Orchard Care Homes.Com (5) Limited

Norton Lees Hall and Lodge

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on the 6 February 2018 and was unannounced. This meant staff and the registered provider did not know we would be visiting. Norton Lees Hall and Lodge is a residential care home. The service can accommodate up to 80 people. The Hall and the Lodge each have forty bedrooms. The two buildings share the laundry and kitchen facilities. At the time of the inspection there were 62 people living at the service. The service was originally registered as two services, Norton Lees Hall and Norton Lees Lodge. The registered provider registered as one service on the 12 April 2017. The Norton Lees Lodge service was last inspected on 24 January 2017 and its overall rating was 'Good'. The Norton Lees Hall service was last inspected on 17 October 2016 and its overall rating was 'Requires Improvement'.

At this inspection we found five breaches of the Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The overall rating of the service is 'Inadequate' and the service is in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures."

We saw leadership of the service had been weak and inconsistent since the registered manager had left in April 2017. Relatives we spoke with told us there had been a lack of consistency in the management of the service and this had caused some concerns about the care of their family member. The registered provider's improvement management team and senior managers had been overseeing the service at the end of 2017. A new manager had started working at the service at the beginning of January 2018.

The new manager told us they had submitted an application to register with the Care Quality Commission. 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 had a plan of care in place. We saw the life story work for people diagnosed with dementia was detailed and personalised. However, some people's daily charts were not being fully completed. The records did not evidence these people were receiving the care they needed to reduce and manage their risks.

The management of medicines was not always safe and required improvement.

During the inspection we received concerns from relatives and the staff about the staffing levels at the service. This showed there was not enough staff deployed to appropriately meet people's needs.

Staff rotas and feedback received from relatives showed the service was using a high level of agency staff. This meant people were receiving care and support from agency staff who may not know and understand their history, likes, preference and needs.

The service was not kept sufficiently clean and properly maintained.

We saw some people did not have access to a call bell in their room so they could call for assistance from staff. Following the inspection the manager confirmed action had been taken to ensure people who could use a call bell had one in their room to use. They told us regular checks would be completed.

The staff recruitment records we looked at showed people were cared for by suitably qualified staff who had been assessed as safe to work with people.

The staff were aware of their responsibility to protect people from harm or abuse.

We found there were satisfactory arrangements in place for people who had monies managed by the service.

People told us they were treated with dignity and respect, but we found that some people's dignity was not always upheld.

People we spoke were satisfied with the quality of care that had received and made positive comments about the staff. However, records showed that people were not receiving the care they required.

We received mixed views from relatives about the quality of care their family member had received. Some relatives were satisfied, but other relatives shared concerns about the care their family member had received.

We found the registered provider had not ensured where a person lacks mental capacity to take particular decisions, any made on their behalf must be in their best interests. There was no evidence to show that a best interest meeting had been undertaken to administer one person's medication covertly.

Staff received induction and refresher training to maintain and update their skills. We received mixed views

from the staff about how they had been supported at the service. There had been a number of changes to the management of the service since the registered manager left the service.

The registered provider had not ensured all complaints were identified, received, recorded, handled and responded to.

We saw the arrangements to provide person centred activities for people living at the service required improvement. We found the registered provider had not ensured people living with dementia did not become disengaged with their surroundings.

There were end of life care arrangements in place for people living at the service. The service was working closely with the district nurse and the local GP to ensure people had a comfortable and dignified death.

Our findings during the inspection showed some of the systems and processes to monitor the quality and safety of the service were ineffective in practice.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The management of medicines was not always safe.

Adequate numbers of staff had not been provided to ensure people were appropriately supported.

The service was not sufficiently clean and maintained.

Is the service effective?

Requires Improvement

The service was not always effective.

People were satisfied with the quality of care they had received.

We received mixed views from relatives about the quality of care their family member had received.

Staff received induction and refresher training to maintain and update their skills.

The service had not fully complied with the MCA 2005 when a person had been given their medication covertly.

Is the service caring?

Requires Improvement

The service was not always caring.

The feedback received from some relatives showed that some people's dignity was not always upheld.

Our observations showed that people were not always treated with dignity and respect whilst participating in activities.

People made positive comments about the staff.

People's records were kept securely

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were not provided with enough meaningful activities.

The registered provider's complaints system was not always operated effectively.

There were end of life arrangements in place at the service.

Is the service well-led?

Inadequate

The service was not well led.

We found there had been weak and inconsistent leadership at the service.

Some of the systems and processes to monitor the quality and safety of the service were ineffective in practice.

We found some of the systems in place to monitor people's wellbeing were ineffective in practice.

