Normanton Limited

Normanton Lodge

Inspection report

14 Normanton Avenue, Bognor Regis,
West Sussex, PO21 2TX
Tel: 01243 821763

Date of inspection visit: 02 and 06 February 2015
Date of publication: 31/03/2015

Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Inadequate**
Is the service effective?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

The inspection was unannounced and took place on 02 and 06 February 2015.

Normanton Lodge is a 26 bedded residential care home that provides care and support to older people with a physical disability, dementia and/or related mental health conditions. At the time of inspection there were 23 people living at the home.

During our inspection the registered manager was present. 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.

Management of the home was reactionary and this translated into a culture of inconsistency in the way people who lived with dementia were cared for and treated. Quality assurance processes and audits completed by the manager had not identified the shortfalls in service provision. Therefore, they were not effective. People's records and those relating to the management of the home were not always accurate or in place. The registered manager had not ensured her

Summary of findings

knowledge and management skills were current to ensure the home was well led. Everyone said that the registered manager was approachable and listened to people's views, opinions and concerns.

People told us that they felt safe in the home. However, staffing levels did not ensure that people received all the support they required at the times they needed. In-house activities only took place in the morning due to low staffing levels in the afternoon. Medicines were not always managed safely. Risks were not always fully considered and assessed in relation to equipment and staff did not always practice safe moving techniques.

The registered manager had not sought people's consent or acted on advice when she thought people's freedom was being restricted. She confirmed that best interest meetings had not taken place with external professionals to ensure that decisions were made that protected people's rights.

The registered manager had not completed mental capacity assessments or made DoLS applications. This meant that people's rights were not protected.

Staff understood the importance of protecting people from harm and abuse. People felt able to raise concerns and complaints were investigated. However, the registered manager had not notified the local authority safeguarding team when safeguarding issues had arisen at the home. Therefore, people were not protected and we could not monitor that all appropriate action had been taken to safeguard people from harm.

Staff said that they felt supported by the registered manager to undertake their roles. However, they had not been receiving training relevant to the needs of people who lived at Normanton Lodge.

People's nutritional needs were assessed but not always managed effectively. Despite this, people said that they were happy with the food and meals provided. When recommendations were made by external healthcare professionals these were acted upon to ensure people received the care and support they required to manage their medical conditions. Staff knew the needs of people and treated them with kindness, dignity and respect.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we have told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Medicines were not always managed safely. The registered manager had not raised safeguarding alerts with the local authority safeguarding team or notified us in line with her registration requirements when complaints included potential allegations of abuse. At times there were not staff present to help people. Staffing levels had not been assessed in line with people's needs. Equipment was not always assessed or used safely, putting people at risk.

Is the service effective?

Requires improvement

The service was not effective.

The manager had not obtained people's consent for the use of equipment that could restrict their movements. When people did not have the capacity to consent the manager had not made suitable arrangements to ensure decisions were made in their best interests.

Staff were not provided with training that helped equip them with the knowledge and skills to care for people in relation to dementia, diabetes, MCA and DoLS despite people who lived at the home having needs in these areas.

People said that they were happy with the food and meals provided. However, individual dietary needs were not always managed effectively. People's health care needs were met.

Is the service caring?

Requires improvement

The service was not consistently caring.

People were not actively involved in making decisions about their care and treatment. However, people told us that they exercised choice in day to day activities throughout the day. Meetings were not held for relatives to ask for their views about the home.

People told us that they were treated with kindness and that positive, caring relationships had been developed. People were treated with dignity and respect. Privacy was promoted.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

Some activities were provided. However reduced staffing levels in the afternoon impacted on the times activities took place.

Summary of findings

People's needs were assessed and care given that reflected changes in people's needs. When recommendations were made by external professionals these were acted upon to ensure people received the care and support they required.

People felt able to express concerns and these were acted upon.

Is the service well-led?

Requires improvement

The service was not well-led.

