Oldfield Residential Care Ltd

Norton Grange Nursing & Residential Care Home

Inspection report

10-12 Crabmill Lane
Coventry
West Midlands
CV6 5HA

Tel: 02476684388
Website: www.oldfieldcare.co.uk

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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 3 and 4 December 2015. The inspection was unannounced.

Norton Grange is a nursing home which provides nursing care and specialist dementia care for a maximum of 27 people. The home provides care on two floors. People whose primary care need is dementia, are mainly supported on the first floor, and people with more complex nursing needs are mainly supported on the ground floor. Twenty three people were living at the home at the time of our inspection.

The home does not have a registered manager, however the manager has applied to the Care Quality Commission to be registered to manage the service. Like registered providers, registered managers 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.

At our last inspection in May 2014 the home was fully compliant. Since then, the home has been through a challenging period of time. The previous registered manager and deputy manager left, and the provider recruited a new manager to start in April 2015. The person recruited informed the provider a week before they were due to commence employment and after the provider had waited three months for them to give notice, they decided not to take up the post. The current manager started work at the home in May 2015 at a time when many staff had left or were leaving the home, and relatives had raised concerns about the care provided.

Since May 2015 the manager has worked with the relatives and staff to improve the care provided to people. However there continued to be concerns about staff numbers and staff deployment. This was because the home continued to use agency and bank staff to cover staff vacancies whilst recruiting permanent staff, and staff worked with people whose needs they were unfamiliar with.

Recruitment practice did not always meet the requirements of the Health and Social Care Act 2008 legislation to reduce the risk of recruiting unsuitable staff.

Staff were kind and attentive to people when they provided personal care. However, staff interaction with people was mostly when supporting people with care tasks. We saw little involvement between staff and people at any other time of the day. There were limited opportunities for people to be involved in social activities.

Care provided was not person centred. Staff did not always know the individual needs, preferences, interests and capabilities of people who lived at the home.

People who were independent, received food and fluids which met their nutritional and hydration needs. However, there was a limited choice of menu, and not all people who depended on staff to ensure their meals and drinks met their needs, received their meals and drinks prepared as advised by health care

professionals to keep them safe.

Staff had received training but their training did not equip them with the skills to provide the 'specialist dementia care' service the provider had advertised they provided. We observed staff had not put into practice some of the training in areas of health and safety.

The manager understood their responsibilities and the requirements of the Mental Capacity Act and the Deprivation of Liberty Safeguards, however, care practice at times did not adhere to the principles of the Act, and DoLS had not been applied for people who required it. Permission needs to be sought when a person who does not have capacity has their liberty restricted.

There were mixed views from staff as to whether there was an open and transparent management culture.

Medicines were mostly managed safely, however some concerns about the management of people's medicines were identified .People's health needs were met, and they were referred to the appropriate health or social care professionals.

Relatives and friends were able to visit the home at any time in the day or evening.

Improvements had been made to the premises. The ground floor bedrooms and corridors had been redecorated and refurbished.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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.

The use of agency staff and recruitment of new inexperienced staff meant that people did not always get support from staff who were knowledgeable about their needs. Risks were not always clearly identified and acted upon. Recruitment procedures did not reduce the risk of unsuitable staff working at the home. Medicines were mostly managed safely, however some concerns were identified. Improvements had been made to the ground floor premises.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not received sufficient training to provide a 'specialist dementia service'. Training relating to health and safety had not always provided staff with sufficient information to keep people safe, and staff did not always put into practice the training they had received. The principles of the MCA and DoLS had not been fully applied. People received sufficient food and drink but had limited choice, and special dietary needs had not always been followed.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff were kind and compassionate to people but did not always know how best to support people, particularly people with advancing dementia. Staff respected people's privacy but did not always think about the impact of their actions or words. Visitors were welcomed at any time of the day or evening.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were given limited opportunities to follow interests or be involved in social activities. Care was not responsive to people's individual likes and dislikes. The manager had investigated

formal complaints however they had not completed their investigations in line with the provider's complaints policy.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The service had experienced leadership changes, with the registered manager and deputy manager leaving, and a period of time with no manager in place. The current manager had worked at the home since May 2015 and had many challenges to deal with. There have been improvements since May but the home required further improvements to ensure people receive a quality service.

