environmental Officer in November 2013 and had awarded the food safety standards at level four. The maximum number that could have been awarded was five. This meant that food was handled and prepared safely. However, due to the concerns found during this inspection we referred the home to the Environmental Health Officer (EHO) who said they would carry out their own inspection.

We spoke with two staff and the manager about their understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The staff told us they had not had any training on this subject but were aware of the importance of not depriving people of their liberty unlawfully. We were told by the manager that no person living in the home was deprived of their liberty so no application had been applied for. They said that a new training provider was about to begin with a number of training courses that included the MCA. One staff member spoken with had not received any safeguarding training in the year they had been employed in the home. However, they were able to tell us what potential abuse might be and said they would blow the whistle and contact relevant professionals if they had any concerns that any form of abuse was happening.

Requires Improvement

Is the service safe?

We looked at staff rotas for three weeks. This included the week of this inspection and the two weeks previous. We noted that, on occasions there were three care staff on duty throughout the day, but on the majority of days there was two plus the manager who we were told helped when they were short of staff. This home was caring for 20 people at the time of this inspection.

On the day of this inspection, call bells were answered quickly and people were supported when they asked for help. We were told one senior care staff member was sick but no replacement had been found to cover them to date. However, the manager was covering the shortfall and who told us they had advertised for another senior care staff member. People we spoke with told us the staff came 'fairly quickly' when called but said the home was short of staff. We could not be assured there were enough staff to support people safely and meet their individual needs. The manager showed us the job applications of potential staff members who had been invited to attend an interview. This, we were told would meet the staffing shortfall.

We looked at two personnel files of staff who had been recruited in the past two years. The two staff members we spoke with told us the process they had been through when they were recruited. We found that the correct checks had been carried out to ensure those staff members did not have a criminal record, that they were allowed to work in the UK and had relevant forms of identification and past work history. Both files showed one previous employment reference for each staff member. The manager told us they had received a verbal second reference and was confident the staff members were suitable and safe employees.

Requires Improvement

Is the service effective?

Our findings

As part of this inspection we looked at the risks around people's nutritional needs. We found that in the six people's care plans we looked through the Malnutrition Universal Screening Tool (MUST) had been completed for only one person. MUST is a tool that assesses a person who may be at risk of being malnourished or of being overweight. Although a risk of possible malnutrition was identified for this person they only had one record of their weight over the previous four months. This person had been referred to a dietician in February 2014 and was prescribed high calorific drinks three times per day. In May 2014 this amount was reduced by the home when 1kg of weight had been gained yet the person's weight was still 4kgs less than when they were admitted to the home. There was no evidence to show that this reduction on the fortified drinks had been on the advice of the dietician, who had identified this person as underweight, or that further professional support had been obtained. Staff spoken with said they had not weighed the person and that the senior staff member (who no longer worked at the home) was monitoring this person's nutritional intake. Therefore the monitoring of the person's food intake had not been taking place. We could not find records to confirm how much this person was eating. This person was not protected against the risk of inadequate nutrition. This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at the dates supervision and appraisal support was offered to care staff by the manager. We noted that they were completed approximately every three months. This was more of a tick box process. One staff member did not think the support and training offered was suitable and that little was done to ensure they had full knowledge and support to do their job. The other care staff member felt the training could be improved upon. Through observations of the staff members on the day of this inspection we saw they were able to do the job required and knew what was expected of them. They told us this was knowledge and experience they had gained prior to starting work at this home.

We noted that the manager had a paper record of who was due training and when the training was booked. The manager said the training provider they had been using had let them down and the home was now behind with the training schedule. A new training company had been found and plans for training was booked in the future. We saw details of this new training provider and what courses were planned and which staff members were to attend. However, staff were dissatisfied with the training and supervision support, the manager had taken action to address the shortfall but staff were not receiving appropriate training, supervisions or appraisals. This is a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At lunchtime on the day of this inspection there was no meal choice. There were no alternatives for those people who may have preferred something different at the time the meal was served. However, the manager told us they could have something different if they did not like what was on the menu. We spoke to three people at the table who said the food was 'good and tasty'. Some people, who required support to eat, were given this at a pace and in a manner that was suitable for the individual. However, one person was assisted by a staff member by putting too much food on the spoon and the gravy was left to run down their face compromising their dignity. We made discreet observations where a person was cared for in bed and was being assisted with their meal. No interaction was heard so the person having assistance was not given the opportunity to know what they were being offered with each mouthful, or asked if they were enjoying it.

