Norbury Hall Residential Care Home Limited

Norbury Hall

Inspection report

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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?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We carried out this unannounced comprehensive inspection on 22 and 24 August 2018. At our last inspection in January 2017 the service was rated Good overall.

During this inspection we found four breaches in safe care and treatment, staffing , person-centred care and good governance. We found the provider was responsive to all our findings and has either already rectified or is in the process of making improvements to the service. You can see the action we asked the provider to take on the back of our full-length report.

Norbury Hall is a residential care home that provides support and personal care for up to 81 older people. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided and both were looked at during this inspection. Norbury Hall is set in a landscaped park. One section of the home is an older large Grade ll listed building and the other is a purpose-built extension. Accommodation within the home includes bedrooms on the ground, the first and second floors. There are two passenger lifts to access all floors. At the time of our inspection 50 people were using the service.

We met with the manager at this inspection who was in the process of becoming a registered manager with the CQC. 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.

People were not always protected from the risk of harm due to environmental concerns. We found adequate window restrictors were not in place meaning people could fall from height. We found call bell cords had been tied up and some areas of the service were not clean. On the second day of our inspection we found the provider had fitted window restrictors and work had started to deep clean some areas.

Not all risks had been identified for people and some risk assessments had not been reviewed after people had fallen. Some information about people's care was not always complete. This meant staff did not always have the guidance they needed to support people and manage their risk according to their individual needs.

There were not enough staff to keep people safe. People and their relatives told us the service needed more staff. There had been a large about of unwitnessed falls at the service and relatives told us they thought this was due to a lack of staff. We saw staff were task focused in the mornings and woke people early to get them washed and dressed. The provider had not completed an assessment of needs for each person so could not be sure how many staff were needed and at what time of the day to support people safely. Not all floors or communal areas were staffed during our inspection resulting in an increased risk to people sustaining injuries, or not receiving the care they needed. The provider assured us they would address these issues.

People and staff told us they liked the new manager and the changes they planned to make. We found communication methods were in place to obtain the views of people and their relatives although it was not always clear how these were acted upon.

We found some systems were not in place to ensure all care records and risk assessments were up to date and accurate. Audits were regularly completed, however, some health and safety and infection control audits were missing so issues that could put people who used the service and staff at risk had not been identified.

Newly introduced care records focused on people and gave a good picture of the individual including their physical, health and social needs. Plans were in place to update all care records, but at the time of inspection not all care records provided accurate or complete information about people's needs.

Staff recruitment procedures were safe and staff told us they received regular supervision. All staff received an induction when they first started to use the service and staff were in the process of completing their mandatory training.

Medicine management was good and people received their medicines as and when they should. The storage of people's medicine was not always safe as temperatures sometimes exceeded the recommended levels. However, the provider put systems in place during our inspection to rectify this.

People had opportunities to access the community and in-house activities were provided by two activities coordinators. Staff knew people well, their likes and dislikes and life history's and could tell us how they involved people to stop them feeling socially isolated.

People had access to healthcare services and received on-going healthcare support when they needed this, records of visits with healthcare professionals were in people's files and feedback from healthcare professionals was good.

People and their relatives spoke highly of the staff at Norbury Hall. We observed kind and considerate interactions between staff and people using the service. Staff were friendly and polite when speaking with people. Staff respected people's privacy and maintained their dignity.

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

Some aspects of the service were not safe. There were not sufficient numbers of staff to safely support people or meet people's needs.
The environment was not always safe.
Not all areas of the service were clean.
Safe medicines management was maintained but storage temperatures had to be addressed.
Staff followed procedures regarding safeguarding people from harm.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective. People had enough food and drink to meet their nutritional needs but their mealtime experience was sometimes poor with a lack of choice and a structure that did not always meet people's immediate needs.
The manager and staff understood the main principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DOLS).
People's health was regularly monitored and they had access to a variety of external healthcare professionals and services.
Outside space was not always easily accessible for wheelchair users and the ground surface was uneven in places. We found some improvements were needed to make the environment more dementia friendly.

Is the service caring?

