Mr David Lewis & Mr Robert Hebbes

Normanhurst Nursing Home

Inspection report

Brassey Road
Bexhill On Sea
East Sussex
TN40 1LB

Tel: 01424217577
Website: www.normanhurst.com

Date of inspection visit:
28 June 2016
29 June 2016
04 July 2016
05 July 2016

Date of publication:
07 September 2016

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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**

Summary of findings

Overall summary

This inspection took place on 28 and 29 June, and 4 and 5 July 2016. It was unannounced. We inspected Normanhurst Nursing Home at the same time as we inspected the service's sister homes, which were next door. There were 29 people living at Normanhurst Nursing Home when we inspected. People cared for were all older people. They were living with a range of nursing and care needs, including arthritis, stroke and heart conditions. Some people were also living with dementia. People needed support with most of their personal care, nutritional care and mobility needs. The home also provided end of life care.

Normanhurst Nursing Home had accommodation provided over three floors. A passenger lift was available to support people in getting between each floor. A lounge and separate dining room were provided on the ground floor and there was a wheelchair accessible garden. The home was situated near the sea-front in Bexhill on Sea

Normanhurst Nursing Home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The providers for the service were Mr David Lewis and Mr Robert Hebbes. They owned Normanhurst Care Home and Normanhurst EMI Home.

Normanhurst Nursing Home was last inspected on 31 July 2014. No issues were identified at that inspection.

During their audits of service provision, the provider had not identified a range of areas. This included people not always being left with access to their call bells and audit of time taken by staff to respond when call bells were used. The provider had not audited the training plan to ensure all staff were trained in areas to meet people's individual nursing and care needs. Recruitment systems were not audited to ensure that all staff folders included all required information and the provider's policies were consistently followed.

Some staff had not been trained in their responsibilities under the Mental Capacity Act 2005 (MCA). Systems for ensuring people's consent were not clear. Deprivation of Liberties (DoLS) applications were made, however there was a lack of best interest decisions documentation where people needed to have their liberties restricted, for example by the use of bed rails.

Assessments and care plans for people who had specific needs relating to living with dementia and need for engagement with activities required improvement. Some staff did not always fully engage with people who were frail and living with dementia. Other staff were responsive and consistently supported people in the way they needed.

Systems for supporting people with 'as required' (prn) medicines were not person-centred. In all other areas, registered nurses supported people in taking their medicines safely and ensured there were appropriate systems for storage of medicines.

There were fully established systems for ensuring people received the nursing and treatment care they needed. This included appropriate care of people's wounds, and end of life care. There were effective systems for liaison with external healthcare professionals, where appropriate.

The registered manager was new in post and was developing a range of areas including audit of accidents and development of systems for staff supervision.

There were a wide range of meals offered to people. People commented favourably on the meals. Where people needed support with their food and drinks, they were helped in the way they needed.

People said they were supported by kindly, caring staff. They said there were enough staff on duty to meet their needs, and they felt safe in the home.

Staff said they were supported by the provider's induction and training programme. Staff showed a clear understanding of how to protect people from risk, including risk of abuse.

We found a number of breaches of the HSCA 2014 Regulations. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Some systems for prevention of risk to people were not in place. Other areas relating to risk were addressed appropriately.

The provider's own systems for recruitment were not being consistently followed.

Medicines management was safe, with one area requiring improvement.

People were safeguarded from risk of abuse and there were enough staff deployed to meet their needs.

Is the service effective?

Requires Improvement

The service was not always effective.

Systems to ensure the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberties Safeguards (DoLS) were not being consistently followed and some staff were not aware of their responsibilities.

The provider had not ensured the home environment followed current guidelines for people in all relevant areas.

The provider's training plan did not ensure all relevant training took place. The registered manager was developing systems for staff supervision.

People received the support they needed with their diet and fluids. People commented favourably on the meals.

People's nursing care needs were met and referrals were made to relevant healthcare professionals to support people when needed.

Is the service caring?

Requires Improvement

The service was not always caring.

Some people were not always responded to by staff who supported them in the way they needed.

People's privacy, dignity, involvement and independence were respected.

Staff were consistently polite and respectful to people.

Where people were at the end of their life, their needs were met.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's assessments and care plans did not always ensure they were responded to in a consistent way. There was a lack of focussed activities for people.