Norton Grange Nursing & Residential Care 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.

This inspection took place on 3 and 4 December 2015 and was unannounced.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also looked at the information received from our 'Share Your Experience' web forms, and notifications received from the provider. These are notifications the provider must send to us which inform of deaths in the home, and incidents that affect people's health, safety and welfare.

The inspection team comprised of an inspector, a specialist nursing advisor, 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. Our expert by experience had personal experience of caring for a person who lived with dementia.

During our visit, we spoke with three people who used the service, and four relatives and friends. We spoke with seven staff, the manager and regional manager. We also spoke with a visiting GP. Most of our information came from informal and formal observations of people because not many people who lived at the home were able to communicate with us due to ill health or mental capacity.

We used the Short Observational Framework for Inspection (SOFI) on the first floor dementia unit. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spent significant time observing the care provided to people in the home throughout our visit.

Prior to our visit we received information about the home from the local authority contracts monitoring team, and the Clinical Commissioning Group (CCG) (people who provide funding for people to receive care at the home). They told us that whilst they had concerns about the home, they had been closely monitoring the home and thought there had been improvements in care provided to people.

We looked at five care records, a minimum of four supplementary records (for personal care, food and fluid intake), staff rotas, quality assurance records, health and safety records, and nine medicine administration records.

Requires Improvement

Is the service safe?

Our findings

We checked whether people were protected from risk and avoidable harm. A relative told us, "I believe my father is safe. He has been here about five years and I've never had any concerns." During our observations we saw instances where people were not always safe. We saw two instances where staff moved a person from their sitting position to a standing position, under the person's arms. This is not considered good practice as it could potentially cause injury to the person. We saw one instance of good moving and handling practice, where staff used a hoist and a sling appropriately. We saw staff re-assure the person when they were moving them. After the person had been moved we asked staff how they knew which size sling to use. They told us, "I looked at the size of [person's name] and guessed what size they would be." We were concerned that the member of staff guessed the size of sling, as this could also lead to injury if the wrong sling was used. We looked at the 'At a glance' care plan for the person. This informed staff of the size of sling to use, and was the size used by the member of staff. However, they did not know to check this information in the care file.

Throughout the morning we saw instances of staff stopping a person from leaving their chair when they attempted to do this. We heard staff asked the person to 'sit down' and told them it was not safe for them to stand. We saw a table was put in front of the person that stopped them from standing up and walking, and we could see this frustrated the person and potentially caused them psychological harm. We looked at the person's care records to find out why it was unsafe for the person to stand and walk. The care record informed us the person was 'prone to falls'. However we did not see information to inform why and when the person was prone to falls, and what actions staff should take to minimise the risk. We were concerned that by placing a table in front of the person and limiting the person's freedom of movement, the home's staff had breached the person's human rights. The manager told us the table should only have been placed in front of the person when they were undertaking an activity or eating. They acknowledged it was unacceptable for it to be placed there to restrict movement. The same person was also at risk of blood clots if their legs were not raised for short periods of time through-out the day. We did not see staff raise this person's legs at any point during our visit.

We checked how people's medicines were managed. We found these were mostly managed safely; however a person told us "There's one bad thing, I have to have my Glycoma drops every day and they are fine. I'm supposed to have drops for dry eyes too, but I've not had any for about a week, they tell me it's the chemist but why can't they be on repeat prescription like the other one?" The GP confirmed they had just been told of a person who had not had their eye drops for a week. The manager told us they had experienced difficulties with the pharmacy.

