Care Quality Commission

Bupa Care Homes (CFChomes) Limited

Northlands House Nursing and Residential Home

Inspection report

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Southampton,
SO15 2LY
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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?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This inspection took place on 9 and 10 December 2015 and was unannounced. The home provides accommodation for up to 101 people, who require nursing care. There were 87 people living at the home when we visited.

The service had a registered manager. 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.

Arrangements to manage medicines safely were not always being followed. This meant medicine administration records were not always accurate and staff could not account for all medicines. In some cases, information about when staff should administer 'as

Summary of findings

required' medicines was not available. Staff left medicines which had not been given, unattended. Meaning they could have been taken by another person and caused harm.

Decisions taken on behalf of people were not always documented in accordance with legislation designed to protect people's rights. People had not always been consulted in making decisions about their care. Staff were not always following the legislation that protected the liberty of people living at the home as they had not considered someone's best interest with regards to using a positioning belt when they were using their wheelchair.

Every floor supported people who were older adults, some of whom were living with dementia or had mental health care needs as well as physical health needs. There were registered nurses as well as care staff on every floor. Staffing levels for each of the three floors of the home had been determined by the level of need for that area. This was not always been sufficient during mealtimes.

Staff recruitment had not completed all the required checks to ensure staff's suitability of working with vulnerable people before they began working in the home as the service had not obtained full employment histories for their staff. Staff knew how to keep people safe; they were knowledgeable about the signs of abuse and how to report their concerns.

People were not involved in assessing, planning and agreeing the care and support they received. Care plans were not personalised to meet people's individual needs. Risks to people were not always personalised and appropriate actions had not been documented. There were risk assessments in place for pressure injuries, malnutrition, falls and confusion, these were recorded, monitored and managed effectively.

Care plans did not always show people's current health and support needs were being met. One person who had diabetes was not having their blood sugars monitored as documented. Failure to identify any changes could have resulted in a hospital admission. Reviews of care were conducted regularly and care records showed that people's needs were met.

There were a variety of activities for those people who were able to attend the activities room. There was a lack of mental and physical stimulation for those who were being cared for in their bedrooms. The provider sought, and acted on, feedback from people, for example in changing the activities they supported people to take part in.

Effective systems were not in place to assess, monitor and improve aspects of the service, such as the management of risks to people, medicines and care planning.

People, staff and professionals felt the home was organised, well-led and praised the registered manager, who they described as "approachable". Staff understood their roles and worked well as a team. They were motivated and enjoyed working at the home.

Staff were encouraged to gain formal qualifications in health and social care and received appropriate support and supervision in their roles.

People had mixed views about the quality of the meals and were not always supported to eat and drink well. People were supported to attend health care appointments and saw doctors, psychiatrists, nurses and other health professionals when needed.

Appropriate arrangements were in place to deal with foreseeable emergencies, such as a fire. People had individual evacuation plans in place and took part in regular fire drills

We identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken at the back of the full version of the report.

Summary of findings

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.

Medicines were left unattended by staff. Medicines had not been given as prescribed and there were gaps in the recording.

Risk assessments were in place; however they were not always person centred. Emergency plans were in place.

Full employment histories had not been obtained for the staff. There were not always sufficient staff to meet the needs of the people during mealtimes.

Requires improvement

Is the service effective?
The service was not always effective.

People's consent was not always obtained and the service was not following the MCA or considering people's best interests.

All staff had a comprehensive induction and essential training. Supervisions were held regularly and staff received an annual appraisal.

Not all health needs were being monitored; checks on people's blood sugars and stoma sites were note being carried out as documented. Referrals were made to health care professionals as required.

Requires improvement

Is the service caring?
The service was caring.

People received support from staff who knew their individual care and support needs.

Staff were kind and caring in their approach to people and ensured privacy and dignity were respected during personal care.

Good

Is the service responsive?
The service was not always responsive.

People's care was not always personalised or responsive to their needs.

Records were not being maintained, meaning the next staff on duty would not know what had occurred and therefore would not be able to respond to the people's needs.

There were no activities for those people who remained in bed; however there were plenty of activities for those who could access the activities room.

Requires improvement

Is the service well-led?
The service was not always well-led.

Requires improvement

Summary of findings

Audits had been completed, but not identified when there had been errors had occurred.

Some policies had not been updated since 2006, meaning the service was not working with the most up to date information.

Northlands House Nursing and Residential Home

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 was planned to check 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 the 9 and 10 December 2015 and was unannounced.

The inspection team consisted of an inspector and a specialist advisor in nursing and dementia care.

