TOB Care Ltd

Northwood Nursing & Residential Care

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

Summary of findings

Overall summary

This inspection took place on 30 and 31 August 2018; the first day of the inspection was unannounced. This was the first inspection since a new provider had taken over the running of the service in July 2017.

Northwood Nursing and Residential Care (referred to throughout the report as Northwood) is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. the Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

TOB Care Ltd is registered to provide accommodation at Northwood for up to 27 people who require support with personal care or have nursing needs. At the time of the inspection, there were 24 people accommodated in the home.

The service had a registered manager in place. A registered manager is a person who has registered with CQC 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. However, we were told the registered manager had taken the decision to step down from this role and was intending to de-register with CQC. A new manager had been appointed and had been in post for one month when this inspection was carried out. They told us they intended to apply to register as manager with CQC.

During this inspection we identified four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people were not always provided with care which met their individual needs and preferences. The provider did not have effective systems for the safe handling of medicines and for identifying, handling and responding to complaints. The systems in place to monitor the quality and safety of the service were not sufficiently robust.

This was the first inspection for the service and the first time it has been rated as 'Requires Improvement'. At the time of the inspection, the provider had already identified many of the issues we found and had put an action plan in place to improve the quality and safety of the service. However, this had not yet been embedded in the governance arrangements for the home.

Although there were systems in place to monitor the quality and safety of the service, these had not been effective; this had resulted in many of the shortfalls we identified during the inspection.

We found there was a culture in the home of staff doing things to people rather than checking this was what each individual wanted.

Some areas of the home, particularly the bathroom and toilets, were not clean. We have therefore made a recommendation in relation to infection prevention. Following the inspection the provider sent us evidence

to show that sluice rooms had been refurbished.

We were told one person was at risk of wandering at night. Although there was an alarm on their door to alert staff if they left their bedroom, we were concerned this room was located very close to a door which opened directly onto a flight of stairs. We were also concerned that staffing levels at night, as well as the layout of the home, meant there was a risk staff would not be able to respond in a timely manner if the alarm was activated, placing the person at risk of falling down the stairs. Following the inspection we received evidence to show the manager had taken action to reduce the risk of people accessing the stairwell.

Safe systems were in place for recording the administration of oral medicines. However, some improvements were needed in relation to topical medicines and medicines prescribed 'as required'. At the time of the inspection, storage of medicines needed to be improved to ensure it was safe. Following the inspection, the provider sent us evidence to show medicines had been moved to a larger and more secure room.

The complaints procedure was not sufficiently robust. We noted two concerns raised by people who lived in the home during residents' meetings had not been recorded as complaints. We could not find any evidence that these concerns had been properly investigated to ensure people received safe and appropriate care.

People told us they did not always feel safe in the home; this was mainly due to the attitude of staff. The manager raised a safeguarding alert with the local authority after we informed them of concerns a person had raised with us about the way they had been treated by staff. Our observations showed staff did not always take the time to interact positively with people who lived in the home.The operations manager told us they were in the process of arranging communication training for all staff to help improve their interactions with people who lived in the home.

People who lived in the home gave us mixed feedback about staffing levels and the amount of time they had to wait for staff to respond to their requests for assistance. Some staff considered it could be difficult to meet all people's needs in a timely manner due to the level of care many people required. The manager told us they were in the process of recruiting more staff to help ensure staffing numbers were sufficient to cover for leave and sickness.

People told us the quality of food was generally good. The manager told us they had plans to improve the quality of the dining experience for people who lived in Northwood.

Records showed all staff had completed the training courses considered as mandatory by the provider.

There was a lack of meaningful activity for people to maintain or improve their sense of well-being. The manager was in the process of recruiting an activity coordinator to improve the opportunities for people to engage in activities in the home.

Care records included an assessment of people's needs and a series of care plans to inform staff about how these needs should be met and how any identified risks should be managed. However, care staff were not always able to speak confidently about people's needs. In addition, people were unaware of their care plans and told us they had not been involved in any reviews of how their care needs were met.

We received mixed feedback from staff about the way the home was run. Some members of care staff told us they did not feel engaged with improvements the manager intended to make. However, we noted a staff

meeting had been held to inform all staff of the changes the manager had identified as necessary.