Quality assurance processes were not effective because audits had not identified aspects of the service that required improvement. There was a reactive management style and culture at the home. As a result, people received an inconsistent service.

The registered manager was kind and caring but her leadership skills were at times lacking and this had impacted on the running of the home. People and their relatives felt able to approach the registered manager and there was open communication within the staff team.

Normanton Lodge

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 02 and 06 February 2015 and was unannounced. The inspection team consisted of two inspectors and an expert by experience who had experience of dementia care. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we checked the information that we held about the home and the service provider. This included statutory notifications sent to us by the provider about incidents and events that had occurred at the service. A notification is information about important events which the provider is required to tell us about by law. We also reviewed comments that we had received from two health and social care professionals who agreed to us using their comments in this report. We used all this information to decide which areas to focus on during our inspection.

We spoke with seven people who lived at Normanton Lodge and three relatives. We also spoke with three care staff, a chef, an activity member of staff and the registered manager.

We observed care and support being provided in the lounges and dining areas. We also spent time observing the lunchtime experience people had. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We also observed part of the medicines round that was being completed.

We reviewed a range of records about people's care and how the home was managed. These included care records and medicine administration record (MAR) sheets for five people and other records relating to the management of the home. These included staff training, support and employment records, quality assurance reports, policies and procedures, menus and accident and incident reports.

Normanton Lodge was last inspected on 07 November 2013 and there were no concerns.

Inadequate

Is the service safe?

Our findings

Medicines were not managed safely at Normanton Lodge. The registered manager told us that only one person had their medicines administered covertly. We found two people's morning medicines were in pots mixed in with lactulose in the medicines cupboard. Both people had refused their medicines. The registered manager said she would try later but got distracted by our inspection. Both these people's medicines were signed as administered by the registered manager before they had been given. With regard to disguising medicines the manager said of one person, "She refuses to take this, this is the only way we can get it in". With regard to the second person the manager said, "He spits out the tablets so we find it easier for him to take it in lactulose". There was no evidence that the decision to disguise medicines had been assessed by the prescriber. There was a covert medication procedure in place but this was not being followed. The home's policy stated covert administration should be 'in accordance with MCA, permission from GP and family, best interest decision and recorded in care plan'. This had not been followed. On the second day of our inspection the manager produced evidence that she had sought advice from the individual's GP and that they had confirmed in writing it was safe to give the medicines in this way.

There were no guidelines or protocols for the administration of medicines required as needed (PRN). Staff knew when PRN medicines should be given and why and were able to describe symptoms that might indicate a person who could not communicate verbally was in pain. We found evidence that PRN medicines were offered as part of the normal medicine rounds but not at any other times.

Other concerns with regard to medicines management included systems for the safe disposal of medicines and records. Medicines that were waiting to be returned to the pharmacy were in an open box. Medication administration record (MAR) charts had been signed to confirm people had their medicines at 8.00am but we saw some people did not have their medicines until 10.30am and one person's MAR chart did not include the fact that they were allergic to two medicines. On occasions staff had recorded 'X' as a key which was not a legitimate key code so it was unclear why or whether this medicine had been administered.

Two staff confirmed that they administered medicines but have not completed training or a written competency assessment. Both informed us that they were currently completing a medication course and one that they had watched other staff administering medicines. All of the above was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Some prescription medicines are controlled under the Misuse of Drugs Act 1971 - these medicines are called controlled drugs or medicines. Controlled medicines were stored safely and separate records maintained. The stock of controlled medicines reflected the amount recorded in the controlled drugs book.

Complaint records evidenced that the registered manager investigated concerns raised by people and took action to resolve issues. However, when needed the registered manager had not raised safeguarding alerts with the local authority safeguarding team or notified us in line with her registration requirements when complaints also included potential abuse of people. This meant that potential safeguarding situations were not known to all agencies that had a responsibility to monitor people's safety and wellbeing. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People told us that they felt safe. They said that they could speak up and express any concerns without fear. One person said, "I am very safe and happy here and I would talk to the manager straight away if I wasn't". Another person said, "I've not been here long and I'm a bit nervous but I think I would speak to someone if I had to yes". A third person said, "Of course it's safe here, they've always got their eye on you to make sure you're alright". We observed that people looked at ease with staff.