The registered provider had not ensured that people's records were completed fully.

Norton Lees Hall and Lodge

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 6 February 2018 and was unannounced. This meant no one knew we would be visiting the service. The membership of the inspection team consisted of four adult social care inspectors, a specialist advisor and two experts by experience. The specialist advisor was a registered nurse who had experience of caring for older people. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection, we reviewed the information we held about the service. This included correspondence we had received and notifications submitted by the service. A notification must be sent to the Care Quality Commission every time a significant incident has taken place, for example, where a person who uses the service experiences a serious injury.

We gathered information from the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. This information was reviewed and used to assist with our inspection.

Before the inspection, the provider had not been asked to complete a Provider Information Return (PIR) due to the rescheduling of the inspection. This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

We used a number of different methods to help us understand the experiences of people who used the service. We spent time observing the daily life in the service, including the care and support being delivered. We spoke with 13 people, nine relatives, the manager, two improvement managers, the administrator, a deputy manager, six care staff, the activities worker, two domestic staff, the laundry assistant, the cook and a kitchen assistant. We also spoke with an external healthcare professional who was visiting the home. We were not able to fully communicate with some people living at the home. We used the Short Observational

Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We carried out an observation in both the Hall and the Lodge. We looked round different areas of the service; the communal areas, bathroom, toilets, and some people's bedrooms. We reviewed a range of records including people's care records, four staff files, medication administration records, incident records and other records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

People we spoke with told us they felt safe. Comments included, "Yes I feel safe, I like it here" and "Yes I'm safe." We checked to see if the service was safe.

We saw people using the service had individual risk assessments for such things as moving and handling and deterioration in skin condition. The purpose of a risk assessment is to identify any potential risks and then put measures in place to reduce and manage the risks to the person. For example, if a person was at risk of developing pressure sores, one of the measures in place would be to ensure they were regularly repositioned whilst they were in bed. During the inspection we found concerns about the completion of some people's daily records. For example, we saw some people's repositioning charts were not fully completed. Some people's fluid charts were not being fully completed. The records did not evidence these people were receiving the care they needed to reduce and manage their risks.

Some of the people at the service had behaviour that could challenge others. Care staff we spoke with could describe how they supported people living with dementia at the service. They used different methods to distract the person when they becoming distressed or agitated. We reviewed the records of one person who could display verbally aggressive behaviour when they became agitated. A care worker described how they responded to de-escalate the person's agitation. In the person's cognition care plan, the management for the behavioural problem was mentioned, but not risk assessed, although we had been told by staff the person could push out at staff. We also looked at the person's emergency situation care plan and found aggressive behaviour documented, but there we no mention of charts being kept to understand the triggers for the persons behaviour. Staff told us the person was prescribed a medicine to be given as and when required to help them when they became agitated. Staff were aware this medicine was only to be given when all other de-escalation techniques had been tried. The person's daily notes held some descriptions of the person's behaviour. However, we found a record of triggers of behaviours, which may increase in severity and incidence, had not been completed. For example, a staff member told us the noise of the television could cause the person to become agitated and the action to take was to move them to a quieter area.

We found some concerns about the management of medicines at the service. We looked at the systems in place for managing medicines in the home. This included the storage, handling and stock of medicines and how the administration of medicines were recorded. Medicines were stored safely, at the right temperatures, and records were kept for medicines received and administered. We found each unit (hall and lodge) had a clinical room. However; only one unit had hand washing facilities. The senior staff member told us that they used the sink in the kitchenette to wash medicine pots. The cleanliness of this area was unsuitable for this purpose. Only one unit had a stock of disposable medicine pots, but these were not in use at the time of the inspection. This meant medicine pots were used multiple times and could contaminate medicines which come into contact with other substances.

Staff who were responsible for administering medicines had received training. Staff we spoke with told us they had received additional training in the use of the electronic medicines administration record (EMAR)

which was used to record people's medicines and their administration. This was provided by the supplier of people's medicines. The senior staff member was able to fully explain to us how the system worked, which included information about people's allergies and a photograph of the person. They also told us how they would add items such as antibiotics which may be prescribed for a person.

We observed staff administering medicines to people who used the service. We saw that on most occasions staff did this in a safe way that reflected good practice guidance, such as confirming medicines had been administered and asking people if they required any pain relief. We observed one occasion where a staff member took two people's pots of medicine to both individuals at the same time. This is not safe practice; this can lead to errors and the person receiving the wrong medicines.