We found that people were helped to the dining table for their main meal 25 minutes before the meal actually arrived. Staff did not seem aware that this was institutionalised practice. People were left sitting on hard chairs or remained in their wheelchairs for a period of time with nothing to do as staff helped others to the table. One person got up to leave and another fell asleep bent over on their chair. People were expecting a meal and when this did not occur some people became restless.

The menu for the week was on the board in the dining room. This menu was discussed with the cook. This menu had not been revised or changed since 2009. People we spoke with told us that the food was always the same. We could not find any evidence to show the meals planned had considered the nutritional needs of people living in the home adequately. There was no fresh fruit available, none seen throughout the home for people to help themselves

Requires Improvement

Is the service effective?

and although people told us they were offered six drinks staggered throughout the day these would only be accompanied by biscuits as a snack. One person said, "I have to buy my own fruit."

The cook presented a meal that was enjoyed by those people we asked. However, this cook had not received any specific training in menu planning or meal preparation. Therefore when meals were discussed they did not have the knowledge on special diets or meals for people with swallowing concerns. However, they were providing Halal meals which was confirmed by the person who had requested these.

The two care staff members we spoke with gave knowledgeable and clear answers to our questions about their work. They knew the people they were supporting. This was confirmed by the people receiving the service. One person told us, "I have to have help with everything. I came here and I was in a dreadful state. Nurses [care staff] here are my lifesavers."

We read in care plans the professional input provided to support people with their health needs. In one care plan the assessment and outcome for some continence aids required had been addressed and the appropriate aids were seen in the person's room. We also read in another care plan the advice requested from the stoma nurse and then the action taken. On talking with staff it was evident that they had listened and acted on the advice the medical professional's had given.

Throughout our inspection we found that responses to questions asked about individual people were given to us in detail. It was clear the manager knew and reacted to the needs of each person when it was required. For example, one person said they had fallen and although they were not hurt they had been supported by the home to carry out suitable exercises. They told us, "I am trying to prevent further falls and stay healthy."

On the day of this inspection we did not have the opportunity to speak with any relatives. However, we did speak to the local GP who assured us that the service acted quickly on medical concerns of people living in the home and that the manager responded fully when referring to the GP practice for advice. They told us that the home was proactive with regard to concerns and asked for health support appropriately when required.

Good

Is the service caring?

Our findings

Throughout our visit we observed staff interacting with people who lived in the home. We heard encouraging words and respectful conversations. Comments we received from people living in this home told us the home and management were caring and courteous. One person said, “They are more than staff to me. More like a relative. If there was a word above excellent I would use it.” People were dressed appropriately, presented well and in clothes they told us they had chosen.

One person, who was asleep during the meal time was very gently awoken and encouraged to eat their meal. This was carried out tactfully and respectfully giving the person time to wake up.

Although we were told the manager and senior staff talked to people about their day to day care and support needs it was not evident they had contributed to their own care plans. Three people spoken with did not know about their care plan and the other three knew they had one but did not really understand the content. However, in the care plan of a person recently admitted we read how involved their relative was. It showed their input and what assistance they were giving in helping their relative settle into the home.

We found through conversations and observing staff throughout the day that most of them treated people in a dignified, respectful manner. However, one staff member was seen walking into a person’s room without knocking. This was mentioned to the manager who told us this concern would be addressed straight away.

We observed conversations taking place between people who lived in the home and the manager. The interaction was fun and showed how staff knew people well.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection on 4 June 2013 we found care plans had not been reviewed and risks assessments had not been updated. An action plan on how this shortfall would be addressed was received from the manager and during this inspection on 7 July 2014 the action was found to have been completed.

People who lived in this home had commented that there were no activities or interests for them to pursue. Even though this had been an issue for a long time and noted as a concern on the 2012 quality assurance survey, very little had been done to improve this lack of support. We were told by the manager one staff member was going to introduce more activities. However, on the day of our inspection we saw that no social activities were taking place and no activities programme was available. People in the home they told us that they had very little happening on a day to day basis. In the care plans looked through we read comprehensive personal histories. This gave staff the background information to enable them to offer care and support that was important for that person. However, even with this information documented there were limited activities, stimulation or interaction to meet people's preferences. Throughout the day of this inspection the television was on and one person was engrossed in a book. There was limited time for staff to interact or support someone on a one to one basis. One person told us they would like to be accompanied to the shop over the road but this was not often possible as staff were too busy. Another person said, "I can have a joke with the staff. I know they listen to me when something is important and will support me the best way they can but they are busy and cannot help all the time."

In the six care plan folders we looked through we found a date for each month of the year showing if or when a change had occurred for the people the care plans belonged to. This showed that people's care plans were reviewed regularly. The information then directed you to the section in the care plan showing what the changes were. For example, we noted that changes that had taken place with the medication needs for one person. These changes were also found on the medication administration chart. We noted the changes required had been followed through and were being acted upon by a senior staff member during the administration process.

