Contemplation Homes Limited

# Northcott House Residential Care and Nursing Home

## Inspection report

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26 September 2017
02 October 2017

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## Ratings

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|---|---|
| Overall rating for this service | Inadequate |

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|---|---|
| Is the service safe? | **Inadequate** |
| Is the service effective? | **Inadequate** |
| Is the service caring? | **Inadequate** |
| Is the service responsive? | **Inadequate** |
| Is the service well-led? | **Inadequate** |

# Summary of findings

## Overall summary

This unannounced inspection took place on 25, 26 September and 2 October 2017. The inspection was bought forward due to information of concern we had received about the safety and management of the home, and the care provided to people.

Northcott House Residential Care and Nursing Home is a care home that provides nursing care. It provides support for up to 55 older people, some of whom live with dementia. At the time of our inspection there were 47 people living at the home. Accommodation is in a very large building with long corridors and over two floors.

At the time of our inspection visit there was 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.

The last inspection of the service was March 2016 and we rated this as overall "Good".

At this inspection we found serious concerns about the safety of the service. People were placed at risk of harm because appropriate measures had not been implemented to identify and assess risks. In addition, measures had not been taken to ensure that risks for people were minimised and medicines were not always safely managed. Staff lacked knowledge of those at risk of choking and measures were not in place to minimise this risk. Skin integrity was poorly managed placing people at risk of injures. Clinical observations which could indicate health concerns were not understood and acted upon. We could not be confident people always received their medicines as prescribed.

Staffing levels varied throughout the inspection and there was no system to ensure these levels met people's needs. Call bell response times were poor and people's comments indicated staffing levels may not be appropriate to meet their needs.

Timely referrals to other healthcare professionals were not made and recommendations from other professionals were not acted upon when concerns for people were identified. People were not always satisfied with the food. The support to eat and drink was disorganised and staff lacked the knowledge required to ensure people received the support they needed. Monitoring of people's food and fluid intake was poor. Person centred care did not take place. Care plans lacked personalised information about how people's needs and preference could be met and as people's needs changed, staff did not respond to these. Staff were not supported through effective supervision and competency assessment to deliver safe and appropriate care.

Although people said their privacy was respected and their independence encouraged, staff approach to support was task orientated and people at times felt uncared for and forgotten. The manager and provider

had not ensured the service was safe which demonstrated a lack of a caring approach.

There was a lack of leadership in the service and the registered manager was not visible. Some staff felt the registered manager was unapproachable. Audits to assess the quality of service provision were not completed regularly and were ineffective in identifying improvements needed. The registered manager and provider had no oversight of these. Action plans were not developed to ensure improvements were made. A complaints procedure was in place and records kept of how these were investigated. However, when staff raised concerns these were not acknowledged or appropriately investigated. Notifications required by CQC were not submitted.

Although staff demonstrated an understanding of the Mental Capacity Act 2005 they could not evidence how they had applied this. Staff did have knowledge of those people subject to Deprivation of Liberty Safeguards and understood what this was for. Staff understood their responsibility in relation to safeguarding people. Recruitment practices aimed to ensure staff were safe to work with vulnerable adults.

Due to the concerns we found we made referrals to the local authority and told the registered manager and provider to take immediate action. Following the inspection we received an action plan from the provider detailing how they would address the immediate risks to people.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

We found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations. We also found one breach of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of the report.

## 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.

People were placed at risk of harm because appropriate measures had not been implemented to identify and assess risks. In addition, measures had not been taken to ensure that risks for people were minimised and medicines was not always safely managed.

Staffing levels varied throughout the inspection and there was no effective deployment to ensure staffing levels met people's needs. Call bells response times and people's comments indicated staffing levels may not be appropriate to meet their needs.

Staff understood their responsibility in relation to safeguarding people. Recruitment practices aimed to ensure staff were safe to work with vulnerable adults.

### Is the service effective?

**Inadequate**

The service was not effective.

Staff were not supported through effective supervision to be competent to deliver their role effectively.

Timely referrals to other healthcare professionals were not made and recommendations from other professionals were not acted upon.

People were not always satisfied with the food. The support to eat and drink was disorganised and staff lacked the knowledge they needed to ensure people received the support they needed. Monitoring of people's food and fluid intake was poor.

Although staff demonstrated an understanding of the Mental Capacity Act 2005 they could not evidence how they had applied this. Staff did have a knowledge of those people subject to DoLS and understood what this was for.

### Is the service caring?

**Inadequate**

The service was not caring.

Although people said their privacy was respected and their independence encouraged, staff approach to support was task orientated and people at times felt uncared for.

The manager and provider had not ensured the service was safe which demonstrated a lack of care for people.

## Is the service responsive?

**Inadequate**

The service was not responsive

Person centred care did not take place. Care plans lacked personalised information about how people's needs and preferences could be met and as people's needs changed, staff did not respond to these.

A complaints procedure was in place and records kept of how these were investigated.

## Is the service well-led?

**Inadequate**

The service was not well led.

