Normanhurst Care Limited

Normanhurst Residential Home

Inspection report

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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?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on the 24 March 2016 and was unannounced.

At our last comprehensive inspection of 29 October 2013 we found the service was meeting the requirements of the regulations in place at the time.

Normanhurst Residential Home (Normanhurst) is registered to provide care for up to twenty three older people, some of whom may live with dementia. Seventeen people were being cared for at the time of our visit.

The service did not have a registered manager currently in post. 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. Following the resignation of the previously registered manager a recruitment process had recently been completed and an appointment made. After the inspection visit we confirmed the registration application process for the new manager was underway.

The majority of the feedback we received was very positive about the service. "Thank you for the wonderful care you have provided for our mother" and "care is first rate" were some of the comments made to us by people who lived in Normanhurst or their relatives. There was some concern expressed about inconsistent record keeping and the pressure at times on staff which were said to have led to people being; "rushed" when being assisted to get up in the morning. We have made a recommendation about this in the report.

There were safeguarding procedures in place and staff received training on safeguarding vulnerable people. This meant staff had the skills and knowledge to recognise and respond to safeguarding concerns.

Risks to people were identified and managed well at the service so that people could be as independent as possible. A range of detailed risk assessments were in place to reduce the likelihood of injury or harm to people during the provision of their care.

We found set staffing levels were adequate to meet people's needs effectively. The staff team worked well together and were committed to ensure people were kept safe and their needs were met appropriately. The senior management team gave additional support when required due to short-notice absences of regular staff.

Staff had been subject to a robust recruitment process. This made sure people were supported by staff that were suitable to work with them.

Staff received appropriate support through induction and supervision. Although formal supervision was

only approximately two to three monthly, all the staff we spoke with said they felt able to speak with the senior management team or senior staff at any time they needed to. There were also team meetings held to discuss issues and to support staff.

We looked at records of training for all staff. We found there was an on-going training programme to ensure staff gained and maintained the skills they required to ensure safe ways of working.

Care plans were in place to document people's needs and their preferences for how they wished to be supported. These were subject to review to take account of changes in people's needs over time. We found some inconsistency in the level of detail and completeness of care records. We have made a recommendation about this in the report.

Medicines were administered in line with safe practice. Staff who assisted people with their medicines received appropriate training to enable them to do so safely.

The service was managed effectively. In the absence of a registered manager the senior management team regularly checked quality of care at the service through audits and by giving people the opportunity to comment on the service they received and/or observed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

There were sufficient staff available, with support from the senior management team, to meet people's assessed care needs.

Risks to people had been appropriately assessed as part of the care planning process and staff had been provided with clear guidance on the management of identified risk.

People were supported with their medicines in a safe way by staff that had been appropriately trained.

Is the service effective?

Good

The service was effective.

People received safe and effective care. Staff were supported to achieve this through structured induction, regular supervision and training.

People were encouraged to make decisions about their care and how it was provided. Decisions made on behalf of people who lacked capacity were made in their best interests.

People received the healthcare support they needed to maintain their health and well-being.

Is the service caring?

Good

The service was caring.

Staff treated people with dignity and respect and protected their privacy.

People were supported by staff who engaged positively with them whilst they provided care and support.

Staff knew people well and understood people's different needs and the ways they liked their support provided.

Is the service responsive?

Good

The service was responsive.

There was a detailed care planning process which helped staff provide people's care in the way they wanted them to.

The service responded appropriately when people's needs changed. This ensured their needs continued to be met and that they could remain as independent as possible.

People were supported, when they wanted to take part in activities and social events in order to provide stimulation and entertainment.

Is the service well-led?

Requires Improvement

Although the providers and staff worked well together as a team the service was not being consistently well-led as the level of detail in and completeness of records was inconsistent.

Staff, relatives and people who used the service were able to talk with the providers and senior staff when they needed information, advice or support.

There were adequate quality assurance systems in place to both monitor the quality of care provided and drive improvements within the service.

Normanhurst Residential 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 24 March 2016 and was unannounced. The inspection was carried out by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the Provider Information Record (PIR) for the service and previous inspection reports. The PIR is a form that asks the provider to give some key information about a service, what the service does well and improvements they plan to make. We also reviewed notifications and other information about the service we had received since the last inspection. A notification is information about important events which the service is required to send us by law.