Good

The service was caring.
People and their relatives spoke highly of the staff and the kindness they showed. Staff treated people with kindness, dignity and respect.
Staff knew people's likes and dislikes

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive
Some people's care records were not complete and information about the daily support people received was missing.
There were a range of activities available within the service to

ensure social isolation was avoided.
People were encouraged to voice their concerns or complaints and they were confident any concerns would be acted upon.
People who were approaching the end of their life were consulted on arrangements if their conditions deteriorated and they received compassionate and supportive care.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led.
Audits were undertaken to review the quality of service delivery, however, these were not always comprehensive and sufficient action was not taken to mitigate all risks to people's safety.
People's records were not always accurate or complete.
People, relatives and staff told us they liked the new manager and the changes they planned to make.
People's views were sought about the service.

Norbury Hall

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 22 and 24 August 2018, the first day was unannounced. The inspection team on the first day included two inspectors, a specialist advisor with expertise in people's medicines and dementia care and an expert-by experience, whose expertise included residential homes. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the second day of our inspection there was one inspector.

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 reviewed previous reports and notifications that are held on the CQC database. Notifications are important events that the service must let the CQC know about by law. We reviewed safeguarding alerts and information received from a local authority.

Some of the people at the home were living with dementia and were not fully able to tell us their views and experiences. We therefore used the Short Observational Framework for Inspection (SOFI) during lunchtime in the dining room. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We spent time observing the care and support people received in the communal areas of the service.

We talked to nine people using the service and six relatives who were visiting or via the telephone during the inspection. We spoke with the provider, the manager, the deputy manager and nine staff members who included care staff, the activities coordinators, housekeeping staff and the chef. We spoke with two health professionals and a GP involved with the care of people in the home. We also spoke to a representative from the local authority who was there to discuss ongoing training at the service.

We reviewed the care records for 10 people residing in the home and looked at how medicines were

managed and the records relating to this. We checked four staff recruitment files. We looked around the premises and at records for the management of the service including quality assurance audits, action plans and health and safety records. After our inspection the manger and deputy manager sent us additional information such as staff training and staff supervision and details of the improvements undertaken because of our inspection.

Requires Improvement

Is the service safe?

Our findings

Prior to our inspection we had received several statutory notifications from the provider regarding injuries to people after they had fallen. We had also received concerns from relatives regarding falls and injuries their family members had received while at Norbury Hall. From April 2018 to August 2018 we had received 10 reports of people falling while unsupervised. Relatives told us they thought there was a lack of staffing at the service and this had an impact on the care their relative received. During this inspection we looked at staffing levels and we found there were not enough staff to support people to stay safe or meet people's needs.

The provider told us they had increased daytime staffing levels from a ratio of one staff member to 10 people to one staff member to eight people following concerns raised and the number of reported incidents. At night the ratio was one staff member to 10 people. Although we were shown a dependency assessment tool, (this helps the provider determine the numbers of staff and type of support a person needs to keep them safe and meet their needs) the provider confirmed this was only used for those people who had high dependency and a full assessment of the 50 people currently using the service had not been completed. Therefore, the provider did not have a formal assessment tool to establish how many staff were required to support people safely. On the first day of our inspection there were five staff on shift, one staff member was sick so we were told the deputy manager was standing in as the sixth member of care staff.

People we spoke with told us staff tried their best but more staff were needed. One person told us," The only issue here is the lack of staff. They need a lot of people to look after us." When we spoke with staff, all but one, told us they thought more staff would help them provide better care and give them more time to speak with people and help them. During both days of our inspection we noticed staff were not always available in communal areas or on other floors of the service. For example, on the first floor one person appeared confused and was unable to access other parts of the home because of locked doors. On four occasions we observed the person trying to move from the first floor but we only once saw a staff member available to help them. We were concerned because without visible staff available to assist people, people were at a greater risk of injuries. We spoke to the provider about our observations and concerns. They explained that although each floor was not permanently staffed, the person we were concerned about had a sensor on their door so staff knew when they moved from their room and was therefore able to go upstairs to assist them.