We observed nurses administer medicines to people during the day. We saw they took their time with people and made sure medicines were swallowed. They checked if people needed 'as required' medicines for pain. For example, a person was asked if they were in pain and if they needed any medicine to help them. The person replied, "No thank you, I am not in pain." We noted, whilst administering medicines, they locked the trolley to secure the medicines inside whilst they delivered these to people in their rooms or in the communal lounge. However one of the medicine fridges was left unlocked so medicines within it were left

unsecure. We looked at a sample of nine medicine administration charts and noted they were mostly accurately completed, however there were some errors such as missing signatures, and a couple of occasions where records reflected medicines were only given once in the day and not twice as prescribed. There was no information to tell us why this was the case.

We saw that medicine administration had been checked by the manager in November 2015. The issues we identified had already been identified as part of this audit and the manager was working with staff to improve recording practice.

One person's record told us the person was able to administer topical creams themselves and advised staff to help them with areas they could not reach. There was no self-administration risk assessment in place, and there was no indication about how staff would monitor skin integrity. This was particularly important for this person's skin type.

We looked at the record of a person who had medicines given 'in disguise' (covertly). The person lived with dementia and they had refused to take their medicines. It had been agreed with the GP, nurse and next of kin it was in their best interest to take them in disguise. The record showed that a review should take place every six months, however the decision had been taken in February 2015 and no review had taken place since then. We also saw additional medicines had been prescribed and administered in disguise than the best interest meeting had originally agreed. This meant there had not been a discussion to determine whether it was in the person's best interest to receive additional medicines in disguise.

The home was in breach of Regulation 12, (2) (a) (b) (c) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the recruitment records of staff new to the organisation since our last inspection. This was to see whether the management team had undertaken checks on staff to ensure they were suitable to work with people who lived at the home. We looked at the recruitment files of four staff. We saw checks from the Disclosure and Barring Service (DBS) had been undertaken. The DBS is a national agency that keeps records of criminal convictions. However references and other information required under the regulations were not always available. For example, not all recruitment records had photos of staff who had been employed, and gaps in their employment history had not been checked and documented as required by the Act. Two references were requested for each person, but action taken in response to references was not always robust. For example, a reference was accepted even though the referee said they could not give a reference because the person had not worked at their previous employment long enough. The provider did not have satisfactory evidence of the person's conduct in their previous employment.

This was a breach of Regulation 19 (3) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Fit and proper persons employed

Staff did not always have the right mix of skills, competencies, and knowledge to meet all people's individual needs. Since our last inspection a high number of staff had left their employment at Norton Grange and the provider had been using agency and bank staff to cover staff vacancies at the home. New staff had started employment but they had not always had previous experience working in care. The PIR informed us that 20 staff had started work at Norton Grange in the last 12 months, and 14 staff had left. This was a high proportion of the staff team.

During our visit we found people who lived on the ground floor of the home were provided with support from staff who had the skills and competencies to meet their needs. A nurse, who had been in post for two

weeks supported the nursing care of people on this floor. We spoke with this person and found they had spent time getting to know the people who required nursing care. Two experienced members of care staff who knew people's needs well, also worked on the ground floor.

On the first floor, people who lived with dementia mostly had support from staff who did not know how to meet their needs. This was because two agency staff supported people with individualised one to one care, and one of the two permanent staff told us they were used to working on the ground floor, and had only recently been moved to work with people who lived with dementia on the first floor. From our observations and discussions, staff did not demonstrate much knowledge of the people they were supporting, and had not been trained to provide 'specialist dementia care'.

We had concerns about the number of staff on duty to meet people's needs. On the ground floor a person and their relative told us the 'tea round' was usually between 10.30am and 11am but they had not had their drink and it was 11.45am. We asked staff why this was the case. They told us "We have had no time to do the tea round yet with only two of us on this floor we are still doing personal care." The manager told us they felt there were enough staff to meet people's needs, and they had 'turned a corner' in relation to the number of permanent staff who were now employed. They explained they had not been informed that a member of staff had not turned up for duty that morning, and would have arranged for a replacement member of staff if they had known. We looked at the staff rota for a two week period. We could not determine from this how many staff were expected for each shift and whether the shift had been fully staffed according to people's dependency needs. We saw varying patterns of staffing levels each day. From our discussions with the management team we could not establish a reason for this.

