Park Homes (UK) Limited

Norman Hudson Care Home

Inspection report

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Date of inspection visit:
07 December 2022
08 December 2022

Date of publication:
03 February 2023

Ratings

Overall rating for this service	Inadequate

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

About the service
Norman Hudson Care Home is registered to provide residential and nursing care for up to 42 people. At the time of the inspection there were 29 people living in the home, the majority of whom were living with dementia. The home is situated across 3 floors, with communal areas on the ground floor.

People's experience of using this service and what we found
There was instability and ineffective leadership in the home, particularly with regard to clinical risks and oversight of people's nursing care. There was a lack of management ownership and accountability within the service. None of the management team had a robust and complete overview of risks in the service. Quality assurance checks were not effective, consistent or robust enough to accurately identify or drive improvement in the service.

People were not always safe. Some relatives shared concerns about how safe their loved ones were living at Norman Hudson. We identified continued concerns around how risks to people were assessed and monitored. Risks to individuals were not identified accurately, and there were not adequate systems in place to ensure actions were taken to mitigate the risk of harm. There were no systems or clear communication in place to ensure people's health was monitored when they were ill or had specific health conditions. Systems and processes were not securely in place to ensure the safe management of medicines.

Fire safety matters, which had been a serious concern at the last inspection, had not all been addressed. Not all staff were confident with emergency evacuation procedures or equipment, and there was limited evidence of fire drills having been carried out.

There were insufficient checks carried out to ensure staff were suitable to work in the home. Staffing levels were adequate on the days of the inspection, although people and relatives told us the home was not always well staffed. There was poor deployment of staff with the appropriate skills and experience to meet people's needs. Staff told us they completed e-learning training, although they could not all recall what they had done or when and there were gaps in the training matrix. Staff supervision had recently been scheduled and completed for a small number of staff, although some staff could not remember having had a supervision meeting and no appraisals had been completed.

Infection control practice remained an area of concern. Staff mask usage was a continued concern at this inspection, qualified nurses were not always bare below the elbow and there were some malodours and equipment in need of thorough cleaning.

People did not have adequate daily opportunities to be purposefully engaged and occupied. Many of the people at Norman Hudson were living with dementia and needed support and reassurance. Staff lacked the skills and abilities to communicate effectively with people who were upset or anxious, and although they remained in their presence, there was little attempt to reassure anyone or involve them in activities and

conversation. People were seated for long periods of time in chairs with nothing to do or seated directly underneath a loud nurse call system during a film. The provider told us they were actively recruiting for activities staff.

Some improvements had been made to the living environment and the décor in the home as well as some new furniture. However, some fixtures and fittings were not safe or secure, such as toilet seats, radiator covers and drawers. Equipment such as tray tables and footstools, were in short supply. Improvements were still needed to make the home more dementia friendly and to ensure living spaces were accessible. We have made a recommendation that the provider seeks relevant expertise in making the home more dementia friendly, and to consider how communal areas in the home could be better utilised.

The recording of people's care and support was inconsistent, inaccurate and incomplete. Care plans were in the process of being transferred from paper to electronic records, but information was not always sufficient for staff to know how to care for people's individual needs. Records in relation to food, fluids and repositioning were inconsistent. Staff did not always know why they were recording and therefore lacked understanding of how to identify and report concerns. There was no systematic review of people's daily notes to ensure people were receiving adequate care. People's weights were not consistently recorded and there was conflicting information in the records we reviewed.

Mental capacity assessments and other related documentation had been completed. People were not always supported to have maximum choice and control of their lives because everyday decisions were made for people, without always asking them. Some staff understood how to support people in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Staff worked with healthcare partners where they were involved to meet people's needs. However, people did not always have their health needs reviewed routinely, such as for the risks associated with diabetes.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was inadequate (published 3 September 2022)

The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection we found the provider remained in breach of regulations.

