Northfield Care Limited

Northfield House

Inspection report

Folly Lane
Uplands
Stroud
Gloucestershire
GL5 1SP

Date of inspection visit:
25 September 2018

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20 November 2018

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

We inspected Northfield House on 25 September 2018. Northfield House is registered to provide accommodation and personal care to 25 older people and people living with dementia.

We carried out this inspection following anonymous concerns raised regarding the service in July 2018, these concerns were focused on the safety of people. As a result we undertook a focused inspection to look into those concerns. This report only covers our findings in relation to /this topic. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Northfield House on our website at www.cqc.org.uk.

At the time of our inspection, 23 people were living at Northfield House, one of these people was in hospital at the time of the inspection. Northfield House is based near the centre of Stroud. Northfield House has accommodation for people over three floors. The home has an enclosed garden which people could enjoy, as well as a lounge diner, and two other communal lounges, one on the first floor and one on the ground floor. This was an unannounced inspection.

We previously inspected the home on 17 August 2017. The service was meeting all the requirements and we rated the service as "Good" overall.
At this inspection in September 2018, we only looked at 'Is the service safe?' and 'Is the service well led?' questions. We found concerns regarding people's recorded care assessments and shortfalls in good governance procedures operated by the registered manager and provider. At this inspection the service was rated 'Requires Improvement' overall.

There was a registered manager in place at Northfield House. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they were safe living at Northfield House. However, we identified shortfalls in people's care records that could place people at risk of unsafe care or treatment. Where staff had identified risks to people's health and wellbeing there was not always risk assessments or guidance in place on how to assist people to reduce these assessed risks. Staff we spoke with were able to tell us how they assisted people to reduce their risks and prevent them from avoidable harm.

People's prescribed medicine stocks were managed well, however there was not clear guidance to assist people with their medicines which had been prescribed 'as required' such as pain relief or anti-anxiety medicines. Additionally, there were not always clear guidance in relation to how people's covert medicines should be provided.

There were enough staff deployed to ensure people's health needs were being met. There was some

unexpected staff absence on the day of our inspection however care staff felt this was manageable. The registered manager had informal systems to learn from incidents and accidents and reduce future incidents of preventable harm and share this information with staff.

The registered manager and provider had some systems to monitor the quality of care people received at Northfield House, however these were not always robust or consistent. Audits were not always effective at identifying concerns that we found in relation to staff performance, people's risk assessments and the management of medicines. There were not always robust and structured systems in place to seek and act on the views of people, their relatives or healthcare professionals.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always as safe as it could be. People could be at risk as there was not always effective guidance on the support people required to reduce the risks associated with their care.

People's prescribed medicines were mainly managed well, however there was not always effective guidance on people's medicines that were given covertly or 'as required'.

There were enough staff deployed to meet the care needs of people. People felt safe living at Northfield House. Staff understood their responsibilities to report abuse.

Is the service well-led?

Requires Improvement

The service was not as well led as it could be. The registered manager and provider had systems to monitor the quality of the service, however these were not always robust and not consistently used. Concerns identified at this inspection had not always been identified through the service's own systems.

The service did not operate robust systems to seek and act on the views of people, their representatives and healthcare professionals.

Staff felt they were supported by the management team.

Northfield House

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 was 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.

We undertook an announced unannounced focused inspection of Northfield House on 25 September 2018. The inspection was prompted in part by concerns we received about people's safety. We 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, concerns or significant improvement were identified in the remaining three 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.

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The inspection team consisted of one inspector. At the time of the inspection there were 22 people living at Northfield House.

We did not request a Provider Information Return (PIR) prior to this inspection, as we had brought the inspection forward following concerns raised regarding the service in July 2018. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We reviewed the information we held about the service, which included notifications about important events which the service is required to send us by law.

We spoke with four people who were using the service and one person's visitor. We spoke with seven staff members; including four care staff, the maintenance worker, the deputy manager and the registered

manager. We reviewed five people's care files and associated records (hand written risk assessments, incident and accident reports). We also reviewed records relating to the general management of the service.

Requires Improvement

Is the service safe?

Our findings

People felt safe living at the home. Comments included: "Staff are first class. I think they're wonderful. They keep us safe" and "Yes, I am safe, I am happy here. There are worse places to be". One visitor told us, "I think it's safe here, I've been visiting every day, I have no concerns."

People could be placed at risk of unsafe care and treatment as their care records did not always provide sufficient information about how they should be supported to stay safe and the actions staff had taken to keep them safe. We discussed risk assessments with the registered manager, who informed us these were an area of development for the service. A number of risk assessments had been handwritten and not been documented on the service's care planning system which staff could access. Additionally, staff had identified some risks however there was no documented risk assessment. For example, staff had identified one person in August 2018 who may be at risk of self-harm. There was no risk assessment in place for the signs and indicators staff should be aware of, or the support the person required to reduce this risk.

