Normanton Lodge Limited

Normanton Lodge Care Home

Inspection report

Normanton Lodge Limited
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Date of inspection visit:
04 October 2016

Date of publication:
16 November 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 4 October 2016 and was unannounced.

A registered manager was in place at the time of this inspection. 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 service is registered to provide nursing and residential care for up to 43 people, including some people living with dementia. At the time of our inspection 38 people were using the service.

Staff knew and understood people and paid particular attention to people so that they received responsive and personalised care. People were supported to engage in enjoyable interests and activities. The environment was used in a way to help orientate people living with dementia. People were asked for their views and people knew how to raise concerns or make suggestions. The provider had taken steps to ensure suggestions could be made through their website, in addition to, for example, speaking with staff or using the complaints procedure.

People were supported by staff who were friendly, kind and caring. People's choices and decisions were respected. Care and support was provided in a way that respected people's privacy and dignity. People's independence was supported.

The provider had taken steps to make sure people were cared for safely. Sufficient numbers of staff were deployed to meet people's needs. Any risks to people were identified and assessed and monitored. Medicines were safely stored and administered safely.

Staff checked with people that they consented to their care and support before this was provided. Policies and procedures were in place to ensure the principles of the Mental Capacity Act (MCA) 2005 were followed. Applications for assessments using the Deprivation of Liberty Safeguards (DoLS) had been made when required. Staff understood how the principles of the MCA related to the services delivered.

People were supported to enjoy mealtimes and received sufficient food and drink that met their nutritional needs. Staff were supported through supervision and training and demonstrated knowledge of people's needs. Staff received training in areas that were relevant to the needs of people using the service. Staff were inspired by the training in dementia care and showed they understood this and applied it to their role. People were supported to access other health care services as required.

The registered manager was viewed as being open and approachable and involved in the day to day management of the service. The registered manager was supported in their leadership by motivated and supportive staff. Records were well maintained and checks on the quality and safety of services were

completed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Sufficient numbers of staff were deployed and recruitment processes to ensure staff were suitable to work with people using the service, were followed. People were cared for safely and risks, including risks from medicines were identified and managed.

Is the service effective?

Good

The service was effective.

Policies and procedures were in place to support the principles of the Mental Capacity Act 2005. Staff received training and support to enable them to care for people effectively. People enjoyed their meals and received sufficient nutrition. People received support from external health professionals when required.

Is the service caring?

Good

The service was caring.

People were supported by kind and caring staff who created a happy and jovial atmosphere. Care and support was provided in a way that respected people's privacy and promoted their dignity. People's views and opinions were respected and people's views were reflected in their care plans.

Is the service responsive?

Good

The service was responsive.

Staff paid particular attention to people so that they received personalised and responsive care and support. People's preferences were understood and respected by staff. People were asked for their views and understood how to make a complaint or offer feedback.

Is the service well-led?

Good

The service was well led.

The registered manager led with an open and inclusive management style. Staff were motivated and understood their roles and responsibilities. Checks were completed on the quality and safety of services.

Normanton Lodge Care Home

Detailed findings

Background to this inspection

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

This inspection was unannounced and took place on 4 October 2016. The inspection team included one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed relevant information, including a Provider Information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also checked whether we had received notifications sent to us by the provider. Notifications are changes, events or incidents that providers must tell us about.

We spoke with 12 people who used the service. Not everyone who used the service could fully communicate with us and so we also completed a Short Observational Framework (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with six relatives.

The registered manager was on leave during our inspection and so we spoke with the regional manager and a senior manager who were at Normanton Lodge on the day of our inspection. We spoke with the registered manager on the telephone after our inspection. We also spoke with three care staff, the chef and two visiting consultants, engaged by the provider in training and health and safety auditing. We looked at three people's care plans and reviewed other records relating to the care people received and how the home was managed. This included some of the provider's checks of the quality and safety of people's care, staff training and recruitment records.

Good

Is the service safe?