The manager demonstrated a commitment to improving the quality and safety of the service. The provider had ensured the manager was provided with additional support from two area managers and a newly appointed operation's manager to drive forward the necessary improvements.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

We received mixed feedback from people about whether they felt safe in Northwood. The manager raised a safeguarding alert with the local authority after a person shared concerning information with us.

Improvements needed to be made to the cleanliness of the environment as well as the arrangements in place for infection prevention.

Some improvements were necessary to ensure the safe handling of medicines.

We were told staffing levels were not always sufficient to ensure people received the care they required in a timely manner.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People told us the quality of food was generally good.

Records showed staff had received training in a large number of topics, although they were not always able to recall the content of the training.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People told us staff did not always have a caring attitude towards them. Our observations during the inspection showed there was limited positive interaction between staff and people who lived in the home. However, the provider had a plan in place to introduce communication training for all staff.

Staff did not always have a thorough understanding of people's needs.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive care which met their wishes and preferences.

At the time of the inspection there was no programme of meaningful activities in place, although the new manager had plans to improve this situation.

Although there were some systems in place to gather feedback from people who lived in the home, there was limited evidence this feedback had been used to improve the quality of care people received.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Although there was a manager registered with the Care Quality Commission, they had stepped down from this role and intended to apply to de-register. A new manager had been appointed and had been in post for one month at the time of the inspection.

The manager had plans in place to improve the experience of people who lived in the home. However, some staff told us they did not yet feel engaged with the process of improvement.

Systems in place to monitor the quality and safety of the service were not sufficiently robust. However, the provider had ensured the new manager was provided with additional support to carry out the improvements they had identified as necessary to improve people's experience in the home.

Northwood Nursing & Residential Care

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 30 and 31 August 2018; the first day of the inspection was unannounced.

When planning the inspection, we received anonymous information of concern regarding the care of people in Northwood. We were also aware that the local authority had received a safeguarding alert following concerns about the care provided in Northwood and the attitude of staff; this was in the process of being investigated by the local authority and the police at the time of the inspection. We included the concerns raised with us and the local authority in the plan for the inspection.

The first day of the inspection was carried out by an adult social care inspector, an assistant inspector 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. The expert had experience of residential care services. The second day of the inspection was carried out by an adult social care inspector, an assistant inspector and a medicines inspector.

Before the inspection, we reviewed the information we held about the service including notifications the provider had sent to us. A notification is information about important events which the provider is required to send us by law. We also contacted the local safeguarding and quality assurance teams, the local clinical commissioning group, the infection prevention team and the local Healthwatch team to gather their views about the service.

We had not asked the provider to submit a Provider Information Return (PIR); this is information we require

providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with nine people who lived in the home. We also spoke with a total of nine staff employed in the service. The staff we spoke with were the home manager, two registered nurses, four members of care staff, the chef and the maintenance person. In addition, we spoke to the provider's operations manager and two area managers who were all involved in supporting the home.

We carried out observations in the public areas of the service. We also undertook a Short Observation Framework for Inspection [SOFI] in a communal lounge area. A SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

We looked at the care records for five people who used the service and the medicines records for a total of eight people. In addition, we looked at a range of records relating to how the service was managed; these included three staff personnel files, staff training records, staff supervision and appraisal records, minutes from meetings, incident and accident reports, complaints and compliments records as well as quality assurance audits.

Requires Improvement

Is the service safe?

Our findings

We received mixed feedback from people about whether they felt safe in Northwood. Comments people made to us included, "No, no I don't. I feel trapped, day after day, night after night", "No. I don't trust them [staff]. They don't treat me properly", "There were problems at the beginning but I stood up to them. They [staff] all gang up together; we've worked it out and they are now very obliging. They help you as much as they can" and "I'm as safe as I want to be."

During our conversation with one person who lived in Northwood, they expressed concerns to us about the way they had recently been treated by staff when they were providing them with personal care. We made the manager aware of these concerns and they told us they would raise a safeguarding alert with the local authority in order for them to be fully investigated; they confirmed this had been completed following the inspection.

While we were planning the inspection, we were informed of a safeguarding alert which had been raised by a professional when visiting the home. The home manager had notified CQC of this alert as they are required to do. At the time of the inspection the investigation into the concerns raised about the standard of care provided in the home were being investigated by the local authority and the police. The CQC will monitor the outcome of the safeguarding investigations and actions the provider takes to keep people safe.