Staff confirmed that they had received safeguarding training and were able to describe the various types of abuse. They told us what they would do if they suspected abuse was taking place and that they would speak to the deputy manager, registered manager or social services. One member of staff explained, "I think first of all if their behaviours change and any unexplained bruises or if I saw someone doing it (abuse) I would go straight to the

manager and I am confident they would deal with it". Another member of staff said, "I do feel confident the manager would act because she is quite particular about how she wants things".

During our inspection we observed that, for most of the time staff were available when people needed assistance with personal care. At lunch time we did observe one instance when a person was attempting to eat a plastic apron. There were no staff present to intervene and we had to ask a member of staff who was in another room to help the person. For people who chose to stay in their rooms we saw that they could call for assistance, as the home had a call bell system in place. We observed four rooms where people could not reach their call bells and one person who was struggling to eat their lunch and could not call for assistance. The manager told us, and records confirmed, that staffing levels consisted of five care staff from 8am until 2pm, three from 2pm until 8pm and two during the night. The manager said that a written assessment was not completed for deciding safe staffing levels. When asked how staffing levels were decided the manager said, "We have always had five on in the morning and two or three in the afternoon since I have been here. If needed I would bring extra in but I've not needed to. Five is sufficient". This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff said that in general there were enough staff on duty to meet people's needs. They did say that shifts could be busy and that routines were in place to ensure everyone's care needs were met. One member of staff said, "We have allocated times for baths in the week but if someone wanted one at the weekend we would do it". Another member of staff said, "We can be busy if the bell is going all afternoon, no shift is the same it depends on what is going on" and "We have to have a routine or it's a nightmare. We have meals at certain times, tea trolley and no one could have a bath at any time – we have a schedule".

Hoists were available for use that had been regularly serviced to ensure that people were moved safely. There were six slings of different sizes available to use with the hoists. Staff that we spoke with were unable to tell us which sling should be used for people who required help to move and this information was not included in people's care records. This meant there was a risk that people could be assisted to move using the wrong size sling and as a result might not be transferred safely. We observed one person being assisted to transfer from a lounge chair to a wheelchair. This was done safely but we noted that the wheelchair used to transfer the person from the room did not have any footrests. This meant that the person was at risk of trapping or dragging their feet beneath the wheelchair as it moved. On another occasion we observed a person who had slid down in a lounge chair. Staff noticed this and assisted the person into an upright position but they did this using an unsafe moving and handling technique. Risk assessments were in people's care records on areas such as moving and handling, skin integrity including pressure sore risk assessments, malnutrition and mobility. These contained basic information such as if a person required a hoist to move safely. They did not include information about the size of sling a person required and when we asked staff about which they would use they were unable to tell us. This is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Checks had been undertaken on lift servicing, electrical portable appliance testing (PAT) and hoists to ensure they were safe. There were several steps and floor areas that had inclines which posed a trip hazard that had not been marked to make them easily identifiable. The registered manager advised us of these when we walked around the home so that we would not trip over. The registered manager confirmed that there was no written risk assessment in place regarding the environment and potential health and safety hazards that included trip hazards. She explained, "Not as such, the handy man goes round each week and checks things and records in a book if work needs done".

We observed that people moved around the home freely, apart from having access to the conservatory and garden, both of which had doors that were locked. People told us this was normal practice. One person told us, "I go where I want. You only have to ask for the key and you can go into the conservatory and when it's nice I can go out for a walk as long as I let them know".

Accidents and incidents were looked at on an individual basis and action taken to reduce, where possible, reoccurrence. People's individual care and support needs were reviewed when incidents occurred to help keep them safe. For one person who had experienced a number of falls from their bed, the registered manager had reviewed the individual accident records and made changes to the

Inadequate

Is the service safe?

care that they received. This included making sure their bed was as low to the ground as possible and putting a mattress on the floor next to the bed to reduce the risk of injury if the person was to fall.

