Four Seasons (No 7) Limited

Norwood Green Care Home

Inspection report

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Date of inspection visit:
22 May 2018

Date of publication:
18 July 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This comprehensive inspection took place on 22 May 2018 and was unannounced.

The last comprehensive inspection was in July 2016. The service was rated requires improvement in the key question 'Is the service Effective?' because we found a breach of regulation regarding premises and equipment. Overall the service was rated good. A focused inspection was carried out in April 2017 when we found the provider continued to breach the regulation regarding premises and equipment and in addition was breaching the regulation in regards to person centred care. We served a requirement notice for the breach related to person centred care and a warning notice on the provider for the breach of regulation in regards to the premises asking them to make the necessary improvements. We also asked the provider to complete an action plan to show what they would do and by when to improve the rating of the key question of 'Is the service Effective?'' to at least good.

At this inspection we found the provider had made improvements and had met the regulation in regards to the premises. However, we found three additional breaches of regulations, and a repeated breach for the regulation in regards to person centred care and the service continues to be rated requires improvement

Norwood Green Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The home is part of Four Seasons Limited a national organisation that provides care to people in the UK. Norwood Green Care Home is registered to provide nursing care to 92 people with dementia, mental health needs and general nursing care. The home accommodates people across three separate units, each of which have separate adapted facilities. There is a central kitchen on the ground floor and a large communal garden. At the time of our inspection there were 88 people living in the home.

There was a registered manager who joined the service in November 2017 and registered with the Commission in May 2018. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider sent us an action plan in April 2017 that stated the bathrooms would be refurbished by June 2017. We found in this inspection that all bath and shower rooms were refurbished to a good standard. We had received no action plan about addressing the concern about person centred care. We found a continuing breach of this regulation because people were still not receiving their choice of bathing or showering in accordance with their care plans.

People, relatives and visitors told us that people were not supported to get up when they wanted to, that

they were not receiving showers when they wanted them and that planned activities were sometimes cancelled. They expressed that there were not enough care staff in the home. We found that the registered manager was assessing staffing need using an electronic system. However, people were not always being supported in line with their care plans and this indicated that staffing levels were not sufficient to provide a person centred service.

We found a number hazards in the service that had not been identified and addressed through checks and audits. These included an overgrown garden that was not safe for people to use as there were trip hazards. There were security hazards that included an unlocked garden gate, an open exit door and a stairway that people could have access to from the ground floor and that were not risk assessed. There was unsecured lift equipment. The registered manager addressed these concerns when we pointed these to them.

Some people were assessed as not being able to use their call bells and measures had been put in place to check on them. However, there were other people who could use their call bells but these were not left in people's reach. This meant they could not call care staff promptly in an emergency.

People's confidential archived information was not being kept in a secure manner.

People and relatives described care staff as "friendly" and "kind" we saw some compassionate interactions by individual care workers. However, we observed care staff did not always try to engage people who did not readily communicate and the provider was not enabling staff to meet people's wishes in accordance with their care plan.

Staff could tell us how they recognised signs and symptoms of abuse and the registered manager had an oversight of accidents, incidents and safeguarding concerns. Where mistakes had been made lessons were learnt and shared with the staff team to help prevent a reoccurrence.

Medicines were administered in a safe manner and were audited regularly by the management team. There was good clinical oversight by the registered manager and deputy manager. They also ensured that infection control measures were robust in the home.

The provider undertook pre- assessment visits to meet with people and assess their support needs. These informed person centred care plans that stated people's preferences and support needs. Where a risk to the person was identified, a risk assessment was completed with measures for staff to take to minimise the risks.

People were supported at the end of their life. There was partnership working with the palliative care nurse to provide effective and appropriate care to people. However, staff had not received end of life training and whilst the were end of life plans in place these did not always take into account people's social, cultural and religious preferences. We have made a recommendation that the provider review best practice in gaining people's views about their end of life wishes.

Nurses worked in partnership with visiting health care professionals to provide good access to health care for people living in the service.

The registered manager was working in line with the Mental Capacity Act 2005 (MCA) and ensured applications under the Deprivation of Liberty Safeguards (DoLS) were made in a timely manner where people were being deprived of their liberty. We observed care staff asking people's permission before offering care and support and staff could tell us how they gave people choices.

