

Mr David Lewis & Mr Robert Hebbes

Normanhurst Nursing Home

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

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 31 July and 01 August 2017 and was unannounced. There were 29 people living at Normanhurst Nursing Home when we inspected. People cared for were all older people. They were living with a range of nursing and care needs, including arthritis, stroke and heart conditions. Some people were also living with dementia. People needed support with most of their personal care, nutritional care and mobility needs. The home also provides end of life care and short stay respite care when required.

Normanhurst Nursing Home had accommodation provided over three floors. A passenger lift was available to support people in getting between each floor. A lounge and separate dining room were provided on the ground floor and there was a wheelchair accessible garden. The home was situated near the sea-front in Bexhill on Sea.

There was a registered manager. 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 providers for the service were Mr David Lewis and Mr Robert Hebbes. They also owned Normanhurst Care Home and Normanhurst EMI Home.

Normanhurst Nursing Home was last inspected in June 2016. At this comprehensive the overall rating for this service was Requires Improvement. Four breaches of Regulation of the Health and Social Care Act 2008 (Regulated Activities) 2014 were identified. This was because audits of service provision had not identified a range of areas that needed to be improved. This included no audit of the training needs of staff to ensure they could meet people's needs safely. Following the inspection, we received an action plan which set out what actions were to be taken to achieve compliance by August 2017.

This inspection on 31 July and 01 August 2017 was to see if improvements had been made and embedded into practice. We found that many improvements had been made. However medicine practices need to be improved further to ensure medicines were given as prescribed and ensured people's health and well-being was protected. We found multiple signature omissions for the month of July 2017, along with medicines being out of stock for essential medicines for up to five days. There were also some irregularities in respect of GP instructions and staff documentation.

Quality monitoring systems and daily documentation completed by staff needed further development to ensure best practice in all areas, for example, medicines and fluid intake charts.

We recommend that the service seeks advice from a reputable source to ensure that staff use the appropriate equipment for people with variable mobility.

The provider was meeting the requirements of the Mental Capacity Act (MCA) 2005. Mental capacity assessments were completed in line with legal requirements. Deprivation of Liberty Safeguards had been requested for those that required them. The Care Quality Commission (CQC) is required by law to monitor

the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The provider, registered manager and staff had an understanding of their responsibilities and processes of the MCA 2005 and DoLS.

People received care that person specific to reflect both their health and social care needs. Care plans had been reviewed and there was acknowledgement from the management team that there was still work to be done to ensure that all reflected peoples personal preferences. There were plans to review the organisational documentation that would streamline peoples care plans to ensure that they were easy for staff to use and access. Risk assessments that guided staff to promote people's comfort, nutrition, skin integrity and the prevention of pressure damage were accurate. Emergency procedures were in place in the event of fire and people knew what to do, as did the staff. Equipment used to prevent pressure damage was set correctly and people identified at risk from pressure damage had the necessary equipment to prevent skin damage. There were activities for people to participate in as groups or individually to meet their social and welfare needs.

Staffing numbers and the deployment of staff ensured that people were safe and supported to spend their day as they wished. There had been a consistent usage of agency staff as many permanent staff have left. However new staff were being recruited and the organisation were committed to further recruitment.

People were complimentary about the food at Normanhurst Nursing Home and the dining experience was an enjoyable experience for people. People were supported to eat and drink in a safe and dignified manner. The meal delivery ensured peoples nutritional and hydration needs had been met and offered a wide range of choice and variety of nutritious food.

The home was clean and well presented. Risks associated with the cleanliness of the environment and equipment had been identified and managed effectively.

There were arrangements for the supervision and appraisal of staff. Staff supervision took place to discuss specific concerns. Staff confirmed that they had regular supervision and yearly appraisals.

People we spoke with were complimentary about the caring nature of the staff. People told us care staff were kind and compassionate. Staff were respectful to people and there was plenty of chat and laughter heard.

People had access to appropriate healthcare professionals. Staff told us how they would contact the GP if they had concerns about people's health.

