Mr David Lewis & Mr Robert Hebbes

Normanhurst Nursing Home

Inspection report

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Date of inspection visit:
17 September 2018
19 September 2018

Date of publication:
06 December 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on the 17 and 19 September 2018 and was unannounced.

Normanhurst Nursing Home is a 'care home'. 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.

The home is registered to provide nursing and personal care and accommodation for up to 31 older people and people living with dementia. At the time of the inspection there were 25 people living there. Some people had complex needs and required nursing care and support, including end of life care. Other people needed support with personal care and assistance moving around the home due to frailty or medical conditions, such as diabetes and stroke and, some people were living with dementia.

A registered manager had not been in place since May 2018. A manager had been appointed and was applying to register at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The providers for the service are Mr David Lewis and Mr Robert Hebbes. They also own Normanhurst Care Home and Normanhurst EMI Home.

We carried out a comprehensive inspection at Normanhurst Nursing Home in June 2016 when we found the overall rating was Requires Improvement, with four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because improvements were needed in the quality assurance process as a number of areas for improvement had not been identified and audits had not been completed for some aspects of the services.

At the last inspection on 31July and 01 August 2017 we found that improvements had been made. However, medicines practices needed to improve further, to ensure people's health and well-being was protected and the quality assurance process needed further development. We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the overall rating was Requires Improvement.

We undertook this unannounced comprehensive inspection to look at all aspects of the service and confirm it had improved. We found improvements had been made. However, the quality assurance system was not effective as it had not identified all areas where improvements were needed, such as medicine records and nutrition. Additional work was needed to ensure all areas of the service provided were monitored and that this was part of everyday practice to drive improvements. This is the third time the overall rating for this service is Requires Improvement.

Staff understood the Mental Capacity Act 2005 and consistently asked people if they needed assistance. People were supported to have maximum choice and control of their lives and staff assisted them in the

least restrictive way possible; the policies and systems in the service supported this practice. Staff had completed relevant training, including moving and handling, infection control, medicines and safeguarding. They had a good understanding of people's needs, how to protect people from abuse and the action they would take if they had any concerns. Robust recruitment procedures ensured only suitable staff were employed and there were sufficient staff working in the home to provide the care people needed. Supervision and staff meetings kept staff up to date with current best practice and they understood their roles and responsibilities.

Staff supported people to be independent, make choices and plan the support they received with staff. People told us staff provided the care they needed and staff treated them with respect. Care plans were based on people's assessed needs and had been agreed with people and/or their relatives. They included risk assessments and clear guidance for staff to follow to reduce risk as much as possible.

From August 2016 all organisations that provide NHS care or adult social care are legally required to follow the Accessible Information Standard. The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand so that they can communicate effectively. Staff were aware people had different communication needs and explained how they supported people to communicate.

People said the food was good, staff assisted people if required and referrals were made to healthcare professionals if there were any concerns about a person's diet. Relatives and friends could visit at any time and were involved, if appropriate, in planning and reviewing people's care.

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 consistently safe.

Staff had not followed current guidance to ensure people received their prescribed medicines.

Staff had attended safeguarding training and understood abuse and how to protect people.

Risk to people had been assessed and there was guidance for staff to follow to ensure people's safety.

There were enough staff working at the home to meet people's needs. Recruitment practices were robust and only suitable staff were employed.

Is the service effective?

Good

The service was effective.

Staff understood the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and were aware of their responsibilities.

Staff attended relevant training to ensure staff had a good understanding of people's needs and the support they wanted.

People were supported to have a nutritious diet, staff assisted people as required and referrals were made to health professionals if staff had any concerns.

Is the service caring?

Good

The service was caring.

People made decisions about their day to day care, they decided how and where they spent their time and staff respected their choices.

Visitors were welcome at any time and people were encouraged to maintain relationships with relatives and friends.

Is the service responsive?

Good

The service was responsive.

People needs had been assessed and support and care was planned and delivered based on people's preferences and choices.

Group and individual activities were organised for people to participate in if they wished

People and visitors knew how to make a complaint and would talk to the manager if they had any concerns.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The quality assurance system was not effective, as areas for improvement had not all been identified and action had not been taken to ensure people received appropriate care and support.

Feedback was sought from people, relatives and staff through regular meetings and satisfaction questionnaires.

The manager kept staff up to date with changes to the services and staff were encouraged to put forward suggestions for improvements during daily team meetings.