Our findings

People we spoke with told us they felt safe living at Normanton Lodge. One person told us they were, "Definitely safe," living at the service. Some people told us they observed occasional behaviour that challenged from other people living at the service. All the people we spoke with told us they felt staff managed this well. One person told us, "[Staff] deal with it pretty well; try and calm them down, find out what's wrong." A visiting relative told us, "Staff handle things very well; it's quite uncommon though." We saw one person showed some behaviour that challenged while waiting for their lunch. We saw they started to hit the table and shout at another person. We saw staff talked with them quietly and the person calmed down. We saw further records to demonstrate how this person's behaviour was monitored and kept under review with the GP.

People were encouraged to let staff know if they were uncomfortable or unhappy with anything. Staff were knowledgeable about keeping people safe and what signs could indicate people were at risk from abuse. Staff knew how to raise any worries about people appropriately. Staff told us and records showed, they received training in safeguarding.

Staff recruitment files showed that staff employed at the service had been subject to pre-employment checks. These helped to ensure staff were suitable to work with people using the service. The provider had taken steps to reduce the risk of abuse to people using the service.

People told us staff were available to provide support when they needed it. One person told us, "There's always somebody to help you; [staff] are really nice." Families we spoke with shared this view and commented, "There always seems to be enough [staff] around." We saw staff responded to people who used call bells in a timely manner. One person told us, "[Staff]) come when I use it [call bell], they haven't disappointed me."

Staff we spoke with told us there were enough staff to meet people's needs. One member of staff told us the number of staff increased when there were more people living at the service. They told us this helped to ensure there were enough staff to support people safely. During our inspection we saw staff had time to meet people's needs, including providing time with people and to engage them in enjoyable conversations and activities. Senior managers told us staffing levels were planned based on people's needs. In addition, extra staff were deployed to support regular activities and trips out with people. Staffing levels were sufficient to meet people's needs safely.

Risks to people from either their health conditions or from the general environment were identified and managed. One person told us, "When you get showered they are always there to make sure you are alright." A visiting family member told us their relative was at risk from falls. They said, "[My relative] now has a pressure mat by their bed." Another family member also told us the service had taken action to reduce the risks of using the stairs for their relative. Individual risk assessments were in place for risks such as falls or pressure areas. These actions helped to ensure any risks to people were identified and well managed.

People told us they were satisfied with how staff managed and administered their medicines. One person told us, "I'm on tablets; a lot; [staff] are very regular with all my tablets." When we spoke with another person about medicines, they told us, "[Staff] deal with that; you always get it on time." We observed staff when they administered medicines to people. Staff checked people were available to take their medicines before preparing them and stayed with people to ensure medicines were taken. We saw medicines administration records (MAR's) were updated after people had taken their medicines. The provider had a staff signature sheet that recorded the signatures of all staff involved in administering medicines. However, the signature of the staff member administering medicines on the day of our inspection was not on this sheet. We made the senior managers aware of this and they confirmed this would be amended.

Good

Is the service effective?

Our findings

People told us they enjoyed their meals. One person said, "The food is pretty good; I get enough and I'm never hungry; I have a choice of two meals." We saw a menu of different choices was available for people and staff had asked each person for their choice. One visiting family member told us their relative had put on weight since being at Normanton Lodge. Another family member told us Normanton Lodge had, "A good cook; the meals are very good, nutritious and about the right size too." The cook knew which people had special dietary needs, including people with diabetes or people who required food of a softer consistency to reduce the risks of choking. We saw people were provided with drinks throughout the day. People were supported to receive sufficient food and drink of their choosing.

We observed people were supported to enjoy their lunchtime meal. People who required staff to assist them with their meals received individual support from staff. We saw staff did not hurry people and staff shared conversations with people as they sat with them. This helped to contribute towards a pleasant lunchtime experience for people. Staff also provided encouragement for people to eat well. For example, we saw one person became distracted and walked away from their meal. Staff gently encouraged this person to finish their meal. We saw most people ate all, or almost all of their meals and were asked if they would like any more.

