Northgate House Care Home
Care Home Service

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Type of inspection:
Unannounced

Completed on:
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Service provided by:
Lanam Healthcare Ltd

Service provider number:
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Service no:
CS2023000032

About the service

Northgate House Care Home is registered to provide a care service to a maximum of 68 adults, aged 55 years and above with assessed physical and/or dementia/memory impairment needs.

The home is in the Balornock area of Glasgow, near to local facilities and public transport. The building is purpose built, with all bedrooms providing single ensuite toilet facilities. Each unit has their own communal bath/shower facilities, lounge and dining rooms. Access to outdoor space is available in their rear garden area and parking for visitors available at the front.

At the time of inspection, there were 61 people living in the home.

About the inspection

This was an unannounced inspection which took place between 21 and 23 May 2024. The inspection was carried out by three inspectors and an inspection volunteer from the Care Inspectorate. To prepare for the inspection we reviewed information about this service. This included previous inspection findings, registration information, information submitted by the service and intelligence gathered since the last inspection.

In making our evaluations of the service, we:

- Spoke with 13 people using the service and six of their family members.
- Spoke with 15 staff and management.
- Observed staff practice and daily life.
- Reviewed relevant documents.
- Spoke with one visiting health professional and the local authority commissioning team.

Key messages

- Positive interactions between staff, residents and relatives was evident.
- Assessments and systems were in place, to assess and monitor people's health and wellbeing needs.
- Staff needed to ensure that everyone living in the home benefited from meaningful engagement.
- The implementation of further improvements in staff practice and care documentation, including continence care, prevention and management of falls, was needed.
- The provider and management team were committed to ensuring that people were well cared for and that staff were motivated to do their best to support people living in the home.

From this inspection we evaluated this service as:

In evaluating quality, we use a six point scale where 1 is unsatisfactory and 6 is excellent

How well do we support people's wellbeing?	3 - Adequate
How good is our leadership?	3 - Adequate
How good is our staff team?	3 - Adequate
How good is our setting?	4 - Good
How well is our care and support planned?	3 - Adequate

Further details on the particular areas inspected are provided at the end of this report.

How well do we support people's wellbeing? 3 - Adequate

We evaluated this key question as adequate, as while some strengths had a positive impact on people's experiences, key areas of performance needed to improve to achieve consistent outcomes.

We observed positive interactions between staff, residents and relatives. The atmosphere within the home was relaxed and calm, with staff who were seen to be kind and caring in their approaches with residents. Staff also showed awareness of maintaining people's privacy and dignity when dealing with personal care.

Feedback from residents and relatives, spoken with, was overall positive about staff and the care and support provided. People told us, 'I like living here, have own tv in bedroom and staff are really nice'; 'lived here for five years and there have been some staff changes recently but it's been okay and they look after me well'; 'been here for about five months, it's been okay, anything we've highlighted or asked for has been sorted'.

How people spend their day is important in maintaining people's physical and mental wellbeing. During our visit, we saw very little day to day meaningful stimulation for residents. Residents and relatives, we spoke with, confirmed our own findings and commented that, 'all activities stopped a few months ago' and although there were some planned entertainers, the majority felt that 'they were left sitting a lot of the time' and 'bored', with television being the only option. People also said that they 'would like to get out in the garden more' or 'out on a trip' but felt that staff were too busy to even 'stop and talk'. We acknowledged that the home was currently recruiting new activity co-ordinators, however, we felt that staff would benefit from additional guidance and leadership about how to make effective use of their time when 'supervising' lounge areas and providing support to people in bedrooms. We discussed with management about how this could be achieved through having key staff, or champions, taking responsibility in each unit **(see Requirement 1).**

People have the right to appropriate healthcare. We saw that assessments and systems were in place to assess and monitor people's health and wellbeing needs. Referrals to and input from relevant healthcare professionals such as, the care home liaison nurse, falls team, podiatrist, optician, speech and language therapist were seen. We were told that some previous challenges, experienced by healthcare professionals, were now improving and had resulted in better working relationships, staff making relevant referrals and following the advice provided.

We saw appropriate management of skin issues including wounds, with use of barrier creams to prevent worsening of conditions and clear evidence of wound healing.

