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Northgate House (Norwich)

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Northgate House is a residential care home providing accommodation and care for up to 22 older people, some living with dementia, in one adapted building across two floors. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. At the time of this inspection, three people were using the service.

This service has a history of non-compliance with continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Seven inspections of this service had taken place since December 2014, three of these inspections with an overall rating of 'Inadequate' and four rated 'Requires Improvement'.

This unannounced inspection took place on 10 September 2018. At this inspection, we found that there were four continued breaches relating to safe care and treatment, staffing, mental capacity and governance. There was one further breach of a regulation relating to safeguarding people.

We took enforcement action following an inspection of the service on 19 April 2017 where the service was given an overall rating of 'Requires Improvement' as we found the registered provider had continued to be in breach of four regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We placed conditions on the registered provider's registration to submit monthly reports to us setting out how they would assess, monitor and where required, take action to improve the quality and safety of the care and support provided to people living at Northgate House.

At the last inspection carried out on 7 March 2018, we found that there were continued serious concerns in relation to the quality and safety monitoring of the service. There was a continued failure to ensure people were protected from the risks associated with improper operation and management of the service including the premises. The service was in breach of seven regulations, which were Regulations 9, 11, 12, 14, 17, 18 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not provided with safe care. Oversight and management of the service was chaotic and disorganised. There continued to be insufficient governance arrangements in the service and therefore was still not effective in mitigating the risks to people's health, welfare and safety.

Following our comprehensive inspection on 7 March 2018, we formally notified the provider of our escalating and significant concerns. We asked the provider to inform us immediately of the urgent actions they would take with immediate effect to protect people and raise standards. We received a response to the urgent action letter on 12 March 2018, followed by an action plan addressing the concerns on 13 March 2018. This contained a basic action plan. We placed conditions on the provider's registration to restrict admissions to the service. In response to our findings we notified the local safeguarding authority. Since our last inspection, the local authority has supported people who they commissioned care for to move to other locations.

At this unannounced inspection on 10 September 2018, we continued to have major concerns regarding the lack of action taken by the provider to ensure a safe service was provided. There was a continued lack of effective leadership and we found the provider continued not to have effective systems in place to provide safe, good quality care. There were three continued breaches and one further breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which we found, relating to safeguarding people. In addition, there was a breach of Regulation 18 of CQC Registration Regulations 2009.

The service continued to operate without a registered manager in post, and there had not been a registered manager for two years. 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 operations manager was currently acting as home manager and had submitted an application to register with CQC as the home manager. This application remains pending with CQC. For the purpose of the report we have referred to this person as the 'manager' throughout. There was a new deputy manager, who was not working on the day we inspected.

Risks to people's safety and wellbeing had not always been identified and those that had been identified were not always mitigated. There remained concerns around medicines administration with no records around people's prescribed topical creams and no guidance provided for staff for the administration of PRN (as required) medicines. Other medicines were given as prescribed.

Recent visits from environmental health inspectors and external auditors such as fire safety experts and a health and safety management auditor highlighted a number of areas where action was required by the provider to improve the safety of the environment and protect people from the risk of harm. Whilst the manager told us they had rectified these shortfalls, we found this was not always the case.

Staff had some knowledge of safeguarding from training, however people were not always properly safeguarded from the risk of abuse.

Accurate records of staffing available to meet people's needs were not maintained. We were unable to ascertain exactly what hours staff had worked and when because the staffing was not accurately reflected in the rota. It was not clear from records maintained that all staff responsible for delivering personal care and support with mobilising people safely were competent in their roles. Staff received some training relevant to their role, however there was not always evidence of sufficient training for all staff delivering personal care. It was unclear whether there was consistent staffing at night to meet people's welfare and safety needs.

The manager lacked understanding in their roles and responsibilities in relation to the Mental Capacity Act 2005. Best interests' decisions were not always made when they were needed, and there remained a lack of understanding around consent. It was not clear how assessments of people's capacity to consent to care were made.