We saw that external health and social care professionals were involved in people's care. One person told us they had seen a physiotherapist, they said, "I've been given exercises to do." Another person told us, "The carers will make an appointment and tell you if you ask for a doctor." Visiting family members also shared the view their relatives were supported to access external health professionals when required. One family member told us, "[My relative] has had an eye test; the optician came to the home; a nurse comes twice a week to change [their] bandages for ulcers." Records also showed people saw chiropodists, district nurses and other health professionals when required. This meant people received appropriate care and support for their health and care needs.

Staff had the skills and knowledge to help people effectively. One person told us, "The staff are really good; they know what they're doing." Staff we spoke with had a good knowledge of what care and treatment people needed. For example, one staff member we spoke with knew when a person was seeing the doctor and for what reason. Another staff member knew about the care and support a person was receiving to help prevent them from the risks associated with developing pressure sores.

Staff told us they had the training they needed to provide care to meet individual people's needs and that training was kept up to date. One member of staff told us, "This is the best place I've worked for training; before I started my shifts I'd done my moving and handling." All staff spoke highly about the dementia training they had received and how they used that to understand people's needs who were living with dementia. We saw that this dementia training had been incorporated into people's care plans and helped form an understanding of the needs of the person living with dementia.

The staff training matrix showed people had been trained in areas relevant to people's needs. For example,

dementia awareness, MCA, tissue viability and managing behaviour that challenged. Staff had also been trained in other areas, such as, health and safety, fire awareness and food safety. Good practice information had also been provided in people's care plans. For example, information for staff on how to provide effective mouth care to a person. Staff provided effective care to people as their skills and knowledge were maintained and developed through a range of training relevant to people's needs.

People were asked for their consent about their care before staff provided assistance and support. Staff asked people if they would like assistance cutting up any part of their meal and waited for people's response before providing help. Another member of staff spoke with two people, asking them if they would like some clothing protection to help keep their clothes clean over lunchtime. The staff member checked again, just prior to assisting them by asking, "Am I okay to put a pinny on you?" This meant people were asked for their consent to their care and treatment and staff checked with people to make sure they had not changed their mind.

We saw staff had attended training on the Mental Capacity Act 2005 (MCA) during our inspection. We spoke with the external training consultant who delivered the training. They told us they used practical examples to relate the training to people's own experiences.

Where people did not have capacity to make a decision we saw arrangements were in place so that any decisions relating to their care followed the principles of the MCA. The 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 they are appropriately supported to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be made in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The provider had identified and submitted the relevant applications for where people required an assessment and authorisation for a Deprivation of Liberty. We also saw that mental capacity assessments and best interest decision making processes were followed when specific decisions were being considered, for example, when consent was sought for personal care. People's mental capacity to make specific decisions had been assessed on different occasions at different times of day to maximise their ability to understand. In addition, where it had been identified as appropriate Independent Mental Capacity Advocates (IMCAs) had been involved with people's decision making. IMCAs are a legal safeguard for people who lack the capacity to make specific important decisions, including making decisions about where they live and about serious medical treatment options. People's freedom was not unlawfully restricted because the provider had taken steps to ensure care and support was provided in line with the MCA.

Staff told us they felt well supported by the registered manager and other staff members. One staff member said, "I do feel supported." They went on to tell us they had received feedback and encouragement when they first started work. They told us this had helped them develop confidence when interacting with people. Records showed staff supervision was planned regularly throughout the year and staff confirmed they could approach their managers for support in between supervision meetings. Supervision is a method used to review and learn from practice, provide support and identify and training needs. In addition, staff meetings were held on a regular basis. This showed that staff were being supported to develop their skills and knowledge to provide care and support to people using the service.

Good

Is the service caring?

Our findings

People told us they felt staff were kind and caring. One person told us, "Staff are wonderful, without a shadow of a doubt; always got time no matter if they're busy, they stop and talk to you." They added, "[Staff] have taken all the worry away." A relative told us, "I looked at a lot of local homes before [my relative] came here. This one impressed me the most with the friendliness of staff and the upkeep of the place. [My relative] has a lovely room."

