Parkside Care Limited

Northlands Care Home (Northumberland)

Inspection report

Northlands Nursing Home
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Northumberland
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Northlands Care Home (Northumberland) is a residential care home providing accommodation and personal and nursing care and treatment of disease and disorder to up to 39 people. The service provides support to people with a physical disability or medical need and older people, including people who are living with dementia. At the time of our inspection there were 37 people using the service.

People's experience of the service and what we found:
People were not always protected from risk and actions to mitigate risks were not always in place. Lessons were not always learned when there had been accidents or incidents. The home was in organisational safeguarding because the local safeguarding team had identified a number of concerns. Actions had not always been taken to address these concerns or keep people safe. People told us there were enough staff to support their daily care needs. However, staff were not always deployed efficiently, and some areas of the home were not always well observed. We found some minor issues regarding support with medicines and infection control.

People were not always supported to access appropriate food and fluids. Care records did not always reflect the most up to date advice and fluid intake records indicated recommended fluid intake levels were not always met. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. People were subject to restriction on their freedom. Whilst these restrictions were to ensure their safety, actions had not been taken in line with the requirements of the Mental Capacity Act. Staff training required further action to address previously identified shortfalls.

Quality monitoring at the home was not consistent. Checks and audits failed to identify shortfalls in care and incomplete records. The provider had not written formally to individuals, offering explanations and apologies following accidents or untoward events. People were involved in care decisions and said staff treated them well. The provider was looking to address the shortfalls and had recently appointed a new quality manager who was working on improvements.

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 Good (Published 12 September 2019)

Why we inspected
The inspection was prompted in part due to concerns received about keeping people safe, delivering the right care to support people, and staffing. A decision was made for us to inspect and examine those risks.

We undertook a focused inspection to review the key questions of safe, effective and well-led only. For those

key question not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Northlands Care Home (Northumberland) on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to managing risks at the home, ensuring people did not suffer from avoidable harm, supporting people to maintain a balanced diet, ensuring where people could not consent to care appropriate processes were followed, staff training and support, maintaining a robust oversight on the quality of care and responding to the provider's duty under duty of candour.

We have made recommendations to the provider regarding improvements to staffing and the safe management of medicines.

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, which will help inform when we next inspect.

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 of 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 effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well led.

Details are in our well-led findings below.

Northlands Care Home (Northumberland)

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 Health and Social Care Act 2008.

Inspection team
The inspection team consisted of 1 inspector who visited the home. Another inspector assisted by remotely reviewing evidence sent to us by the provider.

Service and service type
Northlands Care Home (Northumberland) is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Northlands Care Home (Northumberland) is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
The inspection was unannounced.

What we did before the inspection
We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We also spoke with the local safeguarding adults team and the local authority commissioning team to gain their view on the care provided at the home.

During the inspection
During the inspection we spoke with 6 staff members including the registered manager, the provider's representative, the quality lead, a cook, a domestic and a care worker. We also joined safeguarding staff attending a meeting with a wider staff group to discuss their views on the service. Contact details for one of the inspectors was circulated to all staff offering email contact to gain their views. There were no staff responses to this offer. We also spoke with 3 people who used the service and 2 relatives.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question Good. At this inspection the rating has changed to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management
• The provider did not always assess risks to ensure people were safe. Staff did not always take action to mitigate any identified risks.
• Risk assessments in care plans were not fully completed or lacked detail and did not always reflect the actual risk to people who were receiving care.
• People were identified in local authority or continuing health care assessments as being at high risk of falls or high risk of choking. Care plans did not reflect this risk, identified risk levels as medium and lacked detail about how people should be kept safe.
• Care plans did not accurately reflect people's health conditions and the risk associated with these. One person was at high risk of skin damage, but their care plan made no mention of this, and the action required to mitigate possible skin integrity issues.
• Health and safety audit documents were limited and mainly tick box in nature. They failed to identify a range of issues including the storage of equipment in corridor areas, which presented a potential trip hazard. The door to the laundry area, which was accessible to people living at the home was left unlocked on a number of occasions. The provider subsequently informed us the lock on the laundry door had been replaced.

This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were placed at risk due to effective systems to monitor and mitigate risk not being in place.

• Checks on equipment used at the home were in place and checks of electrical systems, hoists and other services at the home were carried out in a timely manner.