Management of medication was found to be safe although, improvements with recording and reviewing of protocols was needed **(see 'How well is our care and support planned?').**

We saw relevant nutrition and hydration assessment and monitoring records in place and evidence of increases in peoples' weights. Mealtimes, that we observed, were seen to be, overall well organised and calm. Dining tables were well presented, set with relevant condiments and people told us that they enjoyed the meals and food provided, especially the puddings and home baking. However, we did highlight, in one dining room, that staff were slow to recognise that some people needed encouragement to take their meal and that there was no interaction when staff were assisting people to eat and drink. Management agreed to review and monitor this.

Staff, spoken with, were aware of people's needs and clear who required additional monitoring, whether that was observations due to mobility or stress and distress concerns, change of position, food and fluid monitoring. However, we did highlight some residents who required additional personal care in relation to their fingernails' length and cleanliness. This was addressed by staff immediately.

We had made previous requirements in relation to concerns about continence care and falls management. Whilst we saw that some progress had been made with regards to both requirements, we were aware of ongoing issues that management were having to address, to ensure that people's assessed needs were met and better outcomes were achieved **(see 'How good is our leadership?').**

Requirements

1. By 9 September 2024, the provider must ensure that people's physical and mental wellbeing is maintained through meaningful interaction and stimulation. To do this, the provider must at a minimum:

a) Consult with people about how they wish to spend their day.
b) Implement a plan of daily activities which people can choose to participate in.
c) Provide staff with guidance about how to engage, with people, effectively in communal and individual bedroom areas.
d) Designate key staff, in each unit, with the responsibility for guiding and leading staff in meaningful interactions.

This is to comply with Regulation 4(1)(a) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210).

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that, 'I get the most out of life because the people and organisation who support and care for me have an enabling attitude and believe in my potential' (HSCS 1.6) and 'I can choose to have an active life and participate in a range of recreational, social, creative, physical and learning activities every day, both indoors and outdoors' (HSCS 1.25).

How good is our leadership? 3 - Adequate

We evaluated this key question as adequate, as while some strengths had a positive impact on people's experiences, key areas of performance needed to improve to achieve consistent outcomes.

People should have confidence that the service and organisation that they use are well led and managed. There had been a couple of changes in managers since the last inspection, with the operations manager now in post. It was evident that the service had previously not been managed as expected, but that this was now being addressed. People, spoken with, were aware of the changes and were feeling hopeful that the current service manager and staff would make the improvements needed.

The service had a quality assurance system which helped with monitoring the quality of service provided. This included various audits, daily flash, staff and relative meetings. We were told that clinical review meetings were also being introduced. These gave management a current overview of the service and people's current needs. However, it was not always clear how this information was used to improve the service and outcomes for people living in the service.

We also noted that there were no regular meetings for people living in the home and although there was a suggestions box, at the entrance to the home, it needed to be made more prominent to encourage people to use it.

We were aware that the current manager had recruited additional key staff to help with leadership within the home. They were also reviewing all areas within the home and had identified a number of areas for improvement and created action plans to address these. The manager was in the process of developing a Service Improvement plan which will demonstrate the areas identified, progress made with the planned action and how people's outcomes have been improved as a result. The manager agreed to share this with us, once completed.

We had made a previous requirement in relation to the handling of concerns or complaints. Management told us that they had an 'open door' policy and staff spoken with confirmed that they would always try to resolve any issues or concerns immediately before escalating to a senior member of staff. We were told, by some relatives, that they felt confident in raising any issues and that they would be dealt with. We asked management to ensure that their complaints procedure was visible within the home and clearly reflected relevant contact details including the Care Inspectorate. We made an area for improvement, to ensure that the appropriate handling of concerns or complaints was sustained **(see Area for Improvement 1).**

As previously stated, we had also made requirements in relation to concerns about continence care and falls management. Progress with these was discussed with the manager.

We were told, and saw, that the manager had carried out a review of all residents' continence needs and that the initial continence assessment for all new residents had been completed with the appropriate referral made. However, the manager acknowledged that not all individual continence care assessments or care plans had been reviewed and updated. We also noted that the Resident of the Day documentation did not reflect a specific review of people's continence needs and that the storage of continence aids needed to be more person-centred. The manager agreed that further improvements were required. The requirement, therefore, has been rewritten to acknowledge the progress made and the timescale extended to enable the service to fully implement the further improvements needed **(see Requirement 1).**