Accurate, contemporaneous records of people's care were not always kept because records did not reflect actual care delivered.

There continued to be poor leadership with a lack of effective oversight and governance of the service. The manager presented in a manner that lacked openness and transparency in carrying out the regulated activity. Health and safety checks were lacking and action had not been taken when external auditors had identified areas of risk to people's safety.

There continued to be a high turnover of staff which did not provide continuity of care for people who used the service. There had been a further change of two managers since our last inspection. There were recruitment checks carried out to ensure that staff were suitable for the work they were employed to perform. However, the manager did not always maintain and record an oversight of staffs' competency to ensure that staff remained suitably qualified to care for people in a safe way.

Care plans contained information about people's hobbies, interests and social history. However, there was mixed feedback as to regularity of activities and the quality of support provided.

Relatives told us they could approach staff with any concerns, but they were not always resolved quickly. The provider had received some compliments.

There was a choice of meals available and people received enough to eat and drink. Staff supported people to access healthcare professionals and appointments.

The overall rating for this service is 'Inadequate' and the service remains in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as 'Inadequate' for any of the five key questions it will no longer be in special measures.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks to people were not adequately identified and mitigated, and there was not always accurate guidance for staff. Risks associated with the environment had not always been identified, and when they were, these were not acted upon. This included risks associated with infection control.

Staffing records were inaccurate and inconsistent., and there was not always evidence of staff being competent in their roles.

Most medicines were administered as they had been prescribed, but there was not always guidance in place when needed. There was no guidance or recording of the application of topical creams.

Is the service effective?

Requires Improvement

The service was not fully effective.

It was not always clear how and by whom, people's mental capacity had been assessed for individual decisions relating to their care. Best interests' decisions and consent had not always been sought when needed.

Staff received some training, however it was not clear how effective this was, whether it was followed up with competency checking, or that all staff delivering care had the appropriate training.

People had enough to eat and drink and were given a choice.

People were supported with access to healthcare when they needed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Not all staff were always caring towards people.

Staff knew people well and what they liked and disliked.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Staff carried out some activities with people, but did not have a consistent approach to this when they had opportunities to provide occupation and stimulation for people.

Care records contained information about people's needs, but staff did not know details of people's health conditions.

Concerns were not always acted upon in a timely manner.

Is the service well-led?

Inadequate

The service was not well-led.

There was continued poor leadership. The manager presented in a manner that lacked openness and transparency.

There was continued lack of effective oversight and governance of the service. Quality and safety assurance systems in place had not identified the issues and concerns that were raised during this inspection.

Sufficient improvements had not been made since the last inspection, and actions had not been taken following shortfalls found following audits carried out by external health and safety auditors.

Northgate House (Norwich)

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection team consisted of two inspectors.

Prior to the inspection, we reviewed information we had received about the service such as notifications. This is information about important events, which the provider is required to send us by law. We also looked at information sent to us by the provider such as previous action plans, and from other stakeholders, for example the local authority and health care professionals.

We spoke with staff members including the manager, the administration staff member, the trainee deputy manager, four care staff and the cook. We also spoke with two relatives of people living in the home, and observed interactions between staff and people living in the home. A week after our inspection visit, we also spoke with a consultant who had been working with the home to make improvements. We looked at all three care plans in detail and daily records of people's care, the medicines administration records (MARs), as well as a range of quality assurance, recruitment, and health and safety records.

Inadequate

Is the service safe?

Our findings

Our inspection of the service on 7 March 2018 found significant shortfalls in the safety of the service provided for people and we rated the service 'Inadequate' in 'Safe'. During that inspection, we identified breaches of Regulations 12, 19 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection on 10 September 2018, we found there were remaining breaches of Regulations 12 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to safe care and treatment and staffing, and have rated this area as 'Inadequate'.

At our last inspection on 7 March 2018, we found continued serious concerns around safe care and treatment at the service, resulting in a breach of Regulation 12 of the Health and Social Care Act 2008. These were around the management of medicines, moving and handling, the assessment of risks to people and risks associated with the environment. At this inspection in September 2018, we continued to find concerns and the provider remains in breach of this Regulation.

