Park Homes (UK) Limited

Norman Hudson Care Home

Inspection report

Meltham Road
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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

This inspection took place on 26 June 2015. The inspection was unannounced.

Norman Hudson Care Home is registered to provide residential and nursing care for up to forty-two people some of whom may be living with dementia. The home is set out over three floors with all communal living areas, including two lounges and two dining areas situated on the ground floor. There is also a decorated and furnished like a pub for people who live at the home to enjoy. There are safe gardens to the rear of the home.

At the time of our inspection, the Nominated Individual for the company was progressing his application to the Care Quality Commission for registered manager status.

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 told us they felt safe and staff knew how to maintain people's safety. Accidents were analysed to try to reduce risks. Systems were in place to make sure staff were recruited safely.

We found the home to be clean.

Systems for managing medicines were safe.

Summary of findings

Staff training was up to date. Systems for supporting staff were in place.

Staff treated people with kindness. One person told us 'Staff are really good, they are always trying to help me and I get on well with them.' Staff demonstrated a good understanding of the need to treat people with respect and dignity.

People's choices were respected and their views were sought through a residents association and residents meetings.

People received a nutritious diet and found the food enjoyable. Close monitoring of people's nutritional needs was in place and any weight loss was identified and responded to.

Person centred care plans were in place.

People had access to meaningful activities.

People felt able to tell staff if there was something they were not happy with and we saw that concerns and complaints were managed well.

Improvements had been made to the environment and to facilities to support the orientation of people living with dementia.

Robust processes were in place for auditing the quality of service provision. People who lived at the home, their families and staff were involved in decision making about the home.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

People told us they felt safe. Staff had received the training they needed to maintain people's safety.

The home was clean.

Arrangements for staffing were good and this was kept under review in line with the needs of the people living at the home.

Procedures for managing medicines and staff recruitment were safe.

Good

Is the service effective?
The service was effective.

Systems for supporting staff were in place.

Staff received good training and support.

Staff understood their responsibilities in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards.

People received a nutritious diet and systems were in place to identify and address any issues with weight loss.

People were able to make choices about their care and their health care needs were met.

Adaptations within care and the environment had been made to support people living with dementia.

Good

Is the service caring?
The service was caring.

People who lived at the home told us they were happy with the care they received.

Staff were respectful of people's privacy and dignity needs.

People told us they were involved in their care planning and had choice and control over their care.

Good

Is the service responsive?
The service was responsive.

People had access to activities which met their individual needs.

People felt able to tell staff if there was something they were not happy with.

There was a person centred approach to care planning and delivery.

Good

Is the service well-led?
The service was well led

The manager had made a number of improvements since our previous inspections and had clear plans for further development of the service.

Good

Summary of findings

Systems for auditing the quality of service provision were in place and were effective.	

Norman Hudson Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 26 June 2015 and was unannounced.

The inspection was carried out by three adult social care inspectors and a specialist advisor (SPA). A specialist advisor is a person who has particular knowledge in an area relevant to the people who use services. On this occasion the SPA looked into issues relating to people living with mental health issues and dementia, in particular how the requirements of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) were applied.

As part of the inspection process we looked at all the information we held about Norman Hudson Care Home. This included the notifications of events such as accidents and incidents sent to us by the home and reports from local authority contracts visits including infection control. Prior to the inspection we had sent a provider information return (PIR) . This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The manager had experienced problems with accessing the PIR as it had been sent to the previous manager's mailbox but was liaising with the Care Quality Commission to obtain a new PIR.

During our first visit we spoke with 10 people who lived at the home. Some of these people were not able, due to complex care needs, to tell us about their experiences of the home. We therefore used our observations to inform us of how staff interacted with people. We also spoke with five members of staff including the manager. We looked around the home, observed practice and looked at records. This included six people's care records, three staff recruitment records and records relating to the management of the service.

Good

Is the service safe?

Our findings

During our visit we spoke with people who lived at the home and asked if they felt safe. One person said "Of course I'm safe here" and another said they felt safe living at the home and would talk to the manager if they had any concerns. For people who were not able to tell us, we used our observations to help inform us of their experience.

We spoke with three staff members who told us they had received training in safeguarding vulnerable adults. They demonstrated a good understanding of how to keep people safe and how they would report their concerns. We asked them how they would ensure the safety of someone who had difficulty in communicating. One staff member told us "I know through people's facial expressions and body language if there was something wrong and I would talk to them to find out what was the matter." Another staff member told us "safeguarding is about making sure residents safety comes first."