We spoke to one relative who told us they would visit their family member before work in the mornings around seven o'clock, they told us people were always up, sitting in the dining room at that time. On the second day of our inspection we arrived at 6.40 am, we found 15 people in the dining room, sitting quietly. Three people were asleep, one person, still in their wheelchair, was gently snoring with their head on the dining room table, indicating they had been there for some time and were still tired. Two members of staff were also in the dining room writing notes, there was no communication with people or staff, nothing for people to do and nothing for people to eat or drink. At 6.50 am we walked along the ground floor corridor, one person was ringing the bell and asking to get up. We heard a staff member say, "Hello darling, I told you to stop ringing the bell…no you don't need to get up." Another person was still in bed, just beginning to stir

but still in a light sleep, we noted the door was wide open and the light was on indicating it was their time to wake up.

We spoke to three staff on duty who confirmed they would start to wash and dress people around 5 – 5.30 each morning. One staff member told us, "We start at 5am, we give everyone a wash and bring them to the lounge". Another staff member told us, "We start getting people up at 5.30, we wake people up, but normally start on those people who are already awake."

Two people who were more able told us they were up early because it was their choice, however, we were concerned because our observations suggested people were being woken earlier than they wished, to enable the night staff to assist with the task of personal care before the day shift started. The lack of staff at certain times of the day meant staff could not always meet people's needs and the number of unsupervised falls concerned us. The provider has agreed to re-look at the dependency tool to determine the number of staff needed to meet everyone's needs and keep people safe. However, these concerns amounted to a breach in Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not always assess, monitor and review risks to people's safety due to their specific needs. We looked at the accidents and incident reports at the service and what action had been taken to reduce risk and keep people safe. For example, actions following a fall included increased observations and room and bed sensors to help staff know when people were up and about. We were told about future plans to start reviewing this data for trends and feeding information into a risk register to help establish the care required and staff numbers needed to ensure people's safety. However, this had not been fully established and integrated at the time of our inspection. We saw the most current risk register and noted this had basic information with people's immediate needs but nothing else. We saw two people's risk assessments had not been updated after a fall and where risk assessments were in place they did not always give specific information on how to avoid falls or identify the cause of the fall. However, when we reviewed all records, including the input from multi-disciplinary teams we saw the correct action had been taken and at least one person had been referred to the falls clinic for further investigation and advice. However, we were concerned that information and guidance was not always accessible for staff to give them the information they needed. We did not see MUST (Malnutrition Universal Screening Tool) in any of the files we looked at. This tool is used to identify if adults are malnourished or at risk of malnutrition. Although, we noted some other methods used to identify risk including regular weight checks and food and fluid charts were in place we were concerned that best practice guidance was not being followed.

The provider did not always maintain a safe environment for people. On the first day of our inspection, during our observations around the building, we looked at communal areas and people's rooms. We found five rooms without adequate window restrictors, as recommended by the Health and Safety Executive. Call bells cords were tied up in seven people's en-suites, making it impossible for them to summon help, without shouting, should they fall. In six people's bedrooms we found there were no call cords just a button and it was hard to see how people could access these if they needed staff assistance. One person's call bell cord was behind their bed and not accessible to them at all and another person has a call bell cord on the opposite wall to their bed. We looked at the monthly call bell audit although it identified where there was no call cords in place it did not identify whether not having a call cord in place was appropriate for that person or not. It did not distinguish between the call points in people's bedrooms and those in their en-suites. We discussed our concerns with the provider who told us they would immediately look at these issues.

On the second day of our inspection we found robust window restrictors had been fitted to those windows identified, pull cords had been untied in people's en-suites and the manger had undertaken an audit looking at people's call bells and sensor equipment. We found some people's pull cords were shorter than

the recommended guidance in the building regulations, we discussed this with the provider and sent them further guidance after our inspection. We found several uncovered radiators at the service. One relative told us of a portable oil filled heater that was used during the winter to keep their relative warm when the heating was not working and the windows did not close properly. We spoke with the provider about the dangers of using uncovered heat sources in people's rooms, the risk of burns and scalds and the need for adequate risk assessments to keep people safe. The provider told us that some radiators were disconnected and no longer in use and therefore not a risk. We noted on the second day of our inspection notices had been placed above uncovered radiators stating they were no longer in use. The provider assured us people would not be cold because these radiators were not in use.