Recruitment records of four staff confirmed that checks had been undertaken with regard to criminal records, obtaining references and proof of ID. Two of the staff files included a record of criminal convictions. The registered manager confirmed that a formal, written assessment was not completed for staff with convictions to ensure they were safe to work with people who lived at the home.

Requires improvement

Is the service effective?

Our findings

The registered manager and staff did not understand the Mental Capacity Act (MCA) 2005 and the requirements under the Deprivation of Liberty Safeguards (DoLS). The safeguards under DoLS protect the rights of people by ensuring if there are any restrictions to their freedom and liberty these have been authorised by the local authority as being required to protect the person from harm. The registered manager said that she had completed training in these areas but could not explain sufficiently people's rights or her responsibilities in relation to upholding their rights. She was not aware of a recent Supreme Court ruling that placed additional responsibilities on services where people lived who could not leave freely and without supervision.

The registered manager had not ensured people's rights were upheld if they lacked capacity to consent in line with the MCA. They told us that no one who lived at the home was subject to a DoLS authorisation. We saw that there was a key coded lock on the front door. The registered manager and staff confirmed that many people who lived at the home were unable to consent to the use of a locked front door due to them living with dementia. Two people also had their medicines administered covertly and we were told they did not have the capacity to consent to this practice. Individual assessments had not been completed that considered people's ability to consent to this or for actions that should be taken if people did not have capacity to consent. The registered manager confirmed they had not followed best interest decision making pathways for people who did not have the capacity to consent. The manager had not completed mental capacity assessments or made DoLS applications. Later, after we had discussed the situation with the registered manager and explained that these were required she started to complete DoLS applications for people who lived at the home. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Despite formal consent processes not being followed in full, we observed that staff checked with people that they were happy with support being provided on a regular basis and attempted to gain their consent. During our inspection we observed staff seeking people's agreement before supporting them and then waiting for a response before acting on their wishes. Staff maximised people's decision making capacity by seeking reassurance that people had understood questions asked of them. They repeated questions if necessary in order to be satisfied that the person understood the options available. Where people declined assistance or choices offered, staff respected these decisions.

Staff were not provided with training that helped equip them with the knowledge and skills to care for people. A training programme was not in place. With regard to training the registered manager said that as one course was arranged and completed she then made arrangements for another course to be provided. Information was on display that confirmed first aid training was booked for 18 February 2015 and fire safety on 15 April 2015. We looked at eight members of staffs' individual training records. Seven included evidence that they had completed training in safeguarding of adults and all had completed fire safety training. Four staff had completed basic life support training and five moving and handling training. There was no evidence that staff were provided with training in relation to infection control and health and safety. Only three of the eight staff had received training in relation to dementia, diabetes, MCA and DoLS despite people who lived at the home having needs in these areas. This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Support systems for staff were in place such as supervision and appraisal however, not all staff had been receiving this consistently. The registered manager said that individual and group supervision was decided based on need. She explained, "If needed, supervision can be two monthly. If more stable they may receive this once a year. We also have staff meetings about once or twice a year and do a handover on every shift change. There was no written plan in place that the registered manager used to monitor that all staff received regular, formal supervision and support. The registered manager told us, "If I notice something, I arrange to do supervision". Despite this, staff said that they felt supported by the registered manager and deputy manager. One member of staff said, "I have had one supervision in a year, probably at around six months with the manager, they like you to say if you have any concerns". Another said about their appraisal, "We discussed my strengths and weaknesses and my objectives, I was told I was not checking every aspect of a person's room".

Requires improvement

Is the service effective?

People said that the staff were skilled and competent in their roles. One person said, "They are very good at what they do". Another person said, "Yes they all seem to know what they're doing. I've no worries about anything like that".