The manager had notified the Care Quality Commission of safeguarding referrals they had made. This has demonstrated that policies and procedures were in place and followed to keep people safe.

We saw that some people who lived at the home displayed behaviour that could be challenging and cause conflict with other people. We asked staff how they would manage this type of behaviour. They told us they would try to distract people and this usually worked. On the day of the inspection, we saw staff supporting people away from situations which might have resulted in conflict by, for example, walking with people in the garden or talking to them and offering a drink.

All the staff we spoke with were aware of the whistleblowing policy. None of the staff said they'd had reason to use the policy but told us they would have no hesitation in doing so if they had any concerns about the way people had been treated.

We saw recent and appropriate personal emergency evacuation plans in all of the care files we looked at. This meant that consideration had been given as to how people could be safely evacuated from the building in the case of emergency.

During the morning of our visit we witnessed one person fall as they were attempting to sit in a chair. We saw that staff were very quick in attending to the person and calling for extra help via the emergency buzzer. Within three minutes a nurse and another carer were in attendance. The manager of the service also attended to make sure the person was alright and not in need of medical attention.

We looked to see how accidents or incidents that occurred in the home were recorded and managed. We saw that records were maintained and that a monthly analysis of the times and circumstances of when accidents or incidents had occurred was completed. The manager said they used this to assess whether staffing numbers and deployment needed to be re-arranged to ensure people's safety.

To support people's safety, each care file contained personal risk assessments which had been reviewed on a monthly basis and amended to reflect the changing needs of the individual.

The manager told us that staffing was organised according to the needs of the people living at the home. At the time of our visit daytime staffing was arranged at six staff in a morning and five staff in an afternoon. This included a nurse and a team leader on each shift. Care staff were supported by the manager, cleaning, laundry, administrative and catering staff. An activities co-ordinator also worked for five hours a day Monday to Friday. Staffing at night was one nurse and two care assistants. None of the people we spoke with felt there were any problems with staffing arrangements and we saw staff were available to support people as they needed.

We looked at recruitment files for three staff and saw that procedures had been followed to make sure staff employed at the home were suitable to work with vulnerable people. We saw staff members had completed an application form, references had been sought and they had been checked with the Disclosure and Barring Service (DBS) before they started work at the home. The DBS has replaced the Criminal Records Bureau (CRB) and Independent Safeguarding Authority (ISA) checks. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable groups.

We saw records of disciplinary procedures having been followed when this had been necessary.

During our inspection we visited a number of bedrooms, bathrooms and all of the communal areas. We found all areas to be clean and tidy. We noticed malodour in two of

Good

Is the service safe?

the bedrooms we visited. The manager told us that the carpet in one of these rooms was in need of replacement and some redecoration was due to be done. The manager said that plans were in place to support the person occupying that room to move to another one whilst this work was done. In the other room we found it was the mattress that was in need of cleaning. The manager made arrangements for this to be done immediately. We saw that hand wash facilities and personal protective equipment such as gloves and aprons were in place. We saw that staff used this equipment appropriately to minimise the risk of the spread of infection.

We looked at the systems that were in place for the receipt, storage and administration of medicines. A new room for the storage of medicines and medicine trolleys had been developed. We saw that the temperature of the room and the medicines fridge were recorded on a daily basis to make sure that medicines were stored at an appropriate temperature. We saw a monitored dosage system (MDS) was used for the majority of medicines with others supplied in boxes or bottles. We found medicines were stored safely and only administered by staff that had been appropriately trained. We observed some people being given their medication during our visit.

We looked at the medication administration records (MAR) file and saw that staff followed areas of good practice such as the inclusion of a PRN protocol for any medicines given on an 'as required' basis.

We checked the quantities of a sample of medicines available against the amounts recorded as received and the amounts recorded as administered. All were correct. Controlled drugs were stored safely and records relating to these were accurate.

We saw that charts for the administration of topical medicines such as creams were kept in people's bedrooms so that staff could sign as the medicine was administered.

Good

Is the service effective?

Our findings

We asked people what they thought about the food they were served at the home. One person told us they could choose whatever they liked if they didn't like what was on the menu. Other people said "It's good, I stay here (the lounge) to eat mine," and "The chef goes out of their way to make food I like." A person visiting their relative told us the food "always looked and smelt nice." For people who were not able to tell us, we used our observations to inform us of their experience.