We looked at the arrangements in place to ensure the service was kept clean and hygienic. During our observations on the first day of our inspection we found people's rooms and communal dining rooms and lounge areas were clean. We noted the new procedure the manager had introduced so staff had a trolley with the personal protective equipment they needed when delivering personal care. However, several of the en-suites in the older part of the building had fitted carpet and in two of these rooms there was a strong smell of urine and stains around the toilet floor. The communal toilet on the ground floor was dirty, had suffered water damage and required redecoration and a deep clean. The communal toilets on the first floor had worn toilet seats where the plastic had worn away leaving the absorbent base. Many of toilets and en-suites we looked at did not have toilet paper. On the second day of our inspection staff had been reminded to re-stock on toilet rolls, and we were told the en-suites had received a deep clean. We looked again at the rooms in question and found the malodour remained, with stains around the base of the toilets and toilet brushes were dirty. We discussed our concerns with the provider. We saw work had started on the ground floor communal toilet to redecorate and clean. We looked at the cleaning schedules in place and noted these covered people's rooms and the main communal areas. We looked at the kitchen, the deputy manager told us the chef was responsible for the cleaning. However, we were unable to find a cleaning schedule. We had previously asked the deputy manager to remove a dirty and stained tea towel the chef was using as we were concerned about infection control and food hygiene. We were unable to find any infection control audits as recommended by the Department of Health, for the kitchen or for the rest of the service.

Although the provider was reactive to our findings and acted to rectify the issues we found we were concerned that these issues had not previously been identified. These issues have amounted to a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had arrangements in place to safeguard people from abuse. Staff had been provided training in how to safeguard adults at risk and told us the action they would take if they had a concern about a person to ensure the person was protected. The provider had a policy and procedure for staff to follow on how to report any concerns they had about a person to a senior staff member or to another appropriate authority such as the local council. Records showed the provider had reported any concerns they were made aware of about a person to the local council and cooperated fully in subsequent enquiries and/or investigations.

Recruitment checks were carried out before people could work at the service. Each staff file had a checklist to show that the necessary identity and recruitment checks had been completed. These included proof of identification, references, qualifications, employment history and checks with the Disclosure and Barring Service.

People's medicines were managed safely. We looked at the storage and administration of medicines. People's medicines were kept in trolleys on the ground floor in the dining room, these were well kept and

tidy. Only those staff trained in medicine administration could give people their medicine. We observed medicine was given in a safe manner with the staff member following the personalised instructions recorded on the Medicine Administration Record (MAR). Records we looked at were correct and up to date with no recording errors. Guidance was in place for people's "as required" or PRN medicines and we discussed ways with the deputy manager to further improve the information available for staff. We were concerned the recent hot temperatures meant the temperature the medicine was stored at was not safe. The deputy explained the room temperature checks were carried out at 6 AM so the recorded temperature checks were all within a safe range. However, on both days of our inspections around lunch time we checked the temperature again and it was more than the recommended 25 degrees. We spoke with the provider who acted immediately by opening the doors of the dining room, and seeking advice from the pharmacist. Ice blocks were placed in the cabinets until the temperature reached an acceptable level. The provider explained they were looking to create a medicine storage room that would be temperature controlled but in the meantime had increased temperature checks to three times each day to ensure continuing safety of people's medicines.

Requires Improvement

Is the service effective?

Our findings

People were supported to eat and drink enough to maintain a balanced diet. However, people's mealtime experience was not always positive. We asked people if they were offered a choice of food and drink at meal times and if they liked the food. Comments included, "It's edible, nothing else" "They don't offer you an alternative if you don't like something", "The food is not good. It's frozen. Sometimes we get food from the day before. The last concern I raised last week and they said they were getting a new cook", "We have monthly residents' meetings but they decide on the menu" and "it's revolting…I'm not eating. I won't tell them." The provider told us they had recently been looking at a supplier of frozen meals and had a day where samples were given to people and their views sought. We were shown the feedback from people and it appeared most people liked the samples. We discussed how the chef would be able to provide these meals but still offer people alternatives.