We found at our last inspection that there were no protocols for PRN (as required) medicines. At this inspection we found this still had not been rectified. We found that PRN medicines were given without sufficient guidance for staff on when and how to give them. One staff member told us, "It's a judgement." This included psychoactive medicines. This meant that there was not a unified, consistent approach, and staff administering the medicine may not be qualified to make this judgement without guidance. There was a risk that they would receive this medicine inappropriately. We saw that these were administered and signed in the Medicines Administration Record (MAR), however not mentioned elsewhere, for example in the daily notes. Therefore, it was not clear why PRN medicines were given.

In one person's care plan, it specified that a medicine should be given for 'aggression'. There was no additional behavioural management strategies in place to guide staff as to what techniques they should try before resorting to the administration of this type of medicine. There was no evidence that other techniques were attempted prior to its' administration, or guidance in place. We spoke with a staff member about this, and they told us they did not agree with the administration of this medicine. They said it was more effective to simply sit and chat with the person, distract and support them to calm down. They said some staff were quick to judge and administered it without trying this approach. We saw that the MAR reflected two days where the person was given this medicine, and the daily notes reflected no problems or aggression throughout the day, and had no reference to it being given. Another daily record on a day this medicine was administered stated that the person was, 'pressing the buzzer constantly.' We could not be assured that this person was receiving their medicine appropriately when needed.

Another person had a PRN laxative, and there was no guidance about this, and a lack of recording around associated needs. Therefore, there was a risk that the person could have this administered when it was not needed.

There was a lack of staff recording of administering prescribed topical creams. The MARs stated that there was a separate recording sheet for these. These could not be found and there were no references to topical

creams in the daily records. This included creams to protect people against risks of pressure ulcers. We could not be sure these people had received their medicines as prescribed. We saw that topical creams were kept in people's rooms, in cabinets which had keys in the locks but were not kept locked. This was against the provider's own medicines policy and created a risk that the medicines may be accessed and used inappropriately.

The medicines policy stated that for covert medicines to be administered, the input of a pharmacist is required to instruct how the medicines could be prepared, for example, crushed and mixed with food. Where one person at times received covert medicines, there had been a best interest meeting but there was no input from a pharmacist to say how these should be prepared, although the doctor had agreed for them to be crushed. This conflicted with the provider's policy and procedural guidance on the administration of covert medicines.

At this inspection we continued to see staff using unsafe moving and handling techniques, despite developments having been made to moving and handling care plans. Staff did not always follow moving and handling care plans to ensure people were moved safely.

This put them at risk of harm or injury. Although we saw some improvements in manual handling, we saw on one occasion staff transporting one person outside in their wheelchair without footplates being used. The person's care plan specified that these should be in place when staff were transporting them.

We saw that the service was visibly clean in people's rooms and communal areas. However, an external audit report carried out in April 2018 identified a number of areas which needed improving. This included that there were no pest control measures in place. We found that this had not been acted upon. The manager was able to provide evidence that the home had been treated for rats and mice in April 2018. However, a review from the Environmental Health Officer on the kitchen on 8 May 2018 showed the service had been awarded three stars. The report referred to aspects of the kitchen environment not always being kept clean. This included a report of mice droppings being seen in one of the cupboards. We asked the manager about this who told us there were no mice droppings. They were unable to provide any further evidence that this had been investigated further or that action had been taken following this report.

The health and safety report from an audit conducted on 5 April 2018 identified that bed rails were not being checked regularly. We found that this continued to be the case. Monthly checks which had been deemed necessary by the provider had ceased to be carried out for the last year. The last monthly checks of window restrictors, wheelchairs and bed rails were done in September 2017. This meant that people were at risk of being harmed through the use of faulty equipment. The last assessment of the hazardous substances (COSHH) within the home was in June 2016. This had not since been reviewed. Although we saw that items such as cleaning products were stored securely, there was no up to date assessment which included people's personal effects which may come under COSHH. All of these issues had also been identified in a further audit of 5 June 2018 by a consultant who had been working with the service, and still not acted upon.