People were protected, as far as possible, by a safe recruitment system. Each personnel file had a completed application form listing their work history as wells as their skills and qualifications. Nurses employed by the Normanhurst Nursing Home all had registration with the nursing midwifery council (NMC) which was up to date.

We found a breach of the HSCA 2014 Regulations. 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?

Normanhurst Nursing Home was not always safe. Whilst meeting the legal requirements that were previously in breach we found a new breach of regulation. This was because people were not consistently protected by the safe management of medicines.

There were enough staff on duty to meet the needs of people. Appropriate checks were undertaken to ensure suitable staff were employed to work at the service. There has been high agency usage that was now reduced with new staff being employed by the organisation.

Staff had received training on how to safeguard people and were clear on how to respond to any allegation or suspicion of abuse.

People had individual assessments of potential risks to their health and welfare. Staff responded to these risks to promote people's safety. The environment and equipment was well maintained to ensure safety.

Requires Improvement 

Is the service effective?

Normanhurst Nursing Home was effective and was meeting the legal requirement that was previously in breach. However some areas required time to become fully embedded into everyday practice.

Mental capacity assessments met with the principles of the Mental Capacity Act 2005. However some DoLs documentation had been misplaced.

Processes were now in place to make sure each person received appropriate person centred care and treatment which was based on an assessment of their needs and preferences.

Training had been identified as required and the training plan confirmed training completed, and training in progress. This meant staff were working with the necessary knowledge and skills to support people effectively.

People received a nutritious and varied diet. People were provided with menu choices and the cook catered for people's

Good 

dietary needs.

Is the service caring?

Good ●

Normanhurst Nursing Home was caring.

Staff knew people well and had good relationships with them. People were treated with respect and their dignity promoted.

People and relatives were positive about the care provided by staff.

People were involved in day to day decisions and given support when needed.

Is the service responsive?

Good ●

Normanhurst Nursing Home was responsive and was meeting all the legal requirements that were previously in breach.

There were activities for people to participate in as groups or individually to meet their social and welfare needs.

People told us that they were able to make everyday choices, and we saw this happening during our visit.

Care plans showed the most up-to-date information on people's needs, preferences and risks to their care.

A complaints policy was in place and complaints were handled appropriately. People felt their complaint or concern would be resolved and investigated.

Is the service well-led?

Requires Improvement ●

Normanhurst Nursing Home was not consistently well led. Whilst we saw improvements had been made, there were areas that still needed to be embedded in practice to ensure that improvements were consistently sustained.

A new quality assurance system was in place. However, some areas of documentation needed oversight to ensure they were completed consistently and information was appropriately recorded.

The registered manager and staff in the service were approachable and supportive.

There had been a number of positive changes made to the day to

day running of Normanhurst Nursing Home and there was a clear programme in place for continual improvement

Normanhurst Nursing 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.

The inspection took place on 31 July and 01 August 2017. The inspection was undertaken by two inspectors.

Before our inspection we reviewed the information we held about the home, including previous inspection reports, action plans and the provider's information return (PIR). We contacted the local authority to obtain their views about the care provided. We considered the information which had been shared with us by the local authority and other people, looked at safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

We observed care in the communal areas and visited people in their rooms. We spoke with people and staff, and observed how people were supported during their lunch. Some people were unable to speak with us. Therefore we used other methods to help us understand their experiences. We used the Short Observational Framework for Inspection (SOFI) during the afternoon in the main communal area. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spent time looking at records, including six people's care records, five staff files and other records relating to the management of the home, such as complaints and accident / incident recording and audit documentation.

We spoke with 15 people who lived at the service, five relatives, six care staff, the housekeeper, two registered nurses, the maintenance person and the registered manager.

We 'pathway tracked' six of the people who lived at the home. This is when we looked at people's care documentation in depth, obtained their views on how they found living at the home and made observations of the support they were given. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

During the inspection we reviewed records. These included staff training and supervision records, staff recruitment records, medicines records, risk assessments, accidents and incident records, quality audits and policies and procedures.

Is the service safe?