There was a varied menu available and people were supported to eat well and drink enough to remain hydrated.

The provider had a clear vision about the way they operated the service that was shared with people, relatives and staff.

We found four breaches of regulations in relation to, person-centred care, staffing, safe care and treatment and good governance. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. The provider had not always ensured the premises including the garden were maintained to a safe standard. People's information was not kept securely.

The provider assessed staffing need in the home using an assessment tool. However, we found that people were not receiving their care and support in a timely manner. This indicated staffing levels were not always sufficient to meet people's needs.

Medicines were administered and stored in an appropriately safe manner.

There was effective infection control. Care staff used protective equipment and the registered manager ensured good standards of hygiene were maintained throughout the home.

Care staff demonstrated they could recognise symptoms of abuse and understood their responsibility to report any concerns to the registered manager.

The registered manager had an oversight of safeguarding concerns, and accidents and incidents. They ensured lessons learnt from mistakes were shared with the staff team to prevent a reoccurrence.

Is the service effective?

Good

The service was effective. The provider had refurbished the bath and shower rooms and ensured they were now safe for people's use.

The management team met with people prior to admission to assess their care and support needs before offering them a place in the home.

Both management and care staff worked effectively with health care professionals to provide people with good access to health care.

The registered manager worked in line with the MCA and applied

for DoLS authorisations appropriately and in a timely manner.

People were supported to eat a healthy diet and remain hydrated.

Staff received support and training to equip them to undertake their role.

Is the service caring?

Requires Improvement

The service was not always caring. The staff were described by most people and relatives as friendly and kind. The provider however had not ensured people were always cared for according to their preferences and wishes.

Care plans informed staff about how people communicated and we observed staff gave people choices in their daily life. However, we also observed during activities some staff did not always try to engage with people who did not communicate as readily as others.

Care staff promoted people's dignity and privacy.

Is the service responsive?

Requires Improvement

The service was not always responsive. People had care plans in place that told staff how they wanted their care to be provided. However, people told us they were not receiving care as they wanted it to be provided.

Some people and relatives told us social and recreational activities were not always provided to meet people's needs and preferences.

Nurses worked with the palliative care nurses to provide end of life care to people. However, people's cultural, spiritual and personal wishes were not always incorporated in an end of life care plan.

People knew how to complain and complaints were investigated by the registered manager and action was taken where necessary to resolve complaints.

Is the service well-led?

Requires Improvement

The service was not always well led. The service did not have effective systems of governance in that the provider had not

identified the concerns we found at this inspection.

The registered manager held meetings so people and relatives could express their views and receive information about the service.

Four Season Health Care had a vision shared by its services to improve the lives of people using their services.

The registered manager was working in partnership with health care professionals for the benefit of people using the service.

Norwood Green 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 22 May 2018 and was unannounced.

The inspection team consisted of two inspectors, and a specialist advisor, who was a nurse 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.

Prior to the inspection we reviewed information we held about the service, including notifications. A notification is information about important events that the provider is required to send us by law. We also looked at the action plan the provider had sent us to refurbish the bath and shower rooms and previous inspection reports.

We reviewed nine people's health care records. This included their medicines administration records, risk assessments, care plans, daily monitoring records and medicines. In addition, we reviewed five people's care plans and daily notes. We spoke with ten people and four people's relatives. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also observed staff interaction throughout the day including support given to people to eat both in the dining areas and in some people's bedrooms.

We also looked at three staff's personnel records, including their recruitment and training documentation. We spoke with two care staff, two team leaders, a care home assistant practitioner (CHAP), a nurse, the head chef, the maintenance staff, the registered manager and two resident support managers. In addition, we spoke with three visiting health care professionals.

Following our inspection, we spoke with a relative and a friend of a person who lived at the service.

Requires Improvement

Is the service safe?

Our findings

During this inspection we found that people were not always protected against the risks that can arise if the premises are not adequately maintained. The garden was unsafe for people to use. The grass was overgrown and bushes overhung the paths where people might choose to walk. This meant that people who were wheelchair users or had conditions that might affect their mobility would not be able to access most areas of the garden.