There was a lack of leadership in the service. Audits to assess the quality of service provision were not completed regularly and were ineffective in identifying improvements needed. The registered manager and provider had no oversight of these. Action plans were not developed to ensure improvements were made.

Notifications required by CQC were not submitted.

# Northcott House Residential Care and Nursing 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 bought forward in response to concerns that had been raised with us. We carried out this inspection to check whether the provider was 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 25, 26 September 2017 and 2 October 2017 and was unannounced.

Two inspectors carried out the inspection with the support of an expert by experience. The expert by experience had personal experience of caring for a person with dementia. 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 addition a specialist nursing advisor and pharmacist inspector also supported the inspection.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also 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. This information helped us to identify and address potential areas of concern. We also gained feedback from a health and a social care professional involved in the service.

During the inspection we spoke with 10 people and five relatives. We also spoke with 19 staff, the registered manager and a member of the provider's senior management team. We gained feedback from four visiting professionals. We looked at care records for 19 people and the medicines records for 22 people living in the

home. We looked at recruitment, supervision and appraisal records for staff and staff training records. We also looked at a range of records relating to the management of the service such as, accidents and complaints, as well as quality audits and policies and procedures.

It was not always possible to establish people's views due to the nature of their communication needs. To help us understand the experience of people who could not talk with us, we spent time observing interactions between staff and people who lived in the home.

Following the inspection we requested the provider and registered manager send us information related to the action they had taken as a result of our feedback. We received this.

Inadequate

# Is the service safe?

## Our findings

People and their relatives provided mixed views about the service they received. Two residents told us "It's alright. It's not like home" and "The medical care is excellent. The general care is very good. I've got no complaints". Whereas a third person said "It used to be good, now it's pretty awful. Some of the staff were good, excellent. Now they're pretty awful." One relative told us "I wouldn't recommend it for anyone else. If I could take [them] home today, I would".

People were placed at risk of harm because appropriate measures had not been implemented to identify and assess risks. In addition, measures had not been taken to ensure that risks for people were minimised.

Prior to the inspection we were told by external professionals that the registered manager had been advised to ensure that people had been assessed for the risk of choking and measures implemented to reduce this risk. At this inspection we found sufficient action had not been taken to reduce the risk of choking for people living in the home. For example, we found staff were not always aware of the people who may be at risk of choking and staff provided us with conflicting names of those at risk. This information was not discussed in handover and records did not provide confirmation of this or the support that was needed to prevent people choking. One member of staff told us they had not worked in the home before and had not received a handover form staff. They did not know who was at risk of choking and were supporting people with their meals and drinks. A second member of staff who was providing drinks to people was not able to tell us who required the use of Thick and Easy (a substance that is used to thicken fluids for those people who have difficulty swallowing). White boards were in place in the kitchen, kitchenette and nursing station. None of these white boards provided information about who was at risk of choking. The kitchen and kitchenette white boards gave information about the type of diet and fluids service users should be given but this was conflicting. People who had been identified as at risk of choking were left unsupported or unobserved with fluids. For example, one person been left alone in their room and was drinking from a lidded beaker. Being left alone to drink when a risk of choking had been identified placed this person at higher risk of harm.

Although screening for the risk of choking had started staff confirmed this had not been completed and 14 risk screening documents required completion. A member of staff told us that referrals to a Speech and language Therapist (SALT) had not been completed because of a problem with the fax machine. These referrals are of critical important to ensure people receive the correct care and support to prevent the risk of choking. In addition, risk assessments had not been developed for those at risk of choking and care plans lacked the information staff would need to identify a choking episode and take action. We were required to intervene when we saw a person coughing during their meal. The member of staff continued to feed this person while they were coughing (a sign of choking) and we had to tell them to stop. We did this to ensure the person's safety. This person had been assessed as a risk of choking and the screening tool stated they were to have food of a pureed consistency. However, at the time of their coughing they were being given a fork mashed meal. We informed the registered manager and a representative of the provider's senior management team who told us this staff member had told them that the person was not choking but was coughing. A sign of choking is coughing, indicating this member of staff did not know the signs of choking.

One member of staff was unable to tell us how to use the suction equipment (equipment that might be needed in the event of a choking incident). In addition there were no records confirming this equipment was checked regularly to ensure that it was functioning properly.

The environment had not been assessed and made safe against any risk of choking this may pose. Some communal rooms which contained small items such as clay were left unsecured.. Staff regularly left their bottles of drink on handrails in corridors and we found several opened bags and boxes of animal food that people could access.

We instructed the registered manager to take immediate action to ensure the safety of people who were at risk of choking. In addition we alerted the local authority to our concerns. Action was taken by the registered manager and provider's senior management team to reduce the immediate risk to people from choking following our instructions.

People were not always safe because bed rails were inappropriately used and beds were inappropriately placed in rooms. For example, we observed one person in bed with the bed rails in the up position. One member of staff said these bed rails should be used whereas a second member of staff told us they should not be used. A bed rails risk assessment was in place and stated that the bed rails were not to be used as these would cause distress to the person which would increase risk of injury to them, however a sleep and rest care plan said that the bed rail next to the wall was used.