Systems and processes to safeguard people from the risk of abuse and avoidable harm; Learning lessons when things go wrong
• The provider did not always learn lessons when things had gone wrong.
• People were not always safeguarded from abuse and avoidable harm.
• At the time of the inspection the service was in organisational safeguarding. Organisational safeguarding is a process used by the local authority when there are multiple concerns about people's care and safety at the home.
• The local safeguarding team had raised a number of concerns about the care at the home and were working with the provider on an action plan to improve matters.
• There had been a number of incidents at the home including unexplained bruising. These matters were not always identified or referred to the adult safeguarding team in a timely manner.

• Reviews of people's falls and accidents was not always undertaken thoroughly and actions to mitigate or prevent future falls were not always considered or instigated.
• Reviews of accidents and trends at the home were of limited quality and identical actions were documented each month.
• There was limited evidence that action had been taken to learn lessons when things went wrong. People's individual care records did not always highlight previous accidents or falls.

This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were place at risk due to limited action in reviewing and mitigating further falls and accidents.

Staffing and recruitment
• The provider did not always ensure there were sufficient numbers of suitable staff.
• The provider did not use a dependency tool to determine the level of support people needed with their care. The provider's own staffing policy stated that a dependency tool should be used to determine the right numbers of staff on duty, and that this should be regularly reviewed by the registered manager.
• There were no staff continuously deployed on the lower ground floor, despite people living on this floor who had high levels of care needs. The registered manager told us staff regularly checked on people on this floor. On the third day of the inspection the registered manager told us they had established a system in electronic records to ensure staff checked the floor at least hourly.
• On the third day of the inspection the provider told us they were looking at introducing a dependency system to support staffing numbers at the home.
• People and relatives told us that there were enough staff to support needs and staff responded appropriately when they summoned help.

We recommend the provider continuously review staffing numbers and people's care requirements to ensure there are sufficiently trained staff to meet people's needs.

Using medicines safely
• People were supported to receive their medicines safely.
• Medicine records were largely up to date and medicines were managed appropriately.
• Some people were prescribed medicines that needed to be taken at least 30 minutes before food. Records indicated that these were often given late in the morning, and we could not be sure they were taken within the appropriate timescale. We spoke with the registered manager about this.
• A review of medicines by a local pharmacist took place in February 2023. One of their recommendations was to record the date creams and liquids were opened, to ensure they were not used beyond their expiry date. We found this practice was inconsistently followed.
• A small number of people were prescribed topical medicines (Creams and lotions). There were no body map records to show where the creams should be applied and inconsistent recording of their use.
• People told us they received their medicines in a way which helped them, and we observed staff managing medicines appropriately.

We recommend the provider review the systems in place to manage medicines, including time specific medicines and topical applications.

Preventing and controlling infection
• People were protected from the risk of infection as staff were following safe infection prevention and control practices.
• Most areas of the home were maintained in a clean and tidy manner and toilets and bathroom areas were

clean, although there were several gaps in cleaning records maintained by domestic staff.
• There were some areas of the home where malodours were present. Staff were working to address these.
• Staff had received training on infection control and had been observed to ensure they carried out effective hand washing.
• Domestic staff were not always wearing personal protective equipment when carrying out cleaning in people's rooms. We spoke with the registered manager about this. They said they would speak with domestic staff immediately.

Visiting in Care Homes
• People were able to receive visitors without restrictions in line with best practice guidance.
• Relatives told us they could visit the home at most times and were welcomed by the staff.
• Relatives said they could spend as long as they wished with their loved ones. People were supported to keep in contact with friends and family.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question Good. At this inspection the rating has changed to Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Supporting people to eat and drink enough to maintain a balanced diet; Supporting people to live healthier lives, access healthcare services and support
• People were not always supported to live healthier lives, access healthcare services and support.
• People were not always supported to eat and drink enough to maintain a balanced diet.
• Care records did not always demonstrate that people had been taking fluids in line with their assessed need.
• Fluid charts maintained at the home consistently showed people were not drinking enough fluid to maintain their wellbeing. The provider told us they felt this was a records issue as the home had only recently commenced recording this information for all people.
• Care plans did not always reflect the professional advice or risk category. One person was identified in a review as being at high risk of choking, but their care plan listed the risk as medium. The registered manager subsequently spoke with the speech and language therapy team about how best to support this person.
• One person was supported to get their nutrition through a feeding tube directly into their stomach. The person's food and fluid care plan did not include detailed instructions as to how this process was to be managed and what action staff needed to take to keep the person safe.
• Reviews of people's Malnutrition Universal Screening Tool (MUST) were not always detailed and did not always reference people's weight. There were no actions recorded when people's MUST score changed.

