Mr & Mrs F Ruhomutally

Northgate House (Norwich)

Inspection report

2 Links Avenue
Hellesdon
Norwich
Norfolk
NR6 5PE

Tel: 01603424900

Date of inspection visit:
19 April 2017

Date of publication:
21 June 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 19 April 2017 and was unannounced. Northgate House is a residential home providing accommodation and care for up to 22 older people. At the time of this inspection 18 people were living in the home.

There was no registered manager in post. A new manager had been appointed and they were due to take over the day to day management of the home the week after our inspection. They were present during the inspection. They told us that they would be applying for registration. 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.

Our previous inspection of this service took place on 30 November 2016 and had identified four breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014. These breaches related to the provision of safe care and treatment, safeguarding people from harm, consent and the management of the service.

Following the November 2016 inspection we imposed conditions upon the provider's registration. One was to restrict the rate of admissions to the home. The other required the provider to report on the service's progress on a monthly basis.

This April 2017 inspection found that the same four breaches remained as had been found at the November 2016 inspection, but that improvements had been made overall.

Some risks presented by hot water temperatures had not been remedied. The audits for scalding had failed to identify this. Staff had not secured drink thickener and were not using it when required for a person at risk of choking. The safety of one person who required staff to be present when they were outside the home had not been assured.

The service was not working in accordance with the Mental Capacity Act 2005. Some people had not consented to decisions that had been made about the care and support they received. Where people were unable to give consent to specific aspects of their care, there was no record to show that these decisions had been made in the person's best interests.

The governance arrangements were not fully robust. Some audits were yet to be implemented following the recent engagement of a management consultancy team. Some audits required an improved level of scrutiny on completion. Staff lacked effective organisation and leadership of shifts. However, a new manager had been appointed and was due to commence their role the week after our inspection.

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

People's medicines were managed and administered to them effectively and safely. There were enough staff to meet people's needs. Recruitment processes needed improvement, but the management consultant told us that this was known about and action was planned.

Staff received the necessary training and had regular supervisions. People had access to healthcare professionals when needed. We received mixed views about whether people were offered choices about what to eat.

Staff were caring and kind. They treated people with respect and consideration. Staff attended promptly when people required their assistance and pre-empted people's needs appropriately.

The service had undergone a period of considerable change since our previous inspection in November 2016. Much of this change had occurred in the six weeks prior to this inspection. However, we were satisfied that the recent engagement of the management consultancy team would help to bring about the necessary improvements.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Some risks relating to the support people received, and environmental hazards were not safely managed.

Sufficient staff were available to meet the needs of the people living in the home.

Suitable arrangements were in place to ensure that people received their medicines as prescribed for them.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's consent was obtained on a day to day basis. However, the service could not demonstrate that they were following the principles of the MCA and DoLS when supporting people to make more significant decisions.

People's healthcare needs had been determined and were met.

Is the service caring?

Good

The service was caring.

Staff supported people in a patient and kind manner.

The atmosphere in the service was relaxed and people were listened to.

People were supported to see their relatives and friends.

Is the service responsive?

Good

The service was responsive.

Staff were able to respond to people's needs in a timely manner.

People had choices about how they spent their time.

People and their representatives understood how to make a complaint.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Improvements were being made, but there was still work required to ensure that the auditing system was completed and that the day-to-day management of the service was robust.

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 19 April 2017 and was unannounced. The inspection team consisted of one inspector and an inspection manager.

Prior to this inspection we liaised with the local authority and reviewed information held about the service. We reviewed statutory notifications we had received from the service. Providers are required to notify us about events and incidents that occur in the home including deaths, serious injuries sustained and safeguarding matters.

During this inspection we spoke with four people living in the home and relatives of one person using the service. We also spoke with three staff members, the acting manager, the new manager, the provider's representative and a management consultant.

We made general observations of the care and support people received at the service. We looked at the medication records of four people living in the home and care records for four people. We viewed records relating to staff recruitment as well as training and supervision records. We also reviewed a range of maintenance records and documentation monitoring the quality of the service.

Requires Improvement

Is the service safe?