We contacted seven healthcare professionals, for example, GPs, to seek their views about people's care. During our visit we spoke with one visiting healthcare professional. We spoke with seven people who lived in Normanhurst and also to four relatives of people who lived in Normanhurst who were visiting the service.

Some people were unable to tell us about their experiences of living at Normanhurst because of their dementia. We carried out observations over lunch to help us understand the experience of people who could not talk with us.

We spoke with the senior management team and five staff members.

We checked records about how people's care was provided. These included four people's care plans,

medicines records, three staff files containing recruitment checks and details of induction for new staff and supervision and training records for all staff.

Good

Is the service safe?

Our findings

On the day of our inspection we found there were sufficient staff to provide people with the support they needed. We were told staffing levels were assessed taking into account the number and dependency level of people. When we looked at staffing rotas, we found they were complex and not always easy to understand. The senior management team were, in the absence of a registered manager, taking a very active role in the provision of management support and also in the provision of care.

Some of the staff we spoke with felt there were more staff required at key times to relieve the pressure on them, for example when getting people up and ready in the mornings. This was not a concern raised with us by people who received support, who were very positive about the care they received from staff. "I never feel rushed and can get up when I want" one person told us.

We saw staff worked together as a team to ensure people's needs were met appropriately. For example, we carried out an observation over lunchtime and found people received the support they required in a timely manner. People we spoke with told us staff were available when they needed assistance and we heard calls bells were answered promptly.

When there were short notice absences of staff, we were told staff, including the senior management team, worked together to minimise any disruption to people's care routines. Staff displayed great commitment to Normanhurst and the people they provided care and support for. "They are all very helpful" one person who had lived in Normanhurst for three years told us.

People were protected by the service's recruitment practice. There were appropriate recruitment processes in place. This meant people were supported by staff with the right skills and attributes. The three recruitment files we looked at contained the required documents; for example, a check for criminal convictions, written references and confirmation of their physical fitness to undertake care work.

People were protected when they needed support with their medicines. We looked at the service's medicines records and spoke with staff responsible for the administration of medicines. We found people's medicines were managed safely and in line with the provider's medicines policy. There were satisfactory processes in place to ensure people received their medicines as prescribed. We saw medicines were given at the correct time and those medicine administration records (MAR) charts we saw were completed accurately to show the medicines people had received. The temperature of medicines storage were recorded.

Staff who undertook medicines administration were provided with appropriate initial and refresher training. We saw staff had undertaken a competency assessment before they administered medicines on their own. In their PIR the provider indicated there had been one medicine error in the previous 12 months. We were told the competency assessment was re-done if any concerns were identified about the ability of staff to administer medicines safely.

Medicines which required additional controls because of their potential for abuse (controlled drugs) were stored securely. When a controlled drug was administered, the records showed the signature of two staff were recorded as required.

We were provided with a copy of the service's pharmacy advice visit of September 2015. This gave details of those areas where action was required to establish best practice. The overall report did not identify any urgent action required or safeguarding issues. Following the inspection we were provided with an update of the action taken by the providers to address all of the concerns or issues identified.

The service had policies and procedures, in place and being followed, in respect of safeguarding people from abuse. These provided guidance for staff on the procedure to follow if they saw or suspected abuse. Staff had received training to help them to recognise and respond to signs of abuse. Staff were confident about the actions they would take if they felt someone was subject to abuse. Staff confirmed they had regular updates on safeguarding training.

Staff were advised of how to raise whistle- blowing concerns during their training on safeguarding people from abuse. This showed the home had created an atmosphere where staff could report issues they were concerned about and protect people from harm.

People were protected from avoidable risks. Risk assessments were in place to identify risks to people's health, safety and welfare. These set out how identified risks could be eliminated or reduced, to reduce the likelihood of injury or harm to people. These included, for example, the risks of falls and developing pressure damage. Risk assessments had also been written to assist in moving and handling people safely.

The building was well maintained. There were certificates in place which confirmed it complied with gas and electrical safety standards. Equipment to assist people with moving had been serviced and was safe to use.

The building was secure, with the principal access controlled and with an intercom system. There was a signing in and out book for visitors and staff. This meant people were protected from the risks associated with unrestricted access to the home.