Environmental risk assessments were not in place to identify specific risks to individuals within the home and their rooms. The risk assessments in place had not been reviewed since June 2016. Staff signatures on these risk assessments were also dated 2016. Two members of staff including a trainee deputy manager told us they did not know if there were any environmental risk assessments in place or where they were kept.

There was a lack of risk assessments in place to guide staff in steps they should take to mitigate the risk of harm for people who used the service and others. For example, there were some stairs which had been gated off with a bolt lock, which could pose a risk to people. The manager told us that none of the people

were independently mobile, therefore the stairs were not a risk. However, we saw from records that one person had independently mobilised and had an unwitnessed fall in another person's room in August 2018, therefore this demonstrated that they may be at risk of mobilising around the home and potentially accessing the stairs. No further risk assessments had been carried out in order to identify whether there were any risks to people in relation to their environment. All the wardrobes within people's rooms wobbled when pushed, some with heavy items on top. These posed a risk to people of wardrobes falling on top of them. These aspects had not been identified on any environmental risk assessments for people.

Other risks associated with the environment had not been mitigated. Where risks had been identified, action had not always been taken to rectify these. For example, an external company carried out an audit on 19 April 2018 on the fire safety at the service. They found outstanding actions from their previous annual inspection in 2017. This included a lack of fire drills and planned evacuations for staff, fire 'keep door locked' notices, and a lack of a smoke detector to the store room off the kitchen. The manager told us the smoke detector had been rectified. However, we carried out a tour with the manager and found this not to be the case. In a later audit which was sent to us by a consultant who had been working with the service, carried out on 5 June 2018, it was also identified that fire drills had still not been put into place. The manager produced an action plan in which they said they would do this, but there were no dates to be completed by and it had not been done since identified in April 2017, or since the auditors previous visit in 2017.

Fire risks had not always been identified in order to prevent incidents. We saw from records that on 27 August 2018 that a person had set fire to their t-shirt whilst alone in their room refilling their lighter. The person remained unharmed because a member of staff smelt burning and managed to get to the person in time to help them and put out the fire. This person's risk assessment for simply said, 'I have a Zippo lighter which I often refill on my own.' According to the records, following this incident the staff agreed with the person to look after their lighter fluid and supervise them refilling the lighter. However, it is concerning that the lighter fluid had not previously been identified as a fire risk and risk of being accessible to other people using the service when being kept in the person's room had not been considered.

During our inspection we found that the last legionella test was carried out 28 October 2016, expiring 2017. This had also been identified during our last inspection in March 2018, and on the health and safety audit undertaken by a consultant on 05 June 2018. An up to date legionella test had still not been obtained and a risk assessment not carried out.
There was a continued failure to take opportunities for learning from incidents or taking any action on findings to make improvements. The service has not been compliant with regulations since the regulations came into force in 2014, and therefore cannot demonstrate an ability to learn from incidents and improve the service to a sufficient standard.

The above concerns demonstrate a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection on 7 March 2018 we found a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There was not enough competent staff deployed to meet people's needs. We found at this inspection that the provider remained in breach of this Regulation because we were not able to accurately ascertain staffing levels and competency.

There remained a significant turnover of care staff and managers. There had been four managers within the last year. This had resulted in a lack of consistent, effective leadership, care and support, and relatives we spoke with confirmed this.

The staff who were working in the service were not reflected accurately on the rota. We saw several examples, including on the day of our inspection, where the staff who were working according to the rota, were not the staff who were at work. This included the manager, who told us he had worked two nights in the last week, which we confirmed by looking at daily records but this was not reflected in the staffing rota. A further member of staff was called in to work on the day of our inspection, and it was not clear why this was. This person was not included on the current rota for that week. This meant that records were not updated and did not accurately reflect the numbers of staff on shift, so there was no way of ascertaining whether planned staffing levels were met.