Why we inspected
The inspection was prompted in part due to concerns received about safe recruitment, safeguarding, management of risk, and leadership in the home. A decision was made for us to inspect and examine those risks.

We undertook a focused inspection to follow up on specific concerns which we had received about the service and to follow up on action we told the provider to take at the last inspection. We inspected and found there was a concern with how people's needs were being met, so we widened the scope of the inspection to become a comprehensive inspection which included the key questions of caring and responsive.

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

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

Following the inspection visit, the provider arranged a 'gold command' leadership structure to attempt to address the areas identified. We continued to receive information of concern, with continued themes of poor culture and insufficient management of risks. Consequently, we were not assured risks were being mitigated.

The overall rating for the service has not changed from inadequate, based on the findings of this inspection. We have found evidence the provider needs to make improvements. Please see all sections of this full report.

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

You can read the report from our last inspection, by selecting the 'all reports' link for Norman Hudson Care Home on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to people's care and support, safety, staff suitability, and management of the home at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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.

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

Details are in our safe findings below

Is the service effective?

Inadequate

The service was not effective

Details are in our effective findings below

Is the service caring?

Inadequate

The service was not caring

Details are in our caring findings below

Is the service responsive?

Inadequate

The service was not responsive

Details are in our responsive findings below

Is the service well-led?

Inadequate

The service was not well led

Details are in our well led findings below

Norman Hudson Care Home

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection was carried out by four inspectors, a medicines inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Norman Hudson Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Norman Hudson Care Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered CQC to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. A new manager had been in post for 3 months, although they left their post before the inspection process concluded.

This inspection was unannounced.

Inspection activity started on 7 December 2022 and ended on 30 December 2022. We visited the location on 7 and 8 December 2022.

What we did before the inspection
We reviewed information we received about the service since the last inspection and liaised closely with local authority partners and professionals who work with the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 4 people who lived at the home, 1 relative, the home manager and 5 members of the senior management team, including the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We spoke with 4 nurses and 8 care staff, as well as ancillary staff. We spoke with 6 staff and a further 9 relatives by telephone. We observed care in communal areas, including mealtimes.

We reviewed a range of records, on site and remotely. These included people's care records, medicine records, staff rotas, personnel files and documentation to support how the service is run.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question inadequate. The rating for this key question has remained inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- Risks within the environment and to individuals were not identified thoroughly or managed safely.
- There was a lack of safe care where there were particular risks to individual people. Staff did not all know what people's personal risk factors were.
- Staff did not always understand where people required support to reduce the risk of avoidable harm. Care plans did not always contain the control measures for staff to follow to keep people safe. Where people were at high risk of falls, or pressure ulcers, not all staff knew this. Information in handovers was not detailed enough for staff to support people safely, and key information was not shared, such as recent medicine errors.
- People's health needs were not adequately known or monitored and there was no clinical oversight in place to escalate any information of concern. For example, when one person had an infection, there was no monitoring or awareness of the signs of improvement or deterioration. Where records showed some people had not had enough to eat or drink, there was no process to ensure action was being taken. There was a lack of consistency with monitoring and recording people's weight.
- Whilst we observed improvements had been made to the living environment, there were hazards within the environment which had not been identified or actioned and manager daily safety checks were not robustly carried out.
- Evidence of fire point checks was not clear. While some recording was seen, it was not clear that these checks accounted for all the fire points in the home. There was an increased staff awareness of how to safely evacuate the building in the event of an emergency; although not all staff knew how to do so. Night workers, including the person in charge of the shift, were unable to accurately tell us how many people were living in the home. This is important information in the event of an emergency.

This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as risks to people had not been identified or reduced.

The provider told us they had identified some hazards before our inspection and had ordered new furniture,

as well as working to a refurbishment plan for the home.

Staffing and recruitment

At our last inspection the provider had failed to ensure sufficient numbers of staff were available to meet people's needs. This was a breach of regulation 18(1) Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18. There were not enough staff with the skills and abilities to support people, particularly those people living with dementia.

