FitzRoy Support

Northfields

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

About the service
Northfields is a residential care home providing personal and nursing care to seven people with learning disabilities and autism .

The care home accommodates seven people in two linked bungalows. At the time of the inspection visit there were seven people living in the home.

The service was developed and designed in line with the principles and values that underpin Registering the Right Support and other best practice guidance. This ensures that people who use the service can live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence. We found that the service had deteriorated since it's last inspection and was no longer fully meeting these principles.

People's experience of using this service and what we found

The service did not always consistently apply the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence.

The outcomes for people did not fully reflect the principles and values of Registering the Right Support for the following reasons; people did not always receive safe, person-centred care according to their individual needs and preferences.

Risks to people concerning their health and environmental risks were not always recognised and adequately mitigated. There were concerns about the cleanliness in the home.

There were not enough staff at night to ensure people were safe and their needs were met properly. This negatively impacted their independence, comfort and dignity.

Shortfalls had not been identified and sufficiently acted upon by the provider. There was not always evidence of learning from incidents and improving the service accordingly.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems did supported this practice. However, records around mental capacity, consent and best interests' decisions required improvement.

People did not always receive individualised care according to their needs and preferences. Care plans were not always consistent and accurate.

Initial care plans did not always contain sufficient guidance for staff, and care plans were not properly developed in a timely way.

People were supported to have a choice of meals and enough to drink.

Staff knew people well and had built good relationships with them. Staff worked well as a team and supported people to go out and follow their interests.

Medicines were stored and administered safely.

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 January 2017), with requires improvement in the responsive key question.

Why we inspected

This was a planned inspection based on the previous rating.

We have found evidence that the provider needs to make improvements in all key questions. We have identified four breaches in relation to risk assessment, safe staffing levels, person-centred care and governance at this inspection. Please see the full report.

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

Follow up

We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will request an action plan for 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 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 effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Northfields

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.

Inspection team
The inspection was carried out by one inspector and one assistant inspector.

Service and service type
Northfields 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.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. 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 of this information to plan our inspection.

During the inspection
We spoke with three people who used the service and one relative about their experience of the care provided. Due to people living with communication difficulties, the conversations we had with people living in the service were brief. We spoke with seven members of staff including two night care staff, three day care staff, the registered manager and the deputy manager. We also observed support and interactions in communal areas across the service.

We reviewed a range of records. This included three people's care records and a section of a further one, as well as three people's medicines administration records (MARs). We looked at a variety of records relating to the management of the service, including, training, staff rota, incident forms and health and safety documentation.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at additional care planning, risk assessment and incidents records.

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 Good. 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

- People's pressure area risk assessments were not sufficient which meant risks of pressure ulcers were not fully mitigated. For two people who were not mobile, there was no pressure care risk assessment in place which gave full guidance around any specific risks and repositioning support requirements.
- There was a risk that staff were not always available to supervise and support people who were at risk, due to there being only one staff member across the two bungalows at night. People who were at risk of falls and required support from two staff to get up from the floor, were mobile at night. For one person, daily records showed they had been up during the night three times in the last week. There had been a recent incident where staff had to call emergency services to support the person getting up from the floor, as it was at night and they were unable to do this alone. Staff also confirmed this.
- For another person, their manual handling risk assessment and care plan had no information or guidance on how to support them to get up from the floor should they fall. The person could be unsteady on their feet and was at risk of falls and seizures.
- According to records, staff reported that another person appeared unsteady on the stairs at night, and this had not been further considered in their risk assessment, care plan or staffing levels. This person was at high risk of seizures.
- There had been a recent incident where one person, who had recently changed from a hoist plus two members of staff to a standaid with one, had fallen down whilst in the standaid. Three members of staff were required to support the person on this occasion. The registered manager told us that at night, one member of staff was sufficient; no further action had been taken to mitigate the risk of this reoccurring.
- For people whose behaviour could challenge others, there were no mitigating factors put in place. This reflects further risk of there being one staff at night who may not be able to deliver care to others when needed.
- There were no environmental risk assessments in place which assessed the need for safety features such as window restrictors or uncovered hot pipes in bathrooms. There were some people at risk of falls and this had not been considered. The risks were further increased for some people who would not be able to get up from the floor with one member of staff if they fell.
- There were not always required checks for legionella risk, such as descaling and temperature checks being carried out in a timely way, according to the risk assessment.
- The fire risk assessment was not being followed; it stated that all staff should participate in a drill. No night staff we spoke with had done this. Furthermore, it had highlighted that there was a higher risk at night but with no further comment or mitigating factors.
- Personal emergency evacuation plans (PEEPs) had not reflected the risk of there being only one staff member at night, and two people could not be evacuated in the case of a fire.