The manager had implemented systems which allowed oversight of any falls, accidents or incidents within the service. These were discussed, with the wider staff team, at daily flash meetings to ensure that relevant action including updating of care documentation or referrals to other health professionals, had been completed. The manager analysed any emerging themes or trends, and this had recently led to an increase in staffing levels in one unit, to enable staff to 'supervise' the lounge area, minimising the risk of incidents occurring. The manager acknowledged that the standard of recording within care plans, accident and incident records needed improved further and that audits needed to be more frequent in order to address these. The requirement, therefore, has been rewritten to acknowledge the progress made and the timescale extended to enable the service to fully implement the further improvements needed **(see Requirement 2).**

We also discussed the recent submission of some accident and incident notifications, to the Care Inspectorate, which had not contained accurate information. Although, the manager agreed to take action to address this, we made this subject to a requirement till we could be confident that this issue has been resolved **(see Requirement 2).**

Requirements

1. By 9 September 2024, the provider must ensure that people receive the appropriate continence care to meet their needs. To do this, the provider must at a minimum:

a) Ensure that people have up to date continence care assessments and care plans.
b) Ensure that staff follow and document any required actions, as detailed within peoples' continence assessments and care plans.
c) Ensure sufficient staff, with the relevant skills and knowledge, are on duty.
d) Carry out regular monitoring and auditing of peoples' continence care provision and take action where required.
e) Ensure appropriate storage and allocation of individual prescribed continence aids.

This is to comply with Regulation 4(1)(a) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210).

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that, 'My care and support meets my needs and is right for me (HSCS 1.19).

2. By 9 September 2024, the provider must ensure peoples' safety through appropriate prevention and management of falls. To do this, the provider must at a minimum:

a) Ensure that people have up to date mobility, including falls, assessments and care plans.
b) Ensure that staff are aware of falls prevention strategies and the action to take following a fall.
c) Ensure sufficient staff, with the relevant skills and knowledge, are on duty.
d) Carry out regular auditing and analysis of all accidents and incidents, as well as the management of individual people's falls and take action where required.
e) Ensure appropriate and accurate reporting of accidents and incidents, including the submission of notifications to the Care Inspectorate.

This is to comply with Regulation 4(1)(a) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210).

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that, 'I am protected from harm because people are alert and respond to signs of significant deterioration in my health and wellbeing, that I may be unhappy or may be at risk of harm' (HSCS 3.21).

Areas for improvement

1. To ensure that people feel able to raise a concern or complaint and are confident that these will be addressed, the manager should ensure that,

a) Staff are open, honest and transparent in their communication with people or their representative.
b) The complaints procedure, with relevant contact details, is clearly visible within the home.
c) Staff follow the provider's complaints policy and procedure.

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that, 'I know how, and can be helped, to make a complaint or raise a concern about my care and

support' (HSCS 4.20) and 'If I have a concern or complaint, this will be discussed with me and acted on without negative consequences for me (HSCS 4.21).

How good is our staff team? 3 - Adequate

We evaluated this key question as adequate, as while some strengths had a positive impact on people's experiences, key areas of performance needed to improve to achieve consistent outcomes.

Staffing levels were determined by the assessment of peoples' care and support needs. These were calculated, on a monthly basis, and displayed within each unit. The daily allocation of staff, within the home, was displayed within the foyer and each unit deployed their staff to support individual residents within their unit each day. As previously reported, staffing levels had been increased, in one unit, to help reduce the number of accidents and incidents occurring.

However, people told us that they felt that the home needed more staff, mainly due to not always being able to find staff when needed and, as previously stated, that there was very little to do on a daily basis. During the inspection, we did see staff 'supervising' some lounge areas and appropriately responding to call bells, however we asked management to take into account the comments, we received from residents and relatives.

We discussed the new Staffing legislation, with management, and the expectations around including staff, resident and relative feedback when deciding on staffing levels. We also discussed how people could best be supported at busy times or with planned events or outings.