We had been made aware that prior to our visit, people who lived with dementia had been moved to the first floor, with people who had more complex nursing needs moved to the ground floor. This was because the lounge on the first floor gave people more space to walk around. Most people felt this had been a positive change for all people who lived at the home; however some practical considerations had not been addressed. Staff told us this had increased the time taken to support people with their personal care needs as people who had previously lived on the first floor preferred the bathing facilities on this floor. This meant it took longer for staff to provide personal care to people who lived on the ground floor because they now had to support them to go to the first floor for bathing. A staff member told us, 'It takes two of us to hoist residents and we also have to take them upstairs for a bath." We also saw the shower on the first floor had been out of action, and this had meant further disruption to providing personal care. We informed the management team about this, and how it impacted on staff time. They told us they would address this as a matter of priority. On the second day of our visit we saw a plumber attend the home to fix the shower.

We checked whether staff understood how to safeguard people from other types of abuse. Staff told us they had received training to safeguard people from abuse. We gave staff safeguarding scenarios and asked them to tell us what they would do if they were concerned a person who lived at Norton Grange was being abused. All staff knew how to keep people safe and who to report their concerns to.

Since our last visit, there had been improvements made to the décor and furnishings on the ground floor. The bedrooms, communal lounges and hallways had been re-decorated, and refurbished. We saw that this made it a more pleasant environment for people to live in.

Requires Improvement

Is the service effective?

Our findings

We saw people with nursing needs who lived on the ground floor of the home were provided with effective care by staff who had the knowledge and skills to undertake their roles and responsibilities. We did not see this on the first floor. The provider's website informs that Norton Grange provided 'specialist dementia care'. We observed staff who did not understand how to meet people's needs or provide emotional support to people who lived with dementia.

We asked staff how they had been trained to provide specialist dementia care. We were told their dementia training had been limited. One member of staff had received three hours training in dementia care, whereas some had recently undertaken a one day training course on dementia and challenging behaviour. One member of staff who had only recently started working on the dementia unit told us, "It can get stressful working there – you are constantly watching where they are and what they're into." This confirmed what we saw, the staff group spent their time monitoring people as opposed to providing person centred care based on the person's individual needs. Another member of staff also reflected what we saw, they said, "There is a lack of experience on the dementia floor." They went on to say, they felt inexperienced staff did not know how to approach people and communicate with people effectively.

The manager, who was not a dementia care specialist, acknowledged that the dementia training did not fully equip staff to meet the needs of people who lived with dementia at the home. They told us staff were in the process of signing up to undertake a distance learning, level two course on the principles of dementia care. They also told us, and this was confirmed by the local authority, that the local authority occupational therapist had agreed to support the home to make the first floor a more dementia friendly environment.

Staff had received training considered essential to support them meet the health and safety needs of people who lived at Norton Grange, however they did not put their training into practice. We saw poor moving and handling practice by some staff. One member of staff told us the moving and handling training used to be an eight hour training course but recently recruited staff had received two hours of moving people training. The manager confirmed this had been the case and as a consequence had changed the training provider. They told us staff had been booked to receive further training in how to safely move people the following week.

Staff had also received training in infection control. However on the first floor we saw staff come out of people's bedrooms having just undertaken personal care, with their gloves still on their hands. This meant they could transfer potential infections to other surfaces and people. We also saw both sluice rooms were left unlocked and a potential risk to people. Mops had not been stored appropriately. One mop which was supposed to be used 'for isolation' was wet and had recently been used. We asked if any person in the home was being cared for in 'isolation' and were told this was not the case.

We asked staff if they had received supervision to support them in their work. Staff told us they had not received regular supervision, and those who told us they had received it, did not receive it from the manager but other people in the organisation such as the previous training provider and a regional manager. The

manager confirmed they had not provided supervision to staff but expected this to change now staffing levels had improved and they had time to provide this. We saw staff meetings had taken place in May 2015 and November 2015. The PIR informed us the manager carried out regular appraisals and supervisions of staff, however this was not what the manager told us on the day of our visit.