Staff spent time with people. We saw staff sitting with people and talking, or sitting and holding people's hands for reassurance and comfort. We heard staff ask people, "Do you want to sit with me?" when staff were completing records of people's care in communal areas. Other members of staff spent time singing and dancing while holding people's hands. Staff members who had attended training at the service came and sat with people during their breaks. We heard staff ask people how they felt and talk with them about what they had been doing. Staff created a happy and caring environment for people.

People we spoke with told us they felt staff respected their privacy and promoted their dignity. One person told us, "[Staff] knock when they come into my room." We observed staff knock and wait for a response before entering people's rooms. Staff we spoke with told us they were mindful of people's privacy and told us how they promoted people's dignity. One staff member told us staff only discussed people's care and treatment in private and not, for example, in a communal area. They also told us they made sure people's care records were kept private. Senior managers told us the service had been awarded a 'dignity award' from the local authority. This is an award given for work that demonstrates people are cared for with dignity and respect.

Not all people we spoke with could recall having any involvement with their care plans, however we saw care plans were written to support people's involvement in their care. For example, people's memories and experiences from when they were younger had been recorded so as to help staff understand the person more. People's important relationships, such as their parents, their wife, husband and children had been mapped out. Staff told us this information helped them understand people more as well as helping them find areas of interest to talk with people about. People had signed their care plans to show they had been involved in them and people told us they were kept informed about their care and treatment. We spoke with staff about people's care plans. One staff member told us, "We always ask people how they want to be cared for and ask for families to input." They went on to tell us care plans continued to be updated with information provided by people, "As and when conversations emerge with people; to keep [people involved] and their ideas." Care plans reflected people's involvement and recorded personalised information pertinent to each individual.

Staff had identified improvements were needed to give people more choice at meal times. Staff developed a system to record people's choices and we saw this in action during our inspection. People had confirmed they were happy with the choices of food provided in a recent residents' meeting. Throughout our inspection we heard staff offering people choices, for example, on where people would like to sit or what they would like to drink. People were supported to maintain their independence, for example, people were

given their medicines so they could take these themselves when they were able. People were supported in their choices and independence.

Staff told us the provider helped fund all activities, including people's birthday celebrations. During our inspection we saw someone had recently celebrated their birthday and had birthday decorations in their room. Staff told us the provider contributed to any special celebrations and presents for people where there was no family involvement. Staff spoke highly of the provider for their involvement in the services provided for people.

Good

Is the service responsive?

Our findings

People spent time engaged in activities they enjoyed. Staff supported one person on an outing to a local coffee shop. When they returned they chatted happily with staff about what they'd had to eat and drink. When another person heard they'd had a milkshake and said they also liked milkshakes, staff asked whether they would like one and made one for them. Staff assisted another person who had a visual impairment to enjoy the garden. They assisted them to safely find a seat in the sunshine and left them with a call bell, for when they wanted to call for assistance. The member of staff checked with the person they felt confident to use the call bell before leaving them. People's other preferences were known by staff and recorded in care plans. For example, whether people preferred male or female carers, and whether they preferred their door closed or left open during night time. Staff paid particular attention to people so that they could provide personalised and responsive care.

Another person told us they liked, "To sit outside and chat with people." We saw the garden areas had been designed to be accessible with regular seating and areas designed to be of interest to people, such as sculptures and decorations that people had painted themselves. Inside, the premises had been decorated to be supportive of people living with dementia. For example, corridors had been designed to be familiar to people and contained objects of reference to help people orientate themselves. People's bedroom doors were designed to look like traditional front doors on a street, with door knockers and letter boxes. Next to people's bedroom doors were memory boxes, containing special objects or photographs to help people identify their own personal bedroom door. Toilets and bathroom doors were all painted the same colour so people could recognise them easily, and doors into rooms that were not public had been painted black to minimise people's interest in them.