The tables in the dining room had been arranged with table cloths and napkins. At breakfast we saw a laminated breakfast menu had been made available for people to choose what they wanted to eat. We did not see people use this but staff gave people the choices detailed on the menu. At lunchtime, there was no laminated menu available but the lunchtime choice had been written up on a blackboard. The blackboard was not in a prominent position and therefore it was difficult for people to see the menu choices. At lunchtime, people were asked where they would like to have their meal. Some people chose to use a table near their armchair rather than going to the dining table. Other people chose to eat in their rooms and where staff took plated meals to people's rooms, we saw the plates had been covered to keep the food warm. When people required support to eat their meals, staff sat down next to them and supported them patiently.

We saw from care records that some people had trouble maintaining a healthy weight. This can often be an issue for people living with dementia. Staff were aware of this and people's weight had been recorded weekly. Records in three of the care plans we looked at showed that the people concerned had gained weight since they came to live at the home. The nurse told us about one person who had lost weight and the person was having input from a dietician and was being monitored by their GP. The chef told us the manager gave them a list of people who were underweight and discussed with them what they could do to help people increase their weight. The chef told us they used cream and butter to fortify foods and people were offered fortified milkshakes through the day.

The chef explained their understanding of the importance of good nutrition. The menus had been changed recently and the manager told us they had sent the menus to a dietician to review in order to ensure they were balanced and nutritious. The manager also told us they were in the process of taking photographs of the meals on the menus to produce pictorial menus to assist people living with dementia in making choices.

We saw from care plans that, on admission into the service, the chef sat down with people to explore their dietary likes and dislikes. This helped the chef plan the menus and ensured people's preference had been taken into account. We saw that this included people's cultural needs. The chef explained they had prepared dishes aimed at specific cultures for example; jerk chicken and other Caribbean dishes.

We saw snacks were available for people throughout the day and we saw biscuits and cake being served with hot drinks. There was also fruit available in the dining area.

We saw some people had been prescribed a thickener to add to drinks to reduce the risk of people choking whilst drinking. One of the staff we spoke with told us how they would use the thickener and they felt confident adding it to drinks. They told us people who used this had a care plan which explained how much thickener should be used. We saw that where fluid intake charts were used, these had been monitored to make sure people had taken sufficient fluids to maintain healthy hydration.

This meant the service had taken steps to identify and protect people whose health was at risk due to low body weight, weight loss or other difficulties with eating and drinking.

We saw from care records and from information the manager provided to the Care Quality Commission in the form of notifications, that the support and advice of healthcare professionals such as GPs, tissue viability nurses, community psychiatric nurses and social workers was sought as required and in a timely manner. This helped to make sure that people's health and care needs were met.

We saw that new staff underwent a full induction process in line with the recommended Skills for Care Core Standards Induction process. Regular training and updates were then taken. We saw that training issues were identified through the audit process. For example a medicines management check had identified that staff needed refresher training on

Good

Is the service effective?

insulin administration and the process of checking people's blood sugar levels. We saw this training had been arranged and that the issue had been discussed during supervision sessions with staff.

Staff told us they felt they had good training and that it was regular. They told us they felt suitably skilled to do their jobs, and they would ask if they felt they needed any additional training. One member of staff told us that they were being progressed to the next level with regard to the quality of service the home provided and they were really happy that their hard work and commitment was being recognised and rewarded. We asked staff about their supervision. They told us supervision was useful. One staff member told us "It gives me the opportunity to talk about issues."

We saw there were helpful reminders of good practice displayed around the home, for example, in the dining area there was a reminder that assisting someone to eat was a one to one support that should not be disrupted.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act (MCA) 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

We saw from care records that mental capacity assessments had been undertaken and, where necessary, DoLS applications had been made. We looked at a care file for a person who was subject to a DoLS. We saw this process had been managed appropriately but noted that the DoLS was not referred to within the person's care plans.

Another care plan we looked at said that the person lacked capacity but we did not see any evidence of care planning relating to decision specific capacity or best interest decisions.

It is important that the manager follows the good practice they have in place with regard to MCA and DoLS with detailed care planning.

The staff we spoke with understood the MCA and DoLS, and were able to tell us who had DoLS in place and what that meant in relation to their care.

We saw that care files contained consent forms covering a number of areas such as medication and sharing of information. However, in one care file we saw the person's relative had signed consent without there being any capacity assessment to say that the person was not able to consent themselves. We also noted that some care plans lacked reference to DoLS where this was appropriate.

The manager told us that the refurbishment programme within the home was continuing. We saw that the unit for people living with dementia had been re-organised to provide people with comfortable areas to sit to enjoy different activities such as listening to music or watching television. We also noted the provision of 'rummage boxes' containing items such as books, jigsaws and other items of interest for people to engage with. The back garden was accessible from both units of the home. The manager told us that the garden was in the process of being developed to provide a more pleasant place for people to walk around or sit in.