● We noticed that some areas of the home, such as communal bathrooms, were not visibly clean; some areas were dusty and there was limescale in the bathrooms, with dirty shower drains. Not all bins had bin bags in them. There were unidentified urine bottles being stored in all of the communal bathrooms we looked in.

The lack of robust assessment of risk meant people received unsafe care. This meant there was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● The provider had not used a dependency tool to assess how many staff were needed. The registered manager told us they had one member of staff at night. There was no formal assessment of care hours needed, and no assessment of hours required for all duties within the home such as cleaning. There were no domestic staff employed.
● All staff we spoke with said they felt one member of staff at night was not safe. A staff member described working at night as, "If you are next door to change the stoma bag for [person] or respond to [another person], and the other side you have [another person] who can move around and could fall and have an injury, at the same time you have [another person] who is very active at night, and you have to do the cleaning and laundry. Sometimes the moment you do the cleaning and [person] can follow you around when the floor is wet. If you are in the laundry you are not in control of the house." Another said, "If one person is having a seizure you have to watch the others next door." This meant it was not possible for staff to attend to the other people in the event of one person requiring attention.
● The registered manager had taken action to ensure further plans were put in place to further mitigate the risk of some incidents happening again. However, staff told us these plans were not reasonable as people still required two staff despite the guidance put in place.
● Staff also raised the issue of people requiring closer supervision if they had a seizure. One said, "One staff at night is not enough, not really, a lot of these people have got epilepsy." Staff added that risks around some people's behaviour and risks of falls were also heightened due to staffing at night.
● The registered manager told us they implemented staffing based on the funding from the local authority, rather than on what the home required. There was a lack of understanding around the provider's responsibility to ensure there were safe staffing levels to meet people's needs.

The lack of robust dependency assessing of staff required meant that there were not always enough staff on duty to ensure people's safety. This meant there was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded during and after the inspection visit by stating they felt there were enough staff at night and did not plan to alter this.

● The provider continued to maintain safe recruitment procedures and ensured the expected checks were carried out on new staff. This included a criminal record check and references.

Systems and processes to safeguard people from the risk of abuse
● Staff told us they received training in safeguarding, and were able to explain how they would report concerns.

Learning lessons when things go wrong
● Due to shortfalls we identified in safe, we concluded that the provider had not always learned lessons from things going wrong.

● There was not sufficient oversight and analysis of incidents and accidents, which meant improvements were not always made where needed. Sufficient action was not always taken to further mitigate risk following incidents to prevent them from reoccurring.

Using medicines safely

● Medicines were stored safely in individual's bedrooms, secured and at an appropriate temperature.

● Staff administered medicines as prescribed and they received training in this and had their competencies tested yearly or as needed.

● There were detailed protocols in place for medicines used 'as required' (PRN) and we saw these were used only when needed.

● Medicines were reviewed effectively to ensure people were not taking any medicines unnecessarily.

Requires Improvement

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- The registered manager assessed people's needs prior to them moving into the home, however a substantial care plan was not always developed in a timely way. One person's initial interim care plan was used for six months until the full care plan was completed.
- For another person, there was a one page overview of their needs, and staff were still developing the main care plan. However, the interim care plan was very basic. It did not give sufficient detail to provide care as required and had little detail for areas such as diet and equipment used by the person for their health. There was little information about the person's behaviour, which at times could be challenging to others. There was no guidance in relation to triggers prior to the person being upset and how these should be managed.

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 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 to receive care and treatment when this is in their best interests and legally authorised under the MCA.

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

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- We saw that where people lacked capacity to make a decision about their care, they had signed a consent form to receive care. This demonstrated that there was not a full understanding of consent.
- We saw that specific decisions were outlined in a full mental capacity assessment which contained further guidance for staff on making decisions in people's best interests, but these were not reflected in specific records of 'best interests' meetings.
- The registered manager had applied for DoLS authorisations for some people, and we saw that these specified the least restrictive options for people, to ensure they were safe.

Staff support: induction, training, skills and experience

● One staff member told us their recent induction had included shadowing more experienced staff and undergoing training. They said they felt supported and confident in their role when they worked with people.