There was a system for making complaints. There was no system for audit of smaller concerns raised by people.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider's systems did not always ensure relevant action was taken in relation to people's quality of life and welfare.

The provider and registered manager were open to developing new areas, to improve service provision.

Staff commented on the effective teamwork in the home and felt they were listened to by managers.

Normanhurst Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 28 and 29 June and 4 and 5 July 2016. It was unannounced. The inspection took place over four days because we inspected Normanhurst Nursing Home's sister services – Normanhurst Care Home and Normanhurst EMI Home at the same time. We did this because some services like cleaning, catering, training and human resources were managed centrally for all three homes. The inspection was undertaken by three inspectors.

Before our inspection we reviewed the information we held about the home, including previous inspection reports and the provider's information return (PIR). We contacted the local authority to obtain their views about the care provided. We considered the information which had been shared with us by the local authority and other people, looked at safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

We met 11 of the people who lived at Normanhurst Nursing Home and observed their care, including the lunchtime meal. We spoke with four people's relatives. As some people had difficulties in verbal communication, we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We inspected the home, including some people's bedrooms, bathrooms and toilets. We spoke with three visiting professionals, including a healthcare worker. We also spoke with 10 of the staff, including a domestic worker and training manager. We met with the registered manager and one of the providers.

We 'pathway tracked' five of the people living at the home. This is when we looked at people's care documentation in depth, obtained their views on how they found living at the home and made observations of the support they were given. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

During the inspection we reviewed records. These included staff training and supervision records, staff recruitment records, medicines records, risk assessments, accidents and incident records, quality audits and policies and procedures.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe, for example one person told us "I would say I feel safe living here," and another "Because staff are here, I feel safe." However we found some areas required improvement to fully ensure the safety of people.

We saw several people who remained in bed all the time had not been left with access to their call bell. One of these people told us they shouted out if they needed help. There was no information in their care plan about how they could summon assistance if they needed it. We asked staff about why different people did not have access to their call bells. They gave us different reasons as to why people were left without access to their call bell, and how they ensured their safety in the light of this. There were no assessments of risk about people who were left without access to call bells, to ensure their safety.

Systems for prevention of risk of pressure damage did not ensure the safety of people when they sat out of bed. For example, one of the people who was assessed as being at high risk of pressure damage chose to spend all their days sitting out in their chair. A person's risk of pressure damage does not reduce when they are sitting out in a chair, however the person's care plan did not include information on how their risk was to be reduced when they were doing this. We asked staff about what they did to reduce this person's risk when they were sitting out in a chair. Staff gave us differing responses. We discussed this with the registered manager who reported they would address this area.

People had a personal emergency evacuation plan (PEEP). These did not outline a range of factors which could place them at risk, such as whether they were living with memory loss or anxiety, or if they had a disability such as difficulties with vision and hearing, all of which could affect them if they needed to be evacuated in an emergency. The PEEPs were not dated to ensure they were regularly reviewed over time and as people's conditions changed. We discussed this with the registered manager and provider at the end of the inspection and they agreed to review the plans.

The provider was not always ensuring care was provided in a safe way to people. This was because they did not consistently assess risks to people and do all they could to mitigate such risks. This is a breach of Regulation 12 of the HSCA Regulations 2010.

Those people who remained in bed all the time had assessments of risk of pressure damage and very detailed care plans about actions staff were to take to reduce their risk. We saw staff followed these care plans and maintained accurate records of how they supported these people. The relatives of a person who remained in bed all the time told us they had seen that staff changed the person's position in bed on a regular basis to ensure they did not become sore.

During the inspection, an emergency bell was activated. Staff on duty responded quickly to ensure the person was promptly supported. The provider regularly monitored the safety of systems in the home, including maintenance of lifts, monitoring of water temperatures and fire safety checks. All people had clear mobility assessments and care plans, these were regularly reviewed when people's conditions changed. We

observed staff using equipment to support people with their mobility in a safe way, following guidelines. The inspections took place on hot summers' days. One person chose to sit outside most days. Staff ensured the person was protected from risk of heat and sunburn so they could continue to enjoy doing what they preferred.