Staff were able to explain the signs they would look for when people were in pain or distressed to ensure they received their prescribed medicine when required. However, the senior staff member told us there were no written protocols for 'as and when required' known as PRN medication. These should explain how people presented when the pain relieving medicine was required. We spoke with the manager and two improvement managers regarding this. They assured us these would be put in place. It is important there is clear guidance in place for staff to follow so medicines are given consistently and safely.

We checked the controlled drugs (CD's) held for people who used the service. CD's are governed by the Misuse of Drugs Legislation and have strict control over their administration and storage. We found examples where a second member of staff had not signed the record to witness the medicine had been administered. For example, we saw one person was prescribed a controlled drug to be taken at night. The records showed that on three occasions in January 2018 and on one occasion in February 2018, there was only one staff member's signature. The CD record required another member of staff to witness the medicine being administered. We also found concerns in two other people's CD records. We brought this to the attention of the manager and deputy manager for them to investigate the omissions.

Some people were prescribed topical medicines such as creams to apply to skin. We found these were not appropriately stored. We found a number of bedrooms had these types of medicines kept in en-suite facilities. Although all bedrooms had a lockable facility these were not used to store the items safely.

During the inspection we received mixed views about the cleanliness of the home. Some relatives did not have concerns about the cleanliness of the service whilst others raised concerns. Comments included, "The home isn't clean. My [family member] has had an [infection] three times. Dirty cups. I 've said about it, but nothing is done" and "[Family member] bin is over flowing, it's never emptied."

We looked around both units and found several areas of concern. The four kitchenettes on both units were in poor repair. They all had damaged cupboards and drawers and some of the drawers contained hair brushes which should not be stored where food was being served. Units had substances which were hazardous to health. For example, cleaning products. These were in unlocked cupboards. This showed the Control of Substances Hazardous to Health Regulations (COSHH) were not being followed. We showed one of the improvement managers and the items were removed. The fridges in the units were dirty and contained both food for people who used the service and staff. Some items such as cream and bread were past their sell by date. The small freezer sections required defrosting and cleaning. The shelves used to house the microwaves were extremely dirty. The microwaves seen were dirty. The sink units were dirty and the surrounding tiles needed deep cleaning. Walls and flooring were also dirty and required deep cleaning. The dumb waiter which was used to transport food and drinks between the floors of the home was also dirty. The improvement manager took action to instruct staff to clean the areas and she informed us that a refurbishment plan was in place to refurbish both kitchenettes. We have asked that the registered provider

to inform CQC when this work has commenced.

We looked at the night staff cleaning rotas, which covered all communal areas including the kitchenettes. They were not fully completed and it was difficult to evidence that some areas had been cleaned at all. These were shown and discussed with the improvement manager. We spoke with two housekeepers, they told us they usually cleaned the rooms and the communal toilets, but they had been asked to the kitchenettes on the day of the inspection.

We randomly checked a number of toilets, bathrooms and bedrooms on both units. We found some toilets were dirty and one toilet had been blocked with a soiled incontinence pad. Extractor fans in toilets and bathrooms required cleaning and were all switched off. When we turned them on they made a loud banging noise which should be investigated by the registered provider.

We saw one bedroom had a mattress which did not have a protective cover. The mattress was soiled and needed replacing to prevent any cross infection. Maintenance records also showed that the quarterly showerhead cleaning to reduce the risk of legionella had not been completed in January 2018.

We found the pull cords to alert staff that someone needed assistance were missing in a number of toilets. One toilet did not have any means of alerting staff which could be dangerous if a person was to have a fall or need assistance. We also saw there were call bell leads missing in some people's room so they were unable to call for assistance staff. One relative said, "My [family member] can use a call bell, but as you can see in their room, they haven't got one."

We shared these concerns with the manager and the two improvement managers. They assured us a full check of the premises would be completed and action taken to ensure the premises were kept clean and properly maintained to keep people safe. Shortly after the inspection the manager informed us that call bell audit had been completed for the Hall and the Lodge and any missing call bells had been put in place. They also told us a call bell check would be completed regularly at the service.

This was a breach in Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe care and treatment.

We looked at staffing levels at the service. The Hall and the Lodge can each accommodate forty people. People's bedrooms are located on the two floors on each unit. Some relatives we spoke with raised concerns about the high turnover of staff and the number of agency staff working at the service. They were concerned agency staff did not know their family member well. One relative commented, "There is a big staff turnover, agency is used that's difficult as they don't know [family member] well." On the day of the inspection there were three agency staff working 8am to 8pm in the Lodge and one agency staff member working in the Hall. We looked at a sample of staff rotas. Agency staff were highlighted in white and permanent staff were highlighted in red on the weekly rotas. The staff rotas showed there was a high level of agency staff working at the service. For example, the rota showed that agency staff had covered 36 shifts and permanent staff had covered 21 shifts for the week commencing 15 January 2018. The manager told us the service used the same agency to provide staff and tried to obtain staff who had worked at the service before. It is important that people living with dementia and people receiving end of life care are supported by staff who know them well, whose competency has been checked and maintained. The manager told us the registered provider was actively recruiting new care staff for the service.