New staff received an induction that was based on the Skills for Care Common Induction Standards Framework. This is a nationally recognised induction programme that helps equip staff with information and knowledge relevant to the care sector they are working in. Staff confirmed that during induction they shadowed other, more experienced staff before working independently and received training in moving and handling and health and safety. One member of staff said, "I really love this job. I came in to look around and then I shadowed other staff and did bits and pieces as well. How to use a stand aid and infection control was covered by the seniors, and I also had training on how to use a hoist and a course on safeguarding".

People's individual dietary needs were not always managed effectively. One person's records stated that they required a liquid diet and staff confirmed this was needed. At lunchtime we saw that they were served solid food which they had difficulty eating and as a result most was left uneaten. We asked the chef about this and he said, "She's OK with a few lumps". A member of staff told us that the person, "Hardly eats anything". We were informed that the chef passed on information verbally to the registered manager about people who were not eating well. However, staff confirmed that concerns about this person had not been shared with the registered manager. Therefore, this person was not supported to eat meals that met their individual needs and was at risk of malnutrition.

Individual fluid and food monitoring records were in place for people however these had not been completed in full or totalled at the end of each day. The registered manager confirmed that this did not take place. For one person we noted that on some days the fluid intake recorded was 300mls or under. The registered manager was not aware of the recommended daily minimum fluid intake for adults and this information was not available in the home or recorded in the person's care records. This meant that monitoring was not effective as action had not been taken to ensure the person was suitably hydrated.

We spoke with the chef and looked at records maintained in the kitchen of people's dietary needs. These recorded whether people had a china or plastic plate, whether they preferred brown bread, and whether they required liquid or blended food. Other dietary needs were not recorded such as diabetes. The chef was able to tell us about one person with diabetes but not a second whose records and discussions with other staff confirmed they also were diabetic. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People said that they were happy with the food and meals provided. One person said, "This new chef, he's good …the meat is so tender". Another said, "The food is lovely, very tasty" and a third said, "I do enjoy the food yes". A dietician confirmed that the home referred people if they had concerns with nutrition intake and that recommendations were acted upon. They told us, "During my first visit earlier in the year there were a few things that needed implementing in terms of 'Food First' approach therefore information was provided and discussed during that visit. I'm pleased to say that on my second visit recently, they were using some of this information to good effect, in particular using fortified milk and providing milkshakes to 'at risk' residents".

People said that they could choose where they wanted to eat their meals. We observed six people choosing to have their lunch in the dining room around one large communal dining table. Others had their lunch on tables in the lounge whilst others ate in their rooms. Where people required assistance this was done sensitively. Staff were seen giving good eye contact and serving the food gently and calmly. People who had their meal in the dining room were chatting together as they ate and all of them told us they enjoyed their meal and thought the food was good. The mood throughout lunch was relaxed and friendly and people were enjoying the food and each other's company.

We noted that the menu on display did not offer a choice of main meal and when staff spoke to people about main meals again no actual choice was offered. For example, a member of staff informed people, "It's cottage pie for lunch tomorrow". There was no checking that this was acceptable. We did observe that one person had a different meal to others at lunchtime. Most of the time people were offered a choice of drinks. Staff asked people, "Can I get a drink, orange, blackcurrant or water?" One person was served coffee in their room and was not offered a choice. They told us, "They know I do like coffee but sometimes I'd prefer tea but then they forget to put sugar in it".

Requires improvement

Is the service effective?

People said that their health care needs were met. This included calling the doctor promptly as required and also having access to chiropody, opticians, dentists and district nurses. One person said, “I see the doctor if I need one and the chiropodist does my toe nails. A relative said, “X was taken to hospital by X (member of staff) to have her ears checked and she’s having the stuff put in to soften the wax and then they’re going to take her back, so that’s all taken care of”. Another relative said, “If X gets sick they are quick to respond and contact me. I would definitely recommend them”.