This was a breach of regulation 14 (meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were place at risk because proper system to review and maintain nutritional ad fluid in put were not in place.

• People told us they enjoyed the food provided at the home. We saw the type of meals on offer and the quality of the food had been discussed at 'residents' meetings.'

Ensuring consent to care and treatment in line with law and guidance
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 MCA 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 to receive care and treatment with appropriate legal authority.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguarding (DoLS)

• The provider was not always working in line with the Mental Capacity Act.
• Several people living at the home had restrictions in place for their own safety. For example, the use of bed rails, mattresses by the side of their bed to prevent injury and lap belts when sat in chairs. There were no best interests decisions in place to document that these actions had been considered in line with the MCA and that the action taken was the least restrictive possible to maintain people's wellbeing. Best interests decisions documents rewritten during the inspection, continued to fail to demonstrate the actions implemented were the least restrictive possible.
• Consent for care was not always obtained in line with MCA and legal requirements. Records indicated individuals had given consent for care and support, or for treatments such as vaccinations. However, records demonstrated people did not always have capacity to make informed choices and there was no indication of a capacity assessment being undertaken when gaining this consent. Some records indicated relatives had given consent when they did not hold lasting power of attorney or legal powers given through the courts.

This was a breach of regulation 11 (need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were placed at risk and their freedom restricted because appropriate system to ensure the service complied with the MCA were not in place.

Staff support: induction, training, skills and experience
• The provider did not always make sure staff had the skills, knowledge and experience to deliver effective care and support.
• The local authority safeguarding team had highlighted a range of areas where staff required additional training, or their skills updated. The provider had instigated a review if training and required staff to complete various modules. There were still gaps in this training and the registered manager told us outside professionals were still looking to confirm dates when they could provide additional training.
• Staff had received supervision and appraisal sessions with the registered manager or senior staff. Supervision records were mainly tick-box in nature or consisted of lists of actions under a specific heading, such as safeguarding. There was limited evidence of staff interaction with the process. Appraisals were equally limited in detail, with no evidence of staff active involvement in the process. There were limited objectives set during appraisals with no indication these had been reviewed or updated.
• Where agency staff were used to support permanent staff at the home, we found two instances where agency staff had been employed without the service reviewing information to ensure they had the right skills. Induction records for agency staff were mainly tick box and limited in detail.

This was a breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were placed at risk because effective system to ensure staff had the right skills and support were not always in place.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's needs were not always assessed, care and support was not always delivered in line with current standards. People did not always achieve effective outcomes.
• There was some evidence of assessments on people's care records. Although these assessments were not always in line with professional advice or information contained within review documents.
• Care records contained some information to indicate people had made positive choices about their care, including: how staff supported them, what they liked to eat and activities they enjoyed. People told us staff supported them well and took account of their personal preferences and individual choices.

Staff working with other agencies to provide consistent, effective, timely care
• The provider did not always ensure the service worked effectively within and across organisations to deliver effective care, support and treatment.
• The local safeguarding adults team had raised concerns people had not always received care and support in a timely manner. They were currently investigating a number of instances where people may not have received the care and support they needed, or where concerns had been raised by hospital staff following admissions.
• The local safeguarding team told us the service had been receptive to their intervention and was working with them to address issues highlighted. An action plan was being followed to ensure required improvements were being made.

Adapting service, design, decoration to meet people's needs
• People's individual needs were met by the adaption, design and decoration of the premises.
• The design and layout of the building met and supported people's needs.
• There were a range of facilities for people to use, including lounge areas and a hairdressing area.
• Staff had taken time to decorate the home in time for the Christmas period.