Mealtimes and times for hot drinks were very structured and it was hard to see how people were catered for if they chose not to eat at set times or were thirsty outside of the set time. Relatives were asked not to be present at mealtimes and notices were around the service reminding them of this. We discussed this with the provider as current guidance suggests mealtimes can be enhanced by the presence of people's loved ones. The provider explained they discouraged relatives as there was limited space in the dining room. However, they did allow relatives to be present but sometimes it meant people needed to eat in their rooms. We observed breakfast and lunch time at the service and noted the dining room was very crowded with people actively looking for places to sit. A second room on the ground floor was also used and other people sat in the library or dining room to have their meals, although we were not sure if this was their choice or because there was no room anywhere else. One person was eating their meal on their lap, we asked them if they needed a table, however, we could not see that a spare table was available. The person told us they were alright and could manage. At breakfast people were in the dining room well before our arrival at 6.40 am. No one had a drink, when we brought this to the manager's attention they arranged for a hot drink for people. Breakfast was served at 8.35 am which meant that some people had been waiting for their meal for more than two hours. During lunch the service was hurried, with the chef and two assistants serving food to all 50 residents. Staff members took food to people's rooms on trays while the chef moved a heated trolley between the main dining room and the smaller dining room on the ground floor. Occasionally we heard staff offer people a choice of beef or chicken but mostly people were served a meal with no choice or alternatives given. The provider had assured us people were shown each plate of food so they could choose which one they wanted but this did not happen.

We asked the chef how people made their choice of food and were shown a list that had been completed by staff the day before. The chef confirmed they were going to start to ask people at breakfast what they would like for their main meal, as they understood not everyone could remember what they wanted from the day before. We could not see any menus or written information in the dining room about meal choices and a small white board was used outside the kitchen area to record the menu. We spoke with the deputy manager about improving the communication for people at mealtimes, using pictures and showing people alternatives so they could make a choice. We asked how people had access to drinks and food when the kitchen was closed, the chef explained staff could access the kitchen to make drinks and snacks such as

sandwiches if people wanted anything. We spoke with the provider about people's accessibility to food and drinks outside of mealtimes when the service increased its numbers and the possibility of relatives and staff having the facilities to make hot drinks for people on each floor. The provider assured us they would look at the options.

We found people were not always involved in decisions about their mealtimes and the structure of meal and drink times made it hard for staff to meet everyone's need and preferences. This amounted to a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with three relatives who told us they felt fully informed about their relative's care and were involved in the initial assessment before care started. People's care and support needs had been assessed and discussed with them prior to their admission to the service. A full assessment of their needs was completed which involved the person, their relatives or friends where appropriate. This covered people's health and mobility needs their likes, dislikes, daily routines and communications needs. People were asked about their hobbies and interests and if they would prefer a male or female care worker to help them with their personal care. The provider explained they had also included questions concerning outstanding safeguarding investigations, complaints or concerns as this information would help them better understand the persons background, recent history and allow the service to provide the care required.

People were supported by staff who had the knowledge and skills they needed to carry out their role. Staff told us there were good opportunities for training. They told us, "We have enough training, it's on line and face to face" and "The training is good, I asked if I can do the NVQ 3 and I have now started." All new staff received an induction that introduced them to the home, taught them the basics they needed to know, the policies and procedures and any mandatory training. The provider explained although staff were not required to complete the care certificate they were tested on their knowledge of each standard to ensure they had the knowledge and skills required. The care certificate covers a set of nationally recognised standards that have been developed for support workers to demonstrate that they have gained the knowledge, skills and attitudes needed to provide good quality and compassionate care and support. Records were kept of staff training so training needs could be highlighted and monitored by the manager and at provider level. We saw the service was working closely with the local authority to help deliver important training to staff and spoke to one of the training providers about the work underway. However, we found the way the provider was recording this information made it difficult to monitor which staff had received training and when the next training was due. We noted from the training records that some staff had gaps in their training, the provider confirmed they were aware of this and were working with their training provider to rectify this. They told us they were aiming for all staff to complete their training by the end of September 2018. We will look at this again when we next inspect.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 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 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.