This was a breach of regulation 18 (1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing

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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked to see whether a best interest decision had been taken to place the table in front of the person who had been identified as being 'prone to falls'. We saw a best interest decision had been taken to place the table in front of the person, but when we checked whether this was the 'least restrictive option' the record said 'All avenues explored'. There was no reference to what these were and why this was seen as the least restrictive option. This meant the service was failing to demonstrate that the amount or type of restraint used and the amount of time it lasted was a proportionate response to the likelihood and seriousness of harm.

This was a breach of Regulation 12 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We viewed two Do Not Attempt Cardio-Pulmonary Resuscitation forms to check whether it was in the person's best interest not to be resuscitated. One clearly informed us why it was not in the person's best interest to undertaken CPR, and accounted for the person's physical health. The other only said it was because the person had 'advanced dementia' We looked through the care records and could find no further information to confirm why this would be the case. We were concerned that this did not fully explain why it was in the person's best interest to withhold resuscitation, and was therefore potentially not valid.

The PIR informed us that staff had a good working knowledge and understanding of Deprivation of Liberties and the Mental Capacity Act and put these into practice. We did not see this on the day of our visit.

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw people who lived at Norton Grange who lacked capacity and who were under continuous supervision did not have DoLS in place. The DoLS require providers to submit applications to a 'Supervisory Body' for authority to deprive people of their liberty. The manager acknowledged due to other more pressing issues they had not submitted the applications to the supervisory body. They confirmed to us a week after our inspection, that all applications had been submitted.

People were supported to eat and drink, but they were not offered a choice of food for their lunchtime meal. We saw people on a specialised diet did not receive their meal prepared in a way which was designed to keep them safe. One person said to us, "There is no choice of food, mine has to be pureed now and it's tasteless, no flavour." Another said, "There isn't a choice, but they have changed it now and then for me, if I ask."

We did not see a choice of meal, or a menu to inform people what their meal would be that day. We saw

people received a pre-plated meal from the hot trolley, of chips, sausage and baked beans. The manager told us if people wanted something different they would be offered an alternative. We did not see staff check with people if they wanted a different choice. The regional manager told us that all other homes in the provider group offered a choice of menu, and this should be the same at Norton Grange. She said she would make sure this was put into effect at the home.

We observed staff support people to eat and drink. Staff mostly provided support to people at people's own pace and made sure they were ready to receive food from the fork or spoon. We also saw staff encouraged people to drink to ensure they were not dehydrated. However we were concerned that staff did not understand the importance of specialised diets. For example, when, a care worker, told an agency worker that a person required a 'soft food diet' and when the agency worker informed them that there was not any on the trolley, said, "Well give [person's name] that then." They started to give the person food which was not soft. We informed the manager of this who told us they would investigate further.

We looked at the records of one person who needed thickened fluids (because they had problems swallowing and would be at risk if the fluids went into the lungs) and a pureed diet. We found inconsistencies in what staff did, compared to what the records told them to do. In July 2015 the speech and language team advised that the person needed stage 1 fluids (this consistency can be drunk through a straw or from a cup (if advised or preferred). It leaves a thin coat on the back of a spoon). The re-written care plan for nutrition dated 29 November 2015 referred to stage 1 thickened fluid, but on the day of our visit, a senior care worker and nurse both confirmed the person was receiving stage 2-3 thickened fluids. There is no stage 2-3 thickened fluid, and we were concerned that staff were making drinks thicker than had been advised as this would have made it difficult for the person to drink. We informed the manager of this on the day of our visit.

This was a breach of Regulation 14 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Meeting nutritional and hydration needs.

When we visited on the second day, the manager informed us because of the concerns we had raised, they had arranged for the speech and language therapist to provide staff with training in February 2016.