We were not able to ascertain accurately which staff were working when, as the rota did not reflect the daily notes, what we saw or what we were told. During some nights, there was only one member of staff on the rota if a member of staff was sick. There was no risk assessment or dependency assessment in place which explained how many staff should work at night. The time sheets we examined did not reflect the rota. The rota had two staff on at night and the manager told us there had always been two staff at night. However, one member of staff told us that at times there was one member of staff in the building with the other being on-call. We were not assured that the manager was consistently covering shifts with enough staff to meet people's needs because the records were misleading.

This demonstrates a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The staff had some knowledge of safeguarding and had received some training in this area. They said they would report concerns to their senior. However, we were not assured that there were effective safeguarding procedures in place in the home, or an understanding of safeguarding at provider level. Two members of staff told us that one of the registered partners in the provider organisation had regularly asked for cigarettes from one person living in the home. One of these members of staff reiterated to us that these were asked for, not offered by the person. Another member of staff confirmed that they had spoken to the person using the service and told them they felt this was an abuse of personal and professional boundaries, taking advantage of them and that they should not feel under any compulsion to give the registered partner their cigarettes.

Where concerns had been raised around some staff conduct, there was no evidence that this had been properly followed up with competency checks and formal supervision.

The incident report sent to the safeguarding authorities where a person accidentally set fire to their t-shirt omitted important information. For example, where the incident occurred, and how it was identified, which was by one of the staff members in another part of the building smelling smoke.

The above concerns demonstrate a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection on 7 March 2018 we found a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because staff did not always have the appropriate checks in place before starting work. At this inspection, we found that new staff had references and a Disclosure and Barring Record (DBS) check in place. This is a check which identifies if past concerns have been raised about a potential staff member's suitability to work with people. Two new staff members we spoke with confirmed that the provider had waited for the DBS to be returned before they started work. The provider was no longer in breach of this regulation.

Oral prescribed medicines that were not PRN were stored securely, and administered as prescribed. We checked a random stock of these and found that they added up to the expected number. Front sheets of the MARs detailed information about people, such as how they preferred to have their medicines. We observed that staff gave people their medicines according to these preferences.

Requires Improvement

Is the service effective?

Our findings

Our inspection of the service in March 2018 found significant shortfalls in the service provided for people and we rated the service 'Inadequate' in 'Effective'. Staff were not provided with adequate training and supervision, and the service was not compliant with the Mental Capacity Act 2005 (MCA). During this inspection in September 2018, we found two continued breaches of Regulations 11 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and have rated this area as 'Requires Improvement.'

At our last inspection in March 2018 we found a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, because there were not enough sufficiently competent staff. At this inspection in September 2018, we found that there were new induction processes in place where a more experienced member of staff signed off competencies of new staff. These included providing personal care with dignity, and areas such as staff appearance and uniform. A member of staff also confirmed to us that they had shadowed a more experienced member of staff when they started. However, they went on to explain that they had not received any formal or practical training from the provider in addition to this. They said they relied on copying what other staff did, including in aspects such as manual handling.

There were areas where staff did not appear to be fully competent because they were not complying with best practice. For example, we observed one incidence of poor manual handling during the inspection, and there were no protocols around administering PRN medicines. This raised questions around how effective the training was in these areas.

We were not able to ascertain whether all staff who were delivering personal care were competent to do so. We saw that the administration staff member, who was employed in July 2018, had worked with people living in the home in August 2018 and delivered personal care. There was no evidence that their competency to do this had been assessed. Furthermore, this was not reflected in the staff rota but we ascertained that they had worked because they had completed daily notes on the computer system, including through the night, with accounts of the care delivered. We asked the provider to send us the person's manual handling certificate following the inspection and this was provided.

There had been some improvements being made to the induction of new staff in terms of paperwork, as new staff had a checklist which included areas of health and safety and safeguarding. The induction had been followed by a supervision where the new staff member discussed their role. Some staff we spoke with told us they had received enough training for their roles, and that this included practical manual handling training. However, we remained concerned that this did not always translate into staff being competent in their roles. One new member of staff told us they felt they had not received effective training and had been expected to get on with the job by simply copying other staff.