Prior to the inspection we reviewed information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with15 people living at the home; we also spoke with six visitors, the registered manager, the deputy manager, four registered nurses, eight care staff, two activities coordinators, a chef and a visiting physiotherapist who was delivering falls prevention training. We looked at 11 care files and associated records, along with records relating to the management of the service. We also looked at 21 Medication Administration Records (MAR) and 20 staff recruitment files as well as staff training records. We observed interactions between the registered manager, deputy manager, staff and people within the home environment. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of the people who could not talk to us

The last inspection was completed in June 2014 when no concerns were identified.

Requires improvement

Is the service safe?

Our findings

Everyone we spoke with said they felt safe and comfortable with the care and support they received. On person said "I feel safe, happy and comfortable". Another person said "I feel very safe here". Relatives said they felt their loved ones were safe.

Systems to dispose of unused medicines were not always safe. On both days of inspection we saw medicines which had not been given, being left unattended on top of the medicines trolley and on the nurse's station by the nurse on duty. Medicines were also not always administered as prescribed we identified gaps in a person's Medicine Administration Record (MAR) and; staff were unable to say whether this medicine had been given. This was raised with the deputy manager who agreed to look into this further and would be providing extra training for the nursing staff to ensure this didn't happen again. This meant staff were not following provider's policy as none of the other nurses had identified there were gaps or brought the gaps to the attention of the deputy manager or registered manager.

Guidelines were in place for medicines which were given" as required" (PRN). However, these did not always provide sufficient individual guidance. For example, there were PRN guidance in place for the use of laxatives, but these had not been individualised. They provided no guidance to staff about when they should be offered to the person.

The failure to ensure all medicines were accounted for or to keep medicines safe, and that there was clear information as to how 'as required' prescribed medicines were to be administered and records detailing why these have been given are maintained is a breach of regulation 12 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Treatment rooms were kept clean and tidy and those medicines which required being stored in the fridge were done so correctly and the temperature recorded. We observed medicines being administered appropriately, staff explained what they giving and ensured the person was sitting up and had plenty to drink

Individual risks were identified but some lacked sufficient detail about how to manage the risk. For example, there was a risk assessment for a person who had recently suffered significant injuries after they had spilt a hot drink over their self. The risk management plan did not give any details apart from identifying the person should not be left alone with hot drinks or hot food. The assessment did not look at ways to support the person to be as independent as possible. For example, checking the temperature of the drink before giving it to the person, thus maintaining their independence. One person's care file had recorded that when they were distressed, they may place themselves or others at risk. We found no evidence to show the service had explored the reason for this or taken action to minimise the distress to the person. Risk assessments were in place for bed rails, falls and moving and handling including the use of hoists and the type of sling to be used. These had been reviewed and updated as required. We identified these areas to the registered manager and deputy manager who were in the process of updating all care files and risk assessments to ensure they were more person centred.

There were policies in place to protect people from abuse, however these were found to be out of date. The registered manager was made aware of this and a more up to date copy was added to the policies folder. Staff had received training in safeguarding adults and were aware of the different types of abuse. They were able to explain what actions they would take if they had any concerns and described the process, procedures and actions they would take if they didn't feel appropriate action had been taken. All care staff spoken with knew how to contact the local safeguarding adult's team. Staff felt confident that they could raise their concerns with the registered manager.

Previous concerns had been raised about the length of time it took for staff to answer call bells. Call bell logs were checked and we found the previous month there had been delays during specific times of the day. However, the registered manager had since taken action by introducing a member of staff to cover this time period. People had raised concerns about the number of agency staff being used. One person voiced concerns over the high number of agency staff who "don't know what they are doing". The registered manager told us the service was now fully staffed. This meant they would no longer need to use agency staff; instead they would be able to cover sickness and short term absences through regular staff or bank staff.

People told us there were enough staff to meet their care and support needs. People said "staff always come when I need them". However, during our observation of a meal time, we saw there were not sufficient staff to support the

Requires improvement

Is the service safe?

needs of people on the ground floor. This was raised with the registered manager who agreed to look at the distribution of staff during meal times. We saw staff responding to people's call bells in a timely manner. The service used the company's dependency tool, which was visible in all the care files we saw. This helped the registered manager to determine how many staff were required. There was evidence that dependency was being monitored and reviewed regularly. In addition to the care staff, there were three activities coordinators who provided support and activities. During mealtimes they provided additional support to the care staff but even with them supporting there were still insufficient staff on the ground floor. Staff said that staffing levels had improved recently and the service was using fewer agency staff, which provided continuity to the people.