One of the advantages of moving people who lived with dementia to the first floor, was they could walk in to the lounge via one set of doors, and leave via another without having to walk back on themselves. We saw however, that the emergency closure mechanism on one of the set of doors was very sensitive which meant the doors were often closed unnecessarily. This became confusing and frustrated people, as when they reached the doors they could see the lounge through the panel windows but were unable to get into the lounge.

We spoke with the GP who visited Norton Grange once a week. We spoke with them on their weekly visit. They told us there had previously been problems with continuity and nursing staff not following up on the information and advice given. However, they told us this had recently significantly improved. We observed a staff handover meeting at the beginning of the day shift. The night shift leaders informed the day staff of people who had been unwell and needed to be referred to health and social care services. When required, people had been referred to specialist teams such as the tissue viability nurses, and to the Speech and Language Team.

Requires Improvement

Is the service caring?

Our findings

Staff understood the importance of treating people with kindness and compassion and tried their best to do so. We saw staff enjoyed light hearted banter with some people, although some staff, due to a lack of training, seemed unsure of how to support and engage with people who lived with more advanced dementia on the first floor. Sometimes staff did not appear to make sure that people knew they mattered, and did not know how to respond to visual cues which indicated people were getting upset or frustrated.

Staff were not employed to work on a specific floor. We were told this was to provide more flexibility when covering staff absences. However, for people living with dementia this could be confusing as they did not get familiar with a regular and consistent staff group.

We checked how useful care plans were for staff in making sure they provided care to people when and where they needed it. Staff we spoke with told us they did not look at the care plans. These were locked in the nurses' office. One member of staff said, "We never have time to look at care plans. We used to, but sometimes we are not told anything about people, which is quite frustrating." Another said, "We don't have the chance to look at care plans, they are locked away and nurses are not always around." This was in contradiction to what the manager told us in their PIR which said, "All staff are actively encouraged to read and be involved in the care planning for each resident therefore improving person centred, individualised care."

We saw staff treated people with dignity when they provided personal care. People were taken to their own bedrooms and doors were closed so personal care could be undertaken in private. However, on occasions people were not treated as individuals. For example, at dinner time one care worker asked the nurse to "Go and feed Room [number of room]". Another time, a senior member of staff who had taken a phone call from a relative enquiring how the person was, called across the room to ask how the person was. This information was relayed back to the senior care worker who informed the person on the phone. Confidentiality of information had not been considered.

On the day of our visit, a person who had lived on the ground floor had passed away during the night. Staff on duty, were visibly moved by the unexpected death of the person. We saw the person who had passed away and other people who lived at the home were treated with respect at this time.

Staff who had worked at the home for a longer period of time had a good understanding of many of the people they were caring for and were familiar with their life histories. For example, one member of staff had noticed that a person who lived on the dementia unit liked to tidy things away and undertake housework. In response to this, they went into the linen cupboard and got things for them to tidy. They also bought a replicate iron for the person to iron clothes with. This member of staff had also asked family and friends to donate any puzzles or games they could to provide activities for people who lived at the home.

There were no restrictions in visiting times for friends and relatives of people at Norton Grange. Throughout the day we saw many people visit and stay long periods of time to support people who lived there.

Requires Improvement

Is the service responsive?

Our findings

On the first day of our visit, a new person was admitted to the home. We looked at their pre-admission assessment to see whether this would provide sufficient detail to enable staff to meet the person's needs and respond to them appropriately. We found the pre-admission assessment was incomplete, and the areas which had been completed were not very detailed. We checked with the nurse on duty who told us they would have liked more detail to help them have a clearer understanding of the person's needs. We asked to see two other pre-admission assessments of people who had recently been admitted to Norton Grange. One could not be found, and the second also had limited information to support staff in being responsive to the person's needs from the start of their stay.