During the inspection we received concerns from some of the relatives we spoke with about the number of staff deployed in both the Hall and the Lodge. Comments included, "No there is not enough staff to look

after [family member]" and "People need help to eat. If there is not enough staff. They don't. The food gets taken away. I come every lunchtime to help [family member]. I know they have had something. That's a worry". One relative described how they had concerns about the number of night staff deployed at the service because their family member had not been appropriately supported with their continence care. Another relative described how their family member had called out for night staff to come and help them to the toilet. They hadn't received the support they needed and had fallen. We received mixed views from people we spoke with about the response time to their calls for assistance. Some people we spoke with told us staff responded to their calls for assistance in a timely manner, whilst other people told us staff did not respond quickly and they had to wait.

Some care staff we spoke with told us there were not enough staff to meet people's needs appropriately. Comments included, "There's not enough staff. If there are three [staff] on, the senior [staff] is doing meds, then there are two staff for twenty people. One of those staff has to be in the lounge so no one that needs a double up gets seen to. Some people need one to one. Three staff on duty is not safe, we need four on each floor" and "There is not enough time upstairs. You have to do half hourly obs (observations of people), there's too much to do." On the day of the inspection we did not observed any people being supported to move inappropriately. However, one staff member told us because of the shortage of staff there were occasions when a person had been supported to be moved by one member of staff when there should have been two. This was unsafe practice and puts people at risk. We shared this information with the manager and the two improvement managers. A few staff told us they had shared their concerns about their staffing levels with the new manager, but felt their concerns had not been listened to. This showed that staff regularly felt stretched, and focussed on completing tasks rather than on person centred care and support.

During the inspection staff told us a number of people living at the service required regular observations to be completed. For example, on the first floor of the Lodge, 9 out of 17 people required 30 minute observations. On the ground floor of the Lodge 9 out of 15 people required 30 minute observations. Staff were unable to provide an explanation why these people were being supported this way. People may require frequent observations for a range of reasons. For example, the person can become agitated and display behaviour that can challenge others. We shared this information with the manager and the two improvement managers.

The cook told us the kitchen would benefit from having more staff to ensure standards were maintained. This would reflect that kitchen staff had recently been given additional tasks to complete. These tasks included, completing resident of the day paper work, the checking of all fridge temperatures throughout the service and the baking of fresh buns every day.

This was a breach in Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Staffing.

We reviewed staff recruitment records for four staff members. The records contained a range of information including the following: application, references, employment contract and Disclosure and Barring Service (DBS) check. The Disclosure and Barring Service (DBS) provides criminal records checking and barring functions to help employers make safer recruitment decisions. This meant people were cared for by suitably qualified staff who had been assessed as safe to work with people.

The registered provider was in the process of the reviewing their recruitment policy. We recommend the registered provider review of the requirements specified in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which must be available to demonstrate fit and proper persons have been employed.

We saw evidence to show that regular fire drills were completed at the service and fire equipment had been inspected in 2017. We saw the files that contained people's personal emergency evacuation plans (PEEP) required updating. For example, in one file we saw two people's PEEPs plans were missing and their details were missing off the summary sheet. Both these people had moved into the service in November 2017. We found their PEEPs plans being stored in another file. This showed there was a risk that important information about two people living at the service may be missed during a fire evacuation

We recommend the registered provider review the fire risk assessment completed by an external contractor on 8 December 2016 to ensure all the deficiencies recommended to be rectified within six months and 12 months had been actioned.

The registered provider had a process in place to respond to and record safeguarding concerns. We reviewed the safeguarding records and saw referrals had been made where appropriate. Staff confirmed they had been provided with safeguarding vulnerable adults training so they had an understanding of their responsibilities to protect people from harm. Staff were clear of the actions they would take if they suspected abuse, or if an allegation was made so correct procedures were followed to uphold people's safety.

We found there were satisfactory arrangements in place for people who had monies managed by the service. Each person had an individual record of monies held in their name. We checked the financial records for four people and did not find any concerns. There were regular audits of people's monies completed at the service. This showed there were robust procedures in place to help safeguard people from financial abuse.