We looked at information in one care plan written for a person recently admitted to Northgate House. It was written in a caring manner showing the focus was on the individual person and that the information gave the details of the care required for their chosen religion. Their individual medical and social needs were also detailed. Concerns that had been identified following their admission to the home had been acted upon quickly. This person told us improvements were starting to happen. We spoke with staff about the care and support for this person. It was clear they were using caring and appropriate support to encourage and assist this person with their 'settling in' to their new home.

The manager had a complaints procedure in place. There was guidance telling people about the service provided and how and who to complain to. Three people we spoke with told us they would talk to the manager if they had any concerns and they felt those concerns would be dealt with. The manager told us they had not received any complaints.

Is the service well-led?

Our findings

We asked what methods were used to encourage people living in the home or their family members to be part of the home's development and if meetings were held for their benefit. Nothing was recorded and no planned meetings had or were taking place with people living in the home or their families. We were told that family members visited mostly in the evenings and would share any concerns then. However, we could not find evidence of how actively involved people or their families were in the development or quality of the service. One person said, "There is nothing to do here. We say so, but nothing happens." Three people living in the home said that 'not much' went on in the home. They said they just sat most of the time with the television on. One person said, "I am not slow in coming forward. I can speak up for myself." However, when we asked them about involvement in the development of the service we were told they did not know what was happening within the home. We found no systems in place to regularly monitor the effectiveness and quality of the service. People were not actively involved and asked their opinions on the development and quality of the service.

On discussing staff support with the manager we found there had only been one staff meeting in the past 12 months. No minutes were taken and we only found a list of which staff had attended the one meeting in June 2014. Staff had not received structured meetings although they did tell us what had been discussed at the June meeting. The provider could not evidence that staff had the relevant information and knowledge on a regular basis to enable them to do the job required. Nor could staff absent from the meeting have access to records to inform them on what was discussed.

We asked to see the questionnaires circulated to people living in the home and their families on their opinion on the quality of the service provided at this home. There were no questionnaires completed in 2013 and only two had been returned for 2014 showing there was no activities, interests or stimulation provided. The manager had not acted on the results of the questionnaire. We found no support was organised or planned for to offer people support with their own interests.

On talking to two care staff, we found they had knowledge and understanding of their roles. However, they told us they had little to do with the development of the service. They felt their views and ideas were not listened to and that they were not fully supported with their roles and responsibilities.

We requested to see the monitoring processes used for different parts of the service provision. For example, the way cleaning schedules were planned and infection control procedures were monitored. Although the manager had a dated form for when a room was cleaned there was no detail about how often the cleaning was required such as shampooing carpets or deep cleaning rooms and no system to monitor the quality of the cleaning process. Due to the state of some of the carpets we could not be assured that the condition of the rooms were checked or that action was taken to improve the situation.

Effective systems were not in place to regularly assess and monitor the quality of the service. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at accident forms held in a designated folder and noted they were completed on a regular basis. The majority had been completed correctly and action to monitor the person who had the accident was stated. We did not see any recurring patterns to the accidents logged. A system was in place to monitor accidents/incidents when they occurred.

The Care Quality Commission requires providers to inform them of deaths, incidents and accidents. We looked back on our records, before this inspection. The provider had not notified us as they are lawfully expected to do. We were aware that notifications should have been sent to us as death's and hospital admissions had occurred.

The provider, without delay, had not notified the Commission of the death of service users. This is a breach of Regulation 16 of the Care Quality Commission (Registration) Regulations 2009.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control People who used services and others were not protected against the identifiable risks of acquiring infections. Regulation 12 (2) (a) (c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises People who used services and others were not protected against the risks associated with unsafe or unsuitable premises. Regulation 15 (1) (c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The registered person did not have an effective system to regular monitor the quality of the service. Regulation 10 (1) (a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment The registered person had not notified the Commission without delay of the death of service users. Regulation 16 (1) (a).

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs The registered person did not have effective systems in place to ensure people were correctly assessed for risks, regularly monitored and then provided with appropriate nutritional food and hydration. Regulation 14 (2).
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The registered person did not have suitable arrangements in place to support staff to receive appropriate training, supervision and appraisals. Regulation 23 (1) (a)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises People who use the service, visitors and staff members having access to the premises where a regulated activity is carried on were not protected against risks associated with unsafe or unsuitable premises.

The enforcement action we took:
The provider was issued with a warning notice on 5 August 2014 stating they were failing to comply with the relevant requirement of the Health and Social Care Act 2008. They were required to become compliant by 1 September 2014.