Norwood House Nursing Home Limited

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Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 4 September 2018 and was unannounced.

Norwood House 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 care home can accommodate up to 31 older people and older people living with dementia in one adapted building. Accommodation is provided over two floors.

At the time of our inspection there were 26 people using the service.

At our last inspection we rated the service good. At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

There was a manager in post but they had not yet started the registration process with CQC. 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.

People using the service and their relatives were positive about the care and support provided at Norwood House. They said staff treated people respectfully and in a kind and caring manner.

People felt safe at the home and appropriate referrals were being made to the safeguarding team when this had been necessary.

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

Individual care and support needs were fully assessed, documented and reviewed at regular intervals.

People were assisted as required by suitable numbers of staff who were trained and supported in their job roles. Staff members had been safely recruited and had received an induction to the service.

People's healthcare needs were being met and medicines were being stored and managed safely.

Staff knew about people's dietary needs and preferences. People told us there was a choice of meals and said the food was good. There were plenty of drinks and snacks available for people in between meals.

Some activities were on offer to keep people occupied both on a group and individual basis. Visitors were made to feel welcome and could have a meal at the home if they wished.

People and their relatives or friends felt able to raise any concerns or complaints. There was a procedure in place for people to follow if they wanted to raise any issues.

The provider had systems in place to monitor the quality of care provided and where issues were identified they acted to make improvements. There were some areas, however, where further development was required

We found all the fundamental standards were being met. Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains good.	**Good**
Is the service effective? The service remains good.	**Good**
Is the service caring? The service remains good.	**Good**
Is the service responsive? The service remains good.	**Good**
Is the service well-led? The service was not always well-led. A manager was in place but they had not yet applied for registration with the commission. Quality assurance systems were in place to assess, monitor and improve the quality of the service. These needed to develop further to ensure they were effective.	**Requires Improvement**

Norwood House 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 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 4 September 2018 and was carried out by two adult social care inspectors. The inspection was unannounced.

Before the inspection we reviewed the information, we held about the service. This included notifications from the provider and speaking with the local authority contracts and safeguarding teams.

The provider had completed a Provider Information Return (PIR). The PIR is a document which gives the provider the opportunity to tell us about the service. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We spent time observing care in the lounges and dining rooms and used the Short Observational Framework for Inspections (SOFI), which is a way of observing care to help us understand the experience of people using the service who could not express their views to us. We looked around some areas of the building including bedrooms, bathrooms and communal areas. We also spent time looking at records, which included four people's care records, two staff recruitment files and records relating to the management of the service.

We spoke with four people who used the service, four relatives, two care workers, the cook, the housekeeper, one nurse practitioner, one nurse and the deputy manager.

Good

Is the service safe?

Our findings

People were kept safe from abuse and improper treatment. A relative said they thought their relative was safe in the home. They said following incidents, the home had promptly contacted them, been honest and open and addressed the issues to help prevent a re-occurrence. Records showed appropriate action had been taken to log, investigate and respond to safeguarding incidents. We saw appropriate agencies and professionals had been contacted to help keep people safe.

Staff were recruited safely to the service. All the required checks were undertaken including Disclosure and Baring Service (DBS) and references before new staff started work.

There were enough staff on duty to care for people safely and keep the home clean. People said there were enough staff and they didn't have to wait too long for care and support. Our observations of care and support confirmed this. Rota's showed the required number of staff were consistently on shift with agency used to cover any shortfalls.

Medicines were managed safely. Clear records were kept of medicine administration which provided assurance people were receiving their medicines as prescribed. Stock checks were undertaken on boxed medicines to ensure all medicines were accounted for. Protocols were in place for "as required" medicines to guide safe and appropriate use". Medicines were stored safely and securely. A new system had recently been introduced to record the administration of topical medicines such as creams. We saw this was working effectively. Where medicine errors had occurred, we saw action had been taken to learn from them.

A range of checks were undertaken on the premises and equipment to help keep people safe. These included checks on the fire, electrical and gas systems.

Personal emergency evacuation plans (PEEPS) were in place for the people who used the service. These gave information about what support people would need should an emergency arise.

We saw the fire alarm was tested weekly and fire drills were held. Fire training had been provided to staff including how to use the evacuation aids.

The home was clean, tidy and odour free. We saw staff had access to personal protective equipment, such as gloves and aprons and were using these appropriately.

Risks to people's safety were assessed, monitored and managed to help people stay safe and well. Written assessments addressed areas such as the risk of falls, pressure ulcers and poor nutrition. These were reviewed monthly to help make sure the care and support provided continued to keep people safe.

Good

Is the service effective?

Our findings

Staff were well trained and supported to carry out their roles effectively. The deputy manager told us new staff completed induction training and were enrolled on the Care Certificate. The Care Certificate is a set of standards designed to equip social care and health workers with the knowledge and skills they need to provide safe, compassionate care. Existing staff received regular training which was kept up-to-date.

Supervisions and appraisals took place, although these were currently behind schedule. We saw a plan was in place to address this during September 2018.

Overall, we found nutritional needs were met by the service, although some care plans needed updating. A relative told us their relative received a balanced diet and had plenty of access to snacks. People had a suitable choice of food. This included adjustments made to cater for people's specific needs for example, vegetarian and diabetic diets. Snacks including fresh cakes, chocolate and fruit were available throughout the day.

People's healthcare needs were being met. In the care files we looked at we saw people had been seen by a range of healthcare professionals, for example, GPs, specialist nurses, speech and language therapists and opticians. An advanced nurse practitioner told us, "Staff know people well and I get a good history from them. Staff call me in appropriately and follow any instructions I leave."