People were not protected against the risk of skin damage. For people who are assessed as being at high risk of skin damage, regularly supporting them to move position helps to reduce the risk of this occurring. Records for one person who had been assessed as at high risk of skin damage showed that on one day their skin integrity had not been checked for 13 hours and they were not supported to move position during this time. A second person's care plan stated that their position and skin needed to be checked every four hours to prevent the risk of them developing a pressure ulcer. Records were unclear that these checks were consistently happening and that there were no concerns with this person skin. One entry identified a change in the person's skin condition, however no reassessment of the risks had been completed and the plan of care had not been reviewed.

Risks of health complications had not been assessed and plans implemented to reduce the risks. Two people's care records identified a risk of developing urinary tract infections (UTI's). UTI's in older people can impact significantly on them, however no assessment of this risk had been made and no plan developed to mitigate the risks. To reduce the risk of UTI fluid intake should be encouraged however records did not reflect that people's fluid intake was monitored to ensure they had a sufficient fluid intake to reduce the risk.

One person's care records identified they had been diagnosed with diabetes and whilst care plans were in place they lacked sufficient guidance to ensure staff were able to monitor for any risks associated with this condition. One member of staff told us that if this person became unwell they would check their blood sugar level, however records showed there had been two occasions when this person had become unwell and did not respond to staff. The member of staff was unable to demonstrate that the blood sugar levels had been checked and could not find any records to confirm this had taken place.

A failure to ensure that risks associated with people's needs had been assessed and plans developed and delivered to mitigate the risks placed people at risk of harm and was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2017.

When asked about their medicines people told us 'They're (staff) meticulous about that. You don't have to

worry about that." One said "Definitely" when asked if they received these on time and a third said "They bring it at regular times. Well, at all different times really, but it's usually OK."

Although people told us they always received their medicines we found the management of medicines was not always safe and in line with best practice.

We looked at how medicines were administered, stored and managed. We looked at 22 people's medicines administration record (MAR) charts, which were completed when doses of medicines had been given. We saw a laxative medicine had been prescribed each night for one person and staff had handwritten extra instructions to make sure doses were given regularly. However, there were seven days where doses had not been recorded as given, or any explanation for this omission recorded, on their current chart. This meant that we were not assured this person was given their medicines in the way prescribed for them.

Separate recording and instruction charts for people who were prescribed creams were in place, however these were poorly completed and it was not possible to be sure that these creams were applied correctly and when needed.

There were protocols in place for medicines prescribed 'when required' with people's MAR charts. However, four people's records showed these protocols were not up to date with current prescribed medicines. This meant that there was not always up to date and specific guidance for staff as to when it would be appropriate to give doses of these medicines in the way the prescriber intended for people.

We watched some medicines being given. This was done in an appropriate manner and people were asked if they needed medicines that had been prescribed 'when required' such as pain killers. However, on some occasions the medicines trolley was left unattended and unlocked in public areas. On one occasion the keys were left in the trolley door and the medicines were left on top. On another occasion the keys and medicines were left on top of the trolley and on a third occasion the keys were left on top of the trolley. This meant that medicines were not always secure.

Two people were receiving their medicines covertly (hidden). Records showed that for one of these people there had been no input from a pharmacist. This meant if the medicine was mixed with food or drink that it was not compatible with it could become ineffective.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was no-one who looked after and took their own medicines, but there was a policy in place so that people could do this if they wished, and if it was safe for them to do so. Other people were given their medicines by trained care staff or nurses. Checks were made to make sure staff could give medicines safely.

Medicines in treatment rooms were stored safely. The refrigerator and room temperatures were monitored to make sure they were within safe limits and in accordance with the manufacturer's instructions. There were suitable arrangements for the storing, recording and destruction of medicines requiring extra security. There were records of medicines that had been received into the home, and those being sent for destruction, so the handling of medicines through the home could be checked.

Whilst people told us they felt staff generally did a good job, their comments suggested there may not be enough staff to be able to respond and meet their needs. One person said "The staff are generally very good. There's not enough of them." A second person said "They say 'We'll be back' and then they don't come back.

When you get their full attention, they're very good." A relative told us "I've been asking the staff to help my [relative] to use the toilet since 11.30am and its now 12.40pm". The relative was very agitated and said, "I would never advise anyone to come into this home it's an awful place". We spoke with the person concerned and they said, "Please help me to the toilet".

A representative for the provider told us they did not use a formal system to identify the number of staff they needed to meet people's needs and the registered manager said they adjusted the staffing levels based on people's needs but were unable to show us how they did this. The home is large and spread out along lengthy corridors. Two nurses provided support to 30 people who required nursing support. However, they also provided support to the care staff who looked after the 17 people who did not require nursing care. In addition a senior team leader was available to support the 17 people who required residential support. The registered manager said these staff were supported by 10 carers between 7am – 1pm and nine carers between 1pm and 7pm. However rotas for the first day of our inspection showed that additional carers were available in the morning and in the afternoon. The second day staffing was as the registered manager told us it should be. Throughout the first two inspection days we heard the call bell alarm ringing almost continually. Due to the length of time it was taking for call bells to be answered the system moved this to emergency alarm on 13 occasions on the first day of our visit and at least 13 times on the second day of our visit. This was because the calls bells (used by people to alert staff that they need their support) was not responded to within an acceptable time period. We noted that sometimes people could be waiting for up to 20 plus minutes. On some occasions we also observed that the emergency call alarms were not responded to promptly. The log showed sometimes this was as long as three minutes. Staff were not seen to run to people's emergency calls, they often took their time to get to these people. This meant people could be at risk because staff did not respond appropriately and we were not confident the staffing levels met the needs of everyone in the home.