The provider had a good understanding and awareness of their role and responsibilities in respect of the MCA and DoLS and knew when an application should be made and how to submit one. Applications made to deprive people of their liberty had been properly made and authorised by the appropriate body. Staff we spoke with understood their responsibilities regarding the Mental Capacity Act 2005 and Deprivation of liberty safeguarding. People's capacity to make decisions and consent to treatment was regularly monitored by the service and recorded in their care plans.

People had access to healthcare services and received on-going healthcare support. The provider worked closely with the local authority and healthcare services and looked at ways to improve relationships that would ultimately have an impact on people's care. We spoke with one of the GP's that were visiting at the time of our inspection who told us they had no concerns about the care at the service. We also spoke to two community nurses who confirmed there had recently been a huge improvement in communication and they had no concerns about people's care. Two local GP services provided support to the service and we saw there were good links with the local hospice. Notes containing outcomes from the visits of healthcare professionals were recorded. We saw hospital passports were in place, this helped give hospital staff the information they needed if the person was admitted. We also spoke with the provider about their involvement with various forums to help staff identify when people need medical intervention and working effectively with outside organisations.

The atmosphere was warm and welcoming. The older part of the building is Grade II Listed and there were limitations on the structural changes that could be made. Three separate relatives told us of ill-fitting windows and drafts in the older part of the building. The provider was aware on the ongoing issues with fluctuating temperatures and assured us they were working within the parameters of English Heritage to make improvements. People had access to outside space although in areas this was not easily accessible for wheelchair users or those who were prone to falls because of uneven surfaces. After our inspection the provider sent us confirmation of ongoing work to improve the outside surface. There were quiet areas available when people had visitors. Equipment was provided to meet people's care needs and support their independence. We noted that some additional adaptations could be made to help those people living with dementia for example, contrasting coloured toilet seats to make it easier for people to see. We spoke to the provider about these findings.

We recommend the provider consults current best practice about the adaptations of the environment, in relation to the specialist needs of people living with dementia.

Good

Is the service caring?

Our findings

People told us they liked living at Norbury Hall and spoke positively about the caring attitude of the staff. Comments included, "The carers are very nice. They know what they are doing", "I like it here…they [staff] are nice to me" and "I don't think there is a place that would suit me any better."
We spoke to five relatives who all thought the care staff were good and did their job well. Comments included, "The staff are lovely, they are all so cheerful…they can't do enough for you", "The care [my relative] received [while at Norbury Hall] was exceptional…from the word go [my relative] was made to incredibly welcome. We cannot speak highly enough of the staff" and "The staff are absolutely caring."

We were shown several compliments and thank yous the service had received from relatives and some healthcare professionals in addition to the positive responses received on a care home rating internet site. Comments included, "[My relative] is treated as an individual and friendly way", [My relative] was obviously well cared for and [they] enjoyed interacting with all of the staff" and "The staff seem to genuinely care about the residents and are very helpful."

Staff knew people well and could tell us about people's likes and dislikes. We saw information was displayed on people's doors and in their rooms telling staff about the person and what they were interested in, giving staff the information they needed to start a conversation. One person's room contained information to help with their orientation and provide reassurance, this included details of about where their family lived and when they visited. Staff talked about people with care and compassion although some staff said it would be nice to spend more time with people. One staff member told us, "The residents make me happy all of the time." Another staff member said, "I like to help people, I feel like I am doing something good."

People told us staff treated them with dignity and respect. One person said, "They [the staff] do what I ask them to do." Another person told us, "They look after me well." We observed staff knocking before entering people's rooms and addressing people in a kind and courteous manor. Doors to people's rooms and communal bathrooms and toilets were kept closed when people were being supported with their personal care to ensure they were given privacy. People were dressed in fresh, clean clothes and their hair and nails were tidy and trim. We observed all staff including care staff, housekeeping staff and laundry were friendly, compassionate and caring towards people and we saw some good interactions during our inspection. Staff were attentive and respectful in their approach and manner. Conversations were friendly and demonstrated that staff were on good terms with the people they were caring for.

Requires Improvement

Is the service responsive?