Some systems for recruitment of staff required improvement to ensure staff had been employed in a safe way. For two recent employees, the section on their application forms for reasons for leaving their previous post had not been completed. This had not been probed at interview. We discussed this with the registered manager. They were able to tell us about reasons for such omissions, but as such reasons had not been documented, they would not be available for review at a future date. The provider had a procedure for assessing the suitability of prospective members of staff. The procedure used by the provider involved interview assessment forms, but most had not been fully completed, to ensure there was clear evidence of why the prospective member of staff had been judged as safe to work with people. The provider was not auditing compliance with its own recruitment and selection processes, so they could not ensure all staff were being consistently recruited in a safe way.

All other systems for safe recruitment of prospective staff were followed. This included checks with the Disclosure and Barring Service (DBS) to check prospective staff were safe to work with people, two references and a previous employment record. All registered nurses had their registration with the Nursing and Midwifery Council (NMC) checked on employment and annually after that, to ensure they maintained their registration with the NMC.

The home supported people with taking their medicines. Some improvements were needed where people were prescribed medicines on an 'as required' (prn) basis. Where people were prescribed medicines in this way, a protocol was drawn up. These protocols were not individualised. For example one person's protocol stated only 'for pain relief,' with no further information about what type(s) of pain they experienced. Another person was prescribed a mood altering drug 'for agitation' with no information about what behaviours they showed when they were agitated, or other supports the person should be offered before giving them the medicine. The registered manager knew the details of why people would need such medicines, but this was not documented. They confirmed they used agency registered nurses at times. As people's protocols about taking prn medicines were not individualised, the registered manager could not ensure all registered nurses would have relevant information to ensure people were given prn medicines in a consistent way.

All other areas relating to supporting people with their medicines were safe. This included secure storage of medicines, full records of medicines received into the home, given to people and disposed of from the home. There were clear systems where people were prescribed skin creams, including body charts to inform staff of where creams were to be applied on the person's body and records to show how often they had been applied. Where people were prescribed pain patches, there were clear systems for the rotation of pain patches to different areas of their body, to ensure the effective uptake of the medicine and reduce risk of skin damage.

Staff gave people their medicines in a safe way. We observed a registered nurse supporting people in taking their medicines. They carefully looked at each person's medicines administration record (MAR) before giving them their medicines. The registered nurse did not sign the MAR until they saw the person had taken all of their medicine.

We asked a wide range of staff about their understanding of safeguarding people from risk of abuse. All of them showed a good understanding of protecting people from risk of abuse. For example one member of staff told us they would "Always report on any issue." Another member of staff told us "I have had training in

safeguarding. It is about keeping residents safe. If I see anything inappropriate I would go to my manager. If she doesn't do anything I would call the Safeguarding team." The training plan showed all staff were trained in awareness of safeguarding people from abuse when they started employment, and were regularly updated in the area during their employment.

All people we spoke with confirmed there were enough staff on duty to support them. A person who remained in their room all the time told us "They're coming and going all the time," about staff. Another person told us about staff "There's always someone buzzing about." A person's relative told us there were "Definitely enough staff here" and that the ratio of staff to people was "Better" than a previous home their relative had lived in. We saw there were always staff available to support people across all of the home, including at busy periods like mealtimes. Staff also confirmed there were enough staff on duty. One member of staff said "We are well staffed at the moment," and another "There are enough staff. If someone is sick we call an agency but staffing is not a problem." Agency staff were used at times, but there were always several staff permanent deployed who knew people individually, to support agency staff.

Requires Improvement

Is the service effective?

Our findings

People said they received effective care and they felt staff were trained in meeting their needs, however we found some areas required improvement.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

People had assessments for mental capacity, but these were generic and not decision specific. Many of the people remained in bed in their rooms all the time. Most of these people had bed rails placed in a raised position on their beds. One person who spent all of their time in their room remained in a recliner chair all of the day. Several people used urinary catheters. When we looked at such people's records, there was no evidence they had consented to the use of appliances including urinary catheters and some people did not have assessments as to why they needed such ways of support. No people's records showed best interests meetings had taken place to ensure their care was being provided in their best interests and in the least restrictive way possible. For example a person's first language was not English, and they no longer spoke English. The person did not have an assessment of their mental capacity to assess if they would have been able to consent in their own language. There was also no evidence they or their supporters had been involved when a decision was taken that they needed to remain in bed all the time. There was also no evidence a less restrictive option had been considered for them, such as consulting an occupational therapist about suitable seating, rather than their remaining in bed all the time.