Improvements to the environment were on-going. Signage was in place to help people find toilets and bathrooms.

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. The service was acting within the Mental Capacity Act. People's capacity to consent to their care and support arrangements was assessed.

Where people lacked capacity and it had been assessed that the accumulation of restrictions amounted to a deprivation of liberty, appropriate DoLS applications had been made.

People were asked consent before care and support was provided. Where people lacked capacity best interest decisions had been made involving families and relevant people.

The deputy manager had oversight of which people who used the service had Lasting Power of Attorney (LPA) in place. A LPA is a legal document that allows someone to make decisions for you, or act on your behalf, if you're no longer able to or if you no longer want to make your own decisions. LPA's can be put in place for property and financial affairs or health and welfare. This showed us the deputy manager understood their responsibilities to act within the legislation.

Good

Is the service caring?

Our findings

Staff treated people with dignity and respect. One person who used the service said, "Generally staff are good." Relatives comments included, "[Person] is treated with dignity and respect." "Staff are very helpful, kind and attentive."

People's care plans gave information about how they liked to be presented, for example, "I have always had pride in my appearance and want staff to keep my hair tidy with regular hairdressing visits." We saw people were clean, well-groomed and comfortably dressed which showed staff took time to assist people with their personal care needs in line with their preferences.

Staff communicated well with people to provide comfort and reassurance. Through our conversations with staff, they explained how they maintained people's dignity whilst delivering care. Staff told us they always ensured doors and curtains were closed when delivering personal care. We saw staff knocked on people's doors and consulted with them before supporting them with any care tasks. Staff told us they explained to people what was happening at each stage of the process when delivering personal care.

Staff knew people's favourite activities and how they liked to be communicated with. Information about people's life history was included within people's care plans to aid staff to better understand the people they were caring for.

People's beliefs, religion and diverse backgrounds were respected. Regular Church services were held in the home and dietary changes made where required respecting culture and religion.

Staff listened to people. For example, they promoted choice at mealtimes and awaited people's answers before proceeding to assist them.

Visitors were made to feel welcome. One relative said, "Staff are very welcoming and kind. We are always offered a drink."

We looked at whether the service complied with the Equality Act 2010 and how the service ensured people were not treated unfairly because of any characteristics that are protected under the legislation. Our observations of care, review of records and discussion with the registered manager, staff, people and relatives showed us the service was pro-active in promoting people's rights. For example, through the use of adult sensory tools, religion, diet and choice of carers.

Good

Is the service responsive?

Our findings

People's needs were regularly assessed and responded to. People's individual needs were assessed before they came to live at Norwood House. A pre-admission assessment form was completed which staff used to discuss with the person and/or their representatives about the support they required. Care plans were then written and developed as the staff got to know people and their support needs better.

One relative said they were fully involved in the care planning process and was sent any updates by email. Another relative told us, "Staff understand people's quirks and preferences."

People's care plans contained detailed information about the care and support they needed together with their personal preferences. Care staff we spoke with were knowledgeable about people's needs and were described the care as recorded in the care plan. Care plans were reviewed regularly and when people's needs changed.

People's end of life care needs were planned for. We saw some end of life discussions had taken place and people had end of life care plans in place. The service had robust end of life policies in place and was part of the 'gold line' scheme which was designed to ensure people had a pain free and dignified death. The following compliment had been received by the service, "Thank you for all the love and care you showed my mum in the last few months of her life. There is nothing more we could have wished for her. You're all angels, quite literally."

The provider had an accessible information policy in place. We asked the registered manager if anyone living at the home had specific requirements regarding accessible information. We saw clear and detailed information contained in one person's care records who was registered blind.

People provided mixed feedback about activities with some saying they wished there were a few more activities in the home. One relative said "Only thing would be a bit more on the activities, but they have addressed this and an activities co-ordinator is coming on board." We saw an activities co-ordinator was due to start which would increase the opportunities available to people. A basic range of activities was in place which included games, arts and crafts and music sessions. We saw staff encouraging people to participate in activities such as arts and games.

The service maintained links with the local community. For example, members of the church visited the home as well as local students.

Systems were in place to log, investigate and respond to complaints. Where issues had been identified action had been taken to resolve them. A relative told us any minor issues they raised had been dealt with appropriately and they found the management team approachable. Compliments were also logged so the service knew where it had exceeded expectations.

Requires Improvement

Is the service well-led?

Our findings

The registered manager and clinical nurse lead had both left the service following the last inspection. A new manager had been recruited who had not yet registered with the Care Quality Commission. 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 manager was supported by a deputy manager, nurses, care workers and ancillary staff.

As there was no registered manager in post and some improvements needed to be made to documentation this section of the report has been rated as 'requires improvement.'

The manager had only been at the service since May 2018. Staff reported that morale had improved and they felt supported. The deputy manager told us about improvements they planned to make. People and relatives said the management team were kind and approachable.

There were systems in place to monitor the quality of the service being provided. The providers had audits and reports to help them monitor the quality of care provided. Where concerns were identified action had been taken to help staff ensure that there was no repeat of the concern. For example, medicine audits were undertaken and actions from them were used to make improvements to the medicines management system.

Some documentation surrounding the management of complaints and safeguarding needed improving. There was no log of these occurrences and the action taken which made it difficult to review this information and analyse for any trends. Some care plans also needed updating following weight loss.

Providers are required by law to notify The Care Quality Commission (CQC) of significant events that occur in care settings. This allows CQC to monitor occurrences and prioritise our regulatory activities. We found safeguarding alerts had been made by the service and although these had been managed appropriately, CQC had not been informed.

The service had worked in partnership with the local authority commissioning and safeguarding teams to make continual improvements.