Our findings

Our previous inspection in November 2016 identified a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because risks to people had not been managed in relation to behaviour that challenged. One person did not receive the support they required to eat their meals safely. We had also identified potential risks to people from the contents of an unlocked room. The water maintenance control measures in place were not robust. This April 2017 inspection found that most of these concerns had been remedied, but concerns remained in relation to the water system.

A full legionella risk assessment had been carried out. Thermostatic valves used to ensure that hot water taps were kept at a safe temperature had been fitted to rooms on the ground floor. These were yet to be installed on the first floor, but this work was due to be carried out in coming weeks. We sampled several taps on the first floor. The temperature from each tap was too hot for us to keep our hand under the water stream. One room had hot water coming out of the cold tap and vice versa. On the ground floor in a small lounge was a radiator with a very hot unprotected surface. When this was raised with the provider's representative the radiator was turned off pending repair. These concerns meant that people were at risk of scalding.

Drink thickener used to thicken drinks for people at risk of choking was left unsecured in the kitchen. Some people who were mobile and living with dementia resided in the home. There was a risk that if someone accidentally ingested this substance their airway could become blocked.

One person had been assessed by a health professional as requiring thickened drinks to reduce their risk of choking. However, we observed that this person had been given a drink that was not thickened. The person told us that sometimes their drinks were not routinely thickened. This meant that staff were not consistently supporting this person to drink safely.

We spoke with a member of staff who had been supplied by an employment agency. They told us that this was their first day working at the home. However, they had not been shown around the premises and instructed about emergency exit arrangements. Consequently, in the event of an emergency they may not have known what action to take in order to help people remain safe.

These concerns meant that the provider was still in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service was no longer using the computerised care record system previously in place. There was now a standard set of risk assessments in place that were completed in respect of each person. This was supplemented by additional risk assessments for specific areas of risk if necessary.

Risks to people's wellbeing had been identified and plans were in place to reduce the risks. We found a good standard of guidance for staff to reduce risks to people in relation to several areas including falls, pressure areas and assisting people to move safely.

However other risk assessments required improvement and had not been carried out with enough consideration of the individual's wishes or abilities. Some were mainly based on tick boxes, for example, the standard risk assessment used for people leaving the home. There was little space for additional explanatory information and what space there was tended not to be used on the care records that we reviewed.

This risk assessment did not determine the circumstances under which people might wish to leave the home or whether they had the cognitive ability to understand the risks this might present. One of the risks staff had indicated for one person was that they might get lost and they had a lack of traffic awareness. The person told us, "I only wanted to go to the shops up the road to get some chocolate." The person had full mental capacity and the shop was 150 metres away. Therefore, their risk of getting lost and having a lack of traffic awareness may not have been correctly determined. Consequently, some of the risks assessments in place were not sufficiently personalised.

Our previous inspection in November 2016 identified a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because some incidents of behaviour that challenged had not been reported to the local authority as safeguarding referrals.
This inspection found that incidents requiring referrals to the local authority were being reported as necessary.

However, one person who had a Deprivation of Liberty Safeguards authorisation in place needed staff to be present when they were in the grounds of the home. However, a staff member had left them unattended in the garden and the person left the premises for approximately four hours before being returned by the police. Staff had not acted appropriately to ensure this person was protected from the risk of harm.

Consequently, the provider was still in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We reviewed the recruitment records for two staff members. The provider had ensured that references and Disclosure and Barring Service (DBS) checks had been satisfactorily carried out in respect of both staff members. However, improvements were required to ensure the process was robust.

The recruitment records showed one staff member's leave to remain in the United Kingdom was due to expire in four months' time. The provider's representative had not been aware of this. There was also no proof of address on record for this person. The most recent Disclosure and Baring Service (DBS) certificate was dated December 2015. The provider's representative told us that there was a more recent check carried out, but that they had not recorded the details of it.

We looked at the staffing arrangements in the home. One person told us, "Oh yes, there's enough staff here." We found that there were enough staff to meet people's needs. There were 18 people living in the home, three of whom were in hospital at the time of our inspection. On morning shifts there were four care staff, afternoons there were three care staff and two staff were required overnight. In addition there was normally an activities staff member working between 10am to 4pm who could assist with care tasks when necessary, as well as the manager. There were also kitchen and domestic staff on duty.