The manager showed us a shop which was being developed within the home; this was to allow people to buy their own toiletries and snacks, to increase their independence and choice. They also showed us a room which had been designed to look like a small pub; this had been used for quiz nights and other gatherings. The manager told us they were also planning to create a coffee shop for the people who lived at the service and their visitors to use, to allow them to socialise and increase their independence and choice.

We saw that adaptations had been made to support people living with dementia. For example signs on toilet doors were both written and pictorial.

The ground floor of the home has always been divided by means of a coded locked door, to separate the unit for people living with dementia from the nursing unit. The manager told us that they planned to remove this barrier as they felt that all the people who lived at the home were living with dementia and there should not be any separation or restriction. At the time of our visit we noted that the key pad on this, and other doors, had been lowered as it had been recognised that these were not accessible to people who used wheelchairs.

We saw that several bedrooms had been refurbished and that the programme for this was continuing. The manager told us that people had chosen the décor for their rooms.

Some of the rooms had a 'Jack and Jill' type toilet between them. This is an arrangement where the toilet can be

Good

Is the service effective?

accessed from the bedrooms either side of it but requires the person using it to remember to lock and then unlock the door leading to the other person's room. This had previously been identified by the Care Quality Commission as an issue because it enabled people who lived at the home to walk from their room, through the bathroom and into the next bedroom. This was particularly a problem for people living with dementia as they could become confused about which was the door back to their room.

The manager told us they had resolved this problem by applying a small red sticker to the door to the toilet in the rooms of people identified as being at risk of walking through the toilet to the next room. These doors were now kept locked and other arrangements made for people to access the toilet safely. The manager said that where people were able to use these facilities safely, only people of the same gender shared the bathroom.

Good

Is the service caring?

Our findings

During our visit we asked people who lived at the home for the views on how staff treated them and if staff maintained their dignity needs. For people who were not able to tell us, we used our observations to inform us of their experience. People told us they felt staff treated them very well. One person told us "Staff are really good, they are always trying to help me and I get on well with them." We asked people about their care plans and whether they felt involved with their care plan. One of the people we spoke with told us they felt the service included them and their family in their care plan. They told us "Yes I am involved (with my care plan) I feel it gives me choice and control". They told us they felt staff treated them with respect. We saw a feedback form completed by the relative of a person living at the home which read "My (relative) has been a very awkward person to deal with and the fact that (they) show so much affection towards staff shows me how good the care is and (my relative) is happy."

All the staff we observed interacting with the people who lived at the service were kind and friendly, they understood the needs of the people they were caring for and took an interest in their well-being and what they were doing. It was clear from our observations staff knew people well and had a good understanding of their needs. For example, staff knew how to respond to people when they became upset.

The staff we spoke with told us they enjoyed working at the home. One staff member told us "I really enjoy working with the residents." Another staff member told us "I find it very rewarding working here." Staff felt they had a good relationship with people who used the service and knew them well.

Staff felt dignity and respect was an important aspect of the support they offered people. All the staff we spoke with had a good understanding of the need to treat people with respect and dignity. One staff member told us "People here are treated as individuals not as a group." Another staff member told us "people here are treated very well, we know what they like and don't like and how they want to be treated." Staff told us if they saw people being treated in a way that was not respectful they would report it to the manager.

We observed staff being mindful of people's privacy and dignity needs. For example, when a person needed to be assisted with the hoist, staff made sure they were appropriately covered. We also observed that staff acknowledged people as they walked past them in the course of their work. The manager had recognised this as an issue during our previous inspection when we had observed staff just walking past people. In response he had started a 'resident for the day' programme where staff would individually spend a day in the home being completely reliant on other staff to meet their needs. The manager told us this had been a huge success in developing staff's understanding of people's experience particularly in relation to dignity.

People appeared to have had good support with personal care and grooming. People were smartly dressed and hair care was in place.

We saw that, where appropriate, end of life care had been planned. This included obtaining anticipatory medicines to make sure that people remained comfortable and pain free.

Good

Is the service responsive?

Our findings

We spoke with people who lived at the home about what activities they enjoyed. One person told us they were going to be the 'tour guide' on the Blackpool trip as they knew Blackpool really well and were happy to be able to show people where to go when they were away. A visitor we spoke with said there were always activities going on.

We saw that arrangements were in place for involving the people who lived at the home and their families. The manager told us that they held regular residents meetings each month, family members were welcome to attend these; the purpose of these meetings was to discuss matters relating to the home and to plan the following months activities. Email and text messages were also sent out to people who had family members living at the home, giving information about the home and the activities which were taking place, they sent this information by post to people who did not have the technology to use email or text messaging.