The service had a process in place for staff to record accidents and untoward occurrences. We saw examples where the improvement manager had completed route cause analysis for individual occurrences, the lessons learned and the corrective action to be taken. However, our findings showed the some of the corrective actions had not been implemented effectively by the manager at the service.

Requires Improvement

Is the service effective?

Our findings

We looked at a sample of people's care plans. People's care plans showed people were provided with support from a range of health care professionals to maintain their health. These included district nurses, GP and speech and language practitioners.

People we spoke with did not raise any concerns about the care they had been provided. We received mixed views from relatives about the quality of care being provided at the service. Seven relatives we spoke with shared some concerns about the quality of care their family member had received. These concerns were centred on their family member's individual needs, such as support with their continence care or assistance to eat. Two relatives we spoke with were satisfied with the care that was being provided to their family member.

We were aware there had been discussions with district nurses about some people's individual care. These discussions had centred on the management of people's pressure sore, moisture lesion and/or wound care. The discussion also looked at what action could be taken to reduce people's risks of developing problems with their skin. This had resulted in the provision of some training for some staff. For example, 'React to Red' training for some staff. This training helps staff to identify and react to changes in a person's skin. At the time of the inspection five people had problems with their skin integrity and were being monitored by the service.

We saw concerns about the completion of people's daily records by some night staff had been identified by an improvement manager when they had completed an unannounced night check in December 2017. During the inspection we checked to see if people's daily records were being completed to show they had received the care they needed. People's daily records are used by staff to record the care being provided to that individual on that day. These records are tailored to the individual. For example, one person may have a food and fluid chart and a repositioning chart. Daily records are also used by staff to monitor people's wellbeing.

We saw some people's repositioning charts were not being fully completed by staff. We could not be confident that people were receiving appropriate care to minimise their risk of developing problems with their skin. The improvement manager had recently carried out a route cause analysis for three pressure sore cases in December 2017. As part of the lessons learnt for each case was the monitoring of people's repositioning charts at the service. This showed the system in place to monitor people's repositioning charts required improvement.

We saw two people required a chart for monitoring of their bowel movements. Staff told us this information would be recorded on the person's repositioning chart, but we saw it was not being recorded. We looked through one person's daily notes; this indicated they had not had a bowel movement for four days. The person was receiving support from the district nurse at the time of the inspection for the management of pain and they were experiencing stomach pain. It is important that daily records are maintained to ensure people's wellbeing is monitored and enable them to receive appropriate care and treatment.

We looked at a sample of people's food and fluid charts. We saw some people's charts were not fully completed. For example, one person needed their fluid intake monitoring, but no fluids had been recorded by staff on their chart. The person wasn't able to tell us how much they had drunk that day. We could not be confident that people at risk of dehydration were receiving enough fluids. Dehydration is associated with poor health outcomes. For example, poorly hydrated people are more likely to develop pressure sores and skin conditions. Recognising when a person is not drinking enough and helping them to drink more is important. We also saw the system in place to review and take action when low fluid intake was identified required improvement. For example, we saw the daily meeting between the manager and other senior staff had not identified one person had low fluid intake.

Some of the relatives we spoke with told us their family member required assistance to eat. They told us there was not enough staff available during mealtimes to ensure people were appropriately supported to eat in their rooms. A few relatives told us they were coming in to support their family member at some meal times to ensure they ate enough. This showed that people were at risk of not receiving appropriate care which met their nutritional and hydration needs to maintain their wellbeing.

This was a breach in Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe care and treatment.

We spoke with the cook who described how they planned people's meals and they described people's individual likes and dislikes. They were aware of the people who needed a specialised diet and/or soft diet. The cook told us they used to find out what people wanted the day before and 'cook to order' with some extra in case people changed their minds on the day. The cook told us they had now been instructed to cook fifty percent of each choice on the menu and to see how it went. They told us they did not know what would happen when they cooked shepherd's pie as most people choose that to eat. We noticed during the inspection the portions of fish available had been divided in two by staff so each person could have a portion of fish on the day of the inspection. The cook confirmed there had been a lot of pork wasted due to people not choosing this option to eat.

People we spoke with were satisfied with the quality of food provided. Comments included, "Food is good, I can choose," "I like the food, its nice" and "The food is very good indeed, I sometimes eat in my room if I wish." Relatives we spoke with also made positive comments about the food at the service. Comments included, "The food is lovely. [Family member] tells me every time I come what they have had and how much they have enjoyed it." During the inspection we saw people were offered drinks and snacks throughout the day.