On the third day of our visits the staffing levels had been increased and there was a significantly higher management presence in the home. We observed the calls bells did not ring as frequently and the occasions when the alarms moved to an emergency setting had reduced as had the response times. It was unclear if this was due to the increase in staff and management presence or because the senior management had raised this with staff. Following the inspection the provider told us they felt that the deployment of staff at the time of the inspection was not as where they were "less effective".

A failure to ensure effective deployment of staff to meet people's needs was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a policy in place to ensure staff and the registered manager had guidance about safeguarding people. Staff had received training and were able to demonstrate an understanding of the signs of abuse and the action they would take if they suspected abuse. Records were held of safeguarding concerns that had been raised. These had been referred to the local authority although CQC had not always been made aware of these. Records of investigations were held.

Appropriate recruitment practices were in place and operated. Applicants were required to complete an application form, providing a full employment history. They were then invited to an interview where they were required to answer competency based questions. Their answers were recorded and scored by the interviewer. We saw a Disclosure and Barring Service (DBS) check and references had been obtained before staff commenced work at the home. The Disclosure and Barring Service carry out checks on individuals who intend to work with children and adults, to help employers make safer recruitment decisions.

Inadequate

# Is the service effective?

## Our findings

Feedback from people indicated they lacked  confidence in the care they received. One person told us that staff will say "We'll be back' and then they don't come back. When you get their full attention, they're very good." A second person told us "One or two aren't very good and need a bit of a talking to." Feedback from relatives was mixed. One told us how they felt staff knew their loved one's needs well, whereas another described why they felt their loved one wasn't receiving the standard of care they required.

Staff did not always receive effective support, supervision or training. We found no records to suggest that staff had been provided with one to one support sessions whereby they could discuss their progress and raise any concerns. When we asked the registered manager, they provided us with a "supervision" spreadsheet however this focused on supervision in relation to specific training. The training manager told us this consisted of professional discussion or observations of staff and was related to the specific training course. One member of staff said, "I have no idea when I had my last supervision".  Another member of staff told us it had been eight months since their last supervision.

Whilst records demonstrated new staff were enrolled onto the care certificate, they were not always able to tell us about the requirements of the MCA, how to raise a safeguarding concern or tell us when they had their last supervision. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It aims to ensure that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.  Another member of staff said, "We are meant to complete a training booklet alongside the care certificate but it doesn't get done".

The provider's "Contemplation Group person centred learning" work book was designed to support learning and development in areas of care delivery, compassion, competence, communication, courage and commitment. The work book for one member of staff who started on 12 June 2017 was blank.  Their training record demonstrated they had only received two competency assessments which related to the administration of medicine and a phlebotomy assessment.. One member of staff told us how they completed this workbook for people they supervised and signed them off as competent. However, they told us it concerned them because no one had ever gone through the process of assessing them as competent to do this.

Staff received training in areas of moving and handling, falls prevention, infection control, first aid, dementia and dignity in care. The provider had 10 "champions in care" who were responsible for leading and promoting specific areas of care. For example, these included, end of life care, dementia, dignity and nutrition. Three members of staff were unable to tell us who was a champion for each subject. The registered manager told us only one champion was currently working.
We identified a number of concerns about the competency and skills of some staff including their understanding of clinical observations and the use of emergency equipment. No assessments to ensure staff's competence in these areas had been completed. In addition, we identified concerns specifically relating to the risk of choking. The registered manager provided us with a sample of an assessment they said

had been completed in relation to supporting people with food and fluids and the risks of choking. However, of the seven we were given, three of these were incomplete and the fourth did not demonstrate a competency assessment or supervision about this.

A failure to ensure staff were appropriately supported and to ensure they were competent to deliver their role effectively was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives told us their loved ones were supported to access healthcare professionals if this is needed. One relative told us "Oh yes. [Relative] fell off that chair at the weekend. [Relative] tried to get up. [Relative] can't walk now, but [they] had an infection and [they] got confused and tried to stand up. [Staff] found [them] on the floor. The ambulance man was happy for [them] to stay here and not go to [hospital]. The staff cleaned [them] up and called us promptly." People told us they had access to health professionals. One person said "If you have a hospital appointment they say, 'Leave it with us.' And they arrange the whole thing. You don't have to worry about anything, that's how they work. It's quite nice not to have to worry."