Records confirmed that people were supported with wound care management via district nurses who visited the home. Pressure relieving equipment was in place and staff were able to explain how they supported people who were at risk of developing pressure areas. One member of staff explained, “There is a pressure cushion in their room and we have to make sure they are on their side”. They told us about another person who required turning every two hours and records confirmed this occurred.

Requires improvement

Is the service caring?

Our findings

There was little evidence of formal processes for actively involving people in making decisions about their care and treatment however, no one that we spoke with raised any concerns about this. The registered manager confirmed that people were not routinely involved in the reviewing of their care. Residents' meetings took place that were usually chaired by the activity member of staff. Relatives' meetings were not held. The registered manager told us this was because, "They were invited to a residents' meeting but didn't come". Records confirmed that during the residents' meetings people were asked about meals, staff and activities. There was some evidence of action taken in response to requests made but not for all. We discussed this with the registered manager who was able to verbally tell us of actions taken, but there were no records to substantiate this.

The majority of people said that they found the staff to be kind, caring and compassionate and our observations confirmed this. Two people said that at times, some staff did not show consideration. One person said, "They have conversations between themselves when they take me to the toilet or when they're treating me, they're always standing talking like that". Another person said, "Most of them are great but sometimes one or two think they own the place and tell you what time to go to bed like a child but I tell them and they don't do that to me now".

We observed there was laughter and chatting between people and staff. People and staff smiled and were comfortable with each other. We observed staff holding and stroking people's hands. We also observed staff guiding people as they walked along the corridor and talking to them in a calm, kind and reassuring way. Staff were heard talking in a kind and gentle manner. For example, one member of staff was heard saying to a person, "Here we are (name of person), that's it, take your time I'm right behind you, don't worry". Relatives also confirmed that they were made welcome and that staff were friendly and caring. One said, "You get a cup of tea and they're ever so friendly here" and another said, "It's lovely, they are so caring and I know they (family member) is looked after".

There was a stable staff group employed at the home and this helped build positive relationships with people. Staff were able to explain the individual needs of people and people's personal preferences without the need to refer to records. They told us that they got to know people by spending time and talking with them more than reading care records. One member of staff explained about a person's routine, "They like to get up early by night staff, watch TV and has an herbal tea in the morning, come into the lounge for activities at 2pm. They like to go to their bedroom and watch TV and go to bed at 10.30pm".

People felt that staff knew them well and that they exercised a degree of choice throughout the day regarding the time they got up, went to bed, whether they stayed in their rooms and when they bathed. One person told us, "I have a bath or a shower weekly but I always have a strip wash everyday". Three people told us that staffing levels sometimes impacted on their preferences. One person said, "They get me up at 6.30am, no way would I get up at that time if I was at home, it would be about 9.30am". Another person said, "They took me out in my wheelchair once to look at the flowers, it's never happened since, they're always so busy so just doesn't happen". A third person said, "They get me up earlier than I usually would but it's what you make of it".

Staff were able to explain how they supported people who lived with dementia or had limited verbal communication to make choices about their care. One member of staff explained, "One person who is non-verbal, they shut their eyes and mouth when they do not want to eat anymore".

People told us that staff treated them with respect and dignity when providing personal care. When people needed assistance with personal care we observed that staff did this behind closed doors in bedrooms and bathrooms. Attention to detail had been given with people's appearance with many ladies wearing items of jewellery that complemented their co-ordinated outfits and gentlemen were freshly shaved. Staff were able to explain how they promoted respect, dignity and independence. One said, "Make sure doors are shut, curtains and blinds, make sure you do as they would like". Another said, "See if people are able to wash and dress themselves, we encourage this, whether people are slow or have difficulty in walking we encourage them, we say 'use them or lose them' (legs) we encourage people to feed themselves and take themselves to the toilet if they can".

Requires improvement

Is the service responsive?