Prior to the inspection, we received concerns that one person may have been placed at risk of inappropriate restraint. The deputy manager and two members of staff informed us that restraint training had been provided for one person, however this was not currently being utilised. The deputy manager told us, "(restraint) is only used by trained members of staff. In honesty, [the person] actually restrains us during personal care." A member of care staff told us, "We have had PBM support. However, we do not do any restraint at all (due to health of person)." There was no clear information regarding restraint in the person's care assessments or any record of debriefing or discussion after restraint had been used. One member of staff said, "If we approach the person calmly and patiently they usually accept our help."

After the inspection the provider informed us that a red, amber and green behaviour support plan (a recognised tool providing guidance and information on the indicators of people's wellbeing and the action staff can take to support them) were in place. The information in this behaviour support plan had not been included in the care planning system that was in use at the time of our inspection. This meant that care staff may not always work in a way which protected the person, the staff and other people from risk because people's electronic care plans did not include all the information staff needed to support people appropriately with their anxiety.

While people were proactively supported to take risks to maintain their health and wellbeing there was not always clear guidance in place to advise staff on how to assist these people whilst reducing any unnecessary risk. For example, some people were supported to use the home's stairs or to move independently around the home. As there were no risk assessments this could place them at harm if supported by staff who were unfamiliar with their care (such as agency staff). While staff we spoke with could explain people's risks and how they were supported this had not been effectively documented.

Where people were prescribed medicines to be administered 'as required', such as pain relief or anti-anxiety medicine there was not always clear protocols for staff to follow. This may place people at risk of receiving

too much medicine or not receiving effective support. We discussed 'as required' protocols with the deputy manager who informed us that currently there were no protocols in place following a recent change in the pharmacy supplying medicines and the home's systems. One person had been prescribed medicines which could be given 'as required' to assist them with their anxieties. There was no protocol on how staff should give this medicine, when they should give this medicine or any other steps they could take to assist this person. Additionally, a number of people had prescribed 'as required' pain relief. There was no guidance of how and when this should be administered or how care staff should record this administration.

Care staff did not always have clear guidance around administering medicines covertly. For example, the deputy manager informed us one person received all of their prescribed medicines covertly, in a drink, including 'as required' anti-anxiety medicines. There was no guidance for staff to follow on which medicines needed to be given covertly. Additionally, there was no plan to follow if the person refused or spilt their drink, which the deputy manager, confirmed happened. We discussed this concern with the deputy manager and the registered manager who informed us this would be implemented immediately alongside 'as required' protocols.

Care staff kept a record of all incidents and accidents occurring within the home. However, these records were not always detailed and did not record actions the staff had taken to ensure people's safety or any observations (such as monitoring after a knock to a head) in accordance with good practice. For example, one incident form identifies someone was sat on a toilet at 03:40. Staff had identified the person had caught their foot to the side of the toilet at 08:10 in the morning and had assisted them to safety. There was no record of the support this person received during the intervening time. The only action recorded was to ensure maintenance was carried out to avoid a foot from becoming trapped, there was no explanation recorded for the person being on the toilet for this long or actions staff should take. We discussed this concern with the registered manager who informed us the person could spend long periods of time on the toilet and fall asleep there, whilst refusing to get up, however they agreed the recording was not detailed and was planning to discuss this with staff at future team meetings.

Where people had suffered a fall which resulted in knocking their head, staff did not record observations to ensure the person was safe. However, they did record referrals and support received from healthcare professionals following such an incident. Care staff confirmed the process they would follow, including close observation of people following a head injury, however they did not always record the support they provided, which might help them identify a change in condition.

People's risks had not always been clearly documented and assessed. There was not always clear assessments or guidance for staff to follow around managing people's behaviours, 'as required' medicines and covert medicines. These concerns were a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's prescribed medicines were kept secure. The temperature of areas where people's prescribed medicines were, monitored and recorded to ensure people's medicines were kept as per manufacturer guidelines. Where people required controlled drugs (medicines which required certain management and control measures) these were stored and administered in accordance with the proper and safe management of medicines.

People received their medicines as prescribed. Care staff kept an accurate record of when they had assisted people with their prescribed medicines or where people had refused or not had their prescribed medicines. We observed a member of care staff assisting people with their prescribed medicines in a person-centred manner. For example, they assisted a person with their prescribed medicines in a patient, kind and

compassionate way. They clearly communicated what the medicines were for and asked if the person wanted to take them. They gave the person plenty of time and support to take their medicines. The person was in control throughout, offered choice by the staff member and given a drink with their medicines.

People and their visitors told us there was enough staff available to meet their needs. Comments included: "The staff come when I want them; "There are always plenty of staff around" and "Staff are around for us, I don't worry about that. I don't feel alone."

Care staff told us the staffing levels enabled them to ensure people's needs were met and to support them to enjoy one to one time and activities. Comments included: "I feel we always we have enough staff"; "There is someone off today, we work a bit harder, however we have support" and "I don't feel its unsafe."