As previously stated, we had made requirements in relation to concerns about continence care and falls management. Part of the management's action plan included relevant training to improve staff skills and knowledge. We could see that the majority of staff had attended training on Moving and Assisting, Adult Support and Protection. However, we saw that only some staff had attended continence and record keeping training, with staff viewing a short video in relation to falls management. We were aware that falls prevention training was being sourced. The manager had created a resource room for staff, with the home's falls protocol and other useful falls information, however, during our visit, we did not see how staff utilised this area. We were also aware that the manager planned to introduce champions, to lead on improvements within key areas. Whilst we saw that some progress had been made with regards to both requirements, the manager acknowledged that not all actions, in relation to improving staff skills and knowledge, had been implemented **(see Requirements 1 and 2, 'How good is our leadership?').**

We also saw that other staff training in relation to oral hygiene, wound and nutritional care had taken place, with staff meetings and supervisions a working progress. We suggested that staff supervision meetings could be more detailed and link into observations of staff practice. As previously reported, we were aware that the current manager had recruited additional key staff to help with leadership within the home. It was hoped that this would give further support and guidance to staff, in relation to their practice, and enable the management team to drive forward consistent improvements within the home.

How good is our setting? 4 - Good

We evaluated this key question as good, as a number of strengths, taken together, clearly outweighed areas for improvement. Whilst, some improvements were needed to maximise wellbeing and outcomes, strengths had a positive impact on people's experiences.

People who live in the home should experience a high quality environment. People told us that they were happy with the home's environment, décor and furnishings and were able to personalise their bedrooms.

We found the home to be clean, tidy and free from malodours. We saw appropriate infection prevention and control within the home, including staff practice with personal protection equipment (PPE) and management of laundry. This helped to minimise any spread of infection within the home.

Recent decoration and new flooring, within units, was evident. Furnishings within the home and equipment we saw in use, such as hoists and wheelchairs, were clean and in good condition. We saw appropriate maintenance checks were up to date but asked management to ensure that wheelchairs had appropriate footplates attached.

Each unit had separate lounge and dining areas, which were bright and comfortable. Corridor areas were well-lit with contrasting handrails, allowing people to support themselves to mobilise around their unit. Seating areas were also provided, in corridor areas, allowing people to rest when walking around the unit or to sit and socialise with other residents.

The manager had recently completed the King's Fund environmental assessment tool and we asked management to consider improving directional signage, to help people find their way around the units more easily and to provide contrasting colours within toilet areas, to help people maintain their independence. Regular discussions with residents and relatives should also help to develop a communal environment which reflects peoples' tastes and choices.

How well is our care and support planned? 3 - Adequate

We evaluated this key question as adequate, as while some strengths had a positive impact on people's experiences, key areas of performance needed to improve to achieve consistent outcomes.

In order to support people's health and wellbeing, care records should give clear direction about how to deliver each person's care and support, as well as details of personal interests and preferences. As previously stated, continence and falls management, care assessments and plans were not always fully completed or analysed to reflect the assessed need or further action required. This was also evident in relation to food, fluid, stress and distress records where the reason for implementation and achieved outcomes were not clearly recorded. We also found some Adult with Incapacity certificates that were out of date. This meant that it was not always clear that people were getting the right care for them **(see Requirement 1).**

Resident of the Day documentation could be more effective, if used to it's full potential, in assessing the care provided and informing the updating of care plans and risk assessments.

Some recently completed care reviews were seen with resident, relative and social work involvement. Again, these could be more effective if person-centred and focused on what the person could do and the support needed to achieve their goals, even if this was the maintenance of their current quality of life. We also asked that the use of people's available finances be reviewed and discussed, to ensure that their monies were spent to benefit their quality of life.

As previously stated, we found the management of medication to be safe however, some homely remedy agreements had not been reviewed since 2021, and antipsychotic and 'as required' protocol reviews were overdue.

We also found that 'as required' medication protocols would benefit from more signs and symptoms of when medication would be required, and a record of the effectiveness following administration **(see Requirement 1).**

Whilst management and staff had already achieved some improvements in personal plans, they acknowledged that further improvements were needed to bring all documentation up to the required standard.

Requirements

1. By 9 September 2024, the provider must ensure that people receive the care that is right for them. To do this, the provider must at a minimum:

a) Ensure that people have up to date care assessments and plans, which reflect their assessed needs and outcomes achieved.
b) Ensure that Adult with Incapacity certificates and treatment plans are appropriately completed and reviewed within required timescales.
c) Ensure homely remedy agreements, antipsychotic and 'as required' protocols are appropriately completed and reviewed within required timescales.

This is to comply with Regulation 4(1)(a) of The Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 (SSI 2011/210).

This is to ensure that care and support is consistent with the Health and Social Care Standards (HSCS) which state that, 'My personal plan (sometimes referred to as a care plan) is right for me because it sets out how my needs will be met, as well as my wishes and choices' (HSCS 1.15) and 'My care and support meets my needs and is right for me' (HSCS 1.19).

