

# SHC Clemsfold Group Limited

## Norfolk Lodge

### Inspection report

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### Ratings

Overall rating for this service

Inadequate 

Is the service safe?

Inadequate 

Is the service effective?

Requires Improvement 

Is the service caring?

Requires Improvement 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Inadequate 

# Summary of findings

## Overall summary

About the service:

- Norfolk Lodge is a residential care home that provides care and support for up to eight people with a learning disability and other complex needs, including autism and mental health. At the time of our inspection there were five people living at the home.
- Norfolk Lodge is owned and operated by the provider Sussex Healthcare. Services operated by the provider had been subject to a period of increased monitoring and support by local authority commissioners. As a result of concerns raised, the provider is currently subject to a police investigation. The investigation is on-going and no conclusions have yet been reached.
- At the previous inspection in August 2018 we found seven breaches of regulation in relation to person centred care, dignity, consent, safe care and treatment, safeguarding, governance and staffing. At this inspection we found one breach had been met in relation to dignity and six regulations continued to be breached. We also found a new breach of the registration regulations relating to informing us of significant incidents.
- The service has been developed and designed in line with the values that underpin the 'Registering the Right Support' and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen. These values were not always seen consistently in practice at the service. For example, some people could live independent lives and were supported to do so. However, other people were not receiving the assistance with communication they needed to be as independent as possible.

People's experience of using this service:

- Some aspects of the service remained unsafe.
- Some people were at risk from harm as some risk assessments were not effective in reducing the likelihood of harm and staff had not taken steps to keep people safe after an injury.
- Not all incidents had been reported to the local safeguarding authority as per the provider's policy or agreement with the local authority and CQC.
- Staff had not consistently been deployed in a safe way. There were times when staff that were trained to use essential equipment were not working, leaving people at risk of unsafe care and treatment.
- Learning from incidents had not been consistently implemented. One person had experienced episodes of choking and these were not reported by staff.
- Staff told us they needed more training to meet people's needs around behaviours that could be challenging to others.
- Some health needs were not being met effectively.
- People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems in the service did not support this practice.
- People did not always receive personalised care. One person required adaptations, and care documents in large print and these were not being provided.

- There was no registered manager in day to day charge of the service. Although the registered manager was still registered with CQC they were no longer managing the service, had left the employment of the provider, and the provider was recruiting a new registered manager.
- Quality audits had not been effective in highlighting and putting right all the shortfalls we found at this inspection.
- People were supported in a kind and caring way by staff who knew them well.
- People told us that they liked their staff and could get help when they needed it.
- People received sensitive support when they were upset.
- People had enough to eat and drink and knew how to make a complaint.
- The new management team were working towards making positive changes to the service and had worked with other stakeholders to improve the support people received.

More information is in the detailed findings below.

Rating at last inspection:

At our last inspection in August 2018, the service was rated "requires improvement" overall with an Inadequate rating in the safe domain. Our last report was published on 7th February 2019. This is the second time this service has been rated as Inadequate in the safe domain.

Why we inspected:

All services with one key question rated "Inadequate" are re-inspected within six months of our prior inspection. This inspection was part of our scheduled plan of visiting services to check the safety and quality of care people received.

Enforcement:

We imposed conditions on the provider's registration. The conditions are therefore imposed at each service operated by the provider. CQC imposed the conditions due to repeated and significant concerns about the quality and safety of care at a number of services operated by the provider. The conditions mean that the provider must send to the CQC, monthly information about incidents and accidents, unplanned hospital admissions and staffing. We will use this information to help us review and monitor the provider's services and actions to improve, and to inform our inspections.

Follow up:

The overall rating for this registered provider is 'Inadequate'. This means that it has been placed into 'Special Measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their

registration.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded. We will have contact with the provider and registered manager following this report being published to discuss how they will make changes to ensure the service improves their rating to at least Good.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Inadequate** ●

The service was not safe.

Details are in our Safe findings below.

### Is the service effective?

**Requires Improvement** ●

The service was not always effective

Details are in our Effective findings below.

### Is the service caring?

**Requires Improvement** ●

The service was not always caring

Details are in our Caring findings below.