Deprivation of liberties safeguards (DoLS) applications had been made for some people and these people had DoLS care plans. However, these care plans stated only that a DoLS application had been made. They did not give consideration about how their care could be delivered in a least restrictive way to meet their needs and if their needs remained the same.

Mental Capacity Act (2015) (MCA) and DoLS training were included in the home's training plan. However many of the staff we spoke with had not received this training. Staff we spoke with were also not aware of how to ensure the principals of the MCA were followed in practice. Many staff were unaware that the use of equipment such as recliner chairs and bed rails were restrictive and therefore their use needed to be assessed for people and only used if people wanted them, or they were in their best interests. The registered manager had been trained in the MCA and DoLS but the training had not involved how to undertake a capacity assessment.

People did not have individual, decision specific mental capacity assessments, including best interests'

decisions where restrictive practice was implemented. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some areas of the home environment were not supportive of the people living there. During the inspection, the hairdresser came to the home to assist people who were not able to go to the hair salon in the provider's sister home. The hairdresser screened off an area of the sitting room to do this and for periods of time the sitting room was noisy, so conversations between people were difficult, and the space available to people in the sitting room was affected. The corridor carpets were of a flecked design, and there was a lack of signage support people in knowing where they were in the home. Flecked carpets have been identified as inappropriate and a risk factor for people who are living with dementia and visual difficulties. There are a wide range of guidelines available about appropriate environments for people who have a disability and who are living with dementia. Such guidelines had not been considered in the provider's audits or action plans developed so the home environment met the needs of people living there. This was an area which required improvement.

We discussed the training plan with the registered manager. The provider had a training plan which included relevant areas such as fire safety and first aid. We asked about training in meeting the needs of the people who were living in the home. Several of the people used types of catheters where registered nurses needed additional training to ensure they could safely change them. We asked if there were sufficient registered nurses employed who had this additional training, so a registered nurse with the appropriate skills was deployed at all times to support people who used catheters. This was because catheters can block off and so need to be promptly changed to ensure people's comfort, health and wellbeing. The registered manager did not have this information. Several of the people were living with additional dementia care needs. We asked staff about training in dementia, several of the staff said they had not been trained in the area and were unsure of how to effectively support such people. The provider did not ensure their training programme included all relevant areas relating to meeting people's needs, including clinical needs. This is an area which requires improvement.

Staff told us they were supervised regularly and could raise issues with their manager if they needed to. The registered manager reported they were new in post and so were progressing supervision systems. Initially, they had supported staff by giving group supervisions. They were planning next to progress to individual one to one meetings and supervised practice. They were also planning to set up systems for clinical supervision for registered nurses and had started this process by reviewing registered nurses' practice when they gave out medicines.

Staff said they were supported in providing effective care by the home's training and supervision programme. A newly employed member of staff told us "I had an induction and was shown the policies and procedures and also had a few days shadowing with more experienced staff," before they started working on their own. Records of training were maintained. Where a member of staff did not attend mandatory training, the provider had systems to ensure this was followed up and action taken within their policies and procedures.

We observed a lunchtime meal. People could choose where they ate, this included the dining room, sitting room or their own room. The meals were presented in an attractive manner, including pureed meals, and people clearly enjoyed their food. A wide range of choice was offered to people at lunchtime. If people did not like any of the choices, the main kitchen could provide an alternative. One person asked for an omelette and another, a baked potato. These were both promptly provided. Where people needed support to eat, staff sat with them, engaging them with the meal and general conversation. Staff did not rush people who needed assistance and supported people in an appropriate way, for example by using a teaspoon for people

who were unable to open their mouths wide.

Most people needed support with their diet and fluids. People were regularly assessed for nutritional and dehydration risk. Where people were assessed as being at risk, a care plan was put in place to identify how their risk was to be reduced. Staff monitored people's dietary and fluid intake to ensure they received enough nutrition and drank enough. Staff accurately documented what people had eaten and drunk. The amount of fluids people had drunk in 24 hours was assessed to ensure people were drinking enough. Fluids were available in the sitting room and people's own rooms. People were supported with these cold drinks, as well as regular offers of warm drinks if they preferred, throughout the day.