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 our last inspection we rated this key question Requires Improvement. At this inspection the rating has changed to Inadequate. This meant there were 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 provider did not have an effective management structure. The provider did not monitor the quality of care provided in order to drive improvements.
• Audits and checks undertaken at the home were functional and frequently tick box, with little or no actions identified to improve the quality of care.
• Audits were undertaken on care plans, but these had failed to identify risks and did not reflect those areas highlighted by professional review documents. Reviews of care plans had also failed to identify that restrictive actions were not in line with the Mental Capacity Act.
• Care plan audits had failed to identify that people's fluid intake was not in line with the required daily intake level and MUST reviews were not detailed.
• Accident and falls were not effectively reviewed and there were limited actions to mitigate this risk.
• Medicine audits had failed to note pharmacy advice on creams and liquids was not consistently followed.
• Supervision and appraisals were of limited value and objectives were either not set or reviewed irregularly.

This was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were placed at risk because effective system to monitor and improve the quality of care at the home were not in place.

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 provider did not fully understand their responsibilities under the duty of candour.
•The registered manager told us they had not formally responded to accidents or incidents in line with the duty of candour within the last 12 months. They told us they were not fully aware of when an incident would require a duty of candour response.
• There were a number of incidents which would fall within the requirements of the duty of candour regulations, had not been responded to with a written apology and explanation of action taken to reduce future risks. The registered manager told us she had called and spoken with families but had not formally written to them.

• This was a breach of regulation 20 (duty of candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service had failed to follow the requirements of this regulation and provide families with a full explanation and apology where things had gone wrong.

Continuous learning and improving care
• The provider had not consistently created a learning culture at the service which meant people's care did not always improve.
• The local safeguarding team had highlighted a number of areas that required addressing around staff training and knowledge. Action was still required to fully address these.
• Some areas of care had also been highlighted by the safeguarding team. Whilst individually matters had been addressed it was not clear that lessons had been learned across the organisation.
• The provider had recently employed a new quality manager to work across the organisation. They had quickly identified areas that needed improvement and were progressing changes to bring about quality improvements.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• People and staff were involved in the running of the service and fully understood and took into account people's protected characteristics.
• There was a positive and open culture at the service.
• The provider did not always have effective systems to provide person-centred care that achieved good outcomes for people.
• Care records were not always detailed and did not take into account the most up to date information about the person and their needs.
• People told us they were happy with the care they received and found the staff pleasant and approachable. People told us, "Yes, I am well looked after. They have a nurse on duty 24/7 and I'm very pleased about that. I wouldn't want to go anywhere else" and "I'm very well looked after by friendly and efficient staff. We talk about care, and I talk things through with them." A relative told us, "I come here every week. They are well looked after, I can't complain."
• Staff told us they were well supported by managers at the home and any concerns were responded to. They told us any issues with equipment were quickly rectified and often resulted in new equipment being purchased.
• There were regular staff and 'resident' meetings. People were involved in decisions about activities and food. One person told us they had fed back to the provider about their experience on food. They said, "They introduced a new frozen food system for meals, which I wasn't sure about. So, I kept a record and fed back my experience. It was 80% good and 15% satisfactory."

Working in partnership with others
• The provider worked in partnership with others.
• There was some evidence in care records that they service worked with a range of other professionals.
• The local safeguarding team told us the provider had been responsive to concerns and was working to address any shortfalls in care.

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 11 HSCA RA Regulations 2014 Need for consent Systems to ensure consent were nots fully considered and any restrictions had not been instigated in the person's best interests and in line with the MCA. Regulations 11 (1)(2)(3)(5).

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 Systems and processes to ensure the service operates effectively and to promote safety and quality were not in place. Systems to assess, monitor and improve quality and safety and mitigate risks were not rigorously implemented. The maintenance of accurate, complete and contemporaneous records was not followed. Regulation 17 (1)(2)(a)(b)(c)(d)(f).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 20 HSCA RA Regulations 2014 Duty of candour Systems to ensure the registered persons were acting in an open and transparent manner were not followed. Regulation 20 (1)(2)(a)(b)(3)(a)(b)(c)(d)(e)(4)(a)(b)(c)(d)(5)(a)(b)(6)(7)(9)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Systems to ensure sufficient suitable qualified,

Treatment of disease, disorder or injury	competent and skilled staff were not in place. Staff did not receive appropriate support, supervision and appraisal to carry out their employed duties. Regulation 18 (1)(2)(a).