● There were sufficient numbers of staff to meet people's needs, although staff deployment was ineffective.
● Staff rotas did not demonstrate a mix of skills and experience on each shift. On the first day of the inspection, there was a team of temporary and very new staff who did not know people's needs well and did not demonstrate any understanding of dementia care. One new member of staff said they were unsure what to do when people were becoming unsettled in a lounge area and an inspector requested a more senior member of staff's presence.
● Relatives gave us mixed views about staffing levels. One relative said, "There has been a terrible shortage over the weekend, they are all agency staff and you cannot get through on the phone. There is no rapport with agency staff and that's what you need with Alzheimers." Another relative said, "All places struggle with staff and these do too. The people [staff] are good with my relative. They have some good staff, but they are short staffed."
This was a continued breach of regulation 18(1) Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because suitably competent experienced and skilled staff were not deployed.

● Staff recruitment was inadequate and there was no evidence of safe recruitment decisions. Personnel files we reviewed showed staff had been appointed without robust procedures in place. We looked at 5 recruitment files and found key background checks to ensure staff were safe to work with vulnerable people were missing. For example, one staff member was recruited without an application form, references and a current DBS check. Another member of staff had only one reference on file, which was unsatisfactory, yet there had been nothing done to ensure completeness of checks.
● Where agency staff were used, there were no consistent or robust measures taken to ensure their identity or qualifications were checked. Some agency staff worked without evidence of verification or induction. We were given conflicting information by different senior managers about the employment status of one member of staff. Their personnel file was given to the inspection team several hours after it was requested, and this did not show how their suitability had been verified.

This was also a breach of regulation 19, Fit and proper persons employed, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as robust recruitment procedures were not operated, therefore people were at risk of unsafe care.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● People were not adequately protected from the risk of harm.
● Since our last inspection, there was a large scale safeguarding enquiry in progress with the local authority due to concerns over people's safety.
● Where there had been allegations about particular staff, they continued to work in the service without prompt or adequate investigation.

● There was a delay in reporting safeguarding concerns to the local authority and senior managers did not know the process to follow. Staff did not always know how to identify or report concerns.
● There was a lack of robust processes to ensure lessons were learned when things went wrong.
● Insufficient action had been taken to ensure people were protected from the risk of harm. Where concerns had been highlighted through the last two inspections and by the local authority partners' improvement support visits, there was limited evidence of the provider using these as opportunities to learn. There was no management oversight of safeguarding concerns in the home.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as systems were not operated effectively to identify, respond to and report safeguarding concerns.

● Most relatives told us their loved ones were safe from harm, although we had mixed feedback about their confidence in how safeguarding was managed. One relative said, "I don't believe there is any abuse going on, but I don't know if they are looking after all [my relative's] needs. There is a safeguarding case going on at the moment." Another relative said, "I would say much better now, better than 4 months ago when the safeguarding wasn't done." Another relative said, "I am [satisfied about safeguarding] now. I was not before. I am hoping [the new manager] can put things in place."

Using medicines safely
● Systems for the safe management of medicines were not robust.
● There were no clear lines of accountability for medicines management, and this had led to recent and repeated medicines errors in the home. For example, shortfalls in the delivery of some medicines meant many people did not receive their medicines on time. This was not picked up because no staff took responsibility for booking the medicines in.
● Where some people were prescribed medicines to only be taken when required, there were not always adequate protocols to guide staff as to when to administer the medicine. The provider told us this was being addressed and we saw some improved protocols put in place during the inspection..
● There was no evidence of action to take when a person refused their medicines repeatedly, and there was no up to date information on when individual people had last had their medicines reviewed.
● Medicines that are controlled drugs were kept in a locked cupboards, although there was no audit trail to show who had daily authorised access to the cupboard. Arrangements for the disposal of unwanted medicines were in place and a record of disposal was kept. However, some tablets left from the previous monthly cycle were not accounted for.
● The provider's audits of medicines were not effective enough to identify risks and avoid a repeat of previous errors. Matters to be addressed had been discussed during the inspection, yet a subsequent audit showed action had not been taken.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as robust systems were not in place for the safe management of medicines.