Appropriate measures were in place to safeguard people from the risk of fire. Staff had been trained in fire safety awareness and first aid. Records showed fire drills had been carried out and. there were fire extinguishers and fire alarm test records in place. We also saw records of the testing of portable electrical appliances which had been undertaken.

Accidents and incidents were recorded appropriately at the home and appropriate action taken to prevent further injury to people.

Good

Is the service effective?

Our findings

People told us they felt their relatives needs were met appropriately. " Mum is safe, warm and cared for and gets medication as she should" and "They were nearly at the end of their life at home but now, one year later, they are OK because of this home". Were two comments made to us. A healthcare professional told us; "Information is provided promptly, we never get called out for pressure care and we are always called quickly where necessary". One relative said they had; "Low expectations about residential care in general but I have been pleasantly surprised and staff were always caring."

The staff we spoke with had a good understanding of people's needs. Those staff who had worked at the home for several years told us this had enabled them to build up a good understanding of individuals' needs. We saw staff were able to communicate effectively with those people who had little or no verbal communication. Staff showed exceptional patience and compassion when reassuring them and settling them when they had become agitated, using appropriate language and physical contact whilst doing so.

People's healthcare needs were monitored and any changes in their health or well-being prompted a referral to their GP or other healthcare professionals. For example, people were referred to the dietician and speech and language therapists if staff had concerns about their wellbeing.

Care plans identified the support people needed to keep them healthy and well. Staff maintained records of when they had supported people to attend healthcare appointments and the outcome of these. The records showed people had access to necessary healthcare professionals, for example, dentists, opticians and hospital specialists. GPs visited the home regularly from the local surgery. This provided consistency for the people concerned and enabled the home to plan when people could have a routine consultation. Additional visits by the GP or access to other health services were arranged on an 'as required' basis.

People received care and support from staff that were appropriately trained and supervised. We spoke with five members of staff and with members of the management team. They were all positive about the training they received. Staff told us they had received a full induction when they started working. An induction checklist was completed for each new staff member.

Staff training records showed they were up to date with the training determined to be essential by the provider; for example moving and handling, safeguarding and infection control. The senior management team showed us the systems which helped them ensure staff were up to date with the appropriate training for their role and provided us with details of all the training provided and planned for staff.

All of the staff we spoke with said they had received some one to one formal supervision with a manager. People's experience of the frequency of formal supervision varied, some thought it was monthly and others three or six monthly. This variation in frequency was also identified in supervision records seen. However, all of the staff we spoke with all told us they felt supported and that they could approach the provider at any time they needed to. They also confirmed they attended regular team meetings and we saw minutes of these.

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 can only be deprived of their liberty in order to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. We found that the senior management team understood when an application should be made to the relevant authority and how to submit one. The senior management team informed us that two people were subject to deprivation of liberty restrictions and care records included appropriate records to support this. There were eight DoLS applications which had been submitted and were awaiting determination.

When we talked with staff about this, we found they had a good knowledge and understanding of the Mental Capacity Act 2005 (MCA) and had received relevant training. People were given choices in the way they wanted to be cared for. People's capacity was considered in care assessments in line with legal requirements, so staff knew the level of support they required while making decisions for themselves. If people did not have the capacity to make specific decisions around their care, staff involved their family or other healthcare professionals as appropriate to make a decision in their 'best interest' as required by the MCA.

When we spoke with staff we found they understood the importance of gaining consent from people before providing any care. Throughout the inspection, we observed staff spoke clearly and gently and waited for responses.

We saw people had access to a regular supply of fluids. Where necessary people's food and fluid intakes were monitored and recorded to ensure they were appropriate for the maintenance of their health and well-being. People's care records also included details of any allergies or food intolerances, for example to gluten or personal lifestyle choices such as vegetarians.

The people we spoke with about food and staff assistance with meals said this was provided appropriately. We saw staff did not rush people when they were helping them eat and mealtimes appeared to be quite sociable occasions. When we arrived a number of people were sitting at tables having had or were eating their breakfasts. The staff were assisting people with their food where necessary and provided drinks. The atmosphere was calm and staff involved people in conversation. We also observed lunch and saw people had choice of where they ate. This could be the dining room, other communal areas of the home or in their own rooms if they preferred.