What the service has done to meet any requirements we made at or since the last inspection

Requirements

Requirement 1

By 3 May 2024, the provider must ensure that people experiencing care receive the right continence care and support at the right time. To do this, the provider must, at a minimum:

a) Ensure that people experiencing care have an up-to-date continence care assessment.
b) Ensure that where appropriate, people experiencing care have an up-to-date continence care plan.
c) Ensure that staff follow and document any actions required, as detailed within the person experiencing care's continence care plan.
d) Ensure that managers, or other appropriate staff, engage in the monitoring and auditing of continence care records.

This requirement was made on 8 April 2024.

Action taken on previous requirement

The manager had carried out a review of all residents' continence needs however, not all individual continence care assessments or care plans had been reviewed and updated.

We saw that some staff had attended continence and record keeping training but that this was ongoing.

The manager agreed that further improvements were required. The requirement, therefore, has been rewritten to acknowledge the progress made and the timescale extended, to enable the service to fully implement the further improvements needed. See Requirement 1, 'How good is our leadership?'.

Not met

Requirement 2

By 3 May 2024, the provider must ensure the safety and wellbeing of people experiencing care following a fall. To do this, the provider must, at a minimum, ensure:

a) That staff are aware of, and follow, the service post falls protocol.
b) That staff consult other health professionals timeously following any fall that may impact the wellbeing of a person who receives care.
c) Staff monitor an individual's vital signs and general condition in accordance with the post falls protocol, or until they are in receipt of other advice from a health professional.
d) Ensure that managers, or other appropriate staff, engage in the monitoring and analysis of falls.

This requirement was made on 8 April 2024.

Action taken on previous requirement

The manager had implemented systems which allowed oversight of any falls, accidents or incidents within the service. These were discussed, with the wider staff team, at daily flash meetings, to ensure that relevant action including updating of care documentation or referrals to other health professionals, had been completed.

The manager analysed any emerging themes or trends, and this had recently led to an increase in staffing levels in one unit, to enable staff to 'supervise' the lounge area, minimising the risk of incidents occurring.

Staff had viewed a video in relation to falls management and falls prevention training was being sourced. A resource room for staff, with the home's falls protocol and other useful falls information had also been created.

The manager acknowledged that the standard of recording within care plans, accident and incident records needed improved further and that audits needed to be more frequent in order to address these. The requirement, therefore, has been rewritten to acknowledge the progress made and the timescale extended to enable the service to fully implement the further improvements needed. See Requirement 2, 'How good is our leadership?'.

Not met

Requirement 3

By 3 May 2024, the provider must ensure that people receive the right information at the right time, should they or their representative raise any concerns or dissatisfaction with the service. To do this, the provider must, at a minimum ensure:

a) Staff are open, honest and transparent in their timely communication with people or their representative.
b) Staff follow the provider complaints policy and protocol.
c) Staff maintain an accurate record of when a complaint is received.

This requirement was made on 8 April 2024.

Action taken on previous requirement

There had been no formal complaints since the requirement was made in March 2024, but management told us that they had an 'open door' policy and staff said that they would always try to resolve any issues or concerns immediately before escalating to a senior member of staff. Some relatives, we spoke with, stated that they felt confident in raising any issues and that they would be dealt with.

We asked management to ensure that their complaints procedure was visible within the home and clearly reflected relevant contact details including the Care Inspectorate.

We made an area for improvement, to ensure that the appropriate handling of concerns or complaints was sustained. See Area for Improvement 1, 'How good is our leadership?'.

Met - within timescales

Complaints

Please see Care Inspectorate website (www.careinspectorate.com) for details of complaints about the service which have been upheld.

Detailed evaluations

How well do we support people's wellbeing?	3 - Adequate
1.3 People's health and wellbeing benefits from their care and support	3 - Adequate

How good is our leadership?	3 - Adequate
2.2 Quality assurance and improvement is led well	3 - Adequate

How good is our staff team?	3 - Adequate
3.3 Staffing arrangements are right and staff work well together	3 - Adequate

How good is our setting?	4 - Good
4.1 People experience high quality facilities	4 - Good

How well is our care and support planned?	3 - Adequate
5.1 Assessment and personal planning reflects people's outcomes and wishes	3 - Adequate

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