We observed the arrangements at mealtimes at the service. In one of the dining rooms we noticed that a few of people were not offered a hot meal at breakfast. We shared this information with the manager. In one of the dining rooms we noticed at lunch time that most of the people were seated in the dining room at 12:15am, but the serving of lunch did not start until 12:50. A choice of drinks was provided to people, but it was a long time to wait and some people did not receive their meal until one o'clock. One person left during this time and decided to have their meal in a different area. We saw one person receiving a soft diet required assistance to eat. We saw staff were too busy serving food and the person had to wait 15 minutes for support. Another person had chosen to have their lunch in the lounge area. We noticed staff had placed their meal on a tall side table, so they were having difficulty reaching the food without spilling it. We saw there was an adjustable lap table located nearby, but this had not been used by staff. We shared this feedback with the manager.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of

people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The 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.

The service had policies and procedures in relation to the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). The service was aware of the need to and had submitted applications for people to assess and authorise that any restrictions in place were in the best interests of the person.

A senior care worker told us that one person sometimes refused their medicine and on those occasions the person's GP had agreed that they could be administered covertly (hidden in either food or liquids). They told us staff would hide the medicine in the person's food. If a person does not have the capacity to consent, any decision to administer medicines must be subject to a best interest decision. We looked at the person's medicines care plan and found no evidence of a best interest meeting taking place. We discussed this with the manager and improvement manager who were not able to confirm if a best interest meeting had taken place. They said they were not aware that this person sometimes refused their medicines. Following the inspection the manager told us the person's GP had visited the person and confirmed the person had been prescribed covert medicine in May 2017 due to the person being unwell. The person's medicine had been changed so it was no longer given covertly.

When a person lacks mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. There was no evidence to show a best interest meeting had taken place.

The Care Quality Commission recommends the registered provider improves their practice and compliance with the MCA.

We saw the environment within the service varied. We saw some areas required refurbished such as the kitchenettes whilst other areas were not sufficiently clean. However, we saw some environments which were bright and cheerful. Some people had personalised their rooms at the service. Equipment was available in different areas of the service for staff to access easily to support people who could not mobilise independently.

There had been a number of management changes at the service and we received mixed views from staff working at the service about how they had been supported. Some staff felt their views were invited and listened to, but others felt this was not the case and did not feel supported.

The registered provider used a spread sheet to monitor staff training for the Hall and the Lodge. We saw that staff completed a range of training. This training included the following, dementia awareness, understanding and managing behaviour that challenges and equality, diversity and inclusion. We saw in the registered provider's quality audits records that action had been taken to ensure all staff training was up to date. For example, first aid training had been arranged.

The spread sheet seen also monitored the number of staff who had received an annual appraisal. An

appraisal is an annual meeting a staff member has with their manager to review their performance and identify their work objectives for the next twelve months. We looked at a sample of staff training and supervision records. Supervision is regular, planned and recorded sessions between a staff member and their manager to discuss their work objectives and wellbeing. The records checked showed that staff were provided with regular supervision. We also saw examples where informal action had been taken by the registered provider to address some concerns about staff performance. For example, as the result of an unannounced night check completed in December 2017, managers had identified a staff member had prefilled thirty minute observations, repositioning charts and night checks prior to making the checks. We also saw the improvement manager was using the investigations into incidents at the service to identify whether staff required further training or guidance.

Requires Improvement

Is the service caring?

Our findings

People we spoke with told us they were treated with dignity and respect and their privacy was protected. People also made positive comments about the staff. Comments included, "Yes, very kind," "Staff care and make sure we are okay," "The staff are very kind I have no complaints at all," "I'm happy here the staff are smashing. I've no complaints," "I love it here, they [staff] are very kind," "Caring, I never seen any differently" and "Lovely girls."

People were able to bring personal items with them and we saw some people had personalised their bedrooms according to their individual. People could choose where they spent their time and whether they joined in with activities.

Most of the relatives we spoke with felt their family member was treated with dignity and respect. Comments included, "[Family member] is treated with dignity, I've seen it" and "Staff always knock and they are very respectful to me and [family member]. However, some relatives described how their family member had not been supported appropriately with their continence care or supported to go to the toilet in a timely manner by night staff. This had resulted in their dignity not being upheld.

Some of the relatives we spoke with also raised concerns about clothing going missing at the service. We also saw this concern had been raised in the residents and relatives meetings completed in January 2018. One relative told us their female family member had been dressed in some men's clothing; some of the clothing had been tight and caused their family member discomfort. People living with dementia may like to wear the same outfits repeatedly or have favourite outfits. Clothes that they are familiar with may help them perform the task of dressing. The manager was aware that this had been an ongoing issue at the service and a new laundry assistant had been appointed. They had been working at the service for two weeks. We saw the registered provider had not ensured the issue of the laundry had been resolved in a timely manner or effectively to ensure people's dignity was upheld.