Normanhurst Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on the 17 and 19 October 2018 and was unannounced. The inspection team consisted of two inspectors.

Before our inspection we reviewed the information we held about the service, including safeguarding's and notifications which had been sent to us. A notification is information about important events which the provider is required to tell us about by law. We also reviewed the information sent in by the provider and registered manager in the Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service; such as what they do well and any improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection we spoke with 11 people living in the home and four visitors. We spoke with 13 staff including the provider, manager, deputy manager, nurse, five care staff, housekeeping staff, the chef and maintenance staff.

We observed care and support provided in the communal areas, the interaction between people, visitors and staff and medicines being given out. We looked around the home and talked to people who preferred to remain in their own bedroom.

We looked at a range of documents related to the care provided and the management of the home. These included three care plans, medicine records, two staff files, accident/incidents and complaints.

We asked the manager to send us copies of records after the inspection including policies and procedures for equality and diversity and infection control. These were sent to us as requested.

Requires Improvement

Is the service safe?

Our findings

At our inspection in July and August 2017 we found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the management of medicines was not consistently safe.

At this inspection we found improvements had been made, and the provider is now meeting the previous legal breach. However, additional work was needed to ensure the improvements were part of day to day practice and staff followed current guidance when giving out medicines.

This is the third time safe has been rated Requires Improvement.

The manager had made several changes to improve the management of medicines and ensure people's prescribed medicines were available and given when needed. This included audits to check there were no errors on the medicine administration record (MAR) and, that staff followed the provider's policies and procedures regarding giving out medicines. However, we found appropriate action had not been taken when the audits identified there had been errors, such as gaps in the records. These could have been for many reasons. For example, staff may have forgotten to sign the MAR when they had given medicine to people; they may not have given out the medicine or the medicine may have been refused. It was unclear which of these had occurred because although the audits had identified the gaps there was no evidence of an investigation to find out why the nurse responsible had not signed the MAR. As stated in the Nursing and Midwifery Council (NMC) Standard for Medicines Management, 'All errors and incidents require a thorough and careful investigation at local level, taking full account of the context and circumstances, and the position of the practitioner involved'. The manager told us they asked the nurse responsible for medicines when gaps were found, if the medicines had been given. If the nurse said the medicines had been given they were asked to return to the home and sign the MAR. This had not followed current NMC guidelines which states, 'you must make a clear, accurate and immediate record of all medicine administered, intentionally withheld or refused by the patient, ensuring the signature is clear and legible'. This is an area that requires improvement, the practice followed by staff may not have ensured people received their prescribed medicines, as it relied on nurses remembering if a medicine had been given.

There were safe systems for the ordering, storing and disposing of medicines. Medicines were secure, stored in locked cupboards and a lockable trolley in a locked room. Nurse's gave medicines to each person in turn and we observed they signed the MAR when people had taken them. There was guidance in place for giving 'as required' medicines, such as paracetamol for pain relief and, people were asked if they were comfortable or needed something for pain. Assessments had been completed to ensure people who were responsible for their own medicines were able to do this safely. We noted in care plans that people were supported to be responsible for prescribed skin creams and had agreed that staff were responsible for the other medicines they received.

People's individual needs had been assessed to reduce risk, to enable people to be as independent as possible and make decisions about their day to day lives. The assessments included eating and drinking to

ensure people had a nutritious diet. Skin integrity to identify if they were at risk of pressure damage and pressure relieving mattresses and cushions were provided to reduce this risk. People's mobility and risk of falls had been assessed and aids were used to assist people to move around the home safely. People were supported to use walking aids, staff walked with them or observed them discretely to reduce the risk of a fall. If people were unable to stand on their own staff used hoists to assist them to get up and transfer to wheelchairs; so, they could choose to remain in their room or sit with others in the lounge and join in activities. Staff used the hoists correctly and told us the moving and handling training they had attended was very good and enabled them to keep people safe. One member of staff said, "The moving and handling training was great. They made us get into bed and be hoisted. We then knew how scared people can be. Whether it's comfortable. This was really great training." Another member of staff told us it was the best training they had ever done, "I learnt about checking dates on hoists, how to use different slings and how if you don't use it properly there can be problems."

People were protected from the risk of abuse because staff had attended relevant training. Staff knew about the different types of abuse, such as financial, physical and neglect. They had read the whistleblowing policy and explained what action they would take if they had any concerns. One member of staff told us, "I wouldn't have a problem reporting anyone, including staff, so that residents are protected." Another member of staff said they would talk to the registered manager, but was also aware that they could contact the local authority and CQC if their concerns had not been addressed. The manager had followed current safeguarding guidance and made referrals to the safeguarding team as required.