Our findings

People generally felt that there were enough activities offered to entertain and stimulate them. One person told us, "I like anything to do with sport so at night one of the male carers comes and chats to me about football sometimes". Another person said, "The activity lady does my finger nails and paints them for me". Several ladies mentioned enjoying having nails painted. Another person had a keyboard in their room and also told us that they enjoyed knitting and sewing. A relative said, "The activity lady is lovely with them, she gets them involved in things together like painting and decorating the dining room, they have BBQs in the Summer".

We observed the activity member of staff talking with a group of seven people in the lounge and reminiscing about past times and how things used to be in previous years. The layout in the lounge meant that people had to sit in a straight line rather than in a group with the activity member of staff. Despite this, people were seen joining in and responding to the activity person's bubbly persona. After a while people were asked if they wanted to play scrabble and others were asked if they wanted the telly on. Four people said they did. One person needed hoisting to join the others at the other end of the room. Five members of staff in total came into the lounge to do this and then decided it was going to be too much of a job so moved everyone else who wanted to play over instead. No one was asked if they minded.

We were informed that all of the residents were atheists and that the upstairs lounge was going to be allocated as a quiet area for remembrance and thoughts. An activity programme was in place that provided entertainment each morning by the activity member of staff. These included nail painting, quizzes and board games. External entertainers visited the home twice a month.

Some effort had been made to the environment in response to people who lived with dementia. There were pictures in the lift to soften the environment, a day and weather board and there was an activity board but this was not completed on the day of our inspection. However, there was not much physical stimulation such as interactive tactile activities or textured surfaces around the home for people that would have provided them with something to do during the day when organised activities were not happening. **We recommend that the provider researches and implements relevant guidance on how to make environments used by people who live with dementia more 'dementia friendly'.**

Although people told us that they exercised some degree of choice and control over their lives we found that staffing levels in the afternoon impacted on this. As a result, routines were task driven and not in response to people's individual needs. One member of staff said, "In the afternoon we start getting people ready for bed at 2.30pm, we do laundry and answer bells". Another member of staff said, "Night staff are expected to get nine up then from 7.30 day staff do the others". The registered manager said that this was not correct and that people started to get ready for bed or got up in the morning at times of their choosing. However, this was not recorded in any of the care records that we viewed.

Referrals had been made to external health care professionals when changes occurred to people's mental wellbeing and memory. The findings from these assessments were then incorporated into people's care packages and changes made to the delivery of care so that people received the care and support they needed.

Everyone said they felt able to express concerns or would complain without hesitation if they were worried about anything. The registered manager told us that issues were usually dealt with informally and this resulted in the home having few formal complaints made. Records were in place that showed that where concerns or complaints had been raised efforts had been made to address and resolve the issues.

At the entrance of the home, we saw that there was information displayed regarding the fees, service user guides and how to make comments, complaints or suggestions. Contact details for the Commission were also displayed so that people could make contact if they wished to share information about the service they received.

Requires improvement

Is the service well-led?

Our findings

Systems to assess the quality of the service provided in the home were not effective. The registered manager completed audits of the service but these had not been completed on a regular basis and had not always identified shortfalls in service provision. These included gaps in staff training, DoLS applications, incomplete records, medication issues and out of date policies and procedures. The registered manager told us that she should complete a monthly audit of the home but that she had last done this in July 2014. As a result, people received an inconsistent service. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Many records that related to the management of the home were either not in place or inaccurate or out of date. The registered manager told us that she assessed staff competency for administering medicines but that a record of these were not completed. When we asked to view monthly audits completed by the registered manager she was only able to produce the front sheet of the form used for capturing this information. The manager told us that this was the only part of the audit record that she maintained. Recruitment records for staff did not include a record of interview. People's care records were also incomplete and some had not been reviewed at the monthly frequency stated as required. Policies and procedures were in place for staff to follow to ensure safe and appropriate care was provided to people. However, the majority of those we sampled were out of date and did not reflect current legislation and guidance. The consent policy stated, 'Residents have the right to choose their own General Practitioner to provide high quality medical care when they come into the home'. It did not contain any further information about people's rights to consent to any aspect of their care or not or of actions that staff should take if people do not consent. The quality assurance policy made reference to 'National Minimum Standards' guidance. This guidance was replaced in 2010. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We discussed with the registered manager how she ensured that she maintained her knowledge so that the home was well-led. She said, "I try and use journals, look at websites to try and keep abreast of things and I read CQC emails that are sent to us when time allows". The registered manager held a National Vocational Qualification (NVQ) level 4 in management which she obtained in 2006. Since being registered the manager had undertaken a number of courses, which included basic life support and fire safety in 2014. All of the training that the registered manager had undertaken was relevant to a caring position. The registered manager had not undertaken further training to ensure her management skills and knowledge were current and that would ensure the home was consistently well led.