The provider had policies in place to guide staff on how to safeguard people from abuse. Records showed all staff had completed safeguarding training. All the staff we spoke with could tell us the correct action to take should they witness or suspect abuse. Staff told us they would also not hesitate to use the whistleblowing policy to report poor practice and were confident they would be listened to by senior staff.

During the inspection, two people raised concerns with us about the lack of access to any personal monies. They told us they did not know who was dealing with their financial affairs. When we looked at the care records for one of these people we noted one person's finances was being managed by the local authority, although we could not see any evidence on file that the person's ability to manage their own money had been recently assessed or reviewed. We asked the home manager to investigate how people's monies were being managed and whether any action needed to be taken to safeguard people or to protect their rights to manage their own financial affairs if they were able to do so.

We received mixed feedback from people about staffing levels in the home. While some people told us they had to wait for very long periods of time for staff to respond to their requests for support, others told us staff always responded promptly when they pressed their call bell. We noted the provider had installed call bells in the lounge areas to help ensure people were able to request assistance from staff as necessary.

We saw that one registered nurse and four members of care staff were on duty during the daytime on both days of the inspection. We were told the staffing levels at night were one registered nurse and two care staff. However, we were told and records showed that 20 of the 24 people currently cared for in the home required two members of staff to meet their mobility needs at any one time. When we asked staff if there were

enough staff on duty each day they told us, "Some days yes. We don't have many staff to fall back on if there is any sickness" and "No, I don't think so due to the clientele that are in at the moment."

We were concerned that night time staffing levels and the layout of the home, meant there was a risk people might have to wait to receive the care they required. When we discussed our concerns with the manager, they told us they had added an additional member of care staff to the rota at nights when they started work at the home. They told us people's dependency levels were regularly reviewed and there was a commitment from the provider to ensure appropriate staffing levels were maintained. They also told us they were in the process of recruiting new staff in order to ensure there was a 10% surplus of staff to cover for sickness and annual leave.

The audit completed by the operations manager had identified that there was a clear lack of organisational structure in relation to staff rosters and that these rosters were not being completed in a timely manner; this meant some staff were not turning up for shifts they were supposed to work as they had been unable to make appropriate arrangements for child care or other responsibilities. In addition, they had noted that staff did not have job descriptions or contracted hours. The action plan they had completed stated an off-duty book was to be put in place within two weeks and role definitions to be put into place within a month; this should help ensure staff were aware of their specific responsibilities.

We completed a tour of the building on the first day of the inspection and found a number of issues relating to infection control and the safety of people who lived in the home.

We noted there were no clinical waste facilities in any of the bathrooms and staff told us they usually carried such waste in bags to the sluice areas. When we checked two of these sluice areas, we found clinical waste was being stored in open bags. In addition, we noted one of these sluice areas did not have the facility for staff to wash their hands after dealing with clinical waste; this meant there was a risk of cross infection. We also noted two of the bathrooms had not been properly cleaned.

The provider's operations manager showed us an audit they had completed of the home two days prior to our inspection visit. This documented a number of issues relating to the environment, including the fact that the home looked generally grubby/dirty, an unlocked vacant bedroom was a potential hazard to people living in the home, there was mould and mildew around a sink in a communal toilet, people's bedrooms were left untidy and there was a lack of pride taken in ensuring care was provided to people's living space. The operations manager had developed an action plan to address the issues they had found. We were told there was a commitment from the provider to refurbish and redecorate areas of the home, including bedrooms and bathrooms. Following the inspection, the provider sent us evidence to show the sluice rooms had been refurbished.

We recommend that the service ensures it acts in accordance with best practice guidance regarding infection prevention in care homes.

We saw that a number of bedroom doors had alarms on them; we were told this was because some people were at risk of wandering and the alarms were to alert staff should the individuals leave their bedrooms. We saw that the bedroom of one person who was assessed as being at risk of wandering at night was located very close to a door which opened directly onto a flight of stairs. Although the person's bedroom door was alarmed, we were concerned that as there were only three staff on at night, the person could have accessed the stairwell before a staff member was able to reach them. We discussed this with the home manager who told us they would consider what action they could take to protect this person without compromising the ability of other people to move freely around the building. Following the inspection, we were advised a lock

had been fitted to the door to the stairwell. However, it should not have been necessary for us to bring this to the provider's attention. People wishing to access the lower floors of the home were still able to do so by using the passenger lift.