### Is the service responsive?

**Requires Improvement** ●

The service was not always responsive

Details are in our Responsive findings below.

### Is the service well-led?

**Inadequate** ●

The service was not well-led

Details are in our Well-Led findings below

# Norfolk Lodge

## Detailed findings

### Background to this inspection

#### The inspection:

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

#### Inspection team:

The inspection was carried out by two inspectors 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. Our expert-by-experience had knowledge about care of adults with learning disabilities and autism.

#### Service and service type:

Norfolk Lodge 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.

Norfolk Lodge did not have a registered manager in day to day control of the service. The registered manager was still registered as a manager with the Care Quality Commission but they had left both the service and the provider in January 2019 and were no longer managing the service. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

#### Notice of inspection:

This inspection was unannounced.

#### What we did:

We reviewed information we had received about the home since the last inspection in August 2018. This included details about incidents the provider had notified us about, such as allegations of abuse. We assessed the information we require providers to send us at least once annually to give some key information about the home, what the home does well and improvements they plan to make. We used all this information to plan our inspection. We spoke with the local safeguarding adults team and local health

teams.

During the inspection we looked at a range of records including: four people's care records; records of accidents, incidents and complaints; audits and quality assurance reports; rotas and dependency tools; four staff recruitment files, and supervision and induction paperwork. We spoke with five people using the service; and one relative. We also spoke with four members of staff.

# Is the service safe?

## Our findings

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

People were not safe and were at risk of avoidable harm. Some regulations were not met.

When we last inspected the service in August 2018 we found three breaches of regulation in relation to managing risks, safeguarding, and staffing levels. Although we found the new management team were making some improvements to some aspects of care all three breaches remained at this inspection.

### Assessing risk, safety monitoring and management

- People were not consistently protected from risk of avoidable harm. One person was at risk of choking. We observed a mealtime and saw three instances where the person appeared to have been choking on a sandwich and crisps.
- We asked staff about this person choking and were told, "[Person] choked on his sandwich a few months ago. If we do backslaps it just comes out. It has happened before." The person was supposed to have their food cut up finely in to small pieces but had been given sandwiches which were quartered.
- There was a manual de-choker device near the table that was to be used to help a person if they were choking. However, only five staff had been trained to use this device; four staff had not and neither had agency staff who worked at Norfolk Lodge.
- Management were not aware of the person having choking episodes that required backslaps from staff. This was not recorded in the person's risk assessments, eating guidelines or the person's care plan. We requested that the manager and operations manager took urgent action to refer the person for speech and language therapy for review and to ensure that all staff were trained on the de-choker device.
- Risks to people from choking, which had not been appropriately addressed have been found at a number of inspections of others of the provider's services. Learning from those inspections and reports had not been used to ensure consistent improvements to the safety of services to people.
- Since the inspection we have highlighted to the provider that de-choking devices are not currently recommended by the Resuscitation Council (UK). The provider had responded by stating that people with complex presentations may require additional measures due to the risk of injury from measures such as abdominal thrusts and chest compressions. The de-choker devices were implemented as an addition to basic first aid and as a potential alternative treatment for the first responder to use whilst waiting for the Emergency Services to arrive.
- Some health needs were not being supported as fully as possible. People with a learning difficulty can be prone to bowel problems such as constipation. Norfolk Lodge had elimination care plans to help people manage bowel problems. One person was diagnosed with constipation and was prescribed medicines for this. However, there were no bowel charts and daily notes did not track their bowel movements. We discussed with the manager about having a clear elimination care plan that clearly described the symptoms of constipation.
- The lack of appropriate bowel management has been raised at inspections of a number of the provider's other services. Learning from these findings had not been appropriately used to improve constipation care at Norfolk Lodge.