People said they were quite comfortable at Normanhurst Nursing Home. People, or their relatives, had agreed that they needed more support because of changes in their health care needs and the nursing home offered this. One person told us, "I couldn't manage at home, needed more help, they are very good here and come when called." Staff said they were busy but there were enough staff to provide the care people needed. People and relatives agreed there were sufficient staff. One person said, "They answer the call bells. You do have to wait sometimes, but that's life and it's never very long."

There were enough staff working in the home to provide the support and care people wanted and needed. There was a permanent team of nurses and care staff and, agency staff were employed as needed, to ensure there were enough staff on each shift. The manager said the number of agency staff had reduced as they had taken on permanent staff and, as much as possible the same agency staff were employed. They said, "This is so they know all the residents and the residents know them and we have bank staff who also know the residents very well." One person told us, "The staff are all good, I like some more than others as I have a laugh with them, but there are enough around and I don't have to wait too long." A member of staff said, "There are enough of us to look after the residents and it's nice home to work in." Staff understood equality and diversity and were clear that people's needs were different, but they ensured people were treated equally and safe from harm.

Recruitment procedures were robust and ensured only suitable staff worked at Normanhurst Nursing Home. Checks on prospective staff's suitability had been completed; including completed application forms and references, interview records, evidence of their residence in the UK and a Disclosure and Barring Service (DBS) check. The DBS check identifies if prospective staff had a criminal record or were barred from working with children or vulnerable adults. Nurses qualifications were checked with the Nursing and Midwifery Council to ensure they could provide nursing care at the home.

Records were kept of incidents and accidents. The manager said, "I look at what happened, if there is an accident or incident" and, "I audit them monthly to see if there are any trends or other areas where improvements are needed." For example, one person had bruising on their ankle caused by getting their leg

between the bed barriers, wedges had been purchased to reduce this risk. This meant staff learnt from incidents or accidents and actions were taken to prevent a reoccurrence. Records showed that audits had been completed and staff said they reported any incident, "No matter how small, so we can protect residents and reduce risk, like falling."

The home was clean and well maintained. The layout of the communal areas had been changed to suit the needs of people living in the home, with the small lounge used as a quiet room. The larger lounge had been separated into two areas; one used as the dining area and the other used for seating, watching TV and for people to join in group activities. People using the small lounge told us they had chosen to sit there, as it was quieter. A member of staff said one resident liked to sit in the small lounge and watch TV while others chose to sit together and chat in the other lounge.

Relevant training and checks ensured the health and safety of people, visitors and staff. The fire alarm system was tested weekly, staff had attended fire training and knew how they would support people to leave the building safely. One member of staff said they had been pulled along the corridor in the evacuation slide so they knew how to use them correctly. Personal emergency evacuation plans (PEEPs) were available for each person to ensure they could exit the building safely with staff. Staff had attended infection control training and used protective personal equipment (PPE) when needed, such as gloves and aprons. Hand washing and hand sanitising facilities were available throughout the home and laundry facilities had equipment that was suitable to clean soiled washing and keep people safe. A gas safety check and electrical certificate ensured equipment was safe to use, including the lift and people's personal property, such as TVs and radios.

Good

Is the service effective?

Our findings

People's needs were assessed and support was provided in line with current guidance. Staff had completed training in the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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. We found people were supported to make their own decisions about the care they received and DoLS applications had been made to the local authority in line with current legislation.

Staff knew how much support each person needed. They had understood capacity and enabled people to make choices about the care and support they received. Staff told us, "Residents can make decisions about the care we offer, even if they can't speak they can tell us with their expressions and how they respond. Like when we ask them if they want to get up, they might turn away so we leave them and ask again later" and, "A lot of the residents have full capacity and they tell us what they want us to do." Staff consistently asked people if they needed support and were discrete when people needed help with personal care. As they assisted people to sit in the lounges staff asked, "Where would you like to sit?" Are you comfortable, do you have everything you need?" and, "Would you like a cold drink?" It was clear that the management and staff protected people's rights to make decisions and understood issues around consent. The manager told us people's capacity to make decisions was assessed before they moved into the home, this was added to their care plan and updated if a person's ability changed. When a relative or representative had power of attorney for finances and/or health and welfare this was included in the care plan and referred to when people's needs changed and decisions about their care were needed. For example, when their health needs had changed and people needed to move into the nursing home.