Our findings

People and their relatives, where appropriate, were involved in planning their care. The manager explained the service was in the process of creating new care records and we were shown a sample of the new care plans and risk assessments. We found these detailed and reflected people's individual preferences, which helped staff to meet people's needs. However, the older style care plans were more generic and we found some basic plans were missing in some people's records. For example, around mobility and falls, nutrition, pressure area care, eliminations, washing and dressing and pain control. When we spoke to staff we were assured they knew people well enough to provide the care they needed but we were concerned not all the relevant information had been recorded and there was a risk that newly employed or agency staff may not know how to support a person. During the second day of our inspection we were shown more examples of the new care plans and we were assured that in the future people's records would reflect the care they needed. However, we were concerned that at the time of our inspection not all care plans identified peoples care and support needs.

We looked at other records used at the service to record the care people were given to see if care was responsive to people's needs. We found there were no individual records of the personal care received by people. We saw one person liked to have a shower every Monday and then every other day after that. We asked the deputy manager where personal care should be recorded and was told this would be the daily notes. When we looked at the daily notes for each person we found these were basic with no times or detail. For example, for the person who liked to have a shower on a Monday their notes stated personal care had been given and did not indicate if the person had received a shower. We were concerned because we were unable to identify if people had received the personal care they required and wanted, this included baths, showers, oral hygiene and basic checks around dentures, hearing aids or glasses. Although staff were able to confirm personal care was provided records did not provide any detail.
We were concerned that the lack of complete and contemporaneous records in respect of each person suing the service meant we could not be sure people had received the care and support they needed. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were clear about the importance of daily handovers. We attended a handover and noted staff knew people well, they could identify any issues that had arisen or changes in people's health or mood that other staff needed to be aware of to offer the best support.

The service employed two activities co-ordinators and was looking to employ a third. We spoke with one of the activities co-ordinators, they knew people well and told us how they arranged group events and individual actives to stop people feeling isolated. We saw people having a manicure, and doing arts and crafts during our inspection. Staff explained each morning they would take a person to the local shop to buy the newspapers people wanted. We spoke to two people reading their papers, they explained they liked to sit and read their regular newspapers each day and were happy they had the newspaper of their choice. We spoke to one person who told us they enjoyed the bingo and watching old films. We saw another person was busy drawing and colouring. One staff member told us, when they had the time they would play dominoes with one person. And people told us they really enjoyed the live music on a Sunday. Staff were

respectful of people's cultural and spiritual needs and there were regular Christian based visits to the service. Staff told us there were a few people who did not speak English as their first language, however some staff members were able to communicate with them in their native language and this had made a positive impact on their wellbeing. Staff were aware of people's histories and told us about one person who been a cleaner in their younger years and now, if the person wanted to, they would support them to help clean and polish. We observed one person clearing tables and taking plates and cutlery to the kitchen after mealtimes giving them a sense of purpose.

The activities coordinators produced a monthly newsletter with information and photographs of the activities that had happened and those coming up, this included walks in the park, gardening, baking and a visit to a local school. We heard, in the future the service hoped to work with a with a local nursery to help people and children get to know one another.

The service had end of life care arrangements in place to ensure people had a comfortable and dignified death. The service was accredited with the local hospice to improve end of life care for people and the provider explained they were proud of the relationship they had with the local healthcare professionals and the support staff gave to people when they approached the end of their life. Care records showed where people chose to spend their final days in the service and not be admitted to hospital and people were able to specify their preferred arrangements if they wished. Decisions were recorded on people's records so that in the event of their death staff had the information they needed to ensure their final wishes would be respected.

People were asked to give feedback about their experiences of care and support during monthly resident meetings and the manager had started to meet with relatives, to answer any questions they might have and address any concerns. Guidance was given to people on how to make a complaint when they first started to use the service and was contained with the service user guide. This included details about the complaints policy, who to speak to and the timescales involved. We had received some complaints at the CQC and the provider had notified us of others. We found the provider took complaints about the service seriously. Where complaints had been made we noted these had been investigated thoroughly and the concerns raised had been used as an opportunity for learning and improvement. For example, following a recent complaint about additional charges at the service the provider had put in a system to make sure people and their relatives were informed of any additional costs during the assessment process so they were able to give their consent before care started. This helped clarify the costs for additional services such as hairdressing, massage and external trips.

Requires Improvement

Is the service well-led?