People were protected from the risk of abuse. Care staff had knowledge of types and signs of abuse, which included neglect. They understood their responsibility to report any concerns promptly. Staff told us they would document concerns and report them to their line manager or the registered manager. One staff member said, "I would always go to the manager first." Another staff member told us what they would do if they were unhappy with the manager's response. They said, "I can go to the director, then the adult helpdesk and CQC."

People could be assured the premises were safe and secure. Safety checks of the premises were regularly carried out. People's electrical equipment had been checked to ensure it was safe to use. Fire safety checks were completed to ensure the service was safe. Equipment to assist people with safe moving and handling was serviced and maintained to ensure they were fit for purpose.

People could be assured the home was clean and that housekeeping and care staff followed and recognised safe practices in relation to infection control. People and their relatives felt the home was clean. Care staff wore personal protective clothing when they assisted people with their personal care.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager at Northfield House. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered manager and provider had systems to monitor the quality of the service, however these were not always robust and not consistently used. For example, the registered manager operated incident and accident audits, however they informed us these had not been carried out monthly as they expected. Audits which had been carried out focused on the number of individual falls or incidents people had and documented changes that could be implemented, including referrals to external healthcare professionals. The audits were not designed to identify any trends in incidents or falls, such as location or time of fall, to support the registered manager or provider to identify any wider trends or concerns within the service. We reviewed incident records for July, August and September 2018 and assured ourselves there were no apparent trends. Additionally, the registered manager had not reviewed all incidents to identify short falls in the recording of incident and accident charts. This was something the registered manager was planning to discuss with staff.

At the time of our inspection there were limited formal auditing processes in relation to people's care plans and risk assessments. There were no current audits in relation to people's care assessments, their risk assessments and other associated documents and guidance such as 'as required' medicine protocols and cover medicine guidance. The registered manager explained they were aware of the issues regarding risk assessments and the deputy manager and principle carer were writing people's risk assessments before adding them to the care planning system. The registered manager showed us hand written risk assessments, however not all of people's identified risks had been assessed. Additionally, there were no systems in place to ensure care staff had appropriate guidance to follow in relation to 'as required' and covert medicines. We raised these concerns with the registered manager and deputy manager who informed us action would be taken to address these concerns. The registered manager also explained that the provider was looking to implement a new electronic care planning system and this they hoped would have a benefit in relation to people's care records.

The registered manager and provider did not always operate robust processes to seek and act on the views of people, their relatives, care staff or healthcare professionals. The registered manager explained that since they had been in post there had been no surveys done, however this was something they had planned. The registered manager did carry out resident's meetings with the last meeting being carried out in July 2018. Following the inspection the provider informed us they used internet feedback websites and social media sites to seek and respond to people's views. They also informed us they promoted open communication with healthcare professionals and feedback was often positive. However, while the provider and registered manager had these systems there was not always a clear formalised approach which enabled them to record the actions they had taken and the improvements which had been made to the service in response to stakeholders' feedback.

Quality assurance systems had not always been effective in identifying shortfalls, making and sustaining improvements to the service people received over a period of time. These concerns were a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager discussed the informal systems they had in place to monitor the quality of care people received. For example, the registered manager explained to us how they spent time on the floor of the home, and did checks of the home to ensure staff were working effectively and the premises remained safe. They explained on one occasion they identified one member of staff not working in accordance with infection control procedures. They challenged this practice, and carried out a responsive staff discussion to address this practice. While the registered manager and deputy manager carried out these checks, there was not always a record of these checks and the actions that had been taken to ensure the quality of the service.

The service had recently changed the pharmacy which supplied people's prescribed medicines. A new system had been implemented which the deputy manager informed us had had a positive impact on ensuring people received their medicines as prescribed. The registered manager had stopped their audits of medicines at this time to enable staff to get used to the new system, however they planned to discussed box medicines with staff to ensure good practices were being followed at all times.

The registered manager and deputy manager carried out daily health and safety and infection control checks of the service. The registered manager was in the process of reviewing these audits to ensure they remained effective. On top of this, the registered manager or deputy manager provided the provider with an overview of the home on a daily basis, including any concerns, changes in people's needs or new arrivals. This was to enable the provider to have an overview of any changes within the home and identify any support required.

Care staff told us they felt supported by the registered manager and deputy manager and felt they received the information they needed to ensure people's needs were maintained. Comments included: "They gives us a lot of support. It is really great"; "I feel I have everything I need" and "(Registered manager) is a cracking manager."

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 17 HSCA RA Regulations 2014 Good governance The registered manager and provider did not always operate robust systems to monitor the quality of the service. The service did not always keep an accurate and current record of people's care needs. The service did not operate robust systems to seek and act on the views of people, their representatives and healthcare professionals. Regulation 17 (1) (2) (a) (b) (c) (e).