We looked at the medicine administration records (MARs) for eight people across the home. We observed medication being administered to people safely. However, we noted medicines were not stored safely and access was not restricted to authorised staff. Following the inspection, the provider sent us evidence to confirm they had relocated the room used to store medicines to a larger room with increased security.

We looked at three topical medication administration records and saw that the records were not fully completed and some creams had not been applied at the frequency prescribed. The topical medicine administration record (TMARs) included body maps to show where the cream should be applied but these did not always match the prescriber's instructions. Some medicines were administered as a patch. The application was recorded on the MAR but the site of application was not always documented; this is necessary so that they are rotated in line with the manufacturer's guidance to prevent side effects.

Some medicines were prescribed to be used 'as required'. There was additional guidance for these medicines however the guidance contained mistakes for tablet strength and dose; the guidance was amended during the inspection. In addition, we found staff did not always record the reasons for administration or the outcome after giving the medicine, so it was not possible to tell whether medicines had had the desired effect.

Systems in place for the handling of medicines were not always safe. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed the recruitment records for three staff and noted all required pre-employment checks had been completed, including a DBS (Disclosure and Barring Service) check. The DBS carries out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions. However, we noted the provider had not followed up on a reference for a staff member which stated the previous employer would not re-employ a person; such checks are important to help ensure people are protected from the risk of unsuitable staff.

The provider had systems in place to assess, manage and review risks, including those relating to mobility, falls and nutrition. We saw that risk assessments had been regularly reviewed and updated where necessary. Records we looked at showed us all equipment used in the service was maintained and regularly serviced to help ensure the safety of people in Northwood.

There were processes in place to help ensure lessons were learned from incidents, accidents or safeguarding concerns. The provider maintained a log of all such incidents and the action taken to help prevent reoccurrence.

We saw a fire risk assessment had been completed for the service. The home had recently been visited by the local fire and rescue service and we were told that action had been taken to address the issues identified. A personal emergency evacuation plan (PEEP) had been completed for each person who used the service and these were written on different coloured paper to indicate the level of support people would require in the event of an emergency. However, we noted these were undated so we could not check if they were an accurate reflection of people's current needs. We noted one person's PEEP did not detail the additional support they might require due to their visual impairment. In addition, it was indicated that some people would be evacuated using wheelchairs, when in fact this might not be possible. Following the

inspection we received evidence from the provider to show that all PEEPs had been updated.

Requires Improvement

Is the service effective?

Our findings

We looked at what considerations the provider gave to the Mental Capacity Act 2005 (MCA). The 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The 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, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Records we reviewed contained detailed assessments of individual's capacity to make particular decisions; these included the use of restrictions to help ensure their safety. We saw the manager maintained a tracker to document when applications had been submitted to the relevant local authorities to authorise restrictions in people's care arrangements. At the time of the inspection, nine applications for DoLS had been submitted, with a total of five having been approved.

We checked whether staff received the induction, training and supervision they required to deliver effective care. The provider had introduced a new system for training, most of which was now delivered on-line. Records we reviewed showed all staff were up to date with the training which the provider considered as mandatory for their roles; this included safeguarding, health and safety, infection prevention, Mental Capacity Act, end of life, first aid and fire safety. When we asked staff specifically what training they had completed we were told, "Loads, about 40 modules to do on the computer. Moving and handling was face to face" and "I did moving and handling, but a lot of courses are on e-Learning". We were told staff had to complete a knowledge check at the end of each training course and that if the outcome of this raised any concerns about their level of understanding in particular areas, they would be provided with additional support.

From our discussions with staff and our review of records, we found staff were not receiving regular supervision or an annual appraisal of their performance; these meetings are important to enable staff to have the opportunity to reflect on their practice and discuss any learning and development needs. We saw there had been infrequent checks of staff competence to perform particular tasks such as hand washing which had been recorded as supervision. The operations manager showed us a template document which they had introduced in the week of the inspection to make staff aware of the purpose of supervision as well as the vision and values of the service. The area manager also told us a more robust competence assessment tool was due to be introduced into the service; this would help identify any areas in which staff required additional training.

Staff told us they had completed an induction when they started work at Northwood, which had prepared

them for their role. Two of the three staff recruitment files we reviewed contained completed induction checklists.