Staff were positive about the management, culture and quality of care at Normanton Lodge despite a lack of formal processes being followed to obtain staff views.. They were able to explain the aims and objectives of the home. As one person explained, "To help people who can no longer live by themselves, help them with independence and when they are no longer able, help people with their everyday needs". Staff were able to explain about whistleblowing procedures and how these encouraged them to raise concerns although none had felt the need to do so. The registered manager told us that she operated an 'open door' policy and anyone could have access to her when they wanted to. We observed that people freely entered the registered manager's office and were welcomed when they did this which promoted an inclusive atmosphere for people. The registered manager completed regular reports that were shared with the registered provider and the provider visited the home on a regular basis in order that they were kept informed about the service.

People said that the registered manager was approachable and friendly. One person said, "Oh yes the manager she's a darling and really looks after me". Another said, "You know you can have a private chat with her anytime". A relative said, "You can speak to her anytime and its well run and organised". A member of staff said of the registered manager and deputy manager, "They are my backbone, without them I would crumble". We observed that the registered manager treated people in a warm, supportive and friendly manner. Referring to the atmosphere in the home a staff member said, "It's a good atmosphere, staff get on well, if there are any problems the manager gets people in the office to sort it out". Another said, "If there is a problem it is usually quickly fixed, I never feel worried about coming into work which is nice".

The registered manager had analysed quality assurance questionnaires that had been completed by 21 residents in

Requires improvement

Is the service well-led?

August 2014. The majority of people said that they were happy with the quality of service provided. This included choices available to people, menus, personal care and support and activities. When people had made suggestions for improvements, action had been taken to address these.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The registered person had not protected service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the recording, using, safe keeping and administration of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse Regulation 11 (1)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The registered person had not made suitable arrangements to ensure that service users were safeguarded against the risk of abuse by means of responding appropriately to any allegation of abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The registered person had not taken appropriate steps to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced persons employed.

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment Regulation 16 (1)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The registered person had not made suitable arrangements to protect service users and others from the use of unsafe equipment by ensuring that equipment was used correctly.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment Regulation 18 (1)(a)(b)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The registered person had not ensured suitable arrangements were in place for obtaining and acting in accordance with the consent of service users or establishing and acting in accordance with the best interests of the service user in line with Section 4 of the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff Regulation 23 (1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The registered person had not made suitable arrangements in order to ensure that staff received appropriate training.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs Regulation 14 (1)(a)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

This section is primarily information for the provider

Action we have told the provider to take

The registered person had not ensured that service users were protected from the risks of inadequate nutrition and dehydration by means of a choice of suitable and nutritious food and hydration in sufficient quantities to meet service users' needs and support to eat and drink sufficient amounts for their needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision Regulation 10 (1)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The registered person had not protected service users and others against the risks of inappropriate or unsafe care and treatment by means of the effective operation of systems designed to regularly assess and monitor the quality of services provided.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records Regulation 20 (1)(a)(b)(ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The registered person had not ensured that service users were protected against the risks of unsafe or inappropriate care and treatment by means of the maintenance of accurate records in respect of each service user. The registered person had not ensured the maintenance of such other records as are appropriate in relation to the management of the regulated activity.