People's healthcare needs were met. During the inspection, a person looked unwell. This was promptly noted by a care worker, who went to find a registered nurse to ensure the person's medical condition was attended to. Clear clinical records were maintained. This included when people had wounds. All people who had wounds had them regularly assessed. People had clear care plans about how their wound was to be managed. Care plans were written in a way which would support an agency registered nurse in knowing what dressings were being used and how to apply them. Where people had urinary catheters, there were clear records about their management, which complied with guidelines, including the type of the catheter. People also had clear care plans about drainage bags, these care plans were followed by staff. Where staff needed additional healthcare support for a person, the registered nurses promptly sought advice. This included a person who had recently been seen by a psychiatrist. The person's care plan had been up-dated following the visit by the psychiatrist.

Requires Improvement

Is the service caring?

Our findings

People said the staff were caring. One person told us "Everyone is very nice." A person's relative said "They're a good bunch," about the staff. However we found some areas which required improvement.

We observed staff interactions with people, including during our SOFI. Some of the people who sat in the lounge were living with dementia and needed support with engagement. Some of these people were disengaged and sat staring about them, or sat with their eyes closed, although they were not asleep. Staff did not engage with people in the lounge when they supported other people coming into the room. A member of staff was sometimes with people in the lounge, but they did not support people with engagement, although they were supportive when a person said they wanted something. Most of the people remained in their rooms all day. Some staff supported people in a functional way when they provided care or checked on their condition. Other staff used the opportunity to support people as individuals. We discussed this variance between staff with the registered manager who said they would review the area. This is an area which required improvement.

Staff were always polite to people and were patient when they needed assistance. A person who had sat at the lunch table, who needed assistance to move about, said they needed the toilet after the meal had started. The care worker who supported the person attended to them promptly and was very polite, helping them to go out to the toilet and did not rush them in any way, although it was a busy time of day. Staff always addressed people by their preferred name and had a kindly approach when they talked with them

Staff respected people's privacy. Staff consistently knocked on people's bedroom doors, before entering and listened for a response, before they went into the person's room. Staff also supported people's involvement. We saw a member of staff knock on a person's door, carrying their lunch tray. They orientated the person to what their meal was, checked this was what they wanted and asked if they needed any other help, before the left them. Another care worker knocked on a person's door and asked if they were ready to get up yet or if they wanted to wait a bit longer. A care worker told us "We always ask people what they want."

Staff were kindly to people. A person's relative told us about the "Good relationships" staff had with people. A care worker went to support a person who looked sleepy. They gently orientated them to the time of day and told them about how they were going to support them. They waited until the person was fully awake before they started providing the person with support. A care worker told us "I am a firm believer in taking my time when supporting residents." A care worker went to ask a person who could no longer communicate verbally if they were comfortable and wanted anything. The person responded by giving the care worker a big grin. The person's stance towards the care worker showed they knew that care worker and felt safe and comfortable with them. A care worker said about a person who could not communicate verbally "I can recognise what they want from their facial expressions."

Two people's relatives said there was "Good communication" between themselves and staff. They said this gave them confidence in the caring nature of the staff in the home. A care worker described the importance

of working "Hand in hand" with people's relatives to ensure people were cared for in the way they needed.

Staff understood about the importance of people's dignity, including ensuring they were pain free. A person's relative told us how effectively the home had supported their relative in being pain-free. They said that the person's pain was now "Sorted" because of the support staff had given to the person. We observed the registered nurse who was administering medicines check with a person if they were in any discomfort. The person gave the appearance of being uncomfortable, but was also concerned that they did not wish to appear to be difficult. The registered nurse clearly knew the person well and used different types of questions to ascertain how the person really was feeling. The registered nurse listened carefully to the person, empathising with how they said they were feeling and agreed with them how to support them, so that they became more comfortable.

One of the people was at the end of their life. They spent all of their time in their bed in their room. They looked comfortable and peaceful. The person's records showed the home had regularly contacted the local hospice about management of their care and were working with them to ensure the person was as comfortable as possible. The person's relatives commented favourably on the support being given to both their relative and themselves by staff. All of the staff we spoke with knew about the person's condition, their family circumstances and how this affected the person and their family.