This is a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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

At our inspection on 7 March 2018, we found that the service was not compliant with the MCA. This was because it was not clear how specific decisions had been arrived at when people lacked mental capacity. We found on this inspection that the service was still not fully compliant with the MCA.

We found that there was a lack of understanding around consent. This was because where people lacked capacity, the service had not obtained people's proof of Lasting Power of Attorney (LPA) for Health and Welfare when others were agreeing to decisions for them. They were not always recording decisions that had been made relating to people's care and who was involved in these, with the exception of a covert medicines decision.

We found that staff understood the principles of people's mental capacity and were able to tell us about them. However, the principles were not always applied. There was a lack of understanding around consent and people's records were not always consistent. For example, we found that for people deemed to lack capacity, they had signed consent forms for the use of CCTV within the home. We spoke with two relatives who visited regularly about the CCTV and they had not been made aware of any CCTV use within the home or asked for their consent to be filmed when visiting. This demonstrated to us a lack of respect for consent for not only the people using the service, but a lack of transparency towards those regularly visiting the service. CCTV cameras were being used within communal areas of the service, and this was confirmed by the manager. Where people had been assessed as lacking capacity in some areas, it was not clear how the capacity assessments had been carried out and by whom. There were no best interests decisions carried out to show that the CCTV was in people's best interests.

Where a person with full capacity had signed a consent form, there was no evidence that they had been given information about where the cameras were and what they were used for, or how long the data would be kept for.

This demonstrates a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that where a decision had been made around one person receiving covert medicines, a best interests' discussion had been held with relevant people involved in this decision.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). For some people living in the home, DoLS applications had been made for their safety.

At our last inspection on 7 March 2018 we found there was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider was no longer in breach of this Regulation. None of the people living at the home had any specialist dietary requirements identified. We saw that people's food and drink was recorded in the daily records of their care, and their weights were regularly checked. People had drinks throughout the day, and the cook told us they gave people options of meals.

People had access to healthcare and relatives we spoke with confirmed this. Staff called in the doctor if needed, and people had regular visits as needed, for example, from a chiropodist or optician.

Requires Improvement

Is the service caring?

Our findings

Our inspection of the service on 7 March 2018 found that the management of the service provided for people meant that it was not possible to always meet people's needs and uphold their dignity, and we rated the service 'Inadequate' in this area. During this inspection, we identified that some improvements had been made. We have rated this service as 'Requires Improvement' in this area.

Prior to this inspection, in June 2018, we received concerns about very poor care taking place, as well as inaccurate record keeping about people's wellbeing. The person told us that the care was not person-centred and gave examples of poor practice. The two relatives we spoke with gave mixed feedback about whether staff were caring. They were predominantly positive, saying most staff were caring, but that there were a few who were not always caring. We asked them if staff treated people with dignity, and one said, "Sometimes they do not."

Two staff members told us they felt that not all staff were caring. They said that when staff had free time they did not want to spend that time offering people to have a bath or going for a walk. We saw from records that another member of staff had raised concerns about a colleague, which reflected that they had not delivered care in a compassionate way and spent time on their phone instead of interacting with people. We saw that one staff member had raised a concern to management about another staff member's practice which was not caring. We could see no evidence that this had been followed up, and we asked the manager about this. They said they had 'spoken to' the person. They confirmed that there was no formal supervision or competency checking following the concerns.

During the inspection we observed that staff were kind to people. We saw that staff communicated with people about what they were doing when delivering care. One member of staff told us that at times there was a language barrier with some staff members who did not have English as a first language. However, they told us that because these staff had a caring approach that they managed to overcome this.

People and their relatives told us they were not involved in the general planning of their daily ongoing care, but they had been consulted about their preferences with regards to their care. Care records we reviewed did not evidence that people had been involved in the planning and review of their care and their views were not documented. Two relatives we spoke with confirmed that they had been consulted in some aspects of their family member's care, such as changing their rooms.