All the people we spoke with told us the quality of food in Northwood was generally good. Comments people made included, "It was ok today but sometimes there is not enough variety, too much meat. I want something that makes my mouth water", "Breakfast is good" and "We always get something nice." People told us they were unhappy that the morning tea round had been cancelled. One person commented, "They cancelled the morning tea and it's just a case of getting into the new routine. We get one in the afternoon." Another person told us they were upset that they had been told they could no longer have burnt toast for their tea as they did not like the other options available. They had not been given any rationale for this decision which clearly did not respect their wishes and preferences. We discussed this with the manager who told us they would immediately rectify the situation to ensure the person could have their requested food.

We spoke with the chef on duty who told us about the arrangements in place to ensure people's cultural needs in relation to food were met. They also had information about people's dietary needs and how meals should be prepared to ensure the risk of choking or associated risks were managed in line with advice from the speech and language therapy (SALT) team.

People's needs were assessed before they were admitted to the home. The pre-admission assessment was then used to formulate a set of care plans to meet each individual's identified needs. There was a registered nurse on duty 24 hours a day to meet the needs of people who required nursing care and a suite of policies in place for staff to follow regarding health conditions people might experience; we noted these referred to best practice guidance regarding the management of particular health conditions. Records we reviewed showed appropriate referrals had been made to other health professionals. A nurse we spoke with told us how important details about people's health needs were always transferred with them if they were admitted to hospital.

There were systems in place to help ensure staff were aware of any changes in a person's condition. Staff told us a 'handover' occurred at the start of every shift. In addition, the manager had introduced a daily 11 am meeting. The purpose of this meeting was to ensure key senior staff received important updates about people's needs, staffing arrangements and any environmental issues.

We checked the environment to see if it was suitable for the people who lived in the home. We noted there were no easy read signs to help orientate people to bathrooms and toilets. In addition, not all bedroom doors were personalised with people's names or pictures which were of significance to them. The staff we spoke with could not explain why this was the case or whether people had been consulted about whether they wanted their bedroom door to be personalised. There also had not been any consideration given as to whether people were accommodated in rooms which were best suited for their needs. The manager told us they were aware of this and intended to review the situation with people who lived in the home and, where necessary their relatives.

Requires Improvement

Is the service caring?

Our findings

We received mixed feedback from people about whether staff were kind and caring. Comments people made to us included, "Staff are always nice", "I'm not keen on the attitude of some of the staff and the way they address you" and "Yes, they are always laughing and joking."

During the inspection, we observed limited positive interactions between staff and people who lived in the home. We observed staff often walked through communal areas without taking the time to acknowledge people who were sitting there. It is important for staff to ensure all their interactions with people are meaningful to help people feel they are cared for and matter to the staff who support them. The operations manager told us they had already identified communication as an issue and were arranging for training to be sourced and provided to all staff.

People spoken with told us staff generally respected their privacy by knocking on their door before they entered. One person told us staff did not always wait for a response before entering their room.

Care plans contained information about each person's life, with details of people who were important to them, how they spent their time before moving into the home, such as looking after their family or employment, hobbies and interests. We were told by managers that staff were able to access care records to help ensure they were aware of people's needs and preferences. However, we noted people's care plans were computerised and mainly written by nursing staff; none of the care staff we spoke with mentioned looking at people's care plans to ensure they were delivering the care people wanted and needed. In addition, we found care staff did not have a consistent or thorough understanding of people's needs. For example, staff could not tell us about the cultural or religious needs of people living in the home who were of Asian heritage other than a basic understanding of their dietary needs. Staff were also unaware of the language spoken by one person and did not have any strategies in place to help them communicate with them. When we asked one staff member how well they knew people they told us, "New ones not so well, but the ones who have been here a while I know quite well." Another staff member told us they knew people, "As well as possible."

People did not always receive care to meet their diverse needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care records contained information about how staff should support them to be as independent as possible. All the people we spoke with confirmed staff encouraged them to do as much as they could for themselves.

The provider had a policy in place about supporting people's rights to advocacy services. People can use advocacy services when they do not have friends or relatives to support them or want help from someone other than staff, friends or family members to understand their rights and express their views. Although there was no information on display about local advocacy services, the manager told us they were aware of how these services could be contacted when necessary. They told us they would ask the local advocacy

organisation to send them information to display about the services they could provide to people who lived in Northwood.