There were also some tripping hazards in the main paved seating area for people. These included seven used bin bags that had been left on the ground and an unravelled garden hose. There was a discarded mop bucket with some cleaning cloths left where someone might trip over it.

We found security in the service was not robust. The side gate to the garden had been left in an open position. There was no lock or padlock to secure the gate. This meant someone using the garden could exit from the gate unnoticed or a member of the public could enter by the gate and have access to the entire rear of the home.

We found a large shipping container at the rear of the garden. The door was left open and there was no locking device such as a padlock or a chain. When we walked inside we found it was full of boxes of people's achieved records, some boxes had fallen and were open. These had not been safely stacked. Therefore, people's confidential information was not secured and there were tripping and safety risks for a person who might enter the container. It was also a fire risk because it was open and stacked high with card board and paper. There were no risk assessments in place in regards to this container to be used for the storage of archived records and which was located within the grounds of the home.

We found a fire exit near the kitchen area was not secured on two occasions when we checked during the day. This was because the door did not lock automatically as the closing device required adjusting. This exit could have been used by people who might have wanted to go out or by those who have been assessed as unsafe to leave the building unattended. It could have also been used by other people who might have entered the building unnoticed.

In addition, inside the building we found that there was no mean to prevent unauthorised access to the stairs from the ground floor. Therefore, staff, people and visitors could have access to the top floor. This floor contained the lift operating equipment room and the archived records room. Despite the lift equipment room stating it should always be kept locked it was open, as was the archived records room where the door had been left in an open position. People's records in this room were not being kept in a secured manner. As the door was open it also posed a fire risk as it was close to an electrical source. People who were accommodated on the ground floor had not been risk assessed to ensure they were safe to have access to the stairs unaccompanied.

A relative told us, "The call bell is not always given automatically [to people]." Whilst walking around the service we noted that some people did not have call bells in their room. We checked people's records and

found that some people did have risk assessments that assessed their ability to use a call bell. Where they could not use their bell, alternative measures were put in place to ensure their safety. For example, "Unable to use the call bell, hence staff to maintain hourly check and record."

However, we observed that some people who could use their call bell did not have the bell in reach. One person told us, "My call bell is broken. I just call someone. It's been broken for a week." Another person told us, "They always forget to put my call bell in reach. At least five times out of seven the bell is not in reach." A third person who did not have a call bell near them said, "I would shout out, if I needed help." We concluded that care staff were not always ensuring people had a means to obtain support when they needed it. This was a concern as some people may not always be able to call for help when they require urgent support to keep them safe.

The above concerns were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us that they assessed people's staffing needs using a dependency tool. This took account of people's individual needs and determined the staffing numbers required. The dependency assessments were undertaken monthly. The registered manager told us that when care staff phoned in sick they used agency staff to cover. They used one agency and they ensured they received staff profiles prior to staff working at the service. This was to ensure that the agency staff were suitable to work with people.

However, people's and relative's comments were that their support needs were not always being met in a timely manner. This indicated that the assessed staffing levels were not adequate or that staff were not deployed in a manner that was responsive to people. For instance, one person told us, "Last night there was no one to put me to bed until 10.10pm. That's too late and [there are] not always [staff to help] when I need the toilet, I have to wait." Another person said, "When I ring the bell they don't always come." A third person said, "They could do with more staff."

Relatives comments included, "Sometimes you see a bundle of staff, other times not", "They have plenty today. [Day of inspection]. There are extra people in the dining room today helping" and, "Not always." One person told us that they were being supported to get out of bed too late. They said, "I am still in bed, [10.35am]. I hate having breakfast in bed. Before when I was at home, my carer would come at 7.30AM and I would get up then. It's not like that here."

Following our inspection, a visitor contacted the CQC to say the person they visited was on some occasions including the previous weekend, not being supported to get out of bed until after mid-day when they wanted support to get up in the morning. Their visitor had described how this had upset the person who liked to get up early.

People told us that they were not getting the support they required to shower as there were not enough staff. Their comments included, "I am supposed to get a shower once a week. But I only get one about twice a month. I feel sorry for the staff." Another person said, "There is no one to give me a shower. It's getting a bit stupid. I have a shower once a fortnight." We checked people's daily records and found no entries to show that people were being supported to shower or bath on a regular basis according to their care plans.