Meals were a social and relaxed time for people. They chose where they wanted to have their meals, in the dining room, the small lounge or their own room and, staff assisted them to do this. Staff said people could really have what they wanted, "Cooked breakfast is available, while most prefer cereal and toast, it is up to them what they have." There were at least two choices for each meal, although people told us they could have something else if they changed their mind. One person said, "If you don't like the food you can always ask for an omelette or something else." Another person told us, "The food is very good." Specific dietary needs were met, such as diabetic diets, as well as mashed, soft and pureed diets. Staff had a good understanding of people's preferences, how much they ate and drank, if fortified meals were required and if people needed assistance. Staff supported one person to be independent with eating and prompted another person quietly, chatting and encouraging them to eat. The manager had re-arranged the layout of the dining area, to enable people to sit together with friends, as well as adding tablecloths and 'knick-knacks' to make the dining area look homelier. Small cards with different topics had been placed on each dining table for people and staff to talk about during the meals, "To encourage them to chat if they want to."

One member of staff used the cards to engage a person living with dementia while they were assisting them with their lunch, the person responded and chatted as they ate.

The manager and deputy manager had taken on the roles of champions for hydration and nutrition respectively. The manager had been concerned about the recent hot weather, people were supported to drink more fluids and cold drinks were available throughout the inspection. People were weighed monthly and more often if there were any concerns and, food and fluid charts were completed to ensure there was a clear record of the amount people ate and drank.

Staff attended relevant training and were supported by management to develop their practice through regular one to one and group supervision. Staff told us the supervision was good and gave them the opportunity to discuss their work and training needs. There was an ongoing programme of training, which they were required to attend. This included infection control, food hygiene and health and safety and equality and diversity. Staff understood equality and diversity and were aware of the 'protected characteristics'; age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation. One member of staff said, "We are all protected regardless of our differences so we are confident to be ourselves." Nurses attended training specific to their roles, such as medication training and wound care.

Staff were encouraged to work towards vocational qualifications in health and social care. Staff said they had completed level 2 or 3 in care and were confident they had the knowledge needed to support people living at Normanhurst Nursing Home. New staff told us they worked through an induction programme, even if they had previous experience of working in care and, were supported by more experienced staff until they felt confident to provide support on their own. Although people usually needed two people to assist them, using hoists, so care staff generally worked in pairs. Agency staff were also required to complete induction, with feedback from staff they worked with about their competence and, they were signed off by the manager if they had the relevant skills and understanding to support people. The manager told us all new staff without experience would do the Care Certificate. The Care Certificate is a set of standards that health and social care workers adhere to in their daily working life and they had assessed them for each module to ensure they had the knowledge and competency to meet people's needs.

People were supported to be as healthy as possible. Referrals were made through the GP to healthcare professionals, who visited the home to assess people and provide guidance for staff. For example, the speech and language team (SaLT) assessed people's swallowing, they identified any difficulties and looked at their risk of choking. Staff knew which people had swallowing difficulties. They explained that thickener was used to change the consistency of fluids and soft or pureed diets were provided to reduce the risk. Staff told us that one person had not liked the pureed meal the SaLT team advised, a follow up visit was arranged and the person was able to have fork mashable meals, which they were happy to eat. Regular visits had been arranged for the chiropodist and opticians and dentists were available if needed.

People's specific needs were met by adaptations to the home and equipment was provided to enable people to be as independent as possible. Hoists, walking aids and wheelchairs were used to transfer people around the home safely and, the lift enabled people to get from their room to the lounges and dining room. There was a large garden to the rear that people who used wheelchairs and walking aids could access and staff said the warm weather had encouraged people to use this.

Good

Is the service caring?

Our findings

Staff knew people well, they spoke clearly about each person's individual needs and preferences and, provided support and care in a way that protected people's equality and diversity. People decided how staff would support them in all aspects of their day to day lives; they chose how and where to spend their time and staff respected their choices. People told us, "I decide what time I get up and go to bed." "I prefer to spend my time in my room, they tell me there are things to do, but I prefer not to." "We go to bed early because we are tired and need a rest" and, "Staff respect what we want to do, it is like home."