Whilst we saw people were supported to access other health professionals we not confident referrals took place promptly and at the time a need was identified. For example, the referral needed for people to be seen by speech and language therapist (SALT) had not been sent because of problems with a fax machine. In addition, we were not confident that recommendations from health professionals were carried out within appropriate timescales. For example, health professionals had made recommendations about a person's hand care which we were not confident was taking place. In addition, we were not confident staff always recognised when a health professional may be needed. For example, when clinical observations were outside of a person's normal range, no action had been taken to ensure this was reviewed or that health professional were contacted to ensure the changes were not placing people at risk.

Failure to ensure that timely referrals to other professionals were made and recommendations from other professionals were acted upon was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People provided mixed views about the food in the home. "The food is very good, really good. I never grumble". A second said "Well, maybe that's not so brilliant. I don't expect much because they cook for so many, but it's often a bit sparse, the portions are a bit small. There's plenty of space on the plate. But they always say 'Have more, ring the bell and ask, don't ever go hungry'. If I don't like the choice, they get me a jacket potato and cheese. Just for me." A third person said "The food's deteriorated since I came here. They don't seem to be able to cook even basic things. They brought scrambled egg this morning. It was awful. I said I can't eat that. They took it away and brought me a piece of toast, one slice.

Lunch was provided in the dining room for 23 people, while others were supported in their rooms or the lounge. Observations of lunch showed this was disorganised and chaotic. Staff found it difficult to seat everyone in the dining room as chairs and tables had to be moved to accommodate people seated in wheelchairs. A choice of drinks was provided but this was done very slowly. Some people had been provided with a second drink whilst others were not offered one. It took 30 minutes to provide everyone with a drink. Following this meals were then provided. There was a long gap between courses. During this time, one person went to sleep and three people got up to leave the room. One person was not provided with a meal for over an hour. This seemed to be because it couldn't be established what they wanted to eat and they couldn't communicate verbally. Then there were no staff available to assist them to eat. The activities coordinator assisted with supporting a person to eat as the agency worker did not know who should have diabetic ice cream as they did not know people's names. They were then asked to assist diners in their

rooms.

Meal portions were small and included a single floret of both cauliflower and broccoli. The chef told us they were concerned that people may not be sure they could request more. Four people were supported to eat and this was done patiently. When a member of staff had to leave the person they were supporting to assist another momentarily, they communicated this to the person and returned promptly. There was limited conversation between staff and people.

Records for one person showed they had lost 4.1kgs in weight since July 2017. The registered manager and a staff member said this was unplanned weight loss and provided conflicting reasons as to the cause of the weight loss. One member of staff said this person put them self on hunger strike while the registered manager said they had been physically unwell, causing the weight loss. However, insufficient action had been taken to mitigate this risk. Whilst we were provided with a fax which showed the weight loss had been reported to the GP. There was no records to reflect a discussion about any action which may have been needed to ensure this person was receiving sufficient nutritional intake was in place. No care plan was in place but the a member of staff told us they tried to fortify this person food. However, kitchen staff did not have this information and the cook said this wasn't needed as the person ate really well.

People's food and fluid intake was monitored but the records were poorly completed meaning we could not be confident that people were supported to receive or be offered sufficient food and fluid to meet their needs. On the third day at about 18:00 hours we found five people's food and fluid charts which reflected no meals or fluids had been offered since 11am. We were told by management that these people had been supported with meals and fluids but this had not been recorded.

A failure to ensure effective monitoring and evaluation of people's food and fluid intake, and a failure to take action when unplanned weight loss occurred placed people at risk of poor nutrition and hydration. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Four people spoken with provided varied views about whether staff asked their permission and the choices they were provided with. Three provided feedback which reflected this was not consistently asked and offered. One person said "Not generally. They tell me what they want to do and if I say I don't want them to do it now they still insist on going ahead", However a fourth person said "Yes, as a rule. They say 'Can I do such and such?'."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

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

Staff spoken to had knowledge of the principles of the Mental Capacity Act and were able to tell us how they always assumed a person could make their own decisions and would involve others if they felt they did not

have capacity. However, assessments of people's mental capacity were variable across the home and records provided conflicting information. DoLS had been applied for in respect of a number of people and the registered manager confirmed that mental capacity assessments had not been completed for these people before the applications were made.

One person's their consent form recorded they were not able to provide consent. However, no capacity assessment had been completed and there was no record of best interests decisions having involved family members. Bed rails were being used without this person's consent and no capacity assessments had been completed. For one other person they had been assessed as lacking capacity using a tick sheet document that was generic and not decision specific, however there was no evidence of a best interest meeting for areas they were unable to make a decision on.

There was a policy in place for people who may need their medicines given covertly, in their best interests, if they did not have the mental capacity to decide for themselves. We checked two people's records and found that mental capacity assessments had been recorded for medicines support. However, one person had no record of their next of kin being consulted in any best interest decision.

A failure to ensure capacity assessments were undertaken when a person's ability to make a decision for themselves was in question and then a failure to consult with others was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At times other professionals were asked to come and assess people's capacity. For one person it was recognised that they were unwell with a urine infection and that this may affect their capacity so it was to be repeated.  Observations during the day showed that staff checked that people were happy for them to provide support and we saw some consent forms in people's records, although these were not present for everyone.