We concluded that despite the tool to assess staffing levels, the provider had not considered other indicators that we described in the above paragraphs that could have had an impact on the required staffing levels. For this reason the provider had not deployed , enough skilled and experienced staff to meet people's support needs in a timely manner and to provide appropriate person centred care.

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

We brought our concerns about the safety and quality of the premises to the registered manager's and both resident support managers' attention. Following our visit, they sent us photographic evidence to show that they had addressed the concerns we had found. People's records contained assessments to identify risks. Measures were put in place to mitigate risks to people and assessments and care plans gave staff guidance about how to minimise the risks. Risk assessments addressed a range of risks including falls, malnutrition, skin integrity, and moving and handling. The assessments also included measures to address people's specific health conditions.

People's records contained personal emergency evacuation plans that contained information about the support they would require in the event of a fire. People's files were marked with a red sticker to indicate if they were assessed at a high risk and would require two staff to move them from their bedroom.

The provider had a procedure for the safe recruitment of staff which they implemented. Prospective staff completed application forms and attended interviews to assess their aptitude, experience and skills for a caring role. The provider had requested references from previous employers, evidence of identity and eligibility to work in the United Kingdom and checks on their criminal records. One staff member's criminal record check was not in their personnel record and the provider sent us evidence following the inspection that this had been completed appropriately prior to them commencing their role.

We checked medicines administration records (MARs) in the nursing dementia unit and looked at nine people's medicines records and their associated documents. We found that medicines administration and storage were being undertaken appropriately.

Medicines were stored securely and at the correct temperatures. Medicines stocks were well managed. There was no over stocking of medicines and there were appropriate arrangements for the receipt and disposal of medicines.

People's MARs were appropriately completed and were signed by the nurse administering the medicines. Controlled drugs were stored appropriately and were signed by two staff when administered. As and when required medicines and homely remedies (medicines which can be purchased over the counter), were administered safely following clear protocols. There was clear guidance for the administration of covert administration. This was undertaken with the involvement of the multidisciplinary team and with the person's family when appropriate. We found evidence that people's medicines had been reviewed with positive outcomes for people.

Care staff demonstrated they were knowledgeable about the safeguarding and whistleblowing procedures. They gave us detailed information about how they would recognise signs of abuse and how they would respond appropriately. For example, one care worker said they would, "Report and record it, tell the senior who reports to the manager who will report to the local authority safeguarding team." Another care worker told us about whistleblowing, "If you suspect your colleague is doing something wrong, you must report it to your manager." The registered manager had reported safeguarding adult concerns appropriately to the local authority and notified the CQC.

The registered manager showed us they used a database to have an overview of safeguarding, and accidents and incidents. They told us that when a mistake had been made it was shared in 'Flash' meetings. These meeting occurred each day with the heads of each department and nurses attending. The concern

was discussed and ways to prevent further mistakes being made were identified. The registered manager gave an example that they had run out of the medicine insulin for one person because an empty insulin container had been left in the medicines fridge. Staff when auditing the medicines had counted the box and not the contents. They had restocked the insulin within two hours of the mistake being made and they had changed their procedure so contents not boxes were counted to ensure there were adequate supplies and that the same mistake was not repeated.

The care staff had received infection control and food safety training. We observed care staff using disposable equipment including gloves and aprons appropriately. Toilets contained hand sanitizer and paper towels. During the winter months there had been people diagnosed with influenza. The registered manager undertook appropriate actions to inform the health and commissioning authorities and put in place robust measures to contain the spread of infection. A visiting health care professional confirmed the management team took appropriate action and worked well with others to ensure the outbreak was contained and that infection control measures were effective.

Good

Is the service effective?

Our findings

During our last inspection in April 2017 we found a breach of the regulations because bath and shower rooms were not all maintained to a safe standard and the planned actions to address this concern had not been completed. During this inspection we found that this had been addressed by the provider and all bath and shower rooms viewed were refurbished to an appropriate and safe standard. Other areas of the home was also well maintained.

The home was purpose built and had wide corridors to accommodate wheelchairs. There was adequate lounge and dining facilities throughout the service. There were two lifts to enable people to move between floors. The lifts stopped working during the afternoon of our inspection. The registered manager called out the lift repair service who have a contract with the home to maintain the lifts and they ensured that the lifts were back in working order the same day.