Good

Is the service caring?

Our findings

People told us the staff were caring. "Nothing but kindness and care" and "everyone is very kind". Relatives had very positive views of the service and staff; "Wonderful care and staff" was one typical comment made.

We observed caring and compassionate support by staff, who understood people and knew their personal preferences. People appeared very relaxed in the company of staff. We observed positive interactions between residents which provided a sociable atmosphere in the communal areas of the home including mealtimes.

When people asked for assistance, for example with going from a communal area to their rooms or to the toilet facilities staff responded very quickly and with patience. Personal records were stored and kept securely to prevent inappropriate access to them. Staff had received training during their induction and afterwards in the need to promote people's dignity and maintain their privacy. In their PIR the provider informed us they planned to introduce dignity and dementia champions to help advocate for service users.

Where people needed to be supported to move, this was done in a way which promoted people's dignity. We heard staff speak with people throughout the whole process. In one case the use of screens ensured a person's privacy and dignity were protected whilst being assisted to move using a hoist. Those relatives we spoke with did not raise any concerns about the preservation of people's privacy and dignity during their frequent visits. We observed one person who did not have verbal communication was supported with respect and compassion when receiving support in a communal area.

People were able to express their views and were involved in making decisions about their care and support. They were able to say how they wanted to spend their day and what care and support they needed. Normanhurst had several long serving members of staff and a small staff turnover which helped provide stability in the home. We were told the service did not use
agency staff in order to help maintain consistency in the home.

There were some people who received care and support who did not speak English. The senior management team told us they tried to ensure, as far as possible,that there were staff on duty able to speak their language. The service had an equality and diversity policy and the current workforce was reasonably representative of the local population served by Normanhurst.

People were assisted to communicate with their family members by SKYPE or telephone handset. Where staff had any concerns, they were encouraged to report them to the senior staff or provider at staff handover briefings.

We saw minutes of a residents'/relatives' meeting held In February 2016. In their PIR the provider said there were plans to hold these more frequently and also to introduce newsletters for interested parties.

People had access to advocacy services when they needed them. Advocates are people independent of the service who help people make decisions about their care and promote their rights. We were told that where advocacy was required, most people had members of the family who did this on their behalf. There were however details of independent advocacy services available should anybody require them.

Staff training included the implications for their care practice of providing care to people at the end of their lives. In their PIR the provider informed us there were at that time nine people with 'Do not attempt resuscitation (DNAR) forms/agreements in place. When we looked at cards and letters of appreciation, we found a number which expressed gratitude and appreciation for the standard of care provided to relatives at the end of their lives. "You did all you could to make her time with you happy and peaceful to the end". The senior management team told us they would always try and meet people's wishes to remain in what was their home, rather than be transferred to hospital. This was unless their medical needs could not be appropriately met within the home, even with external specialist input.

Good

Is the service responsive?

Our findings

People had their needs assessed before they moved to the home. Information had been sought from the person, their relatives and other professionals involved in their care. Information gained through the assessment was then used to draw up an individual care plan.

Care plans were personalised for each individual. They detailed daily routines and preferences specific to each person. There were sections in care plans about supporting people with different areas of daily living, for example, their health, dressing, washing, continence and mobility.

Care plans showed evidence of regular reviews taking place, involving the person concerned, their family where appropriate as well as key staff with knowledge of the person. This meant any changes to people's circumstances, for example, to their mobility or weight could be identified. This meant people whose needs had changed continued to receive appropriate support.

Staff knew about people's individual communication needs. People could move freely around the home and choose where to spend their time. Staff respected people's choices to be in their rooms if they wished. There were areas in the building where people could sit and talk with visitors and family.

From what people, their relatives and staff told us and from what we observed during the inspection, including a lunchtime observation, people were offered choice. People were able to make choices about their day to day lives for example if they wanted to spend time with others in communal areas, or if they preferred to spend time alone in their rooms. "I can more or less do what I want, when I want" one person told us. People could, within reason, determine how their care and support was provided. Staff were able to tell us in detail about people's needs and how they were met.

We received positive feedback from healthcare professionals about the way the home responded to changes in people's health and wellbeing. Staff were very positive about the regular GP visits which took place and confirmed they provided information and any assistance required during them.