Our findings

At our inspection in June and July 2016, we found that people's health safety and welfare was not always safeguarded. The provider had not taken appropriate steps to ensure that there were measures in place to keep people safe. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

An action plan was submitted by the provider which detailed how they would meet the legal requirements by August 2017. Whilst we found that improvements had been made, the provider was not fully meeting the requirements of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because we found that the management of medicines was not always safe.

People told us they felt safe living at Normanhurst Nursing Home. One person told us, "I am safe and feel I can trust the staff." Another said, "It's a good place to live, I like it here." One relative confirmed they felt confident in leaving their loved one in the care of the staff at Normanhurst. Another relative told us, "I can't think of anything that needs to be better."

Whilst the provider had arrangements in place for the management of medicines, the administration and recording of medicines were potentially unsafe. There were multiple (17) omissions (identified as gaps) of signatures on the medicine administration records (MAR). These gaps had not been identified by the registered nurse administering medicine on the next shift, and had not been followed up to determine whether it was a missed signature or a missed dose. Staff could not tell us whether people had received their medicines as prescribed. There was no explanation recorded on the MAR as to why the medicines had not been administered. This placed people at risk of not receiving their prescribed medicines. Three essential medicines were out of stock for five days and people did not receive their medicines which placed them at risk of harm. The essential medicines were furosemide for water retention, tablets for vertigo and nausea and steroids. Records and audits did not show that these had been raised as an issue and actioned to ensure people received their prescribed medicines. There was no evidence of staff observing for any possible side effects from these medicines not being given, such as swollen ankles or shortness of breath. One person had been prescribed steroids and there were errors identified in the amount of medicines were given and the instructions received from the GP. This was to be investigated by the registered manager and action taken immediately. This included contacting the GP and dispensing chemist as part of a root core analysis as to why the errors occurred and mitigate future risks. Whilst an audit had been undertaken in July 2017 it had not identified the gaps or the errors we found.

The management of medicines at this time had not ensured the safety and well-being of people and was a breach of Regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always protected by safe moving and handling procedures. One person was experiencing difficulty in standing with a stand aid hoist. Staff attempted three times within 20 minutes before it was successful and then it was not a fully safe manoeuvre. Different staff attempted this move and that might

have worried the person. We recommend that the service seeks advice from a reputable source to ensure that staff use the appropriate equipment for people with variable mobility.

However we also observed a person being lifted and moved by an electrical hoist. An electrical hoist moves people who are unable to move themselves. The manoeuvre was safe, the person was supported by staff who were efficient and spoke with the person reassuring them constantly.

The provider had taken steps to ensure the safety of people from unsafe premises and in response to any emergency situation. Contingency and emergency procedures and a member of the management team were available at any time for advice. First aid equipment was available and staff had undertaken appropriate first aid training. Staff knew what to do in the event of a fire and appropriate checks and maintenance had been completed. Emergency information was readily available, for example a 'fire box' was available near the fire zone board and contained information on the location of people along with individual evacuation plans.

Medicines were stored and disposed of safely. Medicine storage facilities throughout the service were appropriate and well managed. For example, the medicine room was locked and drug trolleys secured to the wall when not in use. The temperature of areas where medicines were stored were monitored to ensure medicines were not harmed before use. Staff were vigilant in locking the trolley when they were talking or giving medicines to people. Some people had been prescribed 'as required' (PRN) medicines. People took these medicines only if they needed them, for example if they were experiencing pain PRN guidelines were in place. These were clear and provided guidance about why the person may require the medicine and when it should be given. Variable dose medicines were also administered appropriately. For example some people had health needs which required varying doses of medicine related to specific blood test results. We found medicines were given in accordance with any changing requirements. No one at this time was receiving medicines covertly, but there was an organisational policy should this become a need.

Since the last inspection in June and July 2016, risks to people's health, safety and well-being had been identified, and a management plan put into place. People had a care plan with accompanying health and environmental risk assessments completed. We saw that risk assessments included the risk of falls, skin damage, nutritional risks and moving and handling had been completed. The care plans also highlighted people's health risks such as diabetes, memory loss, dementia and Parkinson's disease.