- Other risk assessments did not consider action to keep people safe. One person could refuse their medicines as had happened recently. Although the medicines risk assessment directed staff to go back and try later, it did not give any indication about what steps staff should take if the medicines were refused completely, or what effect this could have on the person's condition. This left the person at risk of health problems if they chose not to have their medicines.
- Staff did not always take sufficient action to keep people safe. One person had suffered a head injury following a fall and was seen by their GP. We spoke to the manager about this incident and the manager confirmed that observations of the person were not carried out after their fall and that the provider's post fall head injury protocol was not followed. The manager confirmed that they did not have a copy of the head injury protocol in the service for staff to follow, meaning that checks of the person were not completed and recorded and staff were unaware of the need to conduct checks as per the provider's policy. The protocol is designed to assist staff in monitoring a person after they have hit their head. It highlights any concerns which may need further medical intervention. As it had not been used after the person's head injury, there had been a risk that any deterioration in the person's condition would not have been picked up.
- The failure to ensure effective risk management, to monitor and analyse incidents and to ensure that suitable actions were taken to make improvements and prevent further occurrences is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

#### Systems and processes to safeguard people from the risk of abuse

- People were not consistently protected from abuse. Following concerns at the provider's other locations any bruising or marks had to be reported to CQC and the local safeguarding adults team. We found that one person had sustained bruises on three separate occasions in September 2018 and they had been recorded on a body map. However, the registered manager had not reported these bruises to CQC or the local safeguarding adults team. We spoke to the operations manager who told us that the bruises had not been reported or picked up in an audit, and should have been reported.
- The failure to report safeguarding concerns as per the provider's policy is a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.
- Other concerns had been reported to the local authority safeguarding team in a timely manner. There had been nine incidents reported by the service and these were being tracked by the manager and management team.
- Staff told us that they understood their responsibilities under safeguarding. One staff told us, "Safeguarding is about putting things in place that protect individuals from different types of abuse. It's keeping people safe that may lack the capacity to express their concerns so we make sure they have a voice."

#### Staffing and recruitment

- Staff were not effectively deployed to meet people's needs. One person was at risk of choking and had a de-choker device that was placed in the service for staff to use to clear the person's airways. However, there were times when no staff trained to use this device were working. For example, on the afternoon of 4 January 2019 no trained staff were working during the evening and night time.
- Staff told us that they felt there were not enough staff. One staff said, "There is a big staff shortage, quite a few people have left." Another staff commented, "We need a few more staff. They have been trying to recruit and I've seen and advert." We checked the dependency tool and the rota and found that there were 122 hours of permanent support per week. The service should provide 280 hours of support per week (not including one to one hours). The shortage of directly employed staff was being met by a mix of bank staff, agency staff and permanent staff overtime. We raised this shortfall with the manager who told us that two night staff had joined and they were completing core training.

- Although this would reduce the shortfall of hours there was still a shortfall. We spoke to the operations manager about this. The operations manager told us, "We are actively recruiting for two day staff to join the night staff. We use bank staff and have found a bank staff who will be joining us to pick up hours."
- There was one incident in December 2018 where a person had not received their medicines at Norfolk Lodge, due to a lack of trained staff being deployed in the service. A manager was instructed to take the medicine to the person's relative and administer it there. An investigation found staff had swapped shifts without management approval so there were no trained staff was on duty as required.
- The service was using agency staff and where possible these would be block booked. However, there were some issues with training such as agency staff not having the correct positive behaviour support training or training around the de-choking device.
- The failure to have enough staff with relevant skills, competence and experience to care for people safely is a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- The manager had followed correct procedure for safe recruitment practices. There were up to date documents on file such as, application forms, interviews notes, references and DBS (Disclosure and Barring Service) status confirmation. The DBS checks help employers make safer recruitment decisions and helps to prevent the employment of staff who may be unsuitable to work with people who use care services.

#### Learning lessons when things go wrong

- Lessons had not consistently been learned. Some incidents had not been reported correctly by staff, such as the person choking requiring backslaps to clear their airways.
- Choking was a risk that we had highlighted in some of the provider's other services, and despite this we found the provider had not managed choking risks at this service.
- Some lessons had been learned and action had been taken to put things right. Since the new management team have been in place they had ensured that any incidents were being reported correctly and learning was being shared with the staff team.
- One person had been experiencing problems at a certain time of the day and the management team had contacted the providers autism lead. The autism lead had worked with the local authority to access specialist help and think about different strategies to help the person manage their anxiety.
- We recommend that the management team continue to actively review incidents and implement any learning across the staff team.