Computerised records were password protected and other care records were stored securely; this helped to protect people's rights to confidentiality.

Requires Improvement

Is the service responsive?

Our findings

Our review of care records showed these were written in a personalised way and included people's preferences about how their care should be delivered. However, our observations during the inspection and conversations with people who lived in the home showed people were not always offered care which met these preferences. This demonstrated a lack of respect for people's diverse needs and wishes. For example, some people told us they were not offered the opportunity to have a bath or a shower as was their preference, but were simply provided with a 'bed bath'. The manager told us they had recognised that the number of people being provided with bed baths was inappropriate and intended to improve this situation. Another person told us, they had been up since 6.30am on the day of the inspection and did not have any choice about the time they got up or went to bed. They commented, "I don't like them doing things you don't want them to." People also told us they were upset that the 11am 'tea round' had been discontinued without any discussion with them. In addition, people told us staff were too busy to involve them in discussions about their care or their preferences. One person told us, "Staff just get on with it."

When we looked at the minutes from a residents meeting held in May 2018, we noted people had raised concerns that they felt rushed going to bed. We noted the documented response to this had been, "As I explained there are 20+ people needing assistance and staff cannot wait around for them to decide when they want to go to bed." This demonstrated the culture of the home was one in which people's rights and preferences were not respected.

Although we saw that people's care plans and risk assessments had been regularly reviewed, none of the people we spoke with told us they had been involved in developing or reviewing their care records. We were concerned that one person shared information with us about their inability to access the personal care they wanted due to restrictions on them accessing a shower because of their physical health. We discussed this with the manager who was unaware of this situation. We advised that, if the person had been given the opportunity to discuss and review their current care needs with staff, this issue could have been resolved.

We noted the provider had detailed policies in place about the importance of staff supporting people to maintain links with the community, family and others. However, we found no evidence of such support being provided.

People who lived in Northwood told us there were no organised activities in which they could participate and they mainly watched TV or read books. One person told us they liked to use the mini library in the home but had now read all the books available. Another person told us they had requested the registered manager organise a trip to Blackpool some time ago but had not had any feedback on this request.

During the inspection, we found no evidence of people being involved in meaningful activities which met their interests and preferences. We were informed the provider was recruiting for a new activity coordinator although one member of staff told us they had previously carried out this role and was uncertain why this was no longer the case. We observed people were left without any form of stimulation and one person was asleep in a lounge area throughout the whole of the first day of the inspection, with the exception of the

lunchtime period.

People did not always receive person-centred care. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the file which was used to record complaints and noted the complaints policy it contained was out of date; this was because it referred to the previous provider as well as out of date regulations. Following the inspection, we were sent a copy of the provider's up to date policy. We noted there had been two complaints logged in the previous 12 months; the records relating to these complaints showed they had been investigated and responded to by the registered manager. However, we noted neither of the concerns raised in residents' meetings regarding staff attitude had been logged; this meant there was no evidence this feedback had been used to improve the quality of the service people received.

The provider did not have an effective system for identifying, handling and responding to complaints. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked if the provider was meeting the requirements of the Accessible Information Standard (AIS); this standard was introduced on 31 July 2016 and states that all organisations that provide NHS or adult social care must make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need. Although the provider did not have a policy in place in relation to this standard, we noted all care records included information about people's communication needs. However, staff were not always able to give us consistent information about any specific arrangements in place to support people to express their needs. For example, one staff member told us they used a communication board with one person which they used to point to specific things such as bed and toilet, whereas another staff member was unsure about which person had communication needs and were unaware of such a tool being used.

We saw that the service was using a range of technology to improve the care and support people received; this included equipment such as sensor mats and door alarms to help ensure staff were able to respond promptly and provide people with the support they required.

There was no one in receipt of end of life care at the time of the inspection. However, we noted care records contained information about the care people wanted to receive at the end of their life. One person's records contained detailed information about the action staff should take to ensure their cultural needs were met at the time of their death.

Requires Improvement

Is the service well-led?

Our findings

Our findings during this inspection showed systems in place to monitor the quality and safety of the service were not always effective. Although the home had a registered manager in place, we were told they had stepped down from this role and planned to de-register with CQC.