Staff recruitment files showed gaps in staff's full employment history for 19 out of the 20 files we looked at. This was brought to the attention of the registered manager, who immediately took action to rectify this. All staff had completed an application form, and had an interview and references had been sought along with checking with the Disclosure and Barring Service (DBS). DBS checks identify if prospective staff have a criminal record or are barred from working with children or vulnerable people. We found that appropriate checks had been carried out on the registered nurses to ensure their registration pin remained valid. These checks would help ensure unsuitable staff would not be employed.

Each person had a personal emergency evacuation plan (PEEP) which showed the support they would need if they needed to leave the building in the event of an emergency, such as a fire. These were kept in accessible 'grab bags' together with emergency equipment and information about the home that staff may need in an emergency. Staff had been trained in fire safety, knew what action to take if the fire alarm was activated and took part in regular fire drills. Weekly checks were made of the fire alarm, the means of escape, emergency lighting and automatic door release devices to ensure they were operating correctly. The service used 'walkie talkies' to communicate through the home, this meant support could be summoned quickly, if required.

Requires improvement

Is the service effective?

Our findings

People said staff always asked their consent before carrying out any tasks. One person said "they always ask me before doing anything". However, recent feedback from a survey completed by people living at Northlands House, had asked that staff be reminded to 'knock' before entering people's rooms. A staff member confirmed this by saying "Not all staff remember to knock before entering people's rooms, this is their home".

Care plans did not show how people had their current health and support needs met. Care plans for one person with diabetes, stated they needed their blood glucose levels (BM) monitored four times a day. For six days out of eleven days preceding our inspection, we found staff had only been checking them three times a day and for two days they had only been checked twice a day. Nurses stated that the checks had been reduced to three times a day but this had not been up dated in the care plan. Another person's care plan stated their BM's needed to be monitored weekly. The records showed this was sometimes being carried out monthly. The failure to ensure routine checks were completed placed the person at risk of changes in their health not being identified promptly.

We found another person who had a PEG, did not have a detailed care plan about how to care for the stoma; this was discussed with the registered manager and deputy manager who confirmed that there should be a care plan in the person's file for their PEG and were going to review this file. However, care files showed the person was receiving regular support from an external nurse and no concerns had been raised about the care management of the site.

People had access to healthcare services and referrals were made to appropriate professionals as required. People said they just needed to tell the staff and they would contact the doctor. The doctor visited the home twice a week as well as when needed. The Speech and Language Therapist (SALT) had been involved by the service when required. However, the guidance of the SALT was not always followed. For example, we found that one person's care plan documented they should have a puree diet with plate guard. We saw the main meal was pureed but no plate guard was being used. We also observed this person eating sandwiches under the supervision of the person daughter. Staff were not aware of this and we informed the deputy manager as this posed a choking risk to the person.

Referrals were also made to other external healthcare professionals such as physiotherapist and tissue viability nurse. Their input helped ensure that appropriate support was given to prevent pressure areas breakdowns.

The failure to follow the care plans of people was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The deputy manager had implemented clinical meetings with the nursing staff to review people's care needs and identify and address any issues which may arise. This was being used for the development of clinical staff by sharing best practice knowledge and skills amongst the team. The deputy manager was based on the first floor and was visible throughout the inspection providing support to both nursing and non-nursing staff. There had been a noticeable difference in the care plans since the new deputy manager had been appointed and the number of agency staff being used had been reduced. However, we found the date a urinary catheter had last been changed was not recorded and there was no date for when it was next due to be changed. This placed the person at risk that their catheter may not be changed when required placing them at risk of infection. This was raised with the deputy manager who took action to prevent this from happening in the future.

People had not been involved in making decisions about the care and support they received. For example, one person's file showed a mental capacity assessment had been completed. However, there was no evidence to suggest this person had been involved, despite the outcome being that the person did have capacity. 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. The service was not always working within the MCA. Where care files recorded the person's ability to make decisions was variable there was inadequate information about how they could be best supported to make decisions.

One person had guidelines in place for their medicines to be given covertly through their PEG tube. A PEG is a tube which goes directly into the person's stomach and is used where people are unable to take food and drink safely by

mouth. When discussed with the nurse they believed this was needed as the medicine was being crushed, however the person had full capacity and could consent to the medicines to be given this way. This protocol was removed from the file during the inspection and brought to the attention of the deputy manager and registered manager. They agreed that all staff would receive further training in assessing capacity and decision making.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of the people using the service by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect people from harm. Staff had recently undertaken essential training in MCA and DoLS. They had been given a pocket sized prompt card to remind them to consider these when they provided care. The registered manager was able to explain when and how they would need to apply for a DoLS. No DoLS authorisations were in place at the time of the inspection. However applications had been made for people who required them.