We saw that staff only carried out personal care with people behind closed doors and people's privacy was respected. People had their rooms how they wanted them and friends and family had supported them to personalise their rooms.

Requires Improvement

Is the service responsive?

Our findings

Our inspection of the service on 7 March 2018 found that people did not receive personalised care that was responsive to their needs, and we rated the service 'Inadequate' in this area. Therefore, there was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During this inspection, we identified that improvements had been made to this area and the provider was no longer in breach of this regulation. However, further improvements are needed to ensure that improvements continue and are sustained. We have therefore rated this area 'Requires Improvement'.

Some activities were on offer to people, and people's interests and hobbies were included in their care plans. One staff member told us that they felt with only three people living in the service, they had more time to spend with people. They went on to say that they felt this time could be used to offer baths, go for a walk, or do things with the people living there. However, they said that some staff members did not want to do anything. This was also reflected in a concern raised by a staff member about another staff member, around staff not always taking opportunities to spend time with people.
We asked staff about people's health conditions, and found that they did not know about these in any detail, despite there being only three people there. However, we found that there had been some improvements in the care plans. For example, people's social and emotional needs were covered in these plans, with guidance for staff on how best to support people with these. However, some staff we spoke with told us that not all staff had a consistent approach to meeting people's emotional needs. During the inspection we observed that staff did reassure one person who became distressed.

Care plans contained information about people's hobbies, interests and their life histories and information about how they preferred the care to be delivered to them.

Where people had a care plan in place, for example for their mealtime, we saw that staff adhered to this, gently encouraging them. When staff noticed any changes, this was added to the care plan and communicated to other staff and there had been improvements around the care plans recording needs related to people's conditions.

The relatives we spoke with told us that they felt confident to go to staff if they had any concerns, and the home had not received any recent complaints. However, one relative told us that any issues raised were not always resolved in a timely manner. We looked at the complaints and compliments file and found the service had received some compliments about the care provided.

There were not always in-depth end of life care plans in place which provided staff with guidance on how people would prefer to be supported towards the end of their lives, for example, who they would want to be involved and how they would like to be cared for. However for one person, we saw that their last wishes had been recorded, and this included information about whether they would want to go into hospital or not.

Inadequate

Is the service well-led?

Our findings

Our inspection of the service on 7 March 2018 found significant shortfalls in the way the service was run, and we rated the service 'Inadequate' in 'Well-led'. The inspection on 7 March 2018 found the provider demonstrated that they continued to lack effective oversight and governance of the service. The service was in continued breach of Regulations 11, 12, and 17 of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014. There were also further breaches of Regulations 9, 14,18 and 19 in relation to fit and proper persons employed, insufficient staffing, nutrition and hydration and person-centred care. The provider had continued to be in breach of some Regulations over the previous six inspections since 2014.

Seven inspections of this service had taken place since December 2014, with three of these leading to an overall rating of 'Inadequate' and four rated 'Requires Improvement'. Following an inspection in April 2017, we had serious concerns and we informed the provider in writing of these. We placed additional conditions on their registration requiring them to submit monthly reports to us setting out how they would assess, monitor and, where required, take action to improve the quality and safety of the care and support provided to people living at Northgate House (Norwich). The provider had relied on the manager to submit regular progress reports, which have been submitted as requested since that time. However, these have demonstrated a continued lack of understanding as they did not reflect what we found when we inspected, in either our last inspection on 7 March 2018, or this inspection of 10 September 2018.

At this inspection on 10 September 2018 we found that the provider remained in breach of Regulations 17, 12, 11 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There was a further breach of Regulation 13 of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014. There was also a further breach of Regulation 18 of CQC Registration Regulations 2009 relating to notifications.