Other communal areas had relevant objects of reference available to help orientate people. For example, people could see into the kitchen area and pots and pans and a washing up bowl had been placed outside for people to use as reminiscence items. Staff told us one gentleman had been reluctant to use the hairdressing room as he wanted to go to the 'barbers'. In response staff had put a red and white striped barber's pole outside the hairdresser's room and reported the gentleman had then enjoyed going to the barbers. Staff used creative ideas to help people relate to the services offered.

Staff supported people with enjoyable pastimes. In addition, the environment had been designed so people living with dementia could start and leave activities as and when it suited them. People spoke highly of the entertainment. One person told us, "A lot of people [entertainers] come in, we've had three lately." Another person told us the entertainment was, "Fantastic; really enjoyable." A third person told us, "I sit and read or talk. There's a lot going on actually; singers and what have you." A visiting family member commented on the trips out that were arranged for people. Staff told us the next trip out was to a garden centre. People's care plans recorded what their individual interests and hobbies were and potential activities of interest were assessed as to whether they were suitable for people. For example, whether people preferred group activities or individual activities. For people living with dementia, staff assessed whether their dementia affected their ability to engage with a particular activity or entertainment. For example, whether a person's memory would impact on any particular activity.

Staff spoke with people about their experiences when previous entertainers had visited. One person recalled a visit by a person who had brought in reptiles for people to pet. They went on to talk with staff about their memories of seeing snakes when they had travelled to other countries. People's faith and religious needs were supported with church services held every couple of weeks at the home. Staff told us if people expressed different faith needs these would be supported.

Conversations between staff and people were frequent and created a happy atmosphere. As lunchtime approached, staff initiated a conversation with a group of people about baking bread. This began a jovial conversation over bread baked in the oven by the side of an open fire and the taste of butter. People continued to chat happily over other food memories, such as homemade pies and trifles.

People's need for companionship was valued and supported. One person had requested to bring their dog with them when they came to live at the home. This was risk assessed and the dog moved to the home with the person. We saw other people in the home enjoyed petting the dog throughout the day. Another person enjoyed sitting next to their fish tank, and the home also had a parrot and some finches which we saw created opportunities for conversation and companionship. Family members were free to visit when they wanted and we saw families visited throughout the day. People were supported to maintain relationships that were important to them.

Staff responded promptly when people needed care. We saw one person rolled up their sleeve and showed staff a dressing that had come loose. Staff immediately went with the person to attend to it. At most other times, but not all the time staff noticed when people required assistance. For example, when a person was sleepy at dinner time, staff arranged amongst themselves for a staff member to sit and provide assistance with their meal. However, we observed staff interact with another person and not notice they required assistance with their personal care. When we brought this to the attention of staff they took immediate action to assist the person. Staff responded to people's needs in a personalised and responsive way.

Care plans showed care and support provided was responsive to people's needs as it was regularly reviewed and updated. One member of staff told us, "If something changes, we involve people and inform their families." Family members we spoke with told us they were involved in reviews of their relative's care plan. We saw people who were at risk of weight loss were monitored regularly and their weight kept under review. Where staff had noticed changes in people's behaviour they had followed this up and confirmed appointments had been made with the GP for a review of their care and treatment. Care and support provided was responsive to people's needs.

People told us they had no reason to complain, however they would feel confident to should they need to. Where people had raised issues with staff they told us these had been dealt with or they felt they were in the process of being dealt with. For example, one person told us, "I've no complaints care wise but we have had a few problems with clothes; staff did say they'd put name tags on and they haven't yet." Another person told us, "I've only had little niggles; but all were dealt with ok."

People were asked if they were unhappy about any aspect of their care and support during meetings with staff. The meetings stressed that if anyone was not happy about anything they could always let staff know. These meetings were held in a way that provided an opportunity for anyone who wanted to contribute to do so. This was achieved by staff visiting people in different parts of the home, rather than holding one meeting, in one place, at one time. We saw one person had said they were concerned they asked for too much help and staff had reassured them it was fine to ask for help. People had also been asked their views on the garden and how to make it more accessible. We saw information for families had been made available in the main reception area on understanding dementia. Minutes of meetings held with families showed actions

had been taken in response to their views and feedback. For example, changes had been made to the cleaning products used to tackle an unpleasant odour which families had identified. One family member told us, "They do have meetings and I've been to see what's going on." People's views were listened to and acted on.