Staff said, "We know some residents need more support than others, some people need help with washing, dressing and moving around while others might need help with eating and drinking as well, but they all decide how much support they want and when." Staff protected people's privacy and dignity when they offered people support with their personal hygiene and to use the facilities. Staff helped a person to move from the dining area to the bathroom during lunch in a kind and respectful manner, ensuring their clothes were positioned correctly and were comfortable.

Staff treated people with respect, using their preferred name, knocking on their bedroom door and asking permission to enter before going in. One member of staff said, "Their room is their personal space, we are visitors to their home and are lucky to be able to work here." People who preferred to remain in their room said there were always staff to talk to, including housekeeping and activity staff. One person who chose to stay in their room told us, "Staff pop in to see I am ok regularly and if I need them I can use the bell. It's enough for me." People were overall positive about the care and support they received, one person said, "They are very good here." Another person told us, "I am highly satisfied," because staff left them to enjoy their own company watching TV and reading, which was how they wanted to spend their time. Relatives were equally positive about the support provided. One relative told us, "The staff are kind and caring" and, another said, "We are pleased with the home."

Staff had a good understanding of people's lives before they moved into the home, their hobbies and interests and, people who were important to them. Relatives and friends could visit at any time; they knew people and staff very well and chatted as they joined people in the lounges, or their family members in their rooms. Staff offered drinks and snacks as visitors arrived and conversations between people, staff and visitors were relaxed and friendly. People had developed friendships within the home and they sat together in the lounge and during meals, chatting with each other, staff and visitors. People were supported to stay in touch with family and friends, landline phones could be fitted in people's rooms, although most used mobiles and, staff said broadband was available if people wanted to use it.

Confidentiality procedures were in place and staff were confident that information about people was protected. Computers containing care plans and daily records were password protected and only accessible to staff and, the computer used to review and update care records were only accessible to senior staff. Other records were kept secure in locked cupboards in the manager's office. Staff said, "Any information about residents is strictly private" and, "We don't discuss residents needs with other people without their permission."

Good

Is the service responsive?

Our findings

The manager said, before they moved into the home, people and their relatives were encouraged to visit Normanhurst Nursing Home, to look at the home and meet people and staff. This enabled people to talk to staff about their expectations and needs, "To ensure we can offer the care they need." The manager told us that people had moved from their own home or hospital, or from Normanhurst Care Home, (known as the 'hotel') the adjoining building, to the nursing home when their health care needs changed. One person said, "I used to join them in the lounge for some activities so I knew what it was like here and I still go back to the hotel to have lunch and see my friends. I need more help as I can't move around so easily and had to move here." A relative had also supported their family member to move from the care home to the nursing home as they needed more support. They told us the transfer had been arranged, the home was clean and the staff were kind and caring.

People's needs had been assessed before they were offered a room, with the person and their relatives, if appropriate, and this information was used as the basis of their care plan. The care plans included details of each person's mental and physical health needs, including communication, mobility, continence and behaviour. People and/or relatives who chose to be involved in writing and reviewing their care plan could demonstrate their agreement by signing on the hand-held computer, which was saved on the system. One person said they knew about their care plan, but did not want to be involved in it. The manager said they were making changes to the online care plan programme, to fit in with exactly what they needed and, it would be some time until they were happy with them. Although staff said the hand-held computers were much easier to use than paper records, because they would sit with people and talk while they were writing up the daily records and could also discuss people's care with them if they needed to.

From 1 August 2016, all providers of NHS care and publicly-funded adult social care must follow the Accessible Information Standard (AIS) in full, in line with section 250 of the Health and Social Care Act 2012. This requires service providers to ensure those people with disability, impairment and/or sensory loss have information provided in an accessible format and are supported with communication. Details about people's individual communication needs were included in their care plans and there was clear guidance for staff about how to communicate with people. For example, one person had several cards to show staff how they felt and tell staff if they needed anything, such as a drink or something to eat. One member of staff said the cards were very useful and enabled the person to be independent and make choices.

A range of activities were arranged for people to participate in if they wished. During the inspection people, visitors and staff joined in 'play your cards right', a quiz and a floor game. The atmosphere in the lounge where the activities took place was relaxed and everyone enjoyed their time together. Activity staff also provided one to one time with people who preferred to remain in their rooms and people could join in activities in the adjoining homes if they wanted to. One person spent time with her husband in the care home each day, another person's relative joined them in the nursing home and they took part in activities together. Activity staff said there was an activity programme, "But it is very flexible and depends on what residents want to do on the day and there are regular external entertainers that people really enjoy, like the singers, exercise classes and church visits."