Good skin care involves management of continence needs and regular change of position. There was guidance for people who stayed in bed to receive two or four hourly position changes and the use of a pressure mattress. People sitting in chairs or wheelchairs in communal areas had regular changes of position and were offered toilet breaks. One person said, "I like to be up in a chair and staff come and get me so I can freshen up and use the bathroom."

People at risk from developing pressure damage were monitored and repositioned regularly to reduce pressure and risk of skin damage. Pressure relieving mattresses and cushions were in place to help reduce the risk of developing a pressure ulcer. Mattress and cushion settings were checked daily by staff to ensure they were on the correct setting and adjusted accordingly. Wound records and risk assessments were up to date and demonstrated clear management strategies. One person told us, "I have a special mattress and staff ensure I move regularly."

Accidents and incidents had been documented. There was a clear follow up and actions taken as a result of accidents and incidents. For people who had had falls, a record of an investigation and a plan to prevent further falls had been completed. This meant that the provider had put preventative measures in place to

prevent a re-occurrence and protect the person from harm. The provider therefore was able to show there was learning from accidents and incidents.

The service was clean and health and safety maintenance was in place, the system to report and deal with any maintenance or safety issue was effective. One person talked about the cleanliness of the home and said, "Spic and span." Other comments included, "(the cleaning) This has improved, we have a great team of cleaners," and "There are never any nasty smells, it smells fresh and clean."

There were sufficient numbers of suitably trained staff to keep people safe and meet their individual needs. People told us there were enough staff to respond to their needs although there were some comments regarding the use of agency staff. Agency staff were used at times, but there were always several permanent staff deployed who knew people individually, to support agency staff. Staff told us, "I feel staffing levels are sufficient" and "We are actively recruiting, new staff have recently joined us, both trained nurses and care staff."

There was additional staff in the home to respond to domestic, catering, entertainment, administration duties. The registered manager confirmed staffing arrangements were flexible and extra staffing was available to respond to any changes in people's needs. We found the staffing arrangements ensured people had their individual needs attended to.

Staff received training on safeguarding adults and understood clearly their individual responsibilities. Staff and records confirmed that staff received regular training. Staff were able to give us examples of poor or potentially abusive care they may come across working with people at risk. They talked about the steps they would take to respond to allegations or suspicions of abuse. Staff were confident any abuse or poor care practice would be quickly identified and addressed immediately by the senior staff in the home. They knew where the home's policies and procedures were and the contact number for the local authority to report abuse or to gain any advice.

People were protected, as far as possible, by a safe recruitment practice. Records included application forms, identification, references and a full employment history. Each member of staff had a disclosure and barring checks (DBS) these checks identify if prospective staff had a criminal record or were barred from working with children or adults, completed by the provider. Interviews were undertaken by two senior staff who completed these using an interview proforma. There were systems to ensure staff working as registered nurses had a current registration with nursing midwifery council (NMC) which confirms their right to practice as a registered nurse.

Is the service effective?

Our findings

At our inspection in June and July 2016, systems to ensure the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberties Safeguards (DoLS) were not being consistently followed. Improvements were needed to improve the environment for people and further staff training was required to ensure staff could support people effectively.

An action plan was submitted by the provider which detailed how they would meet the legal requirements by August 2017. We found improvements had been made, the provider was now meeting the requirements of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person said, "Everything they do here is well done." One relative said, "The staff are competent they knew exactly what they were doing when mum came here to live." Another said, "They appear to be well trained and knowledgeable, I have no concerns. I am extremely pleased with the care, they are efficient, personable and kind." People felt the care and support provided was focussed on them and provided an individual approach. Visiting health and social care professionals told us staff had relevant skills and listened and responded to advice given. People were complimentary about the food and how they were provided with choice and variety.

Staff understood the principles of consent and therefore respected people's right to refuse care or treatment. Staff were understanding and patient of people who initially refused assistance by allowing them time to settle and approaching them again to gain their participation or consent. We saw one person initially refuse their meal. Staff removed the food and just sat and chatted before asking, "Would you like your meal now." The person was happy this time to accept their meal. All staff had received training on the Mental Capacity Act 2005 (MCA) and mental capacity assessments were consistently recorded in line with legal requirements. The care plans contained mental capacity assessments, best interest meetings and gave guidance to staff on how to continually assess people. We saw some good examples of how staff had individualised care plans to ensure people were supported in making decisions.

The CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS form part of the Mental Capacity Act (MCA) 2005. It aims to make sure people in care settings are looked after in a way that does not inappropriately restrict their freedom, in terms of where they live and any restrictive practices in place intended to keep people safe. Staff had received training in this area and were confident of the processes to support people. There were people who had bed rails to prevent harm by falling out of bed.

People were supported to have enough to eat and drink and had a pleasant dining experience. People had access to drinks throughout the day. One person said, "They're good about making sure you have drinks, I've always got a drink here on my table."

People could choose where they had their meals and the dining room was attractively presented. One person said "I usually go down to the dining room, it's nice to eat properly at a table and enjoy other

people's company." There was enough staff to attend to people in the dining room and to support people in the lounge and their own rooms. Staff were not rushing and gave people time to eat at their own speed. People were supported according to their need and equipment to maintain independence was provided, for example plate guards and adapted cutlery. The offer of assistance in cutting up food was provided to people who needed it.

People's nutritional needs had been assessed and regularly reviewed. Risk assessments were used to identify people who needed close monitoring or additional support to maintain nutritional intake. For example a nutritional risk assessment was used routinely for people and staff monitored people's weights regularly to inform this risk assessment. Staff asked for professional advice if people lost weight or showed signs of difficulty with eating. Drink supplements were used when specialist advice indicated this treatment. For people who had difficulty in eating and swallowing suitable meals were provided that included soft and pureed meals. Where a need had been identified staff monitored how much people ate and drank each day to ensure they received appropriate nutrition and fluids. Associated records were completed and included fluid charts that recorded fluid offered and taken.

Specific dietary needs were recorded on diet sheets used by the catering staff and were updated in conjunction with the nursing staff on a regular basis. Surveys were also used to gain additional feedback on preferences and choice. We found individual needs were given a high priority. For example one person liked pureed food and this choice was responded to.

Staff and training records confirmed a programme of training had been established and staff had undertaken essential training throughout the year. This training included health and safety, infection control, food hygiene safe moving and handling, and safeguarding. Staff training was closely monitored to ensure staff had completed required training and the computer system highlighted if staff had fallen behind. Staff told us the training provided them with the skills they needed and included practical sessions along with time to discuss specific areas of care. Senior staff reviewed staff training at supervision and supported them to complete the required programme.

Staff said they were supported in providing effective care by the home's training and supervision programme. A new member of staff told us, "I had an induction and was shown the policies and procedures and also had a few days shadowing with more experienced staff." It was confirmed that staff shadowed until they were confident and assessed as competent before they started working on their own. Records of training were maintained. Where a member of staff did not attend mandatory training, the provider had systems to ensure this was followed up and action taken within their policies and procedures.

The registered manager said it would be a priority when new nurses and senior care staff were settled in to their role to introduce various champions. A champion was to be a staff member who will take responsibility and lead staff to ensure safe care provision and check documentation in certain areas. Additional training would be provided to support staff with developing roles, specific interests and to meet the changing needs of people living in the service. For example, a nutritional champion, infection control champion and medicine lead. The training programme was varied and reflected the needs of people living in the service.

The registered nurses were supported to update their nursing skills, qualifications and competencies. For example, one registered nurse told us they had the opportunity to reflect on their own practice through a supervision process and could request training. They confirmed training would be provided when they requested. The registered nurses were also supported in maintaining their registration with the training they are required to undertake to maintain their registration with the Nursing and Midwifery Council (NMC). One registered nurse told us they were being supported with their re-validation process and training on this area

had been provided by the organisation.