Staff emphasised the importance of knowing people as individuals. One care worker said "Building rapport, building a good relationship" was a key area when providing care. Another care worker stressed the importance of "Getting to know the residents really well." Another member of staff told us they needed to be aware of people's past lives when providing care. A care worker said empathetically, "Some of them have such sad stories to tell me."

Requires Improvement

Is the service responsive?

Our findings

People said staff were responsive to their needs. One person told us "I'm well looked after." However we found there were areas where improvements were required to ensure staff responded to people's needs.

People told us about the lack of activities provision in the home. One person told us "There isn't much to do." People who went to the lounge had some activities provided. The timetable of activities had been drawn up by a member of staff who was no longer employed, and the programme was not being followed. The timetable showed 'film club' on one day but a film was being shown on the previous morning when the timetable had stated 'board games'. People who remained in their rooms all the time were visited by the activities manager at times, but there was no provision of activities for these people outside these times.

There are a range of guidelines available on supporting people with activities. These advise that a key area for people is engagement, particularly where they are living with dementia, to prevent boredom and isolation. Although there was an activities manager employed, they also had responsibilities in the two other homes owned by the provider. People's care plans related to their nursing and physical care needs. There was an absence of strategies in care plans to support people with engagement, particularly where people remained in bed all the time. The activities manager maintained activity sheets which were ticked to show people's attendance or not at activities. This did not include evidence of benefit of engagement to people or otherwise. As these records were maintained by the activities manager, who was based in the sister home, this information was not readily available to staff when developing individual care plans to support people with activities.

Staff were not responsive to some people's other needs. Staff told us about a person who was living with dementia who could show aggression. When we discussed this person with staff, they said the person's first language was not English, and they no longer spoke English. It was not clear from staff, or the person's assessments and care plan, if their reported aggression related to their frustration because of difficulties with communication or related only to their dementia care needs. The person's care plan stated some staff knew the person's language. Discussions with staff indicated this was no longer the case. There had been no recent assessment of the person's needs in relation to their communication difficulties to assess the most effective way staff were to care for the person in the light of their language difficulties and dementia. The care plan did not identify how staff were to care for the person in the light of their culture, individual communication and dementia care needs.

We met with a person who had been seen by the psychiatrist due to a mental health need. We observed them showing symptoms of these needs. The person's care plan recorded the behaviours the person might show. It did not direct staff on actions to follow when the person showed these behaviours. When we asked staff they gave us differing replies about what they did when they showed such behaviours. This means the provider was not ensuring this person received consistent care in relation to their mental health needs.

The provider was not ensuring people's care was appropriate and met their needs. This was because they were not carrying out assessment of people's needs and designing care to meet such needs. This is a breach

of Regulation 9 of the HSCA Regulations 2010.

People all had clear care plans about their other needs. These were regularly reviewed. Care plans were detailed. For example where people had air mattress provided to reduce risk of pressure damage, care plans stated for each person what the setting on the air mattress needed to be. Records were maintained. These showed such care plans were followed. When we discussed people's nursing and care needs with staff, where they had full care plans, they knew how to meet people's individual needs. A care worker told us the care plans helped them because people often had complex and changing needs, so they used care plans to ensure they knew how each person's needs were to be met. Another care worker said "The folders in each resident's room shows their likes, dislikes, whether they need a standing aid, their dietary needs and their mobility levels. I will browse through these folders while I talk to the resident in the mornings when I'm on duty." Care workers said where people had difficulties with communication "We know what they want from their reaction." Care workers said if they were unsure about how to meet people's needs or if a person's needs were changing, they would ask the registered nurses. They said when this happened the registered nurses supported them so they could respond to people's individual needs.

People said they could raise issues of concern with the registered manager. One person's relative told us "If I have any concerns or issues or if something goes wrong we can discuss it with the manager." People told us about when they had raised issues. For example a person told us they had issues with the laundry "But this has improved considerably." A relative said they had raised something with one of the registered nurses about a carer worker's attitude, which they said had been addressed. Another relative said they had raised an issue which they were "Not happy about" with the registered manager and it was "Ok now." None of the people had raised these issues as a formal complaint. The provider did not currently have a system for documenting smaller concerns and issues raised individually by people. We discussed this with the registered manager. They said such matters were dealt with at the time they happened. Now they had been in post for a longer period they were planning to set up a record so they could review any concerns raised for trends and ensure people received a consistent response when they did raise issues.