The management team met with people and their relatives and completed a pre-admission assessment to identify people's care and nursing support needs. People's care was then planned in response to their identified needs. Staff carried out assessments of people's needs including those associated with their general health, medicines, hearing and vision, diet, communication, sleep, continence and mental health. The registered manager confirmed they used other health and social care professional's assessments to inform their own assessments prior to offering a placement to new person at the home.

New staff told us that they had received an induction when they started work at the home. This consisted of familiarising themselves with the service, shadowing experienced staff and training. Both care staff and nursing staff described that they mentored new staff to the home. One care worker confirmed that all staff were shadowed and said, "Be it nursing or care staff." Staff training included basic life support, safeguarding adults, Mental Capacity Act 2005 (MCA), food safety, moving and handling, fire safety, bed rails certification and equality and diversity. To ensure care staff understood specific conditions affecting people in the home they had received training to cover these conditions including dementia and pressure ulcer care training.

Staff received supervision every three months. All care staff told us they felt well supported by the registered manager and provider. One staff member told us they had, "Supervision quite often," and was due to have an annual review.

People and their relatives had mixed views about the meals provided. People's comments included, "I choose my meal at night for lunch the next day. At supper I just have sandwiches," and, "The food is OK," and "The food is not very good." Relatives told us, "The food is very nice. We had a relatives' meeting about it about a month ago. The menu is due to be changed," and "The sandwiches don't have salad in them."

When we arrived at the home on the first day of the inspection care staff were supporting people to eat breakfast. There was a good choice of cooked or continental breakfast both in the dining area and being taken to people's rooms. There was a varied four weekly menu with choices of both traditional English and Asian meals that reflected the diversity of the service. People were encouraged to ask for an alternate meal

such as an omelette if they did not like the meal choices. Specific dietary needs were also catered for, including diabetic diets.

People were supported to eat and drink in a personalised way which enabled them to be as self-supporting as possible to maintain their dignity and privacy. People who required pureed meals had their food piped onto their plate so it was presented in an appetising manner. We observed care staff in the dining areas and in people's bedrooms who took their time to support people to eat their meals to reduce the risk of choking. People appeared to enjoy the eating experience and having the care staff support. There was information displayed for staff to support them to recognise signs and symptoms of when a person might be choking or when food might be going down their airway.

People were offered drinks with their meals and throughout the day. This included a variety of hot and cold drinks. We saw people being supported to drink thickened liquids correctly on most occasions with staff using a spoon to help them drink the liquid. One relative was concerned their family member did not drink enough. The person had been served a drink, however the care staff had forgotten to put the thickening agent in the drink to prevent the person from choking. The relative noted this and asked for the thickener to be added.

The nurses used the Malnutrition Universal Screening Tool (MUST) to assess if people were at risk of malnutrition. People's weights were recorded monthly and if there were concerns of potential weight loss then the person was weighed on a weekly basis. People who were assessed as being at high risk of malnutrition received nutritional supplements and were monitored by a dietitian and the GP. There was evidence of good weight record keeping to monitor people's nutritional condition.

Nurses completed a pressure ulcer risk assessment and took measures to prevent the development of pressure ulcers where people were at high risk of skin breakdown. People at risk of developing pressure ulcers had appropriate equipment such as pressure relief mattresses and seat cushions.

Care records showed timely referrals for people and input in their care from health and social care professionals including optician, audiologist, mental health team, dietitian, speech and language therapist, occupational therapist, tissue viability nurse and palliative care nurse. We saw the GP visited the home for a regular session each week.

We spoke to a visiting health care professional who told us that there had been a change of senior staff including some nurses and that they felt the senior team were, "Finding their feet." They described the registered manager as, "very good and involved", responsive and approachable. Other health care professionals we spoke with told us they visited the service on a regular basis and that care staff supported their visits and were well informed. The registered manager and the deputy manager both had clinical backgrounds and this was a positive factor in providing good clinical support to the nurses in each unit.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. People's care records included assessments of people's mental capacity to make decisions. Staff had undertaken mental capacity assessments and when appropriate had arranged best interests meetings with the multidisciplinary teams and people's representatives. DoLS applications had been made when people were assessed as not having the capacity to agree to their care and treatment.