On the day of our inspection the provider's representative, the acting manager, a management consultant, a compliance officer and the new manager who was due to take over the week following our inspection were also present.

We found good practice in the management and administration of people's medicines. Records showed times of medicines administration so that staff could ensure that appropriate timing gaps were maintained between doses of the same medicine. This was particularly important to support people living with specific health conditions where the timing of their medicines was crucial to ensure that the beneficial effects did not wear off.

We saw clear recording that showed when people's medicines had been discontinued, stock levels were regularly checked and protocols were in place to provide guidance for staff when it was appropriate to administer medicines prescribed for use 'when required'. Medicines were stored safely and within an acceptable temperature range.

Requires Improvement

Is the service effective?

Our findings

Our previous inspection in November 2016 identified a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The November 2016 inspection had found that staff did not always seek people's consent. Some mental capacity assessments held conflicting or incorrect information and a DoLS (Deprivation of Liberty Safeguard) application had not been made to the local authority to request authorisation to deprive a person of their liberty in order to help keep them safe.

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 particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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). We checked whether the service was working within the principles of the MCA.

This April 2017 inspection found that concerns remained. Several DoLS applications had been made since our previous inspection. However, they did not always show why people were being deprived of their liberty or show what alternatives to the restriction had been considered in order to keep people safe.

Some risk assessments and the resulting risk management plan had been agreed and signed by people's family members. For example, two people's records that we reviewed showed that relatives had signed to say that the person had consented to leaving the home when accompanied by staff only. There was no authority recorded in either case to show that the relative was able to make decisions on behalf of their family member. One of the two people told us that they had not agreed only to go out with staff. They said, "They told me that I wasn't allowed to go out."

We were told that one person was using equipment to help keep them safe which they had agreed to. There was no mental capacity assessment for the use of this equipment or evidence of a best interest's decision having been made. A local authority DoLS assessor had subsequently determined that the person lacked mental capacity in relation to issues regarding their safety. There was no process to assess people's mental capacity to determine whether people were able to make significant decisions in relation to their care.

Consequently, we found that the provider was still in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However, during the day of our inspection we saw that staff sought people's consent before providing care or support. Staff had received training in the MCA and DoLS. People were assisted to make their own decisions when necessary, for example by staff offering them choices about how to spend their time.

Most people were positive about the food. One person told us, "You can't fault the food." However, we received mixed feedback about what choices were available. One person said, "I get a choice of one, but if I don't want that then they'll get me something else." Lamb or chicken were the two options on the menu board for lunch. We asked one person what they had chosen. They told us, "I wasn't asked which, but I like them both anyway." During lunch we saw that orange squash was poured into people's glasses without an alternative being offered.

Later on during our inspection we saw care staff offering people a choice of what to have for tea. We overheard two people speaking to each other. One was heard to say, "This doesn't happen usually does it?"

Some people told us that they did get the food they asked for. One person liked to have their breakfast served in a particular way and this was arranged. However another person told us that they had twice been served shepherd's pie and they didn't like mince. On the day of our visit one person had been served boiled potatoes, despite their records saying that they didn't like them. The person told us, "It's okay."

There were few records to show that people were routinely offered a choice of what to have to eat. The provider's representative told us that they were confident that people were given choices about what to eat. Due to the poor spoken English of the cook on duty we were unable to converse with them very easily, so it was possible that people living in the home were not always clear about the options available to them.

Some people required assistance to eat and drink and they received this. We saw that people who chose to stay in their rooms had drinks and snacks available. If people's drinks had gone cold we saw that replacements were offered. Drinks and snacks were also available in communal areas and staff frequently offered refills.

A staff training matrix showed which training that staff had undertaken and which training they were due to refresh. Subjects included safeguarding, health and safety, medicines management, moving and handling and infection control.

The provider had engaged the services of a management consultant. A review was being undertaken in relation to training. Some changes due included staff training on a nutritional risk assessment tool, and a senior staff member was to be given enhanced training in medicines in order to help support other staff in this area.

A programme of staff supervisions was in place and with the support of the management consultant these were being increased to a two monthly basis. The first of these had taken place. Staff told us that they felt supported and that there were lots of colleagues available with whom to discuss matters or ask questions.