People were supported to maintain good health and received on-going healthcare support. People said they could see the GP when they wanted which was a great reassurance and were supported in attending hospital appointments. One person told us, "One day I felt unwell, I told the nurse and they rang for a doctor and then came and told me they had phoned which relaxed me and the doctor came a bit later." Relatives confirmed health care support was sourced appropriately and they were kept informed of any health changes. Records and discussion with staff confirmed staff liaised effectively with a wide variety of health care professionals who were accessed regularly. The staff worked hard to communicate effectively and co-ordinate a multi-disciplinary approach to care. For example, a community psychiatric nurse was involved in planning and reviewing care for a person with specific mental health needs. Specialist nurses were also used to advise staff on specific care needs such as skin pressure damage. Staff demonstrated professionalism and a commitment to providing the best care possible working in conjunction with all additional health care professionals available.

Is the service caring?

Our findings

People told us they were treated with dignity and respect, "Staff are kind and caring, and, "I find them all quite caring and helpful" and "They treat you like you're in a hotel here. " A visitor told us, "Staff are kind and compassionate."

At the last inspection improvement was needed to ensure care delivery by all staff was consistently caring in its approach. At this inspection staff had the time to ensure people received their care and support as they desired.

People's dignity was promoted. People's preferences for personal care were recorded and followed. We looked at a sample of care notes, which included documentation on when people received oral hygiene, bath and showers. People confirmed they had regular baths and showers offered and received care in a way they wanted. One person said, "They know how I want my care given." Care plans detailed how staff were to manage continence. This included providing assistance taking people to the toilet on waking or prompting to use the bathroom throughout the day. Throughout our inspection we observed that people were prompted and offered the opportunity to visit the bathroom. People who were not independently mobile were supported regularly to bathrooms.

People's need for privacy was promoted and respected. For example, staff ensured people's dignity was protected when supporting them to the bathroom. People were supported to wear make-up and jewellery and wear clothes of their choosing. When prompting people to eat or drink, staff talked in a quiet manner ensuring other people did not hear. Relationships between staff and people receiving support consistently demonstrated dignity and respect. Staff understood the principles of privacy and dignity. Throughout the inspection, people were called by their preferred name. We observed staff knocking on people's doors and waiting before entering. We observed one person calling staff as they wanted to go to their room. This was attended to immediately, with appropriate support used by staff and good interactions between the person and staff. Staff were patient and responsive to people's mood changes and dealt with situations well by using diversional verbal tactics and a kind word.

Staff told us they promoted people's independence. One staff member commented on how they encouraged people to be as independent as possible. They told us, "We support people to go out with families and friends and encourage people to make everyday decisions, like what to wear or where to have lunch." We heard staff talking with people before they undertook care tasks. For example, "Shall I help you to the bathroom before lunch to freshen up?"

People were offered choices and enabled to make safe use of all communal areas of the home, this included the garden area. People were encouraged to help themselves to cold drinks as staff ensured there was always a glass or a jug nearby. A comment from one person was relayed to the care team they found the jugs heavy to lift and the staff member took this feedback to the kitchen team to take forward. Staff shared ideas they were exploring to encourage people to be independent and make choices of what they did and how they spent their time. Where people had remained in their room they were now offered opportunities of

visiting communal areas and joining activities. We observed staff were caring and patient in their approach with people and supported people in a kind way.

Relatives told us they felt welcome at the home at any time. They said, "The staff always welcome us, there is a nice calm atmosphere here," and "A nice bunch of staff, seem happy and they speak to everyone nicely." Relatives described the care as positive and felt staff genuinely cared about the people they supported. A relative told us they thought their family member looked, "Content and settled."

People told us they were well cared for. One person told us, "Really kind staff." Another person told us, "I'm content, not exactly happy because I'm not at home but this is nearly as good." People were supported to maintain their personal and physical appearance and to make choices about how they spent their time. A hairdresser visited on a regular basis and people enjoyed this visit. People were able to spend their day as they chose. People spent time in the communal areas, garden or in their bedrooms. Staff checked on them regularly ensuring they had everything they required or wanted.

Care records were stored securely. Information was kept confidentially and there were policies and procedures to protect people's personal information. There was a confidentiality policy which was accessible to all staff. Staff demonstrated they were aware of the importance of protecting people's private information.

Is the service responsive?