Inadequate

# Is the service caring?

## Our findings

People provided mixed views about the way in which staff treated them. Whilst people said staff were kind, not everyone felt respected and treated well. We received some positive feedback from people about feeling their privacy was maintained and that they were supported to be independent. For example, one person told us "They always knock the door and don't come in until I say. They shut the door for the least little thing, even if they're just washing my face. This room, it's my domain. It's my last little piece of independence". Another person said " now they let me go to the toilet on my own. They praise me when I do things; I made my bed once, well just pulled the covers up really. They were so thrilled."

Whilst we received this positive feedback, people also told us that although staff were kind they did not always feel staff treated them with respect. One person said "The [staff] are marvellous ..... But there's no follow on. You see one one day and another the next. They don't seem to pass anything on. If there's something wrong with you, bad luck." Another said "I don't get any respect. They treat me like a commodity."

People described being supported by staff who did not understand them and whom they could not understand. One person said "Some can't understand what I'm saying and I can't understand them. It's difficult to get through". Another person told us how they felt staff forgot about them saying "When I first came here you pressed the buzzer and the nurse came. That's all gone to pot, that care. Sometimes, lots of times, they forget me." Another person said "No one comes to say 'hello [name]', how are you doing?', except the chap with the pills."

Observations throughout the day showed that interaction between staff and people seemed mainly task orientated, and when people required direct support with personal care, to move or when eating and drinking. Although staff undertook task with patience, there was often little communication or communication that was confusing. For example, on one occasion we observed four members of staff crowded around one person who was trying to stand up. Staff were telling this person to sit in a wheelchair but their actions of continually trying to stand reflected they did not want to use the wheelchair. All four staff were talking to this person at the same time while not acknowledging what the person's actions were telling them. Eventually another member of staff told these staff that the person wanted to walk.

It was unclear how the service ensured that End of Life Care was delivered in a dignified way. NICE (2017) quality standards 'Care of dying adults in the last days of life' state the importance of continually monitoring the symptoms of those at end of life. We found a note written by external health professionals on the 11.09.2017 requesting a plan to be put in place to monitor end of life symptoms for one person. The plan was not in place. This person did have an end of life care plan but it was task orientated and did not include details about symptom control, spiritual support and their needs and wishes for their end of life care. A service that was caring would ensure that all elements of end of life care were considered and planned for.

Failure to implement a person centred plan at the end of a person life was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In addition it was unclear how the staff ensured people needs were met in a pain free and comfortable way. On 26/9/17 an external health professional visited to review a person who was living with hand contractures. This professional told us that this person's hand had not been washed for some time, that it was offensive smelling and their finger nails were long. We observed a member of staff explaining to this professional that they administered this person medication to help relax their hand and medicines to manage any pain as a result of their contractures so that the hand care could be carried out. However, we found that this information was not accurate as the medicines records showed the person had been given neither medication for a least a month. A service that was caring would ensure that this person received the support they needed to be clean and a pain free as possible.

The failure to ensure this person received the care that they required to reduce any risks associated with their hand care was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Overall the service provided at Northcott was not caring and this could be demonstrated by the concerns found in the other areas of this report. A failure to ensure that risks associated with people's needs were assessed and plans developed to reduce these risks meant people were not safe. The environment left people at risk because items which had the potential to cause choking had been left lying around. Meal times were disorganised leaving people at risk. A caring service would ensure that people were safe. Staff who were caring would respond promptly to emergency call bell but we saw that this did not happen. We found a large spillage of blood on a bedroom carpet of a person who had fallen recently and injured themselves. A caring service would ensure this was cleaned up. A person confined to bed had not been provided with the lidded cup they normally used. A caring service would ensure people had access to the equipment they needed. The registered manager had not ensured that staff had all the information and support they needed to care for people. A service that was caring would ensure that staff would have the information they needed to support people well. People were not aware of their care plans and had not been involved in the development of these. There was a lack of stimulating activities provided for people and there was a lack of systems in place to ensure that people could provide valuable feedback about their care and the service. A caring service would carry out checks to make sure that people were safe and getting the care that they needed. The registered manager did not do this.

Inadequate

# Is the service responsive?

## Our findings

Feedback from external health or social care professionals varied. A social care professional reported positively about the residents she had seen who have recently moved here and whose condition had improved. A health professional said they normally have a good experience but at times struggled to get staff to accompany them to see the patient so that they could feedback information to staff. A second health professional told us how for one person their experience in the home had been positive but for a second person the care had been of a low standard. A third health professional told us they were concerned that recommendations were not carried forward by staff.

People could not be confident that a change in their needs would be appropriately assessed and action taken to ensure their needs were met. Staff did not respond to incidents which reflected a change in a person's needs. For example, we found incident records which recorded a person had "beat" and hit out at staff on more than one occasion. No risk assessment was in place and no plans had been developed to reduce the risk. This lack of assessment and plan to ensure staff had the guidance they needed to recognise and support these behaviours meant this person and others were at risk of harm.