Staff working at the service could describe people's individual communication skills, abilities and preference. However, we saw people were receiving care and support from agency staff who may not know and understand their history, likes, preference and needs. It is important that people receive continuity of care from staff who know them well.

People we spoke with told us staff were very busy and worked hard. We saw some positive interactions between staff and people, but we saw staff focussed their time on completing tasks. We saw staff relied on the activities worker to provide activities to people living at the service. The feedback we received from some people and relatives showed the level of activities provided required improvement. During the inspection we saw poor interaction between the activities worker and people. For example, we saw the activities worker come into a lounge area and switch the television off before asking people. One person asked to keep the television on. The activities worker told them they had to switch the television off for the activity. At the start of the activity, they put the music on and started throwing a beach ball at people without any explanation. At the end of the session (approximately 30 minutes) they said, "That's it now."

This was a breach in Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Dignity and respect.

People's confidentiality was respected and all personal information was kept securely. Staff were aware of issues of confidentiality and did not speak about people in front of other people.

Requires Improvement

Is the service responsive?

Our findings

There was a complaints system, but we saw it had not been managed consistently. Some of the relatives we spoke with told us they had raised formal concerns, but they had not received a formal response. One relative said, "I know how to complain, but you don't get anything back." The complaints records showed that the management of complaints had improved when the provider's improvement management team had been overseeing the service. However, the registered provider had not made sure the complaints procedure had been operated effectively at the service. The registered provider had not ensured all complaints were identified, received, recorded, handled and responded to. Some of the relatives we spoke with told us that the action taken by service did not always resolve the complaint and/or the action taken was not sustained. This resulted in them having to complain again. One relative said, "I complain all the time, nothing gets done really. I will wait and see if it goes back (care provided) again, it usually does." One relative described how they had made a formal complaint about their family member's clothes going missing. They told us they had not received a formal response. They also told us the issue with the laundry had not been resolved. They were still finding their family member in clothes that did not belong to them, including men's clothing. The manager told us the service had appointed a new experienced laundry assistant who had been working at the service for two weeks.

If complaints are not recorded by staff this does not allow the provider to monitor complaints over time, looking for trends and areas of risk that may be addressed.

This was a breach in Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Receiving and acting on complaints

There was one activities worker employed at the service, but they were due to leave. There was a programme of activities displayed in both the Hall and Lodge with details of the activities available. For example, arts and crafts, bingo, exercise and films. The manager told us the registered provider was actively recruiting and interviewing potential candidates for the activities worker post.

We received mixed views from people about the activities at the service. Comment included, "Activities, not much, it's gone down. [Activities Worker] is leaving," "Sometimes there is something on, not always," "There used to be always something, not now," "We have sing songs" and "We have dominoes and bingo sometimes." On the day of the inspection we saw the activities worker providing a sing along activity in one of the lounge areas. We saw people were enjoying the activity, but we noted the activities worker made very little effort to interact and engage with people.

Most of the relatives we spoke with were concerned about the lack of activities provided at the service. Comments included, "I think they are sat in front of that TV too long, this film is on all the time. I know they have a bad memory, but not that bad," "The only real gripe is sometimes they [people] are sat a long time and [family member] gets bored. I think there should be a bit more interaction, the activities chap can't do it all on his own. I did say this to the new manager and they said they were trying to sort it out" and "There is not enough to do for them [people]. They sleep in chairs all day." On the day of the inspection we observed

people asleep in one of the lounges for most of the morning of the inspection.

We saw the arrangements to provide person centred activities to people who stayed in their bedrooms also required improvement. This showed people were at risk of social isolation. We found the registered provider had not ensured people living with dementia did not become disengaged with their surroundings. It is important that people are provided with meaningful activities, linked to hobbies and interests that the person enjoyed before a diagnosis of dementia. Some of the most beneficial activities can be simple, everyday tasks such as setting the table for a meal or folding clothes. They can help a person with dementia feel connected to normal life and can maximise choice, conditions and control.

The improvement manager told us the service was in the process of reviewing people's care plans. We looked at the sample of care plans for people living with dementia. We saw the life story work for people diagnosed with dementia was detailed and had a personal and empathic note to it. We saw the staff member had related in what ways these people's lives could be enhanced living in residential care and their personhood realised. Some of the relatives we spoke with told us they are been fully involved in their family member's care planning. One relative said, "Oh yes they do a plan and update it now and again, it's good that they keep their eye on changes." One relative said the plan for their family member's care was very thorough, but their family member was not provided with enough activities.