We asked people and their relatives if they were involved in the assessment and planning of people's care. One relative we spoke with said, "I think we have had a review about once every year, but if I have an issue I go and discuss it immediately. I am here every day." Another relative told us, 'I've had a meeting with the local authority about a financial review but we haven't been involved recently with the home about reviewing his care." We asked a relative who had supported their relation to walk up and down the corridor for gentle exercise whether this activity was in the person's care plan. They told us "I'm not sure, I don't think so." We asked how often their relative had a shower or bath. They responded, "I think about every couple of days but I'm not sure, I assume [person] gets one." This meant the relative had been given little detail about the care provided to their relation and was not fully involved in their care planning process.

Records indicated that care plans had been reviewed monthly but the quality of the review gave concerns. For example, one person had a care plan in place which related to a specific area of the skin which had reddened and blistered in 2012. This was a short term condition and their skin had been clear for a long time and it was no longer necessary to have this specific care plan, however it continued to be reviewed monthly. A care plan relating to this person's 'challenging behaviour' told us the person's behaviour and mood was 'unpredictable', and 'staff familiar with them are able to note changes in mood'. There was very limited information about what was meant by unpredictable behaviour and mood, and no written information about how staff were able to note changes in mood. Nothing in the notes informed that staff had tried to identify if there was any pattern to the person's behaviour so they could respond more effectively to the person's emotional needs. Because of the changes in staff, they were not familiar with the person's behaviour, and this might mean staff responded inappropriately if behaviours which challenged occurred.

We looked at how the home's staff responded to people who were cared for in bed. We saw people were repositioned to reduce the pressure on their skin every two hours in the day time, and every four hours at night time. There was no rationale as to why each person who required repositioning had the same time frame for both day and night time. We were unclear as to why the risks relating to skin damage were less at night than in the daytime. We were also concerned that one person we observed during the day was lying on their back from 9am when we first checked to at least 3.45pm. At 5pm we checked again to see if they had been repositioned and found that the record which up until then had not been completed, stated that the person had been repositioned at 3pm. This did not reflect our observations. We asked staff if they had completed the record and they told us they had not. We informed the manager of this.

There was very little detail about people's personal history, individual preferences, interests and aspirations. For example, care plans did not indicate how often people wanted a bath or a shower, and what they could do for themselves when personal care was provided. They gave little information about the person's food likes and dislikes so these could inform the cook when planning meals, or what hobbies or interests they had. In one file, we noted the family had spent a lot of time a couple of years ago, making a life history book for the person. This told us a lot about the person. This information was not transferred into the person's care plans to support them with activities or interests.

On the first floor dementia care unit, the radio played most of the time we were there. Apart from care tasks, there was very limited engagement between staff and people. Very occasionally staff would support people to walk around the lounge. One person was given a small set of children's plastic building blocks as an activity which they seemed disinterested in. We did not see any activities which were meaningful to people. The manager confirmed the dementia unit was, "A bland boring place" and went on to tell us they were intending to change this.

A person who lived on the ground floor told us there used to be staff who would come and talk and play a game with a special dice with her. They said now there was, "Absolutely nothing" regarding activities. They went on to say, "There aren't enough carers to do activities with me." "All I want is someone to come and have a chat or help me do a crossword." A relative told us there used to be an activities worker and said they thought there should be another one employed as the care workers were not able to do activities as well as care work.

We asked the manager whether there was an activities worker. We were told a decision had been taken not to employ a specific activity worker, but rather, have more staff on duty so all staff could participate in 'meaningful 'activities with people. This did not happen on the days of our visit and people did not receive personalised care responsive to their needs. The PIR acknowledged this was an issue. The manager told us the home hoped to improve staff understanding of each person's social and diversity needs and how they could best meet their needs and support their individuality.

This was a breach of Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations. Person centred care.

We were aware that some relatives were dissatisfied with the quality of care and had concerns about the changes the new manager had implemented and proposed, when they first started work at the home (moving people to different floors). The manager met with the relatives to explain why they wanted to move the people. The manager told us that relatives were now happy that the changes had improved people's quality of life. In August 2015, 10 responses were received to a relatives' survey. These were mostly positive about the standard of care.