The provider had a number of audits in place to monitor the quality and safety of the service; these included checks on care plans, falls and infection rates and medicines. However, we found the medicines audits completed had not been effective in identifying the shortfalls we noted regarding the storage of medicines and the poor recording regarding the administration of topical medicines. In addition, the area managers completed a monthly audit which included a review of social and leisure activities provided in the home. However, we found this audit was not effective as it did not take into account people's individual and diverse needs or interests.

Systems to monitor the cleanliness of the home were not effective. People were placed at risk as the environment was not always clean, infection prevention measures needed to be improved as well as the disposal of clinical waste. Complaints processes were not used effectively to drive forward improvements in the service and effective systems were not in place to ensure people received care delivered in line with their wishes and preferences

Some systems were in place to gather feedback from people. However, we found these were not always effective in driving forward improvements.

The provider had carried out a satisfaction survey with people who lived in the home in March 2018. As a result of the responses from this survey, pull cords had been installed in the lounge areas so that people were easily able to attract the attention of staff if they required assistance. Improvements had also been made to the way in which a person's food was cooked following feedback from surveys completed regarding the quality of food.

Records showed a number of residents' meetings had taken place in the previous 12 months, although the most recent had been in May 2018. Only one person we spoke with told us they were aware of these meetings taking place; they told us they did not feel anything changed as a result of any suggestions made. Our review of the minutes taken at the meetings showed there was no record of any action taken between meetings. We were also concerned to note that at the meeting held in April, one person had raised the fact that they had been told by a staff member, "We are not servants" when they had pressed their buzzer. There was no evidence that this allegation had been taken seriously or any attempt made to investigate. We were unable to clarify this with the registered manager as they were on sick leave at the time of this inspection.

There was a lack of robust processes to monitor the quality and safety of the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2008.

A new manager had been appointed by the provider and had been in post for one month at the time of this

inspection. The new manager was open with us about the difficulties they had experienced since starting in the role, but they had a clear plan of the improvements they intended to continue to make. They told us they wanted to focus on the dining experience of people living in the home as well as the refurbishment of some of the bedrooms. During our discussions, we asked the manager to consider how they would improve the current culture of the home which had led to people feeling disempowered and unable to make some basic choices and decisions about the care they received. They and the operations manager told us there was an action plan in place which included the manager spending time with staff to model the behaviour they expected of them. This was intended to promote people's rights and provide respectful, dignified and compassionate care. We also noted the provider had ensured a senior management team consisting of two area managers and a newly appointed operations manager were at the home several times a week to support the manager in making the required changes to the way the service operated.

The manager told us they had found the documentation recording the personal care people had received to be below the standard they expected. They showed us copies of the new documentation they intended to introduce the week after the inspection. This demonstrated their commitment to service improvement.

Staff spoken with provided mixed feedback about the leadership of the service. Some staff told us they were positive about the changes introduced by the new manager while other staff felt the new manager had not yet taken time to engage with them. However, we saw evidence that the new manager had held a staff meeting shortly after they started work to introduce themselves to the staff team and inform them of the changes they intended to make; these included a focus on the safety of people who lived in the home, activities and the introduction of an 'Employee of the Month' scheme. A further staff meeting was planned for shortly after the inspection; the purpose of this was to update staff about planned changes in the home.

We saw there was an overarching action plan which included the shortfalls identified on each of the audits completed by the manager and the provider, with timescales for completion. We were told progress against these actions could be monitored by the provider through their dashboard system. We also noted accidents and incidents in the home were analysed for any patterns and trends. This meant that there were systems in place to learn from events in order to help prevent a reoccurrence.

We saw evidence that the service worked in partnership with a variety of other agencies. These included, GPs, podiatrists, opticians, dentists, hospital staff, speech and language therapists, dietitians and social workers. This helped to ensure that people had support from appropriate services and their needs were met.

Although the provider had a suite of detailed policies in place to guide staff, these were all undated and did not include a date by which each policy should be reviewed. This meant there was a risk staff could be working to policies which did not reflect current best practice.

From our review of records prior and during the inspection, we found the provider had notified us of all significant events which had occurred in line with their legal obligations.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always receive person-centred care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems in place for the handling of medicines were not always safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider did not have an effective system for identifying, handling and responding to complaints.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems to monitor the quality and safety of the service.