There were end of life care arrangements in place for people living at the service. On the day of the inspection a few people were being supported with end of life care. The service was working closely with the district nurse and the local GP to ensure people had a comfortable and dignified death. We observed a senior care worker holding a person's hand and talking to them softly whilst the district nurse was administering pain medication. The staff member was explaining what was being done to help them. The district nurse we spoke with complemented the end of life care provided by one of the deputies at the service.

Inadequate

Is the service well-led?

Our findings

We saw the leadership of the service had been weak and inconsistent since the registered manager had left. We saw there had been widespread and significant shortfalls in the way the service had been led. Relatives we spoke with told us there had been a lack of consistency in the management of the service. There had been three managers who had managed and left the service since April 2017. The registered provider's improvement management team and senior managers had been overseeing the service at the end of 2017. The new manager had started working at the service at the beginning of January 2018. They told us they had submitted an application to register with the CQC. They told us they were being supported by the managers from the improvement team. An improvement manager was regularly visiting the service. Some of the people and relatives we spoke with were aware that a new manager had started working at the service.

During the inspection we found concerns about people's records. Our findings during the inspection also showed the corrective action to ensure people's repositioning records were fully completed was ineffective in practice. This showed the registered provider had not ensured that an accurate and complete record for each person using the service was maintained.

We saw some of the registered providers systems and process, such as regular audits to monitor and improve the quality and safety of the service were ineffective in practice. For example, the medicines audit had not identified that a person was receiving their medicine covertly. We reviewed the maintenance records for the service. We found that COSHH data sheets were in place and populated, but we found that some substances were not stored appropriately and these were removed during the inspection.

The registered provider had completed a quality audit in December 2017 and in January 2018. The audit monitored and assessed the performance of the service against the CQC's key questions. The service had been given a comprehensive action plan to complete. At the time of the inspection this was in the process of being fully completed. For example, it was identified manager needed review the cleaning schedules as an outcome of January audit.

Our findings during the inspection showed some of the measures put in place to monitor some people's wellbeing and risks were ineffective in practice. We saw the managers regular walk round had not identified the issues about the cleanliness and maintenance of the service. The manager had not identified that some people did not have a call bell in the rooms. The daily meetings with senior staff had not always identified that people had not received adequate fluids or people's charts were not being fully completed. Our findings showed that people's daily charts were not being monitored to ensure people received their required care. The feedback received from staff and relatives also showed the staff deployment of staff required improvement.

The registered provider had changed the overall management of the two services so there was one manager overseeing the service. They had also changed the registration of the service and the name to Norton Lees Hall and Lodge. The service was registered on the 12 April 2017. During the inspection we found the culture

of the service required improvement. We noted there was some animosity between the two staff groups that worked at the Hall and the Lodge. Staff spoken with told us there had been a large turnover of staff since the registered manager had left the service and the changes of manager. This turnover was reflected in amount of agency staff working at the service. The culture of a service impacts on the care people using the service experience.

We also saw that some of the shortfalls we found at our inspection of the Norton Lees Hall service in October 2016 were the same shortfalls we found at this inspection. This showed the provider had failed to monitor the progress against plans to improve the quality and safety of the service and taken appropriate action without delay where progress is not achieved as expected. For example, the registered provider had not ensured the complaints system was operated effectively at the service. We saw the delivery of high quality care had not been assured by the leadership, governance or culture in place.

This was a breach in Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good Governance.

The new manager had held two residents and relatives meetings at the service in January 2018. The manager had introduced themselves and provided information and updates. We saw that a range of topics had been discussed at the meetings. These topics included, the improvement team and their involvement in the home, updates for the planned work for the home, care plan audits and review, communication and recruitment. There was also a discussion about the outcome of the registered provider's quality audit which had found shortfalls across the service. The service had been given an extensive action plan to improve the service. Relatives were also asked if they would like to be part of a relative's committee, to help and support the service to move forward. A next steps action plan had been completed as an outcome of the meetings. This included improving the lounges so they were more person centred and to look for an alternative clothing label machine.

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 10 HSCA RA Regulations 2014 Dignity and respect The provider had not ensured service users were treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured that care and treatment was provided in a safe way for service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints We found the provider had not ensured that any complaint received was investigated and necessary and proportionate action was taken in response to any failure identified by the complaint or investigation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured there were sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed to ensure peoples needs were met.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured that systems and processes were operated effectively. The provider had not ensured there were effective systems and processes to assess, monitor and improve the quality and safety of the services provide. The provider had not ensured there were effective systems and processes in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. The provider had not ensured that an accurate, complete, contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user.

The enforcement action we took:

A warning notice was served.