Northfield Care Centre (Thorne) Ltd

Northfield Care Centre

Inspection report

Chace Court
Thorne
Doncaster
South Yorkshire
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20 April 2021
29 April 2021

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Northfield Care Service is a care home providing personal and nursing care for older people, including people living with dementia. It can accommodate up to 80 people. There were 39 people using the service at the time of the inspection.

People's experience of using this service and what we found
We found there was insufficient staff and ineffective deployment of staff to ensure people's needs were met. We observed staff were not present in communal areas. We observed people waiting for assistance and staff not having time to talk with people.

We found systems and processes used to ensure the service was running safely were not effective. They had not identified required improvements. There were systems in place to safeguard people from abuse. However, we referred three safeguarding concerns to the Local Authority, which we identified at inspection.

Risks associated with people's care were not always identified or managed in a way that kept people safe. Incidents and accidents were not effectively reviewed to ensure lessons were learnt to drive improvements. We identified some shortfalls in the way people's medicines were managed. We were not fully assured people were protected by the risk and spread of infection.

Staff did not support people appropriately. Their approach was not person-centred and care and support we observed, was task orientated. Staff told us they wanted to spend time with people but were unable to because they were too busy. We observed people left with no support, interaction or stimulation for long periods of time.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was requires improvement (published 22 September 2020)

Why we inspected
The inspection was prompted due to concerns received from complaints and whistleblowing. These were regarding, inadequate staffing, infection control and risks not being managed. We completed a focused inspection to look at the safe and well led key questions.

We looked at infection prevention and control measures under the safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

The overall rating for the service has changed from requires improvement to inadequate. This is based on

the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see all sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Northfield Care Centre' on our website at www.cqc.org.uk

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to person centred care, safe care and treatment, staffing and good governance.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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.

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.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Northfield Care Centre

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors.

Service and service type
Northfield Care Centre is a 'care home.' People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. However, they were the group operations clinal lead and there was a manager designate overseeing the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced. Inspection activity started on 20 April 2021 and ended on 29 April 2021. We visited the home on 20 January 2021.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We received feedback from the local authority and professionals who work with the service. The provider was not asked to

complete a provider information return prior to this inspection. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all this information to plan our inspection.

During the inspection
We spoke with five people who used the service and eight relatives via the telephone about their experience of the care provided. We spoke with twelve members of staff including the provider, operations manager, manager designate, deputy manager, nurses, care workers and ancillary staff. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included five people's care records, medication records and weight records. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. The provider and registered manager have also submitted an action plan following our feedback.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Risk associated with people's care were not suitably assessed or managed. For example, people at risk of weight loss did not receive care and support in line with their care plan to ensure the risk was managed. Another person we observed could present with behaviours that may challenge. During our observations they became more and more agitated. However, staff did nothing to support this person to improve their well-being, putting them and other at risk of harm.
- People's records did not always reflect their current needs. For example, we found incorrect risk assessment scores were recorded for weight loss, which meant people did not receive the correct line of treatment.
- We identified food and fluid charts were not always properly completed and did not accurately reflect what people had eaten or drunk. Charts were not reviewed, monitored or evaluated.
- Accidents and incidents were reviewed. However, the manager designate showed us three different monitoring records which could cause confusion and increased the risk that themes and trends might be missed. From records seen there had been a high number of incidents and we found forms were not always completed properly and many had no time of incident recorded. This meant they could not be effectively analysed to reduce risk and ensure lessons were learned.

The provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

- Medication systems were in place to ensure safe management of medicines. However, medication was not always recorded appropriately. Therefore, it was not possible to effectively audit they systems to ensure medicines were appropriately and safely administered.
- Medication prescribed on an 'as required' basis, (PRN) were not always recorded appropriately when it was administered. We saw some PRN protocols did not detail adequate information for staff to determine when to administer these medicines. Therefore, it was not clear if PRN medicines were being given as prescribed.

The provider had failed to ensure the proper and safe management of medicines which is a breach of regulation 12 (Medicines) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● The environment was predominantly clean. However, we identified some areas were not clean. For example, the refrigerator, freezer and microwave in the kitchenette area, dining chairs and bedding.
● We found some areas of the home were not well maintained so could not be effectively cleaned. For example, untreated wood in the kitchenette. We also found storerooms cluttered and unorganised, with many items thrown on the floor. These could not be effectively cleaned.
● The infection, prevention and control audit tool had not identified all the concerns that we found on inspection so was not effective.
● The manager designate was not able to provide us with cleaning schedules or evidence of changes made in cleaning regimes during the pandemic. There was no evidence of how often high touch points were cleaned to minimise spread of infection.
● Staff were seen following the guidance regarding personal protective equipment (PPE) in relation to the Covid-19 pandemic. However, we were not fully assured by infection control practices. For example, on occasions we saw staff not washing their hands as frequently as required and not offering to wash people's hands frequently.