● Training included epilepsy, dementia, first aid and manual handling. Staff told us they felt supported with training needed to deliver care to people, however they told us they would not know how to deal with a fire at night. Night staff told us they did not always feel well supported because they did not feel one member of staff at night was safe and that they were able to deliver the support people needed.

● Staff had access to supervisions when they required. These provided opportunities to discuss their role with management staff.

Supporting people to eat and drink enough to maintain a balanced diet

● People were supported to have a choice of meals, and the registered manager was planning to discuss menus further with people living in the home. Staff supported people to follow a balanced diet, an encouraged healthy eating.

● Where people had specific dietary requirements, such as a soft diet, staff supported them with this.

● People had access to drinks throughout the day.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● Staff supported people by working with other healthcare professionals such as physiotherapist, dieticians and occupational therapists. However, their recommendations were not always fully embedded into care plans.

● Staff supported people to access healthcare services such as the GP and nurse, and consulted other teams, such as learning disability and mental health, when needed.

Adapting service, design, decoration to meet people's needs

● The service was accessible to people and had accessible outdoor areas. People's rooms were personalised to their own preferences.

● There were communal areas such as a kitchen in each bungalow, and people were able to use this with support from staff. There were also communal lounges, bathrooms and a dining area in each bungalow.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence

- Some people's dignity, comfort and independence was negatively impacted by staffing levels at night. We saw from records there had been incidents where people had been left in soiled beds at night due to staffing shortages. Staff reported another person being uncomfortable due to not being able to move in bed.
- One member of staff felt they were not able to support someone to use the toilet at night due to staffing; they said, "[Management] have advised us not to wake [person] to go to the toilet but [person] could be soaking wet on the bed. We used to prompt [person] to go and use the toilet but now because [person] is more unstable on foot we don't do it, because I'm not able to help alone if they fall." This meant that at times their independence was limited.
- During the day, staff were able to support people to maintain as much independence as possible. One person told us, "I help the staff, check the laundry, wipe up, help staff get the shopping in."

Supporting people to express their views and be involved in making decisions about their care

- A relative we spoke with told us they felt the management team called them to let them know if an incident occurred regarding their family member, or if they were ill.
- We did not always see evidence in people's care plans that they, or family members, had been involved and regularly consulted about their care.

Ensuring people are well treated and supported; respecting equality and diversity

- The relative we spoke with said, "[Staff] are very good. [Person] is always laughing when we go to see them." We saw pleasant, caring and reassuring interactions between staff and people. Staff talked through what they were doing when delivering care to people.
- People's equality and diversity needs were recognised in their care plans, for example if they had any spiritual needs and preferences.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People's daily notes did not always reflect that they received person-centred care as per their care plans during the night. There had been several incidents at night where people had not had support when they needed from staff. This included four incidents where people had not received personal care.
- Records showed that one person in the last week had requested repositioning at night on four nights, more than once, and staff had not been able to deliver this. Staff told us, "[Person] keeps slipping down the bed at night time and the one person cannot reposition them." This meant the person was at increased risk of pressure damage, and this was not further updated or reflected in the pressure care risk assessment.
- Staff did not always support people according to their care plans. For example, one person's care plan stated that they should be referred to a dietician if their weight increased over a certain level. The person's weight had increased over this for several months and no referral had been made to the dietician. For another person, there was inconsistent advice and recording around the amount of prescribed thickener required in their drinks. A dietician visited this person on 18 January 2019; they advised weekly weights due to weight loss. This had not been done and staff continued to weigh the person monthly. They were deemed to be at high risk of malnutrition but their nutrition care plan was not completed.
- Not all aspects of people's care, such as support with wearing hearing aids, were covered in care plans.
- People did not always receive personalised care according to their needs. This was mainly due to staffing levels at night. One staff member said, "I feel like we're depriving [person] as [person] needs at times repositioning in bed. But there's nothing I can do for person." One person had in their care plan that they preferred care from female staff, but there were times there was only one male staff member at night, who also delivered personal care to this person.
- People's needs and preferences had not been taken into account when assessing staffing levels. One member of staff said that at night, "If [people] had to go to hospital they would have to go on their own, I think that's quite scary for the people who can't speak."
- People's care plans were not always kept consistent and reviewed effectively to reflect changes in people's care, and inconsistencies had not always been identified.