People's cultural and religious needs were taken into consideration. Activities were arranged to reflect different cultural celebrations, important national events and other special occasions, for example Christmas and New Year. The service supported people to take part in social activities. People told us activities were provided and we saw a range of games and puzzles were used. Several people had newspapers delivered each day, to keep up to date with current affairs. We saw a hairdresser visited the home regularly and we were told that the day before our visit people had made biscuits. One to one sessions were also carried out; some of these included helping people retain and practice basic skills and interests.

There were procedures for making compliments and complaints about the service. Information about this was displayed prominently in the home. In the PIR, the provider recorded that in the last 12 months there had been no complaints managed under their formal complaints procedure. In the same period there had been 22 compliments.

Requires Improvement

Is the service well-led?

Our findings

Prior to the inspection concerns were raised with CQC that the service seemed to be; "mis-managed and disorganised". During the inspection, some people told us that some aspects of record keeping had become; "Haywire" and "Chaotic".

Following the resignation of the previously registered manager in May 2015 the service had been seeking to appoint a suitably qualified replacement. There was a deputy manager in place and the senior management team were effectively covering the management role as well as providing hands on support where staffing levels fell below the required numbers. For example, on the day of the inspection one of the senior management team was responsible for catering and another was providing some degree of hands-on care.

We were informed a new manager had been appointed and was due to commence shortly after the inspection. We confirmed this had happened and that an application by the new manager for registration with the CQC had been submitted.

When we spoke with people who used the service, relatives and staff they were very supportive of the senior management team and senior staff. Throughout our visit we observed that staff, visitors and people who used the service were comfortable approaching the senior management team. There was a relaxed and informal 'feel' to the home.

The provider had submitted notifications to us about events or incidents they were required by law to tell us about. We used this information to monitor the service and ensure they responded appropriately to keep people safe. The provider was aware of the new requirements following the implementation of the Care Act 2014, including the duty of candour. This is where a registered person must act in an open and transparent way in relation to the care and treatment provided.

The home worked in partnership with health and social care professionals to promote people's well-being. We received positive feedback about the liaison and co-operation between the service and primary health community services.

Although the premises were safe and equipment was subject to routine maintenance checks, the decorative order of some parts of the building now required attention, for example a first floor bathroom. We were told this was recognised and that a structured programme of redecoration and refurbishment was to be put in place to address it.

We were shown the new computer based system for care planning, ongoing care records and risk assessments. The service was currently in transition between a paper based system and the new computer based one. In the PIR the provider acknowledged; "At present we have two care plans for each service user, one on the computer and a paper care plan which is time consuming and can created confusion."

This confusion and the extended period without a registered manager would account for some the negative comments we had received prior to and during the inspection. We found there were individual care and monitoring records which were inconsistently completed. For example, the medicines fridge defrosting and temperature records were incomplete in two cases. We were also told that, for example, food and fluid charts had not always been fully completed in all cases.

Records or information we asked to see were provided promptly and both during and following the inspection the providers and staff co-operated fully with the inspection team.

Staff had access to general operating policies and procedures on areas of practice such as safeguarding, restraint, whistle blowing and safe handling of medicines. This meant staff had ready access to the detailed guidance they required.

Residents'/relatives meetings had been held which provided an opportunity for communication between people who use the service and staff about concerns or improvements that were being made.

Staff and senior management team shared information in a variety of ways, for example face to face, during handovers between shifts and in team meetings. Although the absence of a registered manager since May 2015 had been challenging staff told us they felt able to raise concerns and they were confident concerns would be acted on. One told us "The providers are very active in the home and are approachable".

A significantly positive part of the inspection was seeing how well staff and senior management team worked together as a team. We found staff interacted with each other carrying out routine tasks to ensure people were cared for in a timely manner.

In the PIR, the provider was realistic about the areas of the service which required improvement. For example they told us; " We need to have an inclusive activities agenda for all service users and more one to one time for outings. We will be introducing more frequent resident and family meetings to help us gain feedback about our service.

We recommend the providers take the opportunity of the appointment of a new manager to; address the areas identified by this inspection and in the PIR which require improvement and to achieve more consistent good practice, working with the very able and committed staff team.