Park Homes (UK) Limited

Norman Hudson Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Norman Hudson Care Home is registered to provide residential and nursing care for up to 42 people. At the time of the inspection there were 39 people living in the service, the majority of whom were living with dementia. Care is provided across three floors and the service has two units known as 'Aspley' and 'Pennine'.

People's experience of using this service and what we found
Risks to people had not been adequately managed. Fire safety was a serious concern at this inspection. Following our visit to the service, we made a referral to West Yorkshire Fire and Rescue and wrote to the provider to seek immediate assurances about people's safety.

Airflow mattresses which help to protect people's skin were not set correctly. Infection control practice was poor as used incontinence pads were seen throughout the home. Staff mask usage was a concern at our last inspection and further examples of these not being worn correctly were seen at this inspection.

Staffing levels were not adequate to meet the needs of people. We observed occasions where people needed assistance and they had to wait for extended periods. Staff rotas showed shifts were not fully staffed.

Some improvements had been made to the living environment, but this did not fully address concerns found at our last inspection. We identified new concerns relating to the safety and comfort of the living environment.

The management of the home was poor. Quality checks the provider completed showed the home performed well, but our inspection findings were considerably different. Quality assurance checks were not found to be effective. There was a lack of lessons learned and continuous improvement.

Staff recorded what people had to eat and drink several hours after they had this, meaning there was a risk the recording was not accurate. The management of people's weights needed improvement.

Evidence of formal support for staff through supervision and appraisal could not be provided. People did not always receive care which helped them maintain their dignity.

Relatives felt people were protected from the risk of abuse. People received their medicines as prescribed from staff who were assessed as trained and competent. The recruitment of staff was found to be done safely. Staff worked with healthcare partners to meet people's needs.

Mental capacity assessments and other related documentation had been completed.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update: The last rating for this service was requires improvement (published 13 July 2021) and there were breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
The inspection was prompted in part due to concerns received about staffing levels, risks to people's safety, infection prevention and control and staff communication. A decision was made for us to inspect and examine those risks.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection. Following our inspection, we worked with safeguarding partners, commissioners and health professionals to ensure close monitoring of this service.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Norman Hudson Care Home on our website at www.cqc.org.uk.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to staffing levels, managing the risk of cross infection, reducing risks to people, the living environment and the effectiveness of quality checking.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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.

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 not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Norman Hudson Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
This inspection was carried out by three inspectors. On 15 and 18 July 2022, an Expert by Experience made telephone calls to people's representatives to gather their feedback about this service. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Norman Hudson Care Home name is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Norman Hudson Care Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a registered manager in post.

Notice of inspection

This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We also contacted Healthwatch for their feedback. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with four people who lived in the service and 10 relatives. We also spoke with the registered manager, two senior managers, the operations director, an agency nurse, four care staff and four other workers.

We reviewed a range of records. This included three people's care records in full, as well as medicines records. We looked at the recruitment of two staff members as well as a variety of records relating to the management of the service, including policies and procedures.

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.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at further quality assurance records.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

Assessing risk, safety monitoring and management
• Risks to people had not been adequately managed.
• We identified a fire risk in the service. Suitable steps had not been taken to ensure the risk to people was reduced. We made a referral to the fire service and asked the provider to provide urgent assurances about this risk. Two staff out of four we asked did not know how to access personal emergency evacuation plans (PEEPs). PEEPs we looked at were dated 1 June 2022 and listed seven people who were no longer living in the service.
• The fire panel showed an amber light which we discussed with the registered manager. They arranged for a contractor to visit the service to provide assurances as this had not been noticed before our inspection.
• Where people were at risk of pressure ulcers, airflow mattress settings were not accurate for their weight. For example, one person's pressure relieving mattress was set to 200kg and another set to 180kg, where these people weighed significantly less. Weekly weights were not being recorded for people who the guidance stated should be weighed weekly.
• We saw three beds with unstable bedframes, two of these were in use. Where people needed bed safety rails, there were no protective bumpers to prevent the risk of entrapment. One person was seen to have their foot through the bars of their bedframe, increasing the risk of injury.
• Some parts of the living environment were not safe. For example, radiators were not secured properly and one floor surface on the top floor corridor was uneven.
• The environment was very warm, and one thermometer reading was almost 30 degrees Celsius. One person's radiator was on and we asked the manager to review this.

This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as risks to people had not been identified or reduced.

• Part way through the inspection, we asked to meet with the provider to discuss the seriousness of our concerns. The provider later told us they had removed and replaced one of the beds we were concerned about.