The lack of personalised care planned for and delivered meant that the service was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff supported people to engage with activities and follow interests. One person told us, "Me and [person] now had a game of Ludo. We watch films, me and [person] like our soaps. I have my sister come and visit about once a week." A staff member told us, "We have parties, had a BBQ last weekend here, ask [people] what they want to do, draw, paint, play a game." Staff supported some people to go on holidays to the

coast.
● From speaking with staff, they demonstrated that they knew people's needs and preferences well, and strived to meet these where possible.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● There were care plans which contained guidance for staff on how to support people to communicate. We saw that staff adapted their communication to meet people's needs, for example speaking clearly and slowing down.
● Where required, information was available in an accessible, easy read format, for example, parts of the care plan.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
● Staff supported people to go out and attend day services. Some people also went out to do activities of their choice, for example, lunch or shopping, with support from staff. Staff supported some people to go on yearly holidays.

Improving care quality in response to complaints or concerns
● The relative we spoke with said they would feel comfortable to raise any concerns, but they had not done so, because they had no concerns.

End of life care and support
● There were detailed, person-centred end of life care plans in place and some staff had received training in this area.

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 good. 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Following a recent visit from the local authority where concerns were identified, the registered manager had not taken sufficient action to mitigate risks. We found some areas remained a significant shortfall and not all concerns had been resolved.
- There was no formal assessment of care and domestic hours needed. The registered manager did not demonstrate a full understanding of their responsibility to assess staffing levels based on the needs of the service.
- The provider had not taken sufficient action to mitigate risks to staff at night and had not taken action when staff raised concerns about staffing levels. They had not taken sufficient action following incidents which had occurred to ensure staff were protected, and people had their needs met, at night.
- We discussed the cleanliness of the home with the registered manager, who told us that care staff generally covered cleaning. There were no specific plans and schedules in place which were followed, to ensure the home was kept properly clean.
- Contemporaneous notes did not always contain identifiable information such as the person's name, and were not always dated. This meant there was a risk of mislaying, or not being able to identify, records related to people's care.
- The provider had not identified shortfalls in the cleanliness of the service. Their checks were not recorded, so we were not assured they oversaw the running of the service effectively.
- The audit process did not include a system to ensure adequate health and safety checks were completed therefore safety issues had been left unnoticed, such as potential risks around exposed pipes.
- There were no spot checks at night to assess whether staff were able to complete all tasks expected. No quality audit had picked up concerns which affected people's independence, safety, comfort and dignity at night.
- There was not always evidence that the culture of the service encompassed person-centred care. Management systems did not always promote and maintain a person-centred culture within the home where they responded to concerns and incidents. This was because care plans and care delivered was not always reflective of individual needs and preferences.
- There were systems in place which checked and monitored the quality of the service, however some of these were not effective. The service had deteriorated significantly since the last inspection and the provider had not identified this prior to our inspection visit.
- We received mixed feedback about the leadership within the home. Whilst some staff told us the

registered manager was approachable, others said they did not feel this was the case. Staff felt they had raised the issue of staffing at night repeatedly and it had not been acted upon.

Potential problems were not sufficiently foreseen and identified and acted upon in a timely manner. The lack of robust governance systems constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 relative we spoke with felt that the registered manager was open and transparent, and told them if anything happened concerning their relative. However records of incidents did not always show that family members had been contacted if there had been any concerns about their wellbeing or incidents involving them.

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

● The provider had requested satisfaction surveys last in 2018, and the feedback from the people and relatives who completed them was positive.

● We did not see evidence that people using the service and their relatives were actively consulted or involved in the running of the service. However, the registered manager told us they planned to reintroduce fortnightly meetings for people living in the home so they could discuss the service and any issues.

Continuous learning and improving care

● We saw that not all shortfalls had been identified by the provider and acted upon sufficiently. The registered manager had created an action plan to make improvements, and we found some of these had been implemented, however not all. The systems in place required updating in order to identify shortfalls and lead to improving care.

Working in partnership with others

● The home worked closely with two staffing agencies to ensure they obtained additional cover in the event of staff absence, and ensured they obtained the same staff where possible.

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 9 HSCA RA Regulations 2014 Person-centred care People did not always receive person-centred care and their needs were not always fully assessed in a timely manner. Care plans were not always reviewed and accurate. 9 (1) (3) (a) and (i)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people were not always adequately assessed and mitigated. Infection control practices were poor. 12(1), (2) (a) (b) and (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to implement systems and processes that effectively assess, monitor and determine risks to people or maintain accurate, complete up to date records. The provider had not always sought and acted on feedback. 17(1), (2) (a) (b) (c) (e) and (f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not always available to support people.

18 (1)