People were supported to maintain good health and had access to healthcare services. We saw evidence that the provider made a variety of referrals to external health professionals when needed. People were supported by a wide range of health professionals. These included GP's, community nurses, the Speech and Language Therapy (SALT) team and the falls team. Staff sought and utilised the guidance from these professionals to help ensure that people's healthcare needs were met.

Good

Is the service caring?

Our findings

People and their relatives were complimentary about the care and support received. One person told us, "I'm very happy here." A second person said, "I'm treated well by staff here and they look after me."

Throughout our inspection we observed a relaxed and calm atmosphere in the service and a lot of interaction between people and staff. Staff displayed a gentle and patient approach throughout the day. The interactions we observed between staff and people were caring and compassionate. Staff acknowledged people they were in contact with in a friendly and welcoming way and took time to chat with people's relatives when they visited. One person's relative told us, "Staff make me feel very welcome and offer me drinks and biscuits. My [family member] likes this as this is what they would have done if they had been living at home."

One person had fallen and we saw that staff provided re-assurance and comfort. The appropriate checks were carried out and staff informed the person how they were going to get them up and talked them through the process. This was all done in a calm way which helped lessen any anxieties the person was experiencing. The GP had been due to visit the home shortly to carry out visits to other people. Whilst the person had reported no injuries and no injuries had been found, staff had asked the GP to have a chat with the person to make sure. We spoke with the person later on. They told us, "I'm fine. They got me up no problem and the GP double checked too. Wasn't that nice?."

Conversations we heard demonstrated that staff had a good understanding of the needs and interests of the people they were caring for and supporting. We heard conversations taking place about people's families and places people had visited. Staff took time to get to know people.

The new manager, who was due to take up their role formally the week after our inspection, had spent several days shadowing the acting manager and working as a carer on shifts, including a night shift. On the day of our inspection they spent much of their time chatting with people living in the home and getting to know them and their visitors. People we spoke with were able to tell us who the new manager was.

People told us that their views were sought and acted upon. Records showed people's preferences in the way that they wished to be supported.

Mostly we observed that staff were respectful of people's dignity and privacy. However, the rooms of two people who were in hospital had not been locked. When the GP visited, their consultations with two people were carried out in the main lounge. This did not uphold people's privacy or dignity.

Good

Is the service responsive?

Our findings

People's needs were assessed prior to their admission to the home to determine whether or not the service could provide people with the level of support they required. Two people we spoke with confirmed that a staff member came out to visit them and spoke with them about what they would like assistance with, what they could do for themselves and their preferences.

We found that information available for staff about how to support individuals was detailed and accurately recorded. We saw from the care records that people's health and support needs were clearly documented. Whilst we were satisfied that people's health needs were met and that they had access to health professionals, we did not always see relevant information of concern that preceeded the health professional's intervention. For example, we saw that one person had recently been prescribed antibiotics for a chest infection. However there was no information about any health concerns up to the point that the GP had visited.

We saw that people's requests were responded to promptly during our inspection. Staff anticipated people's needs and requests and often identified when the person required support before the person mentioned it. For example, staff members noticed if people appeared to be uncomfortable when sitting in the lounge and approached them to see if they needed any assistance.

Staff offered people individual choices about their care and respected their wishes. For example, one person told us, "I can have a bath when I want one. I had one yesterday and I'll have another one tomorrow." We saw that one person preferred to get up later in the morning. Staff periodically checked on the person during the morning and offered them support when they were ready to get up. The person looked relaxed and happy when they were up and dressed, and in time for their midday meal.

One person told us, "There's things set up here for us in the day. Sometimes I join in, but often I'm happy enough just watching." A second person said, "There's enough going on here for me."

People's care plans recorded what their interests were and what they liked to do through the day. Some people preferred their own company and did not wish to join in group activities and instead liked to read or watch television in their rooms. Others preferred the company of other people and liked to sit in the busy lounge, joining in group activities on offer. There was also a smaller, quieter lounge. Some people preferred to spend their time here or have their lunch in this room.