We saw that provision of meaningful and stimulating activities had been very much increased since our previous inspections of the home. Social activities care plans were in place and people's preferences were recorded.

On the day of our visit, four of the people who lived at the home were setting off for a weekend in Blackpool accompanied by a nurse and four members of care staff. The manager said they had sourced a hotel which was particularly designed for people who needed care and support. The manager told us that the trip had been discussed in a meeting and people had been asked if they wanted to go. Staff who were accompanying the trip came in to the home to pack people's belongings, prepare medication and supplies and make sure everything was ready for departure. We saw that these staff joined in with all the people living at the home and sat with people to chat whilst they ate lunch

We saw that one of the people who was going on the trip to Blackpool said they weren't going, staff reassured them and encouraged them consistently throughout the lead up to departure and the person went happily? on the trip.

We spoke with one person who said they did not want to go for the weekend but wanted to go for one day. The manager had arranged to accompany this person for one day to join those staying there. The person told us they were looking forward to it.

We saw that arrangements had been made for another person, who had played sport professionally, to be accompanied to an event involving the club they had represented.

An activities co-ordinator worked at the home to plan and engage people in activities. The manager told us care staff would take over the role of activities co-ordinator when they were absent. We saw that recent activities had included two 1940's music events in the community. External entertainers had been invited to the home and the co-coordinator told us people enjoyed the event, with people getting up to dance. We saw people's art work had been put up around the home.

Within the home we saw people taking part in an art session in the morning. We saw staff all took an interest in what people were making to keep them interested, and praised their results. Other people had chosen to watch a film and had requested 'Grease'; this was playing in a small lounge and was actively being watched and enjoyed by four people. In the afternoon there was a game of bingo which was well attended.

We saw that before people came to live at the home, an assessment of their needs had been completed. This helped ensure the service would be able to meet the needs of the individual. At the assessment stage, people's needs were identified and a care plan developed to meet the needs. Each plan was based on individual need and included what people liked and disliked, how they communicated and what their abilities were. We saw that the care plans had been developed using a person centred approach. This meant that the person, their needs, abilities and choices had all been considered so that staff knew how to provide the support the needed in the way they preferred. Reviews of care plans were made to make sure that the information was current and reflected the person's changing needs.

To support the person centred approach we saw that care files included personal life history books. We looked at one of these books and saw it contained photographs of family and items relating to the person's hobbies and interests.

Good

Is the service responsive?

This kind of information is valuable in helping staff to get to know the person and to support people living with dementia with what is familiar to them. We saw records of when staff had used one person's book to help them to settle when they had become disturbed and their behaviour had become challenging.

We saw that a detailed complaints policy was in place and this was followed. However we saw one minor complaint which had not been followed through to evidence that the complainant was satisfied with the outcome.

Good

Is the service well-led?

Our findings

During our visit we asked people who lived at the home if asked if they knew the manager. One person told us "(manager) is a good guy, he makes time to chat." When we asked people if things could be done differently or better they told us "No things are good here."

We also looked at feedback forms the home had used to assess the quality of the service they offered. One person had said "I'm happy here; I've got nothing else to say."

Staff told us that the manager had been the driving force behind the improvements in the service. They told us that the manager was "firm but fair" and they felt that they understood their role and responsibilities and that the manager gave them clear guidance and support. One member of staff said "It's a lot better here now."

We saw that the manager had made considerable improvements in the way the service was audited since our previous inspection. Environmental audits had led to redecoration and refurbishment and the manager had worked with the local authority's infection prevention team to revise and improve cleaning and infection control systems within the home.

Improvements in the kitchen had resulted in a recent five star award certificate from environmental health.

Medication audits were robust with each area given a rating of green, amber or red. Any areas assessed as amber were followed with an action plan whilst areas assessed as red would be actioned immediately.

Views of people who lived at the home, relatives, staff and professional visitors were all sought as part of the auditing process. The manager told us that when all the feedback had been collated, it would be analysed and the results included in the home's Statement of Purpose.

Regular meetings were held with heads of departments and staff to discuss quality issues.

Since the last inspection the manager had demonstrated a willingness to work with the Care Quality Commission and other agencies to improve the service provided by the home. The manager had provided the Care Quality Commission with updates of how they had worked to achieve and maintain compliance with the regulations.

The manager, who is a director of the company and the Nominated Individual, was in the process of applying to the Care Quality Commission for registered manager status.