Our findings

At our inspection in June and July 2016, we found the provider had not ensured the care and treatment was person centred to meet with people's needs and reflect changes to their health. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

An action plan was submitted by the provider which detailed how they would meet the legal requirements by September 2017. We found improvements had been made, the provider was meeting the requirements of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People commented they were well looked after by care staff and staff listened to them. One person said, "They seem to know when I'm not feeling 100%, and look after me very well."

Since the last inspection the service had employed specific staff to organise and facilitate activities and entertainment and they worked as part of the team. The registered manager told us of the improvements made and of how the activity person knew people well and were attentive to people's individuality and differing needs and abilities. For example, ensuring everyone had one to one time as well as group activities as they needed. As the activity person was not on duty, staff took over activities and spent time with individual people as well as having film sessions.

There was an activity programme that reflected people's interests. This included quiz times, visits out and external entertainers and pet visits. During the inspection people told us of events they enjoyed. One person said they enjoyed quizzes as it kept their mind active, whilst another said, "I go next door and join my husband in the hotel." The hotel is an adjoining service. There were celebrations and events held in the home which were enjoyed by the people living in Normanhurst Nursing Home. This included celebrating birthdays.

Staff felt things were progressing well but acknowledged there was still a lot to do to ensure that everybody had the social interaction they wished and lifestyle to enhance their life. One area discussed was the documentation to support one to one sessions for those people who remained on bed rest or preferred to stay in their room. There was a need for documentation to be further developed as to what was delivered to prevent isolation and boredom when the activity person was not on duty. The registered manager had identified this through the audits and a new computerised care plan for social activities with identified goals was being developed and due to go live in September 2017. This will allow staff to update daily on the outcome experienced. The records told us that staff did record one to one but lacked detail of the benefits of the interaction to that person and whether it was enjoyed.

Before people moved into the service a senior staff member carried out an assessment to make sure staff could provide them with the care and support they needed. Following this assessment the possible admission was discussed by the senior staff in the service to ensure a suitable placement and the admission process is managed appropriately. For example ensuring all appropriate equipment and specific health related training is in place before admission. Where people were less able to express themselves verbally or

they wanted less involvement peoples next of kin or representative were involved in the assessment process. This meant people's views and choices were taken into account when care was planned. One person told us "My family helped me and the staff were so kind."

The assessment took account of people's beliefs and cultural choices this included wishes surrounding people's death. Care plans were written following admission and updated as people's needs changed and on a monthly basis. One day a month was allocated to one person for a full care review which was completed in consultation with all staff. Relatives all told us they were kept fully informed of any changes in care and felt they were included and involved as their relatives would want. Care plans gave guidelines to staff on how to meet people's needs while promoting an individual approach. The care documentation was mostly detailed and supported staff to view people as individuals. Senior staff were aware some care plans needed further attention and were progressing this. Staff had a good understanding of people's specific care needs and responded to them appropriately. For example, one staff member told us, "We have had people whose mental health needs have changed and we liaise closely with the community mental health team and the GP." Staff were regularly updated about changes in people's needs at handover and throughout the day. During the inspection we saw staff communicating effectively with each other. Staff listened to each other and shared information provided by visiting professionals with care plans updated accordingly.

People told us, preferences and choices were respected. Comments included, "I have a shower whenever I like, usually every couple of days," and, "I have my routine of when I like to go downstairs so I please myself what I do" and "Sometimes I stay in my room and sometimes I might go down to the dining room." This told us the staff team were responsive to peoples individual preferences on a day to day basis.

Complaints were responded to and used to improve the service. The home had a clear complaints procedure that was available to people within the home. People spoken to said they were able to complain and were listened to. Visitors were also confident they could make a complaint and it would be responded to. One visitor said, "I have no doubts now that I will be listened too and action taken." Another said, "I would not hesitate to talk to a member of staff if I needed to." Records confirmed complaints received had been documented, investigated and responded to in line with the provider policy.

Is the service well-led?