Many issues, including the findings from the environmental health officer, as well as the checks not being carried out or fire safety issues, identified in the health and safety report carried out in April 2018, were again later identified as remaining concerns. This was in an audit carried out by a consultant on 6 June 2018, and still no action had been taken before our inspection on 10 September 2018. This demonstrated that despite continuing support from external quality assurance colleagues, no actions were taken to improve the service. We asked the manager for these audits and reports during the inspection, as they told us they had employed a consultant to support them to improve the service. However, they told us they did not have access to any of these so could not provide them. A week after our inspection visit, the consultant provided their audits to us.

The manager had not added items to their action plan to improve the service when external auditors had identified areas associated with health and safety which required improvements. When we raised the questions around the lack of actions following these issues identified, for example around fire safety, the manager said the previous manager was responsible for this. However, the manager was the named responsible person according to the provider's own health and safety policy. They had not acted to respond to the issues identified. For example, risks associated with not checking bed rails had been identified by an

external auditor in April 2018. Another external auditor had inspected fire safety in April 2018, and actions from this, such as implementing fire drills and installing a smoke detector in one area, had still not been completed.

The manager told us they had been working with a compliance consultant to improve the service. However, they were unable to produce any records of any work that had been completed with this person, such as reports, audits or action plans.

Medicines audits still failed to identify gaps or concerns. Despite previous input from the local authority and CQC inspection findings, medicines administration remained problematic. Nobody had monitored the appropriate administration of PRN medicines or topical creams, and recording around these remained absent or inconsistent.

There were no further audits carried out by either of the partners in the provider's organisation, although one regularly visited the service. Staff confirmed that they saw them regularly and we saw them briefly twice on the day of the inspection. They did not initiate any discussion with us or provide any information about the running of their service.

There was poor leadership in place. Management remained chaotic and disorganised, and one member of staff described management as, "A shambles." We remain concerned that with a low number of people now living in the service, there remained significant shortfalls in the oversight and management of the home. The manager had not developed and sustained effective quality assurance systems. This demonstrated that the providers are unable to make sufficient improvements and sustain a service of a reasonable standard.

Staff confirmed that although the manager was regularly in the home, they turned up at different times, rather than according to the time they were in according to the rota. One staff member said if they felt if there was an issue, for example with staff conduct, they would go to the member of staff themselves to try and rectify it. They said if they went to the manager, they doubted anything would be done. Another member of staff told us if they raised a concern they felt they would, "Get shut down straight away." This demonstrated that staff did not always feel that they could raise and resolve concerns.

We could not be assured that the manager had a transparent approach. The manager was not transparent with us when we requested information. We asked the manager, who had overseen any recruitment following our last inspection on 7 March 2018, if there were any new staff since our last inspection. They told us they did not. It transpired, however, that there were at least six new staff members who had started since our last inspection. This in fact made up the majority of the care staff team at Northgate, despite the manager reiterating to us that they had retained all their staff. The staff we spoke with, and recruitment records, confirmed to us when they had started working in the service.

When we asked the manager if they had taken action on the findings of external audits they said they had. On several occasions throughout our inspection we asked for information and found that what we were told was not the case. When we looked around the home to check that actions had been taken they had not been completed. Two members of staff we spoke with referred to the manager as being dishonest.

During the inspection the manager told us that the consultant they employed was working with them in the home three days a week, but they were currently on holiday at the time of our visit. We spoke with the consultant a week later, and they confirmed to us that they had finished working with the service on 22 August 2018, and that prior to this they had visited one day a week for the time that there were only three people living there. They said prior to this they worked with the home two days a week.

A staff member told us about a staff member being sent home for a disciplinary issue during a shift and they told us this had left some people without their medicines as this had occurred in the middle of a medicines round. This occurrence was later confirmed by the external consultant the provider was working with. When we asked the manager about some staff who no longer appeared to be working in the service, they demonstrated a lack of understanding around employment management and law.

One member of staff told us they had been told what to say to CQC, so they did not feel that all staff felt confident to talk openly.

This demonstrates a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had failed to notify us of all incidents within the service reported to safeguarding authorities.

This meant the service was in breach of Regulation 18 of CQC 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not always protected from the risk of abuse. 13 (1)