Northleach Court Care Home Limited

Northleach Court Care Home with Nursing

Inspection report

High Street
Northleach
Cheltenham
GL54 3PQ

Tel: 01451861447

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Northleach Court Care Home with Nursing is a care home providing personal and nursing care to 28 people aged 65 and over at the time of the inspection. The service can support up to 40 people.

People's experience of using this service and what we found
Risks to people's safety were not always assessed and managed safely. People's care plans did not always identify key pieces of information and had not always been reviewed in accordance with the provider's policy.

Medicines were not managed safely as staff did not always follow agreed processes. Medication audits were regularly completed but did not always effectively identify areas of concern.

We received mixed feedback about adequate staffing levels being maintained. However, during this unannounced inspection, we observed there to be enough staff available to meet people's needs.

The audits, systems and processes to monitor the service were comprehensive. However, they were missing independent checking to ensure they were being used correctly to provide an accurate reflection of the service. The provider's governance systems had proactively identified the need for some further development, but more work was needed to ensure the effectiveness of audits to minimise risks to people.

We have made a recommendation to ensure the audits and systems to monitor the service are working effectively to assess, monitor and mitigate the risks to people.

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 in the service supported this practice.

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 7 March 2020).

Why we inspected
We received concerns in relation to the management of infection control, staffing and people's nursing care needs. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

We looked at infection prevention and control measures under the safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

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

The provider responded immediately during and after the inspection. They confirmed they were developing their governance of the service to ensure that audits were effectively identifying and managing areas of improvement.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Northleach Court Care Home with Nursing on our website at www.cqc.org.uk.

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

We have identified a breaches in relation to regulation 12 (Safe Care and Treatment) at this inspection.

Please see the action we have told the provider to take at the end of this report.

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 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe.	**Requires Improvement**
Is the service well-led? The service was not always well-led.	**Requires Improvement**

Northleach Court Care Home with Nursing

Detailed findings

Background to this inspection

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

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

Inspection team
Two inspectors and an Expert by Experience carried out this inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this case a person who is a relative of older people who live in a nursing home. The Expert by Experience gathered the views of relatives over the telephone.

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

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

Inspection activity started with a site visit on 20 and 22 July 2021. The inspection continued virtually until 23 July 2021.

What we did before 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. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with three people who used the service and four relatives about their experience of the care provided. We spoke with nine members of staff including the head of governance and quality, registered manager, deputy manager, nurses, senior care worker, care workers and a member of the housekeeping team. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included multiple people's care records and medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek further information and clarification from the provider, to validate evidence found. We looked further at policies and procedures, quality audit processes, staff training and supervision arrangements, COVID-19 testing and actions relating to risk assessments. We received feedback from professionals working with the service.

Requires Improvement

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 requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

● People's risks were not always safely managed. The service's approach to assessing and managing environmental risks were robust, but not always implemented as directed. For example, the environmental risk assessment, stated that window blinds/curtains should be used to prevent sunlight entering rooms to regulate the temperature on hot days. Some rooms were not fitted with curtains or blinds and so the risk control measures put in place by the provider could not be implemented.

● People's care plans did not always identify key pieces of information and had not always been reviewed in accordance with the provider's policy. Whilst it was evident that increased risks associated with taking blood thinning medicines such as bruising and prolonged bleeding were known to staff, one person who took blood thinning medicines did not have this recorded in their care plans or risk assessments. This meant that staff did not have clear direction about how to support and manage individual risks to people.

● Staff sought to understand and reduce the causes of behaviour that distressed people or put them or others at risk of harm. Guidance for staff in one person's care plan was not clear enough to support staff to achieve this in line with current guidance. This meant this person and others were at risk of not receiving a consistent approach from staff.

● The service had a proactive approach to anticipating and managing risks to people, which was recognised as being the responsibility of all staff. However, in practice it was evident that staff needed more support to recognise and respond to potential risks such as protecting people from the heat and ensuring people received enough fluid.

Using medicines safely

● Medicines were not always managed safely, and people were not always protected from risks associated with medicine errors. The provider had processes in place to ensure staff received training and practical assessments to confirm they were competent to administer medicines. However, staff did not always follow agreed processes to ensure medicines were managed safely and people received their medicines as prescribed. There were gaps in medication records, evidence of missed medication, boxes of medicines not labelled when opened and medicine fridge temperatures found to be outside of the required temperature range.

● Staff had not always detailed what measures had been put in place to address these shortfalls in medicine management. When medication errors had taken place, there was not always documentation to evidence that staff had responded in line with the provider's organisational policy to reduce risks to people.

We found no evidence that people had been harmed, however, the above demonstrates a failure to ensure the proper and safe management of risks relating to people's care including medicines was a breach of

Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Where risks had been highlighted on inspection around people's fluid intake, the hot weather and medicines, the registered manager and senior management team had acted immediately to reduce these risks.
● People who received medicines on an 'as required' basis, such as pain relief, received their medicine in line with clearly recorded protocols.