Our findings

At our inspection in June and July 2016, there were concerns identified within the quality assurance process, such as audits not being acted upon to drive improvement and identify shortfalls in care. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

An action plan was submitted by the provider which detailed how they would meet the legal requirements by September 2017. We found improvements had been made and the provider was now meeting the requirements of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. However audits for medicines and fluids needed further work to ensure that errors were identified and the systems were fully embedded.

The provider's audit systems had been developed since the last inspection. This included the introduction of an auditor. The auditor undertakes audits throughout the organisation. She explained her role and that she samples 10% of care plans and MAR sheets on a monthly basis as well as undertaking the audits for infection control, environment and meal delivery. This is then entered in to a spreadsheet for an overarching view of service delivery, along with actions needed and timescales. The audits viewed demonstrated that they were extensive, thorough and had action plans and timescales included. However the medicine audit had not picked up the issues we found. This was disappointing to the registered manager as the medicine audit had not identified these errors and the registered nurses had not brought errors to her attention. A further medicine audit was immediately undertaken and appropriate action taken. The auditor also was to undertake medicine training to ensure that they had a full understanding of medicine practices and be able to identify errors. To get a proportionate view of medicine audits, we looked at previous medicine audits undertaken since the last inspection. These had identified errors, omissions (gaps of signatures) and poor recording. They also contained actions taken and dates actions completed. Fluid charts were generally well completed but we did find ones inadequately completed which identified poor fluid intake. Discussion with the registered manager identified that these were audited daily by a senior care staff member but when she was off duty this was not consistently undertaken. It was acknowledged there were still some areas of documentation that required work but now new senior staff had been employed this would be easier to embed in to everyday practice. Therefore further improvements to the quality and consistency of audits was required.

Staff felt their suggestions were listened to, and communication at all levels was good. Regular resident meetings/forums were held and the feedback from the people was used to inform staff meetings. Staff told us they felt supported and enjoyed working at the Normanhurst Nursing Home.

Minutes of staff and resident meetings highlighted the points and the action to be taken following discussion. Staff said the meetings were really good because they got to meet all staff new and old and this meant it became useful for team building. Staff also told us they could make suggestions and these were taken seriously. For example, more training for moving and handling and training in dementia care. Staff told us the registered manager operated an 'open door' policy, which means staff felt able to approach the registered manager at any time. People and visitors also said they felt comfortable in talking to the

registered manager. They said they felt able to share any concerns they may have, in confidence with them. One person said, "She's (the manager) very easy to talk to," and "All staff are professional."

The provider used questionnaires to seek people's views on the quality of services provided. A range of people's views were sought, this included staff and people's relatives. All of the questionnaires we saw responded positively about the service .

Throughout the inspection, the registered manager and staff were open to different ideas when we raised matters. Their responses showed they were keen to develop the service, so they could meet people's needs safely and effectively. The registered manager was encouraging staff to take ownership of the care they delivered and to document this in the daily care logs. One staff member said, "It made me realise that we do have a responsibility to ensure that documents reflect what we have done, makes sense really."

Staff told us they attended regular staff meetings and felt the culture within the home had definitely improved and was supportive. Staff told us they felt confident about raising any issues of concern about care practices at the service, including using whistleblowing process if needed.

Systems for communication for management purposes were well established and included a daily meeting with the senior staff and a daily management check around the service both of which were documented. All care staff attended a handover meeting so staff changing shifts shared information on each person. The service worked in partnership with key organisations to support the care provided and worked to ensure an individual approach to care. Visiting health care professionals were positive about the way staff worked with them, communicated with them and ensured advice and guidance was acted upon by all staff. For example one nurse specialist told us treatment plans followed ensured skin pressure damage had healed.

The service had notified the Care Quality Commission (CQC) of all significant events which had occurred in line with their legal obligations. The registered manager confirmed a procedure was in place to respond appropriately to notifiable safety incidents that may occur in the service.

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 12 HSCA RA Regulations 2014 Safe care and treatment
Diagnostic and screening procedures	The provider had not ensured the proper and safe management of medicines. Regulation 12 (1) (2) (g) HSCA RA Regulations 2014 Safe care and treatment.
Treatment of disease, disorder or injury	