Preventing and controlling infection
• Infection control was poorly managed.
• Inspectors found discarded continence pads in several places in the service. One soiled pad was in a person's sink in their bathroom and one in bed beside a person. There was a further soiled continence pad contained within a cupboard in a communal room. There were strong malodours in rooms where these had been found.
• Doors to two sluice rooms were unlocked, presenting infection control and injury risks to people. The handy person attended the service in the afternoon of the inspection, despite being on annual leave; they had been contacted by a staff member asking for codes to new keypads they had installed two weeks earlier. This led us to believe staff had not been informed of the new access codes and the sluice rooms had been left unlocked since the new keypads had been installed.
• Examples were seen where staff were wearing masks under their nose and chin; this was identified at the last inspection.

This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as action had not been taken to ensure the premises were clean and the risk of cross infection had been managed.

Staffing and recruitment
• There were insufficient numbers of staff to meet people's needs.
• One person was in bed, calling out for help. They told the inspector they had been calling for a long time and no staff had attended. They said they were in urgent need of continence care. The inspector alerted a member of staff who asked the person to wait, as they needed another colleague to support them safely.
• One inspector went into a person's room and found they were on the floor. The inspector pressed the emergency buzzer and no staff arrived. The inspector called for help and the domestic staff came, who agreed to 'ring down' for help. Two staff came after around five more minutes and attended to the person. We heard call bells sounding and observed two which sounded for 15 minutes.
• A member of staff was busy trying to meet the tea-time needs of people, as well as continence needs and offer reassurance for people who were becoming agitated. They told us there was an expectation they would assist people to bed, or into their nightwear, before the night shift came on duty, "To make it easier for them."
• Staff rotas we looked at covering a three week period commencing 20 June 2022, showed day and night shifts were frequently under-staffed.

This was a breach of regulation 18(1) Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as insufficient numbers of staff meant there were significant delays in the care people received.

• Staff had the necessary safety checks in place before starting work, including a criminal record check to confirm they were suitable to work with vulnerable people.

Systems and processes to safeguard people from the risk of abuse
• People were not adequately protected from the risk of harm.
• One person's bedroom we saw was in a very poor state of cleanliness and full of debris, with a dirty carpet, dirty furniture, unclean walls, unclean bedding and drawers missing from furniture. We urgently raised this with the registered manager who told us this person refused to allow staff to clean their room. We made a safeguarding referral to the local authority for this person.
• The provider had a system for recording and responding to safeguarding incidents, which were recorded in a log, although this did not contain all safeguarding incidents as some were kept in a separate file for events

reported to the Care Quality Commission.
• Relatives consistently told us their loved ones were safe living at this service.

Learning lessons when things go wrong
• We found there was an absence of lessons learned.
• Following our last inspection, we served a warning notice regarding safe care and treatment. Whilst the provider believed they had addressed these issues; we saw insufficient action had been taken to ensure people were adequately protected from the risk of harm.

Using medicines safely
• Staff managed people's medicines safely. Staff followed correct procedures when giving medicines to people. Staff giving medicines were not wearing a uniform; they told us uniforms had recently been ordered.

• Records showed medicines were properly accounted for and people were given their medicines safely as prescribed. People's allergies were noted on their medicine administration records, which had a clear picture of each person. People's medicines were audited, and actions were taken when shortfalls were found to improve safety.
• Staff completed appropriate training and had their competence assessed to ensure they administered medicines safely.
• Covert medicines care plans were in place for two people, which had been agreed by the registered manager, pharmacist and GP.

Visiting in care homes
• Prior to our inspection, we received information of concern indicating people's visits to this service were being carried out in different ways. Some relatives said they were able to use a communal room to see their loved one, whilst others had to visit in the entrance area. At this inspection, we found suitable visiting arrangements were in place, although feedback indicated visitors had to wait for extended periods outside the service as staff did not answer the door. The provider told us this was because the doorbell was not working.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

At our last inspection the provider had failed to ensure the premises were adequately managed to maintain people's safety and comfort. This was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 15.

Adapting service, design, decoration to meet people's needs
• The premises continued to be insufficiently maintained.
• We found themes which continued from our last inspection. In April 2021, we found the garden spaces were not safe and people's bedroom doors were damaged. Despite the provider's action plan stating this would be addressed, these were continued concerns.
• In March 2022, a contractor recommended the lift be refurbished. This was not listed on the provider's refurbishment plan. We saw the lift was faulty on the day of our inspection.
• A dining room light fitting was seen flickering and a chair in this area was found to be unsafe. One person asked staff to assist them to a chair with arms in the dining room, but staff explained the only seat of this type available was being used by another person.
• Radiator covers were not securely fitted. A dining table in a communal lounge was seen to be significantly damaged.
• Although some appropriate signage was seen, there was a lack of dementia friendly features in the service.

This was a continued breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as features of the living environment had not been adequately maintained.

• Redecoration to some areas of the service had been carried out and an enclosed garden space had been created.