● Medicine cupboards were clean and medicines were kept at the right temperature.

Preventing and controlling infection
At our last inspection, infection control was poorly managed. and the provider had failed to robustly assess the risks relating to the prevention and control of infection. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, there had been some improvement, although we were not assured appropriate control

measures were in place to prevent the risks to people and the provider was still in breach of regulation 12.

● Although regular cleaning was taking place there were some malodours in the home. Some aspects of cleaning needed to be more thorough, such as pressure relieving cushions and lifting slings.
● There was inconsistent practice; some staff wore masks under their noses and chin; this was identified at the last two inspections. Whilst some improvements were seen since the last inspection, we saw 3 staff members working in the home without a mask on. A nurse was not working in line with good practice guidelines and bare below the elbow, which creates more effective handwashing and reduces the risk of cross infection.
● There was a lack of appreciation that staff could pass infectious diseases between themselves, even if they were not in the immediate space which people occupied.

This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as not enough action had been taken to prevent the risk of infection.

Visiting in care homes
Suitable visiting arrangements were in place. However, we continued to receive feedback which indicated visitors had to wait for extended periods outside the service as staff did not answer the door. At the last inspection, the provider told us this was because the doorbell was not working. This was a continued concern, as although the doorbell was working, there was a lack of timely response.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question inadequate. The rating for this key question has remained inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Adapting service, design, decoration to meet people's needs

At our last inspection the provider had failed to ensure the premises were adequately managed to maintain people's safety and comfort. This was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 15.

● Although we saw some improvements to décor, communal areas and dining furniture, there were still aspects of the premises which were not sufficiently maintained and we found continued themes from our last 2 inspections.
● At the last inspection, we heard and saw the lift was not operating effectively. At this inspection, the lift was noisy and the doors were very slow to open. Staff reported the lift was not reliable and regularly needed re-setting. No action had been taken to ensure previous engineer's recommendations were acted upon. The provider told us these were only recommendations, but said the work was scheduled for completion in early 2023. However, this work was not listed on the provider's January 2023 refurbishment plan.
● We pointed out hazards we found in the environment. For example, there were 2 very loose toilet seats and we brought this to the attention of the manager. We were told these toilets were not used by people, yet we saw these being used even once we had reported our concerns.
● Radiators were not all safely or securely covered and some sharp parts were exposed, causing a risk of injury. Some bedroom furniture was in a poor state of repair and some doors were still damaged, including one we had reported to the provider at our two prior inspections.
This was a continued breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 there were hazards within the environment which had not been identified or actioned.

Staff support: induction, training, skills and experience

At our last inspection the provider had failed to ensure staff were effectively supported through appropriate periodic supervision. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● Some staff told us they had not had any formal supervision and not all staff understood what this entailed.
● Staff told us they did not have regular supervision to be able to review and prioritise their work and development. One member of staff did not know what supervision was and other staff could not recall when their last supervision meeting was.
● There was no clinical supervision for nurses to enable them to reflect on their own practice and engage in professional discussion to improve the quality of care.
● Supervision records we reviewed showed there was no formal staff support recorded from 13 July up to 7 September 2022. From September 2022, when the new home manager commenced their employment, the records showed supervisions were beginning to be scheduled; although for only a very small percentage of the staff team. One staff appraisal had taken place since our last inspection.
● There was no evidence of staff competency checks. Staff, including nurse trained staff said there were no checks made of their work to ensure they were capable and safe to support people. There was a large reliance on agency nurses, but limited assurances as to their competence or induction
● The training matrix we were given identified a list of staff and e-learning modules, but there were gaps and inaccuracies in the information supplied. For example, one member of staff had no training listed and the training matrix showed they had not yet started work at the service. However, different information showed they had been employed for several months. There were some differences between the full list of staff and the names on the training matrix and staff rotas.