#### Using medicines safely

- People's medicines were ordered on time. One staff member had responsibility for checking and ordering medicines, and was doing this.
- People told us that they received support to take their medicines. One person told us, "I get support with meds. I take it every day, same time."
- Where prescribed medicines had been changed by a GP these changes had been recorded on the medicines sheets and people received the correct dose.
- There was a medicines room used to store people's medicines and these were being managed correctly. Temperatures of the room, and of a fridge used to store some medicines, were being recorded and monitored.
- Staff were trained in medicines and were competency checked.

#### Preventing and controlling infection

- There were infection control audits completed. One staff was the infection control champion who had responsibility for making sure the home was clean and free of infection risks.

- People were involved in the upkeep of their home and the home appeared clean and hygienic.
- Staff had access to protective equipment such as gloves and aprons to use during personal care. During our inspection we saw staff used these when supporting people.
- There was a personal hygiene champion recently appointed who checked notes and ensured they were completed correctly and encouraged people how to clean their teeth more effectively.
- There was a daily cleaning schedule and a weekly cleaning schedule. The home appeared to be clean and tidy.

# Is the service effective?

## Our findings

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

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

When we last inspected the service in August 2018 we found breaches of regulation in relation to assessing people's needs, staff training and obtaining consent. At this inspection we found the breaches for training and consent remained but the breach for assessing people's needs was met.

Staff support: induction, training, skills and experience

- Staff told us that they did not feel they had the training they needed to work effectively with people. One staff commented, "We don't feel that we have the skills to support [person]."
- One person had behaviours that may challenge others, and staff had only received a generic training course. We spoke to the manager about this, who confirmed that specialist training had been booked but not yet attended.
- The operations manager told us that the training did not contain break away techniques that would allow staff to safely remove themselves from a person's grip if this became necessary. The operations manager told us, "If we need the training we will get it as a matter of urgency."
- Some people living at the service had learning disabilities and mental health issues but there was no specialist learning disabilities or mental health training. This was raised as an issue at our last inspection and had not been implemented by the provider at this inspection.
- The failure to provide staff with the training and support they needed to be effective in their roles is a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

- People did not always have capacity assessments in place when these were necessary. Where capacity assessments had been completed, and people were found to lack capacity, there had been no best interest meeting to decide the least restrictive course of action.
- Some people with behaviours that may challenge other people had question marks over their capacity to make decisions in certain areas. However, no capacity assessments had been completed around these

decisions.

- The manager and operations manager told us that they were aware that there was work to be done around compliance with MCA and that it was being included in the action plan to our previous inspection.
- One person had a DoLS granted but this had expired and had not been reapplied for. Any restrictions on the person were therefore unlawful without the proper authority in place. We spoke to the manager about this and were told they were aware of the situation and would reapply.
- The lack of consistent practice with regard to obtaining and documenting consent for care and support is a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Adapting service, design, decoration to meet people's needs

- The building was not being utilised as effectively as it could be. The manager told us about their plans to move the manager's office and laundry from the top floor to the ground floor so they are more accessible to people.
- People living at the service had a range of disabilities. However, there were no adaptations or signs for the visually impaired. For example, there were two steps along a ground floor corridor with a sign at head height warning people about the steps, but there was no hazard tape on the steps for people with poor sight.
- Some areas of the building were in need of redecoration and repair to make it appear more homely. There was evidence of wear around one bath and damp patches on the walls in one bathroom. Walls and skirting boards were cracked and the plaster was blistered. The window ledge was cracked with two rusty nails protruding.
- A carpet was worn and discoloured in the middle floor hallway. One bathroom had a stale odour. We discussed this with the manager who said that the flooring may need to be replaced.
- We recommend that the registered provider implements a decoration and maintenance plan to address the issues with the building.

Supporting people to live healthier lives, access healthcare services and support

- People told us they were able to get help with their health. One person told us, "I felt bad yesterday; felt dizzy, I told [staff] my angel, [staff] knows what to do and makes sure I'm alright".
- People's weights were being recorded with any changes highlighted. People had health care passports that were written in plain language with picture symbols to support them to understand.
- People had access to a range of healthcare professionals. For example, one person had appointments with a dentist, psychiatrist, chiropodist, and optician.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- The service was using nationally recognised, evidence based guidance, to track people's health outcomes, such as Waterlow charts to ensure people's skin was healthy.
- People with behaviours that may challenge others had care plans which highlighted essential information such as people's diagnoses and known triggers for behaviours.
- Staff had been directed to support people in a specific way around key times and tasks with a view to reducing their underlying anxieties. There were techniques identified such as how to communicate with the person when they were upset that had proven successful.
- The provider had brought in a specialist to review behaviour charts and identify triggers so that staff could support the person in a more effective way.