The provider had a complaints policy in place that made sure any complaints raised were dealt with within a set timeframe. We saw that any concerns or complaints were recorded and investigated. We found the provider had taken steps to make it easy and simple for people to make a comment by use of their website. We found a complaint had been submitted through the provider's website and dealt with in line with the provider's complaints policy. In addition any compliments were also recorded and shared with the staff team. We saw the provider had received positive comments and feedback from families and other professionals. These comments and feedback were kept and shared with staff. Procedures were in place for people to raise any concerns and people were able to share their views. Action was taken in response to concerns raised.

Good

Is the service well-led?

Our findings

Normanton Lodge is required to have, and did have a registered manager in place at the time of our inspection. Providers and registered managers have responsibilities to send in written notifications when required to tell us about any important changes, events or incidents at the service. We found written notifications had been sent when required for most incidents. However, where potential safeguarding incidents had been identified by the service, the relevant notification had not been sent. We discussed this with the regional and senior manager who confirmed all future notifications for any allegations of abuse would be completed as required.

People using the service knew the registered manager and told us they would be happy to talk to them and any of the staff about any issue. One family member told us, "I don't know names but they all seem friendly and you can talk to them. I know who I'd go to if I had a problem; it would probably be the manager, but to start with I'd probably talk to the carers." Staff we spoke with were confident the registered manager was approachable. One staff member told us, "[Registered manager] comes onto the floor; they're always talking with residents; always approachable and down to earth."

Staff were motivated and understood their roles and responsibilities. Staff with responsibility for leading a team told us they felt confident in their role and had support to do this. One staff member told us, "We've got good staff; we work well as a team." Staff also felt they received support and feedback that helped them develop their practice. One staff member told us, "When I first started I was given feedback to encourage me to interact with people more." They told us this was helpful and we saw this staff member interact with people throughout the day in a way that had a positive impact on people's mood. The service was being developed with an open and approachable leadership style that involved, valued and motivated staff.

Staff were proud of the services delivered for people and motivated in their role. One member of staff told us, "[The registered manager is] wonderful and the things they are doing are great; they always have the residents' best interests at heart." Another staff member told us, "I love this job; all the people I work with and helping the residents." All staff told us they were inspired by the dementia philosophy used to deliver the service. We could see this was integrated throughout the service, for example, in training and development, in people's care plans and in the staffs' understanding of people's dementia. The integration of a dementia philosophy helped staff understand how a person's dementia affected their behaviour as well as identifying any risks associated with certain stages of dementia, such as nutritional risks or risks to people's skin integrity. The provider communicated a clear vison for the service and demonstrated values that were inclusive of staff, people and their families.

During our inspection, we reviewed records relating to the care people received and how the service was managed. Records had been well maintained and care plans were either up to date or being reviewed to reflect changes to people's care and treatment. Systems were also in place to check on the quality and safety of services. For example, we saw audits of care plans and systems to prevent and control infections. Other specific safety checks were also completed. For example, checks on the safety of wardrobes and equipment using when assisting people to mobilise. We spoke with a visiting health and safety consultant

commissioned by the provider to identify good practice or any shortfalls in health and safety and related areas. Including such areas as the care of substances hazardous to health (COSHH) records of maintenance checks completed on emergency lighting and equipment such as wheelchairs and people's beds. Senior managers had also commissioned a review of how well the service responded to people who made enquiries about the provider's locations, including Normanton Lodge. They told us this information was used to plan improvements and developments in customer care. In addition the provider had used survey type questionnaires to obtain the views of people, their families and staff on the quality of services provided. We could see people had responded with positive comments about the services delivered. Systems were in place to check on the quality and safety of care provided and resources were being made available to support improvements and developments at the service.