This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as effective training, support, supervision and appraisal had not been sufficiently provided.

Supporting people to eat and drink enough to maintain a balanced diet
● There was a lack of clear oversight of people's dietary needs.
● We asked the management team for details of people with dietary risks, including those who were diabetic and found they did not have this information readily available. Records we saw were inconsistent. One person was living with diabetes, but this was not recorded in the kitchen and staff working in this area were unaware of this person's dietary needs and risks.
● There was poor monitoring of whether or what people had been offered to eat and drink. Staff completed records of people's food and fluid intake much later than this was offered. This meant recording was potentially not accurate and would not indicate whether people were at risk of dehydration or malnutrition. This had also been raised at the last inspection.
● There was a heavy presence of senior managers during one lunchtime experience which offered people additional positive support, although staff said this did not usually happen.
● We observed a staff member providing one-to-one assistance at lunchtime and saw they did not rush the person they were assisting and provided encouragement to them. They asked the person, "Is it nice? It's not too hot, is it?" A staff member noticed a person was at risk of their plate sliding off their over table and they were provided with a non-slip mat to prevent this.
● People enjoyed the food overall and they had adequate portion sizes and a choice of drinks. People were offered visual choices of the meals available to help them decide what they would like. One person had difficulty choosing, so staff patiently made suggestions until they found something they wanted.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● Care records and assessments were conflicting and lacked detail. There was limited information to guide staff how to support people and identical information had been copied between care records for different people. The manager told us electronic care plans were being updated and did not yet give person centred detail, but paper care records were not up to date.
● There was conflicting information to show how staff worked with healthcare partners, to meet people's needs. There were references to staff working with other professionals to support their health needs, such as for wound treatments, dietician or GP consultations. However, it was not always clear where follow up appointments had been made or advice given.
● There were no systems in place for staff to understand potential signs of deteriorating health and involve other agencies appropriately. One person with an identified infection remained asleep in their chair for a large part of a day and had eaten little. Staff we spoke with said they did not know if this was usual for the person or a sign of concern. Until we raised this with the nurse, no consideration had been made that the person may need additional monitoring or support.
● People did not always have their health needs reviewed routinely, such as for the risks associated with diabetes. One person told us they had not seen a diabetic consultant or podiatrist for 3 or 4 years and we saw their feet looked in need of attention. The provider told us this person declined this assistance, but this refusal was not documented in their care records.
● There were references in some people's care records to staff working with other professionals to support their health needs, such as for wound treatments or GP consultations. However, it was not always clear where follow up appointments had been made. For example, one person's record on 13 November 2022 stated the tissue viability nurse had to be contacted for further review, yet there was no evidence this had been done. Another person's care plan referenced a phone call with the dietician, but there was no record of the advice given.

Ensuring consent to care and treatment in line with law and guidance
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 MCA 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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● The recording of MCA, DoLS and best interests decisions was done. Relatives we spoke with said they had been involved in best interest decision making.
● Records of decision specific mental capacity assessments were contained in people's care plans.
● The provider submitted DoLS applications where people were assessed as not having capacity. The manager told us they had taken responsibility for ensuring DoLS were in place where necessary. We requested, but did not receive, a list of people's individual DoLS conditions to see how the service was supporting people appropriately.