Staffing and recruitment
● Although we received mixed feedback from professionals and relatives about whether there were enough care staff to manage people's needs, at the time of the inspection, we saw there were adequate staff to support people's needs. We reviewed staff rotas which demonstrated that staffing levels were maintained. The registered manager told us things were now improving, "We had high staff turnover and pretty much have a new staff team now. Things are settling."
● Agency staff were used to support vacant positions and some staff leave. Agency staff were block booked to ensure some consistency in people's care. Recruitment of staff was ongoing.
● Staff were recruited safely. All required checks were made before new staff began working with people in the home. These included a criminal record check and references to confirm staff were of good character and had the right skills and experience, as well as checks of nurses' registration with the UK regulator for nurses, the Nursing and Midwifery Council (NMC).

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were somewhat assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

We have also signposted the provider to resources to develop their approach.

Learning lessons when things go wrong

● Staff were aware of the incident reporting process, and where incidents had been discovered they had been reviewed and acted upon by the registered manager.

● The registered manger and senior management team were open to feedback from people, relatives, staff and professionals, and had implemented learning from the recent safeguarding concerns raised. One healthcare professional said, "I have found senior management and the owner very responsive. "Systems and processes to safeguard people from the risk of abuse

● Procedures and processes were in place to ensure people were protected from abuse.

● People and their relatives told us they felt people were safe. Comments from relatives included, "At the moment we are happy with the way that [our relative] is looked after." and "I think that [my relative] is settled now and safe."

●Staff understood safeguarding issues. They knew people well and could tell us how they acted to minimise risks to people's health, even though this was not always reflected in people's care records.

Requires Improvement

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 requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- Systems were in place to enable the provider and registered manager to monitor the quality of care and risks in the service. However, checks had not been completed to ensure they were being correctly used to provide an accurate reflection of the service. Consequently, the specific concerns around medication, infection prevention and control, fluid intake, risk management plans and protecting people in hot weather had not been identified by these monitoring systems and mitigating action had not always been taken to address these shortfalls. Despite this, where the governance systems had accurately identified the need for further development, support and coaching for the staff team, this was reflected in the service improvement plan.
- Staff performance was being monitored and the registered manager accounted for the actions, behaviours and performance of staff. However, the registered manager said that sometimes staff were not acting in accordance with organisational policies and guidance, which was being addressed through constructive feedback about their performance. The registered manager was developing processes to upskill and develop the staff team to promote the engagement and interactions for people.

We recommend the provider develops their processes to ensure their audits and other monitoring systems are able to effectively assess, monitor and mitigate risks to people.

- The registered manager was aware of their responsibilities and of their duty to notify CQC of significant events. The registered manager submitted notifications in a timely manner.
- The registered manager felt supported by the provider and told us they had regular contact with representatives of the provider's senior management team. All were committed to providing a good, high quality, person centred service to people and were enthusiastic to make the necessary improvements.

Working in partnership with others

- Evidence in care records showed the service worked with a range of relatives, professionals and outside agencies to meet people's needs. We saw evidence that the service worked with professionals to resolve any concerns that were identified.

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

● The registered manager acknowledged that there had been some challenges to creating a positive culture which consistently achieved good outcomes for people. One person said, "I know [staff] are always very busy because if you ring the bell, they come, but tell you they are very busy." The registered manager told us that they were developing a staff initiative to improve person centred care within the home, and was monitoring this by reviewing interactions between staff and people.

● People and their relatives told us communication between themselves and the home was good and they were supported to be involved. Relative's told us, "I know who the manager is, and [they] keep in contact with us" and "The staff are very approachable." The head of governance and quality and nominated individual chaired alternate relative meetings. The head of governance and quality said, "It's important to keep people abreast of information, to pick up on any developments and identified improvements." During the pandemic these meetings had continued online.

● People, relatives and staff had been supported to share their feedback through satisfaction surveys. The registered manager told us that these had been used to develop the service and achieve the best possible outcomes for people.

● The service were working towards building community links to raise the profile of the home positively within the local community.

Continuous learning and improving care

● The senior management team showed a clear commitment to the continuous improvement and development of the service. In some instances, they had proactively anticipated risk and clearly communicated this to the home. The head of quality and governance had identified the risk to people in warmer weather and had communicated this to the service ahead of the warmer weather. However, because this had not been implemented fully within the service there were potential risks to people associated with the heat and not enough fluid intake. The senior management team were now developing their systems to include independent verification to ensure continuous development of the service, and there was a 'check the checker' section of the service improvement plan.

● The senior management team undertook checks on the quality of service provision to formulate improvement plans. Where audits were completed thoroughly, they provided valuable data to develop the service. However, where audits had not been completed effectively there was the potential for unidentified risks to develop.

● The provider had been working with an external consultancy to promote a values based recruitment system and improve the quality of care that people received.

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 and registered manager were aware of their responsibilities under the duty of candour, that is, their duty to be honest and open about any accident or incident that had caused or placed a person at risk of harm.

● The provider displayed their CQC rating within the service.

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 12 HSCA RA Regulations 2014 Safe care and treatment The failure to consistently and robustly assess, manage and mitigate the risks to the health and safety of people was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The failure to ensure the proper and safe management of medicines was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.