These areas were addressed immediately by the registered manager and the provider. However, they had failed to ensure the policies and procedures were followed, which is a breach of Regulation 12 (Infection Prevention and Control) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● There were insufficient staff on duty to meet people's needs safely. It was not clear form the dependency tool if the staffing hours were calculated correctly. We saw from our observations the dependency scores did not reflect people's current needs.
● We observed due to lack of staff people were not supported in line with their care plan. Staff were not present in communal areas, people were waiting for assistance and staff not having time to talk with people. Staff we spoke with told us they were regularly short staffed and struggled to meet people's needs. We observed staff not effectively deployed to meet people's needs. Lack of sufficient staff put people at risk of harm.
● Staff told us they did not have time to listen to people, as they were busy and, on many occasions, did not have enough staff to provide the appropriate support.

The provider had failed to ensure there were skilled and experienced staff deployed to meet people's needs. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had a staff recruitment system in place. Pre-employment checks were obtained prior to staff commencing employment. This helped to ensure people employed were of good character and had been assessed as suitable to work at the service.

Systems and processes to safeguard people from the risk of abuse
● There were systems and processes in place to safeguard people from abuse.
● Staff told us if they had concerns that a person was being abused, they would report it to their line manager. However, we identified safeguarding incidents during our inspection and have made three referrals to the local authority.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The service had a registered manager who was the group operations clinical lead. They did not have day to day oversight of the service. At the time of our inspection there was a manager designate. From our observations and from talking with staff and relatives we found there was lack of leadership, direction and oversight. Care was not person centred and people were not always cared for in a safe way. Management in the home did not intervene or guide staff so that people received more appropriate care which met their personal needs.
- The management team did not ensure staff fulfilled their roles and responsibilities Staff were not supervised appropriately. Staff told us they did not feel supported and they were not listened to. Staff told us there were not enough staff on duty to manage risks and keep people safe. Staff did not feel confident in raising any issues, as they had continually raised issues regarding staffing and no improvements had been made.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Care and support provided was not person centred. We saw staff did not always engage with people when providing care and support and were task orientated. People were left in the lounge without support. Support we observed was institutionalised. Relatives we spoke with told us when they visited the service, they found their relatives looked unkempt and dirty and some had been wearing other people's clothes.
- People's preferences were not considered. For example, people's care plans detailed how they could be distracted to improve their well-being. However, staff did not have the time to do this, so people's behaviour escalated and had a negative impact on their well-being.
- People's choices or wishes were detailed in their care plans. However, staff told us they did not have time to support people with social activities as there were not enough staff. The activity coordinator had left, and no alternative had been considered by the provider.
- A positive culture was not promoted; staff did not work together as a team. There were insufficient staff and ineffective deployment of staff to meet people's needs, which meant the service did not achieve good outcomes for people. Staff told us they did not feel involved or able to share their opinions. Relatives told us there was poor communication and felt their views or wishes were not acknowledged.

Continuous learning and improving care

- Systems in place to monitor the service were not effective. There were quality monitoring systems in place

that had been completed. However, these had not always identified issues. For example, the lack of person-centred care, insufficient staffing and infection control issues identified at inspection.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Relatives we spoke felt they were not always kept informed or involved in the care and support of their loved ones. Visiting was being facilitated but it was very restrictive, and relatives were unable to see relatives in private and only had twenty-minute allocations on average every three to four weeks. There were no other methods of communication in place to ensure relatives were able to see or talk with their loved ones. One relative told us, "There had been zoom calls and updates on the Facebook page, this was infrequent but has now completely stopped, as the activity coordinator has left."

There were insufficient and inadequate systems in place to monitor and improve the quality of the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others

● The registered manager and provider engaged and worked in partnership with others. However, due to lack of correct recording, health care professionals had not always been contacted in a timely way. This was rectified following our inspection.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The registered manager and provider understood the need to show honesty and transparency from all levels of staff and leadership. However, it was not clear if this always happened. The provider has responded to our concerns and provided us with an action plan following our inspection, which details how the improvements will be made.

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 The provider did not ensure people received person-centred care that met their needs. Regulation 9 (1)(a) (b) (c)

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 The provider had failed to ensure people's risks were identified and managed to ensure their safety. Medicines were not effectively managed and infection control procedures did not ensure people were protected from the risk of infection. Regulation 12 (1) (a) (g) (h)

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 had failed to ensure the systems or processes established were effective to monitor and improve the quality and safety of the services provided. Regulation 17 (1) (2) (a) (b)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet people's needs. Regulation 18 (1) (2) (a) (b)

The enforcement action we took:

We have served a warning notice