Inadequate

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect. This domain has not been inspected since 2018.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Ensuring people are well treated and supported; respecting equality and diversity

- People were not sufficiently well treated and supported.
- People, particularly those who were living with dementia, were not consistently treated with compassion. Many staff spent time disengaged with people, and although they were present in the same room, there were times when they did not attempt any communication or interaction with people. Some staff looked disinterested and remained seated whilst in the company of people in need of support and reassurance, and this was not challenged by senior staff.
- When people needed assurances or became restless, staff did not always support them in kind and caring ways.
- We received mixed feedback from relatives about the staff's caring approach. One relative said, "I wait to see what happens if [my relative] is wearing their own clothes and if [staff] can find [my relative's] teeth." Another relative said, "I think the staff do genuinely care and they provide everything for everyone, and you don't often get that."

Supporting people to express their views and be involved in making decisions about their care

- People were not always able to express their views or make decisions about their care.
- Staff at times made routine decisions for people, such as what they wanted to drink, and where they would like to sit. More experienced staff directed new staff to take drinks to people, but without any consultation about what they might like.
- Staff were largely focused on completing care tasks and people were often not consulted about what mattered to them, or how they spent their time. Staff completed daily care notes in the presence of people, but without their inclusion.
- One person had a visit from their independent advocate, and this was welcomed. However, the way this was explained was not supportive of the person's needs. The nurse said the advocate would 'shout out' for them. We saw the person continued to be upset, clearly misunderstanding the use of the word 'shout'. The nurse failed to recognise this and was unable to provide adequate assurance.

Respecting and promoting people's privacy, dignity and independence

- Practice was mixed with regard to respect for people's privacy and dignity.
- Staff did not always acknowledge Norman Hudson Care Home was people's home and we heard them call loudly to one another, to communicate what they were doing.
- Where people needed staff to help them move, this was not always done with any discussion. For example, people in wheelchairs were moved by staff without consultation or explanation about where

people were going.
● One person told us there had been redecoration within the home which had gone on into the late evening. They told us staff at night often communicated loudly with each other in corridor areas, without regard for people in their rooms. They told us there was insecure management of the 'jack and jill' style bathroom which meant their en-suite bathroom was unexpectedly visited by their neighbouring resident at times when they wished to use this facility.
● The manager told us the 'jack and jill' bathrooms were monitored, and access was only given to people who could independently utilise the area. However, we found some bathroom areas could be accessed by both adjacent rooms, and the control measures were not always effective.
● Where people remained in their rooms there was little evidence to show staff had provided assistance as needed. One person's daily continence care records were not up to date and there was a strong odour in their room.

All of the above demonstrate a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, because people did not receive person-centred care which met their needs and reflected their preferences.

Inadequate

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs. This domain has not been inspected since 2018.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them; End of life care and support

- There was a lack of personalised care and people were not supported in individual, meaningful ways. Care records lacked person-centred detail and did not reflect people's wishes for their quality of life, or for their end of life support.
- Many people spent the day sitting in chairs around the room with no stimulation at all and the manager agreed this was not person-centred care. There was no activities coordinator at the time of our inspection, although the manager told us care staff were to provide this stimulation, but activities advertised for both days of our inspection did not take place.
- People living with dementia were asleep in the lounge for periods in the morning and in the afternoon, many people were restless. One person attempted to pull the radiator from the wall which had to be immediately repaired. We observed staff did not have the necessary skills to interact with people living with dementia, despite telling us they had received training for this.
- One person told us, "They (staff) hardly have time to answer the buzzer. I didn't think they'd have the time to sit with you."
- A film was put on the television for people to watch during the morning and the afternoon. Many people in the lounge could not see or hear this. There was no interaction from staff about the film and staff did not check if people could see/hear it or if they were enjoying it. In the afternoon another film was put on.
- One person who was unable to mobilise independently had been seated in a chair in the corner of the lounge adjacent to the wall where the television was sited. The person could (possibly) hear but not see the television. Above the person's head on the wall was the nurse call display and sounder. This was going off throughout the morning. We raised this with the
manager who said they could look into moving the nurse call display. We suggested they move the person as an immediate action, but this was not done until after lunch.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, because people did not receive person-centred care which met their needs and reflected their preferences.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to

do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● The provider was aware of their responsibilities to meet people's communication needs and this was outlines in their corporate documentation.