Records of clinical observations for two people showed their blood pressures when checked in September 2017 were lower than usual. There was no date of when these had been checked and no record of any action taken to discuss this drop in blood pressure with other professionals or to ensure this was closely monitored. One member of staff demonstrated a lack of understanding about the need to follow up when clinical observations were outside of usual ranges for people. We were required to them tell the action they should take. The lack of knowledge and action when people's needs changed placed people at risk of harm.

A failure to respond to a change in a person's condition and ensure that risks associated with their needs had been effectively assessed, plans developed and delivered to mitigate the risks was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2017.

People were unaware of their care plans. One person said 'I've been told there is one. I don't know what's in it. A second said 'I don't know, I assume so.' A third person told us 'I don't know. I don't think so. I've never discussed it before.'

Care plans were not always person centred and were often task orientated. For example, one person had a catheter in place. The care plan gave a list of instructions about how to look after the catheter. There was no evidence that any thought about how the person may wish to be involved in this care had been taken, to ensure any procedure of this nature could be done in a discreet and dignified manner that met their preferences.

People and their relatives provided varied feedback about activities. Of the five people we asked about activities, all the comments received reflected that this were not always planned to meet people's preferences. One person said there were activities "but I don't do them, it's my choice. They do ask. I'm not good at joining in. They do tell me, it's just how I am". A second person said "[Activities coordinator ] comes

up to my room, she sits on the bed and shows me photos and we swop stories. They do games and quizzes. They do making figures with plastercine for something to do. I wouldn't want to do that. That's not my scene at all. I like to have a chat. I don't like to be with lots of people. I can't hear what they're saying and I'm embarrassed about being deaf." Whereas a third person said they did not think there was enough to do.

A member of staff told us regular activities took place at different times of the day. There was a list of activities advertised, but they did not seem to be provided. On the first day of our inspection we observed one activities co-coordinator spent most of their time in an office while a second one was providing personal care. A member of staff told us We were told that other than activity staff, other staff did not recognise the importance of the provision of activities.

During our visit we observed very little opportunity for people to take part in meaningful activities. Two people told us there nothing to do and said they were often left alone in their room for long periods of time. A relative said, "She just sits here most days, I have known them (staff) to do some things but not very much". The activities coordinator said, "When there isn't activities going on we put a couple of tables up in the conservatory for them to do arts and crafts if they want". People were seen walking up and down hallways regularly without stimulation.

A failure to ensure care and activities were planned to meet people's needs and preference was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A feedback survey was used to gain people's feedback and an action plan was developed following this. However, the action plan provided no timescales for the action and we found that some areas which required improvement remained a concern during our inspection. For example, one action included the need to ensure spiritual support during end of life care. We found this was not planned for one person during our inspection.

A failure to ensure feedback was acted upon was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

A complaints policy and procedure was in place and people and their relatives knew how to raise a complaint. Records were held of complaints made and how these had been investigated.

Inadequate

# Is the service well-led?

## Our findings

The service was not well led and this was demonstrated by the concerns that we identified throughout this report.

While most people and their relative's spoke positively of the registered manager, describing them as "kind" and "nice", staff feedback varied. Staff reported divides between management and nursing staff and we received reports of the registered manager being unapproachable and not visible.

Throughout the inspection the registered manager demonstrated a lack of knowledge and understanding about what was happening in the home. The registered manager had not identified or acted on concerns found by us and other external professionals. We did not observe them to take an active role in care and the leadership of staff. On several occasions the registered manager told us the size of the home made it difficult for them to monitor what was happening. They told us that no one living at the home displayed challenging behaviour, however we found that at least two people could display both physical and verbally aggressive behaviour. They told us that no one in the home was having their medicines administrated covertly but we found that two people were. They did not demonstrate an understanding of the legal requirement to report incidents to CQC. We found records which showed allegations of abuse which although reported to the local authority and investigated had not been reported to CQC. When asked why the registered manager had not reported these to CQC they told us this was because the allegations had not been substantiated. CQC require all allegations of abuse to be reported. No action had been taken when staff raised concerns about feeling unsupported. Despite external professionals sharing concerns with the registered manager and provider's management team this had not led to prompt action being taken to ensure service user's safety. There was a lack of leadership in the service, which the registered manager and a senior manager for the provider agreed with, however they felt this related to clinical leadership and as such had introduced a new clinical lead. This person had only started on the first day of our inspection.

The provider's policy for quality assurance said that "The Registered Manager is responsible for quality in the service and will carry out clinical audits applicable to the service." However, the registered manager confirmed they did not carry out any audits in the home and delegated these to other staff but were unable to evidence they followed up on the actions they had delegated. The last audit of wounds carried out in June 2017 recorded that regular repositioning could have prevented a wound. Whereas the clinical audit for June 2017 stated that no action was required. During the inspection we found concerns that regular repositioning was not taking place for service users where needed, demonstrating that the audit had not been effective in driving improvements to ensure people received safe and effective care. There was no record to show the registered manager had reviewed this information or that the provider had identified these concerns.

The registered manager told us they did not do whole home analysis of incidents and as such trends and patterns would not be identified. This meant that action had not been taken to address concerns about the management of behaviours for one person, because the behaviours had been repeated but no action taken to ensure staff could support them appropriately.