We saw that the care staff asked people's consent before providing care and support. Care staff could tell us their understanding of the MCA and how they supported people to make decisions. For instance, one care worker told us, "We have training in DoLS and safeguarding and we have that every year. We have to be able to demonstrate knowledge and awareness following the training and we are encouraged to question.

Requires Improvement

Is the service caring?

Our findings

People comments about the staff were mostly positive and included, "Staff are very good and friendly" and "I am happy here. People are nice to me, it's ok. Staff are very friendly."

Relatives were also mostly positive about the care staff approach to their family members. They said, "I am very delighted with the care" and "Staff are good and friendly" and, "The staff are kind." However, one relative told us that staff had shouted at their family member and that they had reported this the social services.

Whilst staff engaged and interacted with people appropriately, the provider did not always ensure that people received person centred care because there were not enough staff deployed to care for and support them. One person said, "I feel sorry for the people working here. They are so busy." People and relatives told us that staff were busy and some of the support to people was not being done on time which caused some of them discomfort and distress. Our findings showed that people were not getting up or going to bed at the times they wanted and some of them were not getting showers and baths as often as they wished. Therefore, although staff's approach was friendly and kind they were not being supported by the provider to spend enough quality time to make sure people received all the care and support they needed in an individualised way.

Care staff described how they gave people choices. One care worker told us, "We have to approach the resident in a holistic way – it should be their choice of care, not ours. What they would like to eat, drink, bathing choice, it's what they want." Care plans reviewed did contain people's bathing preferences however people were not receiving showers as often as they wanted them to be.

We observed that care staff gave people choices such as a visual choice of two meals. However, when we observed care and the way staff interacted with people, we noted that staff were not necessarily trying to get to know people who did not communicate in a confident and clear way. They interacted primarily with people who conversed with them. This meant that people who had communication needs were not necessarily involved in activities and staff were observed to not always recognise people's needs promptly.

We observed some people being supported to eat and saw that individual care workers were compassionate in their manner. They sat down on the person's level and tried to have eye contact with them. One care worker used some words they knew in the person's preferred language and encouraged them to eat in a sensitive and caring way. They brought alternate food they knew the person might like when they were not eating well.

People's care plans described how they communicated and understood people and informed care staff to give people choice, such as, "Staff to communicate with [person] and gain consent prior to any care intervention" and "[Person] is sarcastic at times. Staff to not feel offended and share the same sense of humour with [person]. This will make [person] feel understood and will help [person] settle down."

Care staff told us how they respected people's privacy and dignity. Their comments included, "When we do personal care like giving them shower, changing their clothes we should always close the door. Even when we are giving their medicines we should not interrupt them we should wait until they are finished. We should ask them and always wait until they have finished their activity." Another care worker said, "We always knock before entering." People's care plans stressed people's privacy wishes and choice. Stating for example, "[Person] prefers having a shower on their own" and "Staff to respect their wishes."

People's care plans described, how they liked to be dressed and stressed that people should be dressed appropriately. This supported people's dignity and self image. One relative told us, "My [family member] always looks well dressed. Her nails are varnished properly, her room is tidy and well organised. There is no restriction on visiting and they offer you tea."

Requires Improvement

Is the service responsive?

Our findings

People's care plans described what activities they enjoyed, this included, reading the Metro newspaper, shopping from the mobile shop, bingo and exercise. People's responses were mixed about activities, some people were positive, their comments included, "They try to make my room suitable" and "Girls come around to paint my nails" and "They are quite good. I enjoy snakes and ladders. I do it about once a week."

Other people and relatives told us that they enjoyed the activities when they took place but felt there should be more and found planned activities were sometimes cancelled. Their comments included, "The vicar goes into people's rooms who can't go to the church service. They could do with a few more activities. They do a quiz that [person] likes. They need more stimulation. Perhaps more chair based activities" and "They put up a list of activities, then it doesn't happen. At least two or three every week and you don't get included in all of them." Another person said, "I have not been out a single time. I would like them to just take me to the park opposite. I would like also to go to Osterley Park. They say they are short of carers." There was a trip planned to Osterley Park the week of our inspection but we were told by a visitor following our visit that this trip did not take place as planned.