People and relatives knew there was a complaints procedure. It was included in information given to people and their relatives when they first moved in and displayed on the notice board in the home. One person told us, "They are very good here. I have no complaints" and a relative said they would talk to the manager if they had any concerns.

Staff had attended end of life training and supported people living in the home with palliative care. End of life care plans were in place for people who had made those decisions, these included do not resuscitate forms and, appropriate systems were in place to keep people comfortable if their health needs changed quickly.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection, this key question was judged to be Requires Improvement as time was needed to ensure the quality assurance process was effective and identified areas where improvements were needed. This inspection found that it remains Requires Improvement. We found several audits had been introduced, but further work was needed to ensure monitoring was part of everyday practice and would drive improvements.

This is the third time well-led has been rated as Requires Improvement.

The manager had reviewed the quality assurance system and as stated in the PIR had spent considerable time putting together audits to monitor the services provided. We found most of these had been completed by the manager. These included care plans, nutrition, falls, accidents and incidents, hospital admissions, infections, call bells, and medication, with action plans to address areas for improvement. The care plan audit found the online system was not set up to record information in the way the manager wanted to and they planned to talk to the company responsible to make the appropriate changes. The accident/incident audit had identified areas of concern and action had been taken to reduce the risk of injury to people. However, additional work was needed to ensure other audits were effective. For example, one person had refused their medicines twice, this was recorded on the back of the MAR, but the medicine audit had not picked this up and the nurse responsible for giving out the medicines had not informed the manager.

We saw that people on pureed diets were not offered the same as other people or given choices for some of their meals. There was some confusion as to why this occurred; it may have been a communication difficulty or lack of understanding. Although it was resolved during a discussion with the provider, manager and staff. However, if nutritional audits had been effective this would have been identified and action could have been taken to address it. Further work is needed to ensure the quality monitoring system looked at all areas of the service provided and was part of everyday practice.

The management structure at Normanhurst Nursing Home had changed since the last inspection. A registered manager was not in place at the time of this inspection. A manager had been appointed in May 2018 and, they told us they had applied to register with CQC as the registered manager. They were supported by the deputy manager, appointed at the same time as the manager, and by the providers. They explained their individual roles and responsibilities and the changes they had made since their appointment, to meet the regulations.

The manager knew people very well and was available to talk to people, visitors and staff. One person told us, "Yes she is always around asking if everything is ok" and, a relative told us the manager was very approachable. Feedback was sought about the all aspects of the care and support provided daily and questionnaires had recently been given out to encourage suggestions for improvements from people living in the home and their relatives. The manager was waiting for these to be returned to collate all the information and planned to follow up on any suggestions.

Team meetings had been arranged for 8am every morning to discuss people's needs and allocate staff to support people. The PIR stated, 'this meant team members have a clear understanding of the needs of the resident's and the expectations of their team members'. Staff said these handover sessions were very good, they could discuss people's changing needs and put forward suggestions. Records showed staff discussed topical issues, such as the weather and the importance of having enough fluids, as well as limiting exercises in the afternoon during the heat and encouraging people to have a siesta instead. Staff were kept up to date with details of training, appointments for people, plans for environmental changes and they discussed their philosophy, 'What matters to you will matter to us' and their vision for the next year. This looked at different areas of improvement for each month, in June the focus was on blue plates for people living with dementia or who had limited eyesight. In July they introduced a robot puppy to see if it decreased stress and anxiety and, in August they looked for an oral assessment tool to promote oral health. Each aspect of their vision followed current guidance and each change had been assessed to see if it had improved people's lives. The blue plates were found to encourage people to focus on their meal, but the robot puppy was not particularly popular and alternatives would be sought.

We joined staff for the handover at the beginning of the afternoon shift. They discussed changes in people's needs, staff were allocated to work parts of the home and support people and reminded records in each person's room had to be filled in.

The provider had notified CQC of all significant events which had occurred in line with their legal obligations. The manager was aware of their responsibilities under the Duty of Candour and kept relatives and representative informed of any incidents or accidents. The Duty of Candour is a regulation that all providers must adhere to, it requires providers to be open and transparent and sets out specific guidelines providers must follow if things go wrong.

The General Data Protection Regulation (GDPR) came into effect in May 2018. GDPR was designed to ensure privacy laws were in place to protect and change the way organisations approach data privacy. The manager was aware of this change and training was being arranged for staff.