● One person who had a visual impairment told us staff sometimes read important information to them, such as their post.

Improving care quality in response to complaints or concerns

● The manager told us they tried to respond in person when people or relatives had any complaints or concerns.

● Relatives mostly told us they did not want to make any complaints, but they would know how to and there was information displayed with complaint details. Most relatives said they thought their complaints would be taken seriously, although 2 relatives were less confident. One relative said they made repeated complaints about missing clothing and another relative said the complaint process was not adequate.

● There was a corporate complaints policy and procedure, although we were unable to determine how complaints were recorded and responded to from the records we requested.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question inadequate. The rating for this key question has remained inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection the provider was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as previous breaches of regulation were not met and further breaches were found.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● There were significant and continued failures to ensure the service was safely managed. The regulatory breaches identified at the last inspection had not been addressed. In addition to the continued breaches, new breaches of regulation were found.
● Since our last inspection in July 2022, the registered manager, a turnaround manager and 2 area managers had left their posts. As we finished this inspection, we were informed the home manager had also left the organisation.
● There was a considerable senior management presence in the home during the inspection. However, despite this, there was a substantial lack of effective leadership or clinical oversight. There were no clear lines of accountability or ownership for areas of responsibility.
● Systems and processes to monitor the quality of the provision were weak. Provider quality visits did not provide effective oversight. Reports produced from these were repetitive, with information copied from one visit to another, without evidence of objective review or actions taken to drive improvement.
● Communication in the service was poor. Staff handover documents contained sparse information and lacked detail about people's care or clinical needs during the previous shift, and any critical information staff needed to know. This was a concern at the last inspection.
● Record keeping was of poor quality, and in some cases illegible. Staff lacked regard for confidentiality of documentation, and we found personal information in communal areas.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● Senior leaders in the organisation did not ensure or keep under review, the day-to-day culture in the

service, including the attitudes, values and behaviour of staff. The poor culture in the home was a significant factor in the standards of care being delivered.

● Managers and staff lacked a shared understanding of the key challenges, achievements, concerns and risks There were no clear and transparent processes for staff at all levels to account for their decisions, actions, behaviours and performance.

● Staff did not know or understand the visions and values of the service; these were neither promoted or embedded in practice. Staff spoke about people in their presence and in the presence of others, even after we brought this to the manager's attention.

● Some staff told us they did not feel valued, included or appreciated by managers.

● Relatives told us they felt there had been poor communication in the home until the recent appointment of the new manager. Since then, they said they felt more involved and had more information. One relative said, "They contact me straight away. Before, we struggled to get a response, but when [manager's name] contacted me, we met her team and it felt much better. They write to us now."

● Relatives told us they were beginning to feel more confident in how the home was run because of the new manager, although they were hoping improvements would continue. One relative said, "I think the new manager is committed. [The home] smells of wee and is improving; the dining room has been refurbished [but] my relative's room looks like a prison cell." Another relative said, "I can [give my views] now. With the new manager we are asked; prior to that I have not been asked."

Working in partnership with others

● The service had been working continuously with local authority partners since the last inspection, in order to develop improved ways of working. However, this had had little impact on the quality of the care delivery.

● Since our last inspection, there had been a lack of robust or effective action to address the concerns identified. Where new concerns had arisen, such as recent medication errors, the provider carried out a root cause analysis. This repeated information and suggested actions already brought to the provider's attention by the local authority, prior to the medicine's errors occurring. The provider's report did not establish clear lines of accountability or individual responsibility to ensure mistakes were not repeated.

● The provider had not sufficiently utilised the advice and support provided by the local authority in order to prevent deterioration in the standards of care or drive improvements.

Due to poor governance of the service people were placed at risk of harm. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had engaged the support of 2 management consultancy organisations to help establish and prioritise areas of improvement.