On the day of our inspection there were no staff on duty specifically supporting people with their interests. However, we saw from staff rotas that this was not usual. Pictures displayed in the home showed that a wide variety of activities were available if people wished to participate. On the day of the inspection due to the numbers of staff in the home, including two managers and the provider's representative, staff were able to spend time chatting generally with people and their visitors. Everybody was seen to be enjoying this.

The service had a complaints procedure and posters on walls were clear and encouraged people to raise

any concerns they might have. People we spoke with were aware of who to speak with if they had any concerns.

Requires Improvement

Is the service well-led?

Our findings

Our previous inspection in November 2016 identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to the governance arrangements in the service. The November 2016 inspection found that there was little effective oversight of a new role created in the service, auditing arrangements had not been robust and some care recording charts were not being fully completed. This April 2017 inspection found that some improvements had been made, but that there was still further work to be done.

Water temperatures were not always being recorded for all outlets tested during the monthly 'scalding check'. Sometimes 'no valve' had been recorded rather than a temperature. This was an ineffective audit that had not alerted the provider to the risks presented by high water temperatures.

During this inspection we had found some issues in relation to the recruitment processes. The management consultant told us that they were due to implement a checking process which would help improve this.

We were concerned about the accuracy of some statutory notifications submitted to us. These notifications had often required clarification. We had been notified about the incident where one person had left the premises and been reported missing to the police. However, the circumstances as advised to us in the notification were substantially different to those told to the local authority's safeguarding team.

Robust checks were required to ensure that people's care plans contained accurate information. For example, one person's care records held contradictory information about the person's ability to dress themselves. This had resulted in staff not offering the necessary support when required. The person told us that staff didn't seem to know that they needed assistance with this.

Whilst staff were receiving the necessary training there was not sufficient oversight of the day to day practice of staff. This was evidenced by the issues we found relating to the usage and storage of drink thickener, meal options being clearly communicated to people, and the lack of privacy afforded to people during the GP's visit.

At times there were more staff than people in the lounge. The beginning of the lunch time period was disorganised. People were repeatedly approached by different members of staff asking if everything was okay. Effective leadership was required to better organise staff and ensure that their day to day practice was providing people with an appropriate standard of care and support.

Consequently, the provider was still in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

An infection control audit had been carried out in April 2017 but this was mainly focused on policy and procedures. It asked whether the home was clean, but did not show which areas or rooms in the home had been sampled to make this determination. We found that the home was clean. However, had it not been,

this audit would not have identified this. It said that staff used gloves and aprons appropriately, but again there were no observations to confirm that this was happening in practice.
The registered manager who was in post at the time of our previous inspection in November 2016 had left the service. An acting manager was due to handover the day to day running of the service to a new manager the week after this April 2017 inspection.

A management consultancy group had been supporting the home for about six weeks at the time of our inspection. They told us that their role was to revise care plans, management records and oversee staff training arrangements. We saw the service development plan in place and progress was being made in line with planned timescales. The changes to management records were an improvement to what had been in place previously. We were satisfied that improvements were being made. However, the service was at a relative early stage with this work as the management consultancy group had only been supporting the home for a relatively short period of time.

The service was continuing to make improvements and had experienced significant changes since our November 2016 inspection. Many of these changes had taken place in the two month period prior to this inspection. In this period a new management consultancy team had been engaged and a new manager had been appointed and was due to commence their role. This was the fifth inspection of this service since June 2015 and considerable progress had been made since this time. However, the provider was yet to fully demonstrate that improvements could be further built upon or that those made would be sustained.

There was a pleasant atmosphere in the home. The views of people living in the home and staff were sought on a regular basis through general conversations and meetings. A recent survey completed by people living in the home showed that they were satisfied with the care and support they received.

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 11 HSCA RA Regulations 2014 Need for consent The provider had not acted in accordance with the requirements of the Mental Capacity Act 2005. Regulation 11 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure that appropriate actions were taken to mitigate risks to people's welfare. Regulation 12 (1)

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 The provider had failed to implement robust processes to safeguard a person subject to a DoLS authorisation in order to keep them safe. Regulation 13 (1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not operated effectively to assess and monitor the safety and quality of the service people received. Regulation 17 (1)