The registered manager said they had set up residents' meetings since they had come into post. Records of these meetings were kept. The most recent one showed where people wished to raise issues, for example about the laundry service. This been written down and action taken to address the matter.

The provider had a complaints procedure, which was available to people. All formal complaints were dealt with by the provider. No formal complaints had been made recently.

Requires Improvement

Is the service well-led?

Our findings

People said they thought the home was well run. One person told us the home was "All right, they do all they can," and another person "I wouldn't change anything." A person's relative told us "This is fundamentally a good home." However we found there were a range of areas which required improvement.

The provider had systems for audit of the quality and safety of the service, however the audit had not identified a range of areas, and action plans had not been developed to ensure service improvements. The provider visited the home regularly and produced a report of their visits. These had not identified that a range of areas needed attention, for example several corridor carpets, although clean, were showing signs of staining, and threadbare patches. The home's statement of purpose outlined about the availability of the nurse call system and we heard people using call bells regularly during the inspection. People who need nursing care may be living with acute medical conditions which need prompt attention from staff. We asked about the auditing of response times when people used their call bell. The provider did not have systems to assess if people received a prompt response when they used their call bell. We asked staff about training in supporting people with activities but although they regularly supported people with activities, we were told only the activities manager had been trained in the area. People who had difficulties with engagement, and people who did not go down to the lounge, would need support from staff to ensure they were appropriately supported. The provider had not identified this as an issue in their training plan.

The provider's reports had not identified that regular audits in key areas, including systems for safe recruitment of staff were not being followed for all staff. Although the home's statement of purpose outlined their systems for working only with the consent of people, the provider's audits had not identified that they were not doing so. There were systems for audit of care plans, but these were not taking place. This meant it had not been identified that some people's care plans were not up to date and did not reflect their current care needs. For example a person was living with a risk of being in pain. From discussions with staff it was clear what actions were being taken to ensure the person was pain-free, however this was not documented. This had not been identified as a risk to the person, although the home were regularly using agency registered nurses. This meant the provider could not ensure all registered nurses had the information they would need to support the person in their pain management.

The provider's systems to assess, monitor, mitigate risk to people and improve care did not operate effectively. People did not always have accurate, complete and contemporaneous records about their care. This is a breach of Regulation 17 of the HSCA Regulations 2010.

The registered manager had recently come into post. They had started developing systems for audit of a range of areas in the home. This included an audit of when people had fallen, which identified factors such as time of day and which people were more at risk of falling. Now they had commenced the audit, the registered manager said they would develop actions plans where specific risk factors were identified. The registered manager said they had performed a full audit of systems for management of medicines since they came in post. They would then perform this audit regularly to ensure all registered nurses completed medicines management in a safe way.

The provider, registered manager and her staff were open to new ideas and keen to develop the service as much as possible to support people. For example, by the end of the inspection the registered manager was already considering a range of different options for development of the hairdressing service for people who were not able to go to the hairdressing salon in the sister home.

The registered manager had set up regular staff meetings, including meetings for night staff. Where staff raised issues she took action. For example at a recent meeting, issues had been raised by staff about supper choices for people. Staff told us the issue had now been addressed.

Staff commented positively on the philosophy of care. They said they felt part of a team and that they could contribute ideas, and be listened to. One care worker said "We have a good rapport, staff and residents. Everybody helps each other. I believe in teamwork," another one said "We are friendly and we help each other." A care worker who told us they had worked in a range of other care homes told us "This is the most organised place I've ever worked in."

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider was not ensuring people's care was appropriate and met their needs. This was because they were not carrying out assessment of people's needs and designing care to meet such needs. Regulation 9 (1)(a)(b)(c)(3)(a)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent People did not have individual, decision specific mental capacity assessments, including best interests' decisions where restrictive practice was implemented. Regulation 11 (1)(2)(3)(4).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider was not always ensuring care was provided in a safe way to people. This was because they did not consistently assess risks to people and do all they could to mitigate such risks. Regulation 12 (1)(2)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's systems to assess, monitor, mitigate risk to people and improve care did

Treatment of disease, disorder or injury	not operate effectively. People did not always have accurate, complete and contemporaneous records about their care. Regulation 17 (1)(2)(a)(b)(c).