Staff support: induction, training, skills and experience
• Staff did not consistently receive formal support through supervision and appraisal.
• The staff survey dated November 2021 identified gaps in supervision and appraisal. We found gaps in staff supervision at this inspection which meant action had not been taken to address this feedback.
• We requested records to demonstrate staff members were receiving formal supervision, but the provider

was unable to locate and supply these. We found there was a lack of supervision for the registered manager in 2022.
• The 2021 list of staff appraisals was requested in August 2022, but the provider was subsequently unable to locate these records to demonstrate this support had been provided.

This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as individual records of supervision and appraisal could not be provided to show this support was provided and the matrix showed six staff had not received supervision in 2022.

Supporting people to eat and drink enough to maintain a balanced diet
• We observed the lunchtime experience and found this was not well managed.
• There was a period of 15 minutes where a group of people sat with their meal, some in armchairs and others at dining tables, without staff support. One person's meal was sliding onto the carpet.
• Staff described not having a process in place for monitoring who had been offered or had eaten their meal, for example if the person was asleep.
• Staff did not record people's food and fluid intake at the time they had their meals, but several hours later. We asked a staff member how they knew what to record hours later and they said, "They (staff) just remember." This meant recording was potentially not accurate and would not indicate whether people were at risk of dehydration or malnutrition.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• One person was admitted to the service shortly before our inspection. We found their admission checklist which was blank. It was difficult to see from this how the provider had evaluated whether they could meet the person's needs.
• The provider did not follow guidance from the National Institute of Clinical Excellence (NICE) around referring people for topical creams and emollients which help to reduce risks to people's skin care.

Ensuring consent to care and treatment in line with law and guidance
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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

• The recording of MCA, DoLS and best interests decisions was done appropriately.
• Records of decision specific mental capacity assessments were contained in people's care plans. MCAs and best interests decisions were recorded in people's care plans where they received their medicines covertly (without their knowledge).
• The provider submitted DoLS applications where people were assessed as not having capacity.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live

healthier lives, access healthcare services and support
• Records indicated people received access to healthcare when they needed this.
• The oral health assessment for one person had not been completed. The provider told us this person was reluctant to engage in oral care, which meant there was an increased risk to this person.
• Relatives felt positive about their family member receiving access to healthcare when they needed this.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care
• The service was not well managed. Each of the breaches of regulation we found at our last inspection continued to be a breach at this inspection. New breaches of regulation were found.
• There was a lack of visible presence from the management team in the service. Managers remained in their offices for the majority of the inspection. The staff team lacked direction and we observed care was not organised effectively.
• The management team had not identified shortfalls in service delivery. Audits, spot checks and satisfaction surveys all indicated positive outcomes for people. However, our inspection findings were considerably different to those recorded through the provider's quality checks.
• At the beginning of July 2022, the provider produced a self-assessment in which they rated themselves against our safe and well-led key questions. Both were rated as good for this service by the provider.
• Before this inspection, the provider responded to information of concern from the public and told us the manager's daily walkarounds would be used to address these issues. We requested copies of the walkarounds for a two week period and found the provider could only evidence these checks had been carried out on three occasions in this period.
• Staff handover documents contained sparse information and lacked detail about people's care needs during the previous shift, and any key information staff needed to know.
• Learning opportunities had been missed following our last inspection. There had been a lack of initiative to make relevant changes needed to improve the service people received and to become compliant with the regulations.

This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as previous breaches of regulation were not met and new breaches were found.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• The provider did not ensure people received good outcomes.
• People did not always receive care which was dignified. A staff member responded to a person who had been incontinent by asking, "What is this mess? The toilet is right there." The person responded, "I know, I'm sorry." Two people sharing a bedroom did not have a privacy screen between them. A further person was offered a medical procedure as part of their prescribed medicines, but this was done openly, in a communal space.

• Records showed people had showers, but these were not always frequent. There was a list identifying which person may need a shower. Some people had dirty fingernails and hair. Some people wore clothing which was stained and dirty.

This was a breach of regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people were not consistently provided with dignified care.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
• We identified reportable events in the service which we were not notified about. We have dealt with this outside the inspection process.
• We asked for people's personal emergency evacuation plans. A senior manager told us the registered manager would provide these. We subsequently found the registered manager updating these records in their office, which meant an accurate record had not been maintained and also meant the management team were not being candid with us.
• Following our inspection, the provider wrote to families to advise them the service was under a large-scale safeguarding enquiry. This meant the local authority and partners, including the CQC were closely monitoring this service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• Relatives we spoke with said they were usually contacted if there was an emergency. However, we saw a safeguarding incident where a person had been admitted to hospital and their relative was unhappy as they had not been informed about this. Families gave mixed feedback about routine communication.
• During the inspection, we observed a programme of activities which people were engaged in and enjoying.

Working in partnership with others
• Staff worked in partnership with other agencies.
• Around the time of our inspection, a number of agencies were visiting the service and staff were working with these professionals.