People who wished to walk or sit outside in the garden in the sun or for fresh air would not have been able to do so safely because the grounds were not adequately maintained or suitable for them to do so. There were empty planters but no attractive plants to engage people or make the garden an inviting area to sit in. Equipment in the garden included the two barbeques that had been left uncovered for a long period and were covered in pine needles and bird droppings. Therefore, the provider was not supporting people to enjoy outside activities and although they had employed an activities co-ordinator this was not sufficient to ensure all people had a consistent choice of meaningful activities.

Care plans used person centred language and were detailed to include people's preferences likes and dislikes. However, these were not always followed to ensure people received person centred care because staff did not have the time to fully comply with the plans and respond to people's needs in a person centred way.

The above concerns were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans highlighted people's preferences including their sleeping routine, personal hygiene, favourite food and drink. Care plans informed staff about the things the person liked to talk about including life events that matter to them, their history and where they were brought up. The plans described what people's good days and bad days looked like.

Care plans described what support people required from the care staff. For example, that two staff were required during moving and handling. In addition, plans stressed what people could undertake for themselves to promote their continuing independence. For example, "Teeth to be brushed twice a day, staff to encourage [person] to do this themselves." A care worker described how they promoted people's

independence. Their comments included, "We have to always encourage - like if someone is using a Zimmer frame we should encourage them to walk a few steps to encourage mobility. We have a few residents who always make tea for themselves so we ask if they need help," and "They can do as much as they can independently and if they can't we will assist them."

People's care plans were reviewed monthly to check whether their needs were changing and updated in an appropriate manner to reflect increased support needs.

The provider had The Four Seasons Health Care End of life policy and we saw evidence that nursing staff worked with the community palliative care nurse to provide appropriate care to people. There were Do Not Attempt Cardio-Pulmonary Resuscitation forms (DNACPR) in people's files that showed the decisions made by people and their relatives and their GP in relation to whether they should be resuscitated if they stop breathing. DNACPR were signed by the GP to reflect what had been agreed. Red stickers were on people's files when a DNACPR was in place to alert staff quickly to check their file.

Two care staff told us that they had not received end of life training and there was no end of life training referenced for any care staff on the training matrix that tracked what training staff had received. They described that if someone was at the end of their life, they would refer to the nurse on duty and the appropriate health care professional. Their comments included, "We would refer to the palliative nurse and we would record changes in the care plan and see what care and support we can give to the residents. People were receiving appropriate end of life care and their medical wishes had been recorded by the provider. However, only one care record reviewed had their cultural, religious, and personal wishes in terms of their arrangements. These were not recorded as a matter of course so staff were clear of these when supporting people with end of life care needs.

We recommend that the provider seek and consider national guidance in regards to best practice in providing end of life care to people.

People told us they could complain if they wanted to. One person described complaining about a staff member to the registered manager and they stopped the care staff working with that person. There were posters displayed throughout the home explaining how people could raise a concern or make a complaint. We noted that the font of the posters was quite small and thought some people might have difficulty reading the print. However, people who were new to the home were issued with a service users welcome pack that contained a Four Seasons Health Care complaints leaflet telling them how to make a complaint.

Care staff described that they recorded any complaints on the staff handover sheet and this was flagged to the management team. The registered manager kept a log of all complaints received. This included a recording of actions that had been taken and included information such as if the complaint had progressed to a safeguarding alert to the local authority and if the CQC had been notified. However, this log has not been updated for complaints raised from 9 January 2018 onwards. We discussed this with the registered manager following our inspection. They told us there had been small concerns raised, dealt with immediately and addressed. They explained some other complaints had gone straight to head office and had been addressed by the provider. The registered manager said they would update the folder to reflect the complaints that had gone to head office.

Requires Improvement

Is the service well-led?

Our findings

During our inspection we found a number of concerns that showed that the provider's quality assurance processes and systems for auditing and monitoring the quality of the service were not identifying the shortfalls we identified at this inspection. These included records and information that were not always being stored in a confidential manner and could be accessed by people not entitled to see them.