Supporting people to eat and drink enough to maintain a balanced diet

- People told us that there was enough to eat and that they liked the food. One person told us that their meal and dessert was very good. The person had completed a form about food recently and stated that he

food was good, as had other people.

- Nutrition care plans directed staff to ensure that a variety of fresh fruit and vegetables were included in shopping and meals.
- People were encouraged to drink; some people had their own drinks in the kitchen and bottles of squash in their rooms.
- A recent staff meeting had recorded that staff should be offering choices at mealtimes and that mealtimes can be flexible. People were now serving their own meals from serving dishes. This had generated positive feedback from people and staff.

Staff working with other agencies to provide consistent, effective, timely care

- One person recently moved from the service. Staff worked with the local authority to find an appropriate placement to another service.
- The manager worked with the person's care manager to secure funding for the persons' move. Care documents were shared with the new provider and support work was done with a specialist health team.

## Is the service caring?

### Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People did not always feel well-supported, cared for or treated with dignity and respect.

When we last inspected the service in August 2018 we found a breach of regulation in relation to dignity and respect. At this inspection we found that improvements had been made but this breach was not fully met. □ There is more work needed to ensure that all staff are consistently treating people with the dignity they deserve.

Respecting and promoting people's privacy, dignity and independence

- Whilst there was some demonstration of a caring approach and supporting residents when they were upset, a member of staff announced that a person needed the toilet and when they were going to the toilet in a room with other people, staff and visitors in it. This was undignified for the person.
- Two people chose to go to a local café together without any staff support and have a drink. Staff at the café knew to call the service if there were any problems. However, there were no personal goals or aspirations identified and recorded in care plans so no plans to support people to achieve their future goals and further develop their skills. If people had expressed their wishes for the future it had not been recorded in care plans. Staff were supporting people to achieve independence in day to day activities but this had also not been recorded in care plans.

We recommend that the provider reviews people's care plans to reflect their goals.

- People were being supported to achieve greater independence. One person was being supported to complete banking and do shopping with staff support.
- People were serving their own meals at lunchtime. Some people had struggled with this change but were sensitively encouraged to do more and they had responded positively. People showed a sense of pride in handing out a cake to staff to take home with them after they had made the cake themselves.
- The provider's activities specialist had been reviewing what people enjoy. One person loved going to the pub and there were plans underway to support the person to go on their own.

Ensuring people are well treated and supported; equality and diversity

- Although they were kind, staff did not always find ways to communicate with people with characteristics protected under the Equality Act. One person with a disability needed documents in large print. They enjoyed reading stories but no books in large print were provided. Information was not provided in a meaningful way so that people could have more control, for example what activities were on offer each day and who would be supporting them.

We recommend that the provider reviews people's communication needs and the adaptations each person may require.

- People were treated with kindness in their day to day care. We saw examples of caring and sensitive support when people were experiencing emotional problems. One person was very upset and staff knew

what to say and how to act. Staff crouched down when speaking with the person to maintain eye contact and used touch in a safe and caring way to comfort the person.

- People told us they liked their staff and were cared for. One person said, "They look after me, they are good here."
- Staff knew people well and understood the support they needed. One staff told us, "I've sat for a good hour in the morning to just discuss and talk through anxiety, and [person] hasn't run off which they would do. They will now ask to talk to me and some other staff have noticed how I've supported them and are doing the same thing."
- Staff knew how to communicate with people about some equality issues such as sexuality. People were supported to express their sexuality safely. Staff were directed in care plans not to disturb people at night time and to respect their wishes around their stated sexual preferences.
- People had been asked about their spirituality and what support they may require. Some people had asked to be included in preparations for religious celebrations such as Christmas or Easter.