We were told there had been eight complaints made in the last year. We saw two had been investigated and formal responses had been sent to people. There was evidence that investigations had taken place with the other concerns, but there was no letter to formally inform the person of the outcome. The manager told us the families who made the complaints were now happy and the issues were resolved.

Prior to our inspection we had received one concern from a relative who felt the manager had not been responsive to concerns they had raised. We spoke with the manager about the person's concerns, however at our inspection visit we did not see these concerns recorded in the complaint record.

Requires Improvement

Is the service well-led?

Our findings

Since the last inspection in May 2014, the previous registered manager had left their employment at the home and the deputy manager left soon after. The home had a period of time where there was no manager in place. A manager had been recruited and the provider waited three months for them to work their notice before commencing employment at Norton Grange. The person withdrew from the job a week before they were due to start. In May 2015 the current manager commenced employment at the home. They have submitted their application to be registered with the Care Quality Commission.

The manager came to the home at a time where relatives were becoming increasingly anxious about the care being provided and the number of staff who had left, and were leaving the home. We had received concerns from relatives of people who lived at the home. The local authority and clinical commissioning group (CCG) were working with the provider and manager to improve the quality of care provided at the home. They informed us since the manager came into post there had been improvements in the care provided to people.

Since May 2015, there has continued to be a high turnover in staff and as a consequence of this a high use of agency staff. The manager told us they now felt they had 'turned a corner' in relation to staff vacancies and staff conduct at the home. They told us they have kept under review the attitudes, values and behaviours of staff, and some staff have left in response to them not meeting these criteria.

Whilst the manager told us they felt they encouraged open communication between the staff team, there were mixed responses from staff about how open they thought communication was. One staff member said, "She is fairly new and having a challenging time, but is doing well." Another member of staff said, "I don't really talk to her that much but she seems OK." One staff member told us, "The manager is not very approachable." The manager had written in the PIR that they were 'a hands on manager'; and, 'spent time on the floor, supervising staff, and reviewing their practices'. Some staff told us they felt the manager was rarely 'on the floor.'

The PIR informed us that regular staff and relatives meetings were held. Records confirmed staff meetings had been held in May and in November 2015. We saw relatives had met with the manager in May and in August 2015.

We were aware the manager had faced a challenging time over the last six months and asked the regional manager what the organisation had done to support the manager. The regional manager told us they had been available by phone to talk to the manager and met when possible, however acknowledged that they had recently been working more closely with another home in the group which required their support. They told us they would be providing more support to Norton Grange to support the manager with the next phase of improvements.

The manager had been working with the CCG and local authority to ensure the infection control measures in the home met good practice standards. This was after an inspection by them found improvements were

required. The manager told us this had taken up a lot of their time, and meant some of the other audits and checks had not been carried out as routinely as they would have liked. For example, there had not been an accident or incident audit since July 2015 to check whether there were any emerging themes or patterns to accidents. We looked at the accident and incident log and found no themes or patterns in relation to falls or accidents in the home. We found medicines had been checked as had food safety. We also saw safety checks had taken place for the premises and equipment.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care 9 (1)(a)(b)(c) People did not receive person centred care. People's emotional and social needs were not met. People who lived with dementia received care from staff who did not know how to meet their needs or reflect their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment 12 (2)(a)(b)(c)(g) Risk assessments did not clearly inform of the reasons why practical actions had been taken to reduce risks. Staff did not always support people safely. Assessments of risk was not always carried out in accordance with the Mental Capacity Act 2005. This included best interest decision making and lawful restraint. People did not always have their medicines as required, and records were not always correct.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs 14 (4)(a) Staff did not follow the most up to date nutrition and hydration assessments for each person.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed 19 (3) The home did not have the information available specified in Schedule 3 of the Health and Social Care Act 2008.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing 18 (1) There were insufficient numbers or suitably qualified, experienced, and knowledgeable permanent staff to meet people's needs. 18 (2) (a) Staff had not received appropriate training and supervision to enable them to fulfil the requirements of their role.