We also noted that the daily environment checks had not identified hazards such as unlocked storage room doors, an open lift equipment room door, an unlocked garden gate and a fire exit door that was being left open as the closing mechanism required adjustment, all of which could have posed risks to people's safety. In addition, lack of risk assessments for hazards such as the garden and access to the stairs from the ground floor had not been identified through audit and checks. Whilst the registered manager acted quickly to address these matters once we had identified them, the provider's own systems had not identified these areas for improvement so they could address these.

The provider did not ensure that people were receiving their care and support in a person centred and timely manner. It was evident from people's daily records for instance that there was not recordings of regular showering or bathing as their care plan stated, however this lack of recording had not been picked up in audits. We noted in bathrooms there was some old documentation that was kept in a couple of bathrooms and not others. This included a generic risk assessment dated 2010/11 and a warning about scalds dated 2011. We brought these to the registered manager's attention who agreed to remove them.

The above concerns were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were monthly audits undertaken to monitor the quality of service people received. When a concern was identified, actions and a timescale for completion was put in place to address the concern. Audits undertaken included housekeeping, food safety and the dining experience. Medicines were also audited monthly and random stock checks took place to ensure people received their medicines as prescribed. There were three monthly audits that included home governance, information governance and human relations. The registered manager had a tracker to ensure all aspects of the service was audited and provider targets met. The outcomes were shared with the staff team.

In addition, the registered manager or deputy manager walked around the home daily. There were daily records of cleaning, fridge temperatures and equipment cleaning. The fire system checks occurred weekly. The fire equipment had been serviced in March 2018. People's records were checked and the home had a "Resident of the day" on each unit. This is an initiative where all staff, whether care workers, nurses or housekeepers take time to get to know each person using the service in turn, so that their care can be personalised. The person was asked to discuss their experience of the care provided and their care plans checked to ensure information was up to date. We observed, the chef talking with the resident of the day in the nursing dementia unit to check what meals they had enjoyed.

People who came to live at the home were given a welcome pack that included the provider's vision for the service. This was, "To improve the lives of our residents and the communities we serve by consistently delivering special resident experiences and to be the best place to work in the care centre." We found that the registered manager met with people, relatives, and staff to obtain their views and to share information. People and relative's comments included, "They have meetings about every two months. They had one last weekend," and "There are relative's meetings. I feel the care home does address issues brought up."

The provider employed a team of eighteen resident support managers nationally, two of whom had been visiting the service prior to our visit and were present during our inspection. The team's aim was to ensure people experienced a high quality service and to provide support to the management team at Norwood Green Care Home. People, relatives and visiting professional's' views were obtained using an electronic tablet questionnaire that was made available for them to use.

Staff told us that they found the registered manager approachable and supportive and confirmed they could raise any concerns. There were daily "Flash" meetings with the nurses and heads of departments. This kept lines of communication open across the service and ensured information was shared. There was also a handover between shifts to discuss changes of circumstances for people living in each unit. The registered manager explained they encourage staff to raise new ideas and was offering staff further training to gain national vocational qualifications.

The registered manager explained that the provider's head office cascaded information to the management team at the home. They provided up to date policies and procedures that were in line with changing legislation and best practice. There were two monthly business meetings with the provider to plan and ensure the home's sustainability. In addition, there were regional meetings to share information and learning within the organisation. The registered manager confirmed they found the provider "Very, very supportive."

The registered manager and deputy manager were both clinically trained with the deputy manager taking a clinical lead in the home. They and the nursing staff worked closely with health care professionals to ensure people at the service received good health care access. In addition, the home played a valuable role and was a resource for the community. The management team were working with several local authority commissioning bodies to provide nursing home placements to the local community.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider did not ensure that service users always received care and treatment that met their needs and preferences and in a person centred way. Regulation 9(1)(2)(3a)(3b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured that all risks to the health and safety of service users of receiving care and treatment were appropriately assessed. They had also not done all that is reasonably practicable to mitigate such risks. Regulation12(1)(a)(b)(d)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems to assess, monitor and improve the quality of the services provided to service users. They did not always ensure that service users' records were maintained securely and in a confidential way. Regulation17(1)(2)(a)(b)(c)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 18 HSCA RA Regulations 2014 Staffing

The provider had not deployed enough skilled and competent staff to ensure service users were always cared for according to their needs, wishes and preferences and in a person centred manner.

Regulation 18(1)