Our findings

The provider had some processes in place to review the quality of the service. This included regular audits of medicines management, care records, call bells, sensor mats and a six-monthly workplace inspection. However, at the time of the inspection the provider did not always have sufficient systems in place to review the quality and safety of the service. They had not undertaken a health and safety assessment of the service to identify the risks to people's safety, for example those risks associated with a lack of window restrictors or the risks to people from call bell cords being tied up and out of reach. This meant people were at risk from falls and were unable to call for help if they suffered a fall. Although cleaning schedules were completed. Systems to manage and monitor the prevention and control of infection were not in place and we did not see how the provider assessed the environmental risk of infection to people. We were not able to see any infection control audits at the time of out inspection.

Records relating to the care and treatment of people using the service were not always complete or up to date. For example, records detailing people's daily personal care and risk assessments had not been updated following falls so staff did not have the information they needed to support people appropriately. The provider did not have the systems in place to monitor staffing levels to ensure adequate staff were on duty to meet people's needs and keep people safe.

People were encouraged to share their views and experiences. Regular resident's meetings were held where people's views and opinions were asked for. We looked at previous meeting minutes and noted the discussion points included food and drink, staff interaction and activities and entertainment. However, we noted where suggestions had been made there was no notes of action taken and it was hard to see how the information was acted upon to shape and improve the service. Although, we did see one example where the provider was looking at changes following a recent survey undertaken by a proposed new supplier of frozen meals. The feedback from people after a meal tasting experience was positive and the provider explained they were looking at how this type of meal programme would work at Norbury Hall and were keen to implement this because of the positive feedback.

Although the provider acted quickly to address our concerns during our inspection if they were able or shortly afterward and had provided a full action plan of the improvements they were making after our inspection, we were concerned because the systems and processes were not in place at the time of our inspection to identify the issues we found. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we met with the new manager who had been working at the service for three weeks. The new manager had applied for registration with the CQC and her application was progressing at the time of our inspection.

The manager explained she had just started to meet with relatives individually, she felt it was important to introduce herself, explain her background and give relatives the chance to give their feedback. The manager told us they wanted to encourage an open-door policy where everyone felt comfortable approaching her

with any issues or problems. People, their relatives and staff spoke positively of the new manager. One person told us, "The manager is very practical…she knows what's going on". One staff member told us, "[The manager] is definitely supporting, she understands and gets involved with residents and staff." Another staff member told us, "[The manager] is trying to bring in lots of new, good things."

People benefited from a staff team that worked together and understood their roles and responsibilities. The manager was supported by an experienced deputy and senior care staff. Staff we spoke with were happy with the changes planned by the new manager and felt team work was good.

The provider and the manager spoke about the progress they were making to improve the outcomes of people using the service. They also spoke about the work they planned to do in the future. For example, working on a pilot to introduce the "red bag scheme" to the local area. This is aimed at helping to provide a better care experience for people by improving communication between care homes and hospitals. When a person needs hospital care staff pack a dedicated red bag that includes important information about the person in addition to spare clothes and other personal items such as glasses or hearing aids. The provider was also working with the local commissioning group to help staff recognise significant changes in people's health that could result in a hospital admission. We also heard about work with the local community. for example, working with a local nursery to involve people and children in activities that they hoped would ultimately benefit everyone.

The provider understood their responsibilities in line with the requirements of the provider's registration. They were aware of the need to notify CQC of certain changes, events or incidents that affect a person's care and welfare. We found the provider had notified us appropriately of any reportable events.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always receive care and treatment that met their needs and preferences. The registered person did not ensure people had an adequate choice of food and drink that met their needs. 9(1)(3)(i)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person had not assessed the risks to the health and safety of service users. They had not ensured premises were safe to use and had not maintained the proper storage temperature of medicines. They had not always assessed the risk of infection and applied adequate control measures to prevent the spread of infection. 12 (1)(2) (a) (d) (g) (h).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person had not ensured effective systems were in place to assess, monitor and improve the quality of care and to assess, monitor and mitigate the risks to service users or maintain accurate, complete and contemporaneous notes for each service user. 17 (1) (2) (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person had not ensured there were sufficient numbers of staff deployed to meet people's needs. 18 (1)