Supporting people to express their views and be involved in making decisions about their care

- People were supported to express their views and be involved in decisions around their care. One person told us, "My keyworker is [name] and I know about my care plan."
- Care plans helped people to state what help they needed from staff for their voice to be heard. One person had asked staff to help them to stay focused by returning the conversation gently to the topic. They had also asked staff to respect their wishes around eye contact whilst talking as this helped them to feel more relaxed.
- One person spoke about moving to a different area. The manager was positive and reminded the person they had a review coming up and they could tell everyone at the review that they wanted to move. The person was reassured and asked what a referral meant. After this support the person said they would ask for extra support for an advocate.
- People were involved in their care as much as they wanted to be. Relatives confirmed that they were invited to reviews, were able to 'have their say', and received copies of review notes.
- People were able to ask for things to be done differently. One person told us, "If I want it done differently I ask the staff."
- Some staff told us that they thought that rotas and practical staffing arrangements could be better organised so that staff had more time to spend with and listen to people, provide information, and involve people more in making decisions. One staff told us, "Some days we have enough staff but it could be broken down in to tasks, so someone doing cleaning. Some days there are 3 staff and that can work well but the job could be broken up so someone could clean and support workers could be there for the service users and give one to one support."

# Is the service responsive?

## Our findings

Responsive – this means we looked for evidence that the service met people's needs.

People's needs were not always met.

When we last inspected the service in August 2018 we found a breach in relation to supporting people in a personalised way. At this inspection we found that the specific issue raised had been resolved. However, we continued to find evidence that people's needs were not always met, so the breach continued.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

- The service understood people's information and communication needs. These were identified recorded and highlighted in people's care plans and shared appropriately with other professionals involved in people's care. However, individuals identified needs were not always being met.
- People with disabilities, or a sensory loss, had communication plans. One plan stated that a person had poor eyesight and wore glasses. However, there were no visual aids seen around the service. There were no large print documents, including the person's care plan and health passport. The person's communication plan stated that they used a magnifying glass to read but staff told us this was not the case.
- The person liked books and staff tried audio books once but this was not successful and was not tried again. However, there were other ways staff could try this, such as with an MP3 player. These options had not been explored.
- The failure to support people in a personalised way, with care that was appropriate to meet their needs, is a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.
- Some documents had been written in a way that would help people with communication problems understand them. The manager had introduced new health passports that used pictures and symbols alongside words to help people understand what was written. Some key policies had been written in easy read format.

Preferences, interests, choice and control

- People had a range of activities and were supported to follow their interests. Some people went horse riding, visiting their families, and going out for meals. One person told us how they visited a café, with another person, without staff support. Staff at the café know the people and would ring the service if there are any issues.
- The manager was working with a specialist to increase the range and effectiveness of people's activities. One staff told us, "We need to get better at evidencing activities. We did coach trips to a museum for one person for example. We were going out a lot, even if it was for a coffee."
- Peoples likes and dislikes were explored in their care plans. Important information about things one person did not like that could cause them to become upset had been explained clearly so staff could support the person in the way they wanted.
- New care plans had recorded people's personal care preferences in a person-centred way. Instructions to staff were written in the first person. Where people were refusing to sign their care plans this was being recorded.

#### Improving care quality in response to complaints or concerns

- Staff told us that they completed a questionnaire with people. They were asked if they were happy with the care, whether they were well supported and if they knew who to go to if they had concerns. People told us they knew how to complain. One person said, "Yeah, I just tell the staff."
- There was an easy read complaints policy in the dining room so that people could be supported to let staff know if something was wrong.
- There was a complaints policy that was in date and there had been no complaints in the previous 12 months.

#### End of life care and support

- There was nobody receiving end of life care at Norfolk Lodge.
- One person had been asked to complete a short plan about their wishes and they had recorded that they did not want to discuss it or be asked about it again.
- One person had a funeral plan. The manager told us that nobody else wanted to talk about end of life. The management team were raising the issue with people and their relatives at the next round of reviews.
- The manager told us, "There are resources: end of life planning books. We have end of life plans for people to complete when they are ready."