Care plan audits had not been fully effective in ensuring risks for people were identified an acted upon. For example, the placement of people's beds next to radiators had not been identified as a potential risk for people. Tthe lack of person centred care planning had not been identified during the last audit of care plans undertaken by nurses in June 2017. There was no record to show the registered manager had reviewed this information or that the provider had identified these concerns.

There were monthly medicines administration audits to be completed, however these had not been completed for the last two months, and the issues picked up on the last audit in July had not been transferred to the audit action plan to be followed up. There was no record to show the registered manager had reviewed this information.

Although meetings were held at provider and home level these were not effective in driving improvement. A registered managers meeting in July 2017 and a nurse meeting in August 2017 shared feedback about how poor recording had "let homes down". However at this inspection records were poorly maintained, inconsistent and staff did not know where to find them. Whilst risk screening was carried out, care plans were not always reflective of the findings. Evaluation of on-going care was poor and not responsive. Whilst care was reviewed routinely once a month this did not take place at the times when people's needs changed. For example, when skin integrity showed signs of damage for one person it did not prompt a review of the risk assessment and care plan or delivery. After asking eight different members of staff, they were unable to locate records confirming that bed rail checks took place. We asked them to find someone who knew where they were and show them to us. We did eventually receive them. This meant that important records were not accessible to all staff to ensure people received safe and appropriate care.

Appropriate arrangements were not in place to ensure the safe storage of records. We consistently observed information relating to people's care being left in communal hallways. Records were left unattended in hallways throughout all floors in the home. When we asked the registered manager to tell us why confidential information was not being stored correctly they said, "They (Staff) leave the files in the hall for hours". Even after we brought this matter to the attention of the registered manager, people's records continued to be left unsupervised and in clear site of any visitors.

The provider employed a quality assurance manager who had last undertaken an audit in the home in June 2017. It was difficult to establish that this audit had been fully effective in identifying concerns and driving improvement as it had not been reviewed since June 2017. However, we did find that it had not identified any concerns in relation to the maintenance and use of equipment. We found there were no systems being used to ensure that all medical equipment was checked and maintained. We found there were no systems being used to ensure that medical equipment was checked and maintained. We found the suction machine was dirty; initially the nurse could not find the tubing used with this machine and when they did find it, it was out of date. There were no records to show this was routinely checked. Two nebulisers were found with no maintenance logs and no sterile tubing. We were provided with a document at the end of the second day which the training manager told us would be implemented to ensure these checks were carried out. In addition, we found there was no effective system for ensuring staff were competent in using medical equipment. One nurse was unable to demonstrate how they would use the suction equipment and was also unable to demonstrate how they ensured the machine used for monitoring blood sugar levels was effectively working.

The June 2017 audit also identified choking risk assessments were in place, however we found this not to be the case during our inspection.

The registered manager told us how they were required to complete a weekly management report for the

provider. However we were concerned that the completion of this had not appeared to highlight all of the concerns we found. For example, despite recording that the service were awaiting outcomes of specific safeguarding matters from the local authority the CQC notification section remained blank. This meant the need to ensure CQC were informed of these safeguarding matters was ignored. In addition, whilst the weekly report highlighted the involvement of an external health professional team, it did not highlight the concerns that had been raised and how these concerns were being addressed.

We had been advised prior to our inspection visit that this external health professional team had raised concerns about the risk of choking for people living in the home as well as the understanding of clinical observations and action to be taken when these suggested a possible concern. The registered manager and senior manager for the provider told us an action plan had been developed and gave us a copy. However, this gave no clear timescale or priority to the actions. For example it stated "September 2017" to the completion of choke screening for residents and making referrals to SALT. Screening was not fully completed at the time of our inspection. Not all referrals had not been made to SALT at the time of our inspection. The action plan stated first aid info was to be placed in people's bedrooms who had been identified as at risk. This had not been completed and on 26 September 2017 we instructed the registered manager to do this. The action plan included no actions which would ensure that risk assessments for the risk of choking were implemented and that care plans detailed the risks to people and the support they needed. In addition, the action plan also stated that "better monitoring and follow up of abnormal baseline observations" was needed and the timescale was "immediate". However we found ongoing concerns regarding the monitoring of baseline observations and a continued failure to take the appropriate actions required to ensure people received safe and appropriate care.

The lack of an effective process to audit the quality of the service provided meant concerns regarding risks to service user's health, safety and well-being had not been identified and prompt action taken to address these. The lack of accurate and up to date records placed people at risk of receiving care and support that was not effective or safe. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Throughout the inspection multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations were found to be in breach. These breaches placed people at risk of receiving care and support that was inappropriate, unsafe and did not meet their needs. A failure to ensure these regulations were complied with was a breach of regulation 8 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Registered persons are required to notify CQC of significant events that occur in the service. This includes any allegations of abuse. The records held in the service identified five incidents whereby allegations of abuse had occurred between June and September 2017 that we had not received any notification of. The failure to notify CQC of these significant events was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.