People had mixed views on the food provided. One person said the food was “excellent” another said “the foods alright, I can’t manage some of it, so I just leave it”. One person said “the food is disgusting, you never get green veg and it’s never seasonal”. We saw menus which showed the choice of two hot main meals, but were told by people that you could choose different things if you didn’t like what was on offer. One person was given curry for their lunch which had been prepared especially for them. The majority of people ate their meals in their rooms, but we saw staff asking others whether they wanted to go to the dining room for their meal. People’s cultural dietary needs were met and the chef knew who required any specific nutritional requirements. The chef had completed appropriate training to support this.

Staff received appropriate training to give them the skills required to care for people safely. A comprehensive induction process ensured new staff received the necessary training prior to commencing working with people. Staff confirmed they had completed an induction and essential training before being allowed to work in the home. One care staff member said “I have worked in care before, but I still had to undertake the homes induction including the essential training, before I was allowed to start work”. This ensured that everyone working in the home had received the same training. New staff completed an induction period and training which followed the principles of the Care Certificate. The Care Certificate is a set of standards that health and social care workers adhere to in their daily working life.

All staff had received essential training in areas such as safeguarding, moving and handling and fire safety training, before they were able to undertake any of their caring roles. We saw that staff had received refresher training as required. Staff had completed, or were undertaking, vocational qualifications in health and social care. One staff member said they were being supported to complete their level three qualifications in order to progress with their career in care.

Good

Is the service caring?

Our findings

People said most staff were caring and spoke to them in a kind manner. One person said “They are ok, some good, some aren’t so. I spoke with [the registered manager] who said ‘They all know they are here to look after you’. I just wish they would speak to me like an old woman and not a child”. Other people said the care staff were very friendly and couldn’t complain about the care. We observed caring interactions between the people, their relatives, care staff and other professionals. Staff knew who they could engage in banter with, and those who required a more sensitive or formal approach. Relationships between the staff and visitors were warm and friendly. One family member said “The carers are lovely”. Others said that couldn’t complain about the care their loved one received. There were no restrictions on people having visitors.

All the care files were kept confidential in locked cupboards; meaning only those staff members who needed to see them, had access to the information. Care records of when people were assisted to reposition, or the food and drinks they received were kept in their rooms so staff could complete them after each intervention.

Staff we spoke with were proud of the service and passionate about the people they provided care and support for. They treated everyone with dignity and ensured doors were closed when personal care was being provided. A staff member said “We are visitors; this isn’t our home it’s theirs”. We observed interactions between staff and people to be consistently respectful. Staff got down to the person’s level to communicate with them. Staff spoke with people and each other in a compassionate and respectful way.

The nursing staff were knowledgeable about supporting people at the end of their life, although the end of life care plans were not always personalised. Within the care files there were do not attempt cardio pulmonary resuscitation (DNACPR), these showed where the person had been involved in the decision. There were also clear statements about people wanting to remain within the home rather being transferred to hospital in their last few days/hours of their life. The nurses were aware of the use of anticipatory drugs and had close contact with the local palliative care team.

Requires improvement

Is the service responsive?

Our findings

People and their families told us they were, on the whole 'happy with the care being provided' at Northlands House. One family member said "We can't complain about the care". Another family member was complimentary about the care their relative received. They said "nothing has been too much trouble".

People's care plans were task orientated and not personalised to the individual. They were about the persons 'conditions' and not about what the person was able to do for themselves or what support they needed, or who they wanted to support them. Staff said they knew the people and would always ask before carrying out any care or support. We saw staff asking people's permission before they carried out any support. We saw that for one person there was a fully comprehensive communication passport using pictures in order for staff to be able to communicate with them. However, another person who had difficulty with communication was often overlooked by staff and the person in the room next door said they would "often have to speak on their behalf". We informed the registered manager about this who agreed to look at how to include this person more. This was discussed with the registered manager and the deputy manager who said they would be making changes to everyone's care plans to ensure they were no longer task focused and more about the person. We found care plans were being reviewed monthly by nursing staff but people had had not been included in these.

People's care files contained daily notes for the nurses to complete, these were additional to the repositioning chart records and food and fluid charts which were kept in people's rooms and completed by the care team. The nurses notes were not always completed daily and gaps were found for several days. A nurse we spoke with confirmed that they didn't always complete the daily notes and this was an area that needed to be worked on. This meant not all of the care that had been provided, was being documented, which may mean important information may not have been recorded. The deputy manager was aware that this was an area for improvement and planned on covering the importance of keeping accurate daily records in staff supervisions.