# Is the service well-led?

## Our findings

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

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

When we last inspected the service in August 2018 we found a breach of regulation in relation to auditing the quality of the service. At this inspection we found that the breach remained. We also found a breach of the registration regulations in relation to notifying CQC about significant incidents.

### Continuous learning and improving care

- At our previous inspection we had identified seven breaches of regulation and at this inspection we found that six of these breaches remained.
- We found people still did not consistently receive personalised care. We found people's consent was still not being obtained before decisions were made on their behalf. We found that people were still not safe from risks. We found safeguarding people from abuse could still be improved. We found audits and management checks were still not effective, and we found staffing issues were still not put right.
- Although the new management team had identified areas for improvement, these had not been enacted sufficiently at this inspection
- Quality audits had not been effective in highlighting all shortfalls in the service. For example, we found issues with bruises that had not been reported correctly in September 2018. These had not been reported at the time. They had then been missed when the provider reviewed incidents.
- Other shortfalls that we identified at this inspection, such as risk assessments not containing adequate control measures and mental capacity assessments not being completed correctly, had not been put right by quality audit systems.
- Concerns about choking and bowel management had been highlighted to the provider on a number of occasions at others of their services. This information had not been properly shared or used to improve safety and care at Norfolk Lodge.

The failure to assess, monitor and improve the quality and safety of services, to mitigate risks, and to maintain accurate records, is a continued Breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

- There was a new quality audit system in place. The operations manager explained that following our last inspection the management team had raised their expectations.
- The provider conducted a quality audit in November 2018 which showed a poor rating. An action plan was drafted and the management team are reviewing this every month to try and implement the necessary changes. The manager told us, "We focused on reporting of incidents. This was a big lesson we need to improve on. This is a new quality tool we started in January, and are putting in place a complete service improvement plan."

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Some notifications had not been submitted to CQC for bruising to one person in September 2018, in line with the provider's policy.

The failure to ensure that the Care Quality Commission had been notified without delay of significant incidents is a breach of the Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

- There was not a registered manager in post. It is a requirement of the provider's registration for a registered manager to be in post. The previous manager had left the service in January 2019 and had not de-registered with CQC. The provider had based a peripatetic manager at the service to oversee day to day management whilst there was no registered manager. We spoke to the operations manager about how the provider was going to recruit to the role. The operations manager told us, "We are advertising at moment and have gone out to agencies to recruit. Interviews are planned for the beginning of February. I am going to bring in a deputy manager from another service to oversee Norfolk Lodge whilst a new manager is being recruited."
- The manager felt supported by the provider. They told us, "The operations manager is on the end of the phone and I am line managed by our acting CEO. I am able to call on behavioural specialist and activities specialist and I have contact with other managers if I am stuck with anything."

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility

- The manager kept the day to day culture under review and was an active presence in the service. People and staff told us they liked the management team and could go to them if they needed to.
- The manager got feedback from people and from making observations of staff. They had brought in an activities and behaviour specialist to work with people in relation to observations made. The manager completed a walk around check of the service. They told us, "I am here for handovers in the morning to get handovers from the night staff, otherwise they can get isolated." The manager will be based at the service until a registered manager is recruited.
- The manager told us they supported staff to feel valued through regular supervision, regular staff meetings, and discussions daily. Staff told us they could approach the manager discuss any concerns. One staff told us, "The manager has been very helpful since she has come in and really supportive and brought lots in. We didn't seem to have the right support, like psychologist and behaviour support before."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People and staff were involved in developing the service. There were regular resident's meetings where things like meals and outings were discussed. Any redecoration is done with involving people choosing in colours.
- The manager was working with staff to support them in supervision to question practice and raise concerns. There was a whistle blowing policy to protect people who may want to come forward.
- People were supported to maintain good communication with friends and relatives. People's relationships were maintained, such as one person who is supported to see a particular family member. One person received emotional support with relationships another person had emotional support with their spouse and a third person had support with a close relative with health issues.

Working in partnership with others

- The manager had been working closely with the local safeguarding team. There was a good relationship

with the mental health team and a case worker had been working with the service.

- There were different healthcare professionals involved with the service including, a chiropodist, psychiatrist, and advocate.
- Information was being shared appropriately and safely. The service had secure systems and could send information using encrypted messages.