The service employed three activities coordinators who were seen spending time completing activities in the activities room. People who were able to leave their rooms received the mental and physical stimulation they required on a regular basis. However this was not the case for everyone. During the two days of the inspection we saw minimal activities occurring with people who were nursed in their beds due to their physical health needs. One person said "I'm never asked what I want, I go with the crowd". Another said, "The activities people are very good, I'm bored all day. There are no facilities in my room to have a kettle so if I get visitors I can't even offer them a cup of tea". The area manager said they were keen to improve the activities in the service so all people were able to have access to meaningful engagement and occupation. Some people chose to spend time in their rooms rather than the communal lounges. We noticed some people had their radio's on, and others had their televisions on, when spoken with they said this was their choice.

Care files recorded people's religion; however there was nothing recorded about how their religious needs were met. People said they were able to attend the church service in the home. One of the activities coordinators said there was "an Anglican vicar conducts a weekly church service within the home and a priest was available on request".

People were given opportunities to express their views about the service. Whilst not all people were able to express opinions about the service, the registered manager undertook monthly meetings with those who could and sent out feedback questionnaires. These followed a formal process and were recorded. The records showed topics such as meals, activities, daily living and care were discussed. People were happy with the service they received and had not suggested any changes. One family member said they would prefer to have a separate relatives meeting as their loved one would feel awkward if they raised any concerns. They stated they felt able to approach the registered manager if they had any questions or suggestions about the service and that these would be listened to. For example, they had raised a concern about the state of the carpets in the service and the carpets being replaced.

During the monthly residents/relative meetings, people were asked if they had any concerns or other comments. Relatives knew how to complain or make comments about the service and the complaints procedure was provided to

Requires improvement

Is the service responsive?

relatives in a service user guide when people were first admitted to the home. The service had not received any complaints, but the registered manager was able to explain what actions they would take if they received one.

Requires improvement

Is the service well-led?

Our findings

Providers are required to notify CQC of certain incidents which occur, so we can monitor the safety of services and take regulatory action where required. We identified an incident which had not been reported to CQC although the registered provider had taken appropriate action to report this to the relevant authorities. This was brought to the registered manager's attention, who had not realised that CQC needed to be notified about this type of incident. The service had notified CQC about all other incidents.

There were a range of policies and procedures some of which had not been updated since 2006. This meant staff did not have up to date information and guidance to follow. The registered manager and area manager said they would ensure they updated all the old policies with current ones and this was actioned by the end of the inspection. Records relating to the running of the home were well organised and up to date.

Systems were in place to monitor and assess all aspects of the service, however these were not always effective as we found they had not identified the issues with the checks on medicines, staffing levels, or that reviews of care plans were not taking place to ensure they reflected people's current needs. This was discussed with the service who told us they were planning to introduce further checks are completed and actions taken when issues are identified.

People said there had been a number of different managers at the service in the recent years, and the current registered manager had previously worked at the home so "knew who she was". However, they said there was no manager on duty at the weekend and a number of the people said they never saw the registered manager. There was a new deputy manager in post who had begun working every Sunday to provide leadership at the weekend.

All relatives were aware of who the registered manager was and said they felt able to approach them if they had any questions or worries about their family member. They were confident that any concerns would be addressed. One relative described the registered manager as "good" and "approachable". There was an open and transparent culture within the home. Visitors were welcomed; there were good working relationships with external professionals.

Staff told us that the registered manager had recently been appointed, but had previously worked at the service and they had noticed a significant improvement in moral since she had taken over. Staff told us they enjoyed working at the home and were well-motivated. Comments included: "I love working here". Another staff member told us how they had not worked for the service for long but was being supported to work their way up to become a senior care staff member. People, relatives and staff all used the term "family" when talking about the atmosphere and culture of the home. We observed staff worked well together which created a relaxed atmosphere which was reflected in people's care. We saw positive, open interactions between staff, people and relatives who appeared comfortable discussing a wide range of issues in an open and informal way.

The service sent monthly "You said we did" surveys to people living at the service. They chose different people each month, so they were getting different points of view. They also held relatives and residents meetings every month.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered person has failed to ensure all medicines are stored correctly and that there is clear information as to how 'as required' prescribed medicines are to be administered.** Regulation 12 (1)(2(b)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The registered person has failed to ensure all care plans were being followed.** Regulation 9 (1)(c)(3)(g)