SHC Clemsfold Group Limited

Norfolk Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place over two days on 28 and 29 August 2018 and was unannounced.

Services operated by the provider had been subject to a period of increased monitoring and support by 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 been made. We used the information of concern raised by partner agencies to plan what areas we would inspect and to judge the safety and quality of the service at the time of the inspection. Between May 2017 and July 2018, we have inspected a number of Sussex Health Care locations in relation to concerns about variation in quality and safety across their services and will report on what we find.

Norfolk Lodge is a "care home". People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

Norfolk Lodge is registered to provide care and support for up to eight people with learning difficulties, older people and younger adults. At the time of the inspection there were six people living permanently at the home and one person staying there for respite care. The home is a converted house in the centre of Horsham. The house has an accessible garden and the local shops, park and theatre are nearby.

At the last inspection on 19 September 2016 we rated the home as Good overall. At this inspection on 28 and 29 August 2018 we rated the service as Inadequate in Safe and identified breaches of seven regulations and other areas of practice that needed to improve. Breaches included, failures to keep people safe from abuse, failures to identify and manage risks effectively, failure to maintain sufficient numbers of suitable staff, failures in providing appropriate care to meet people's needs, failure to protect people's dignity and to obtain consent, and failures in management systems to identify shortfalls. The overall rating for the home is now requires improvement.

Systems for recording incidents and raising safeguarding alerts were not operating consistently. Some records included details of incidents that had resulted in physical and psychological ill-treatment of people living at the home. These incidents had not always been identified and reported as potential safeguarding incidents.

Risks had not always been assessed, reviewed and managed to ensure that people were protected from harm and abuse. Systems for identifying trends and patterns had not been effective in identifying and managing risks. Staff did not all have the training and skills they needed to care for people safely and there were not always enough staff on duty to support people when incidents occurred.

Assessments and care plans were not sufficiently personalised and detailed to guide staff in how to provide appropriate care that met people's needs. Care plans had not been developed in line with current best

practice for supporting people with behaviour that could be challenging.

People were not always given the support they needed to protect their dignity.

Management systems and processes had failed to identify the shortfalls in practice that we found. The quality and safety of the service was not effectively monitored, risks were not being assessed, and managed and records were not complete and accurate. This meant that systems were not effective in supporting management oversight at the home.

Staff had received training in the Mental Capacity Act and understood the principles. However, practice was inconsistent with regard to obtaining consent from people and for identifying the least restrictive options for supporting people to be safe.

The registered manager was aware of their responsibilities under the Accessible Information Standard, however there was inconsistent practice with regard to ensuring that people's individual communication needs were met.

Staff had not all received the training they needed to be effective in their roles. The registered manager took action to ensure that staff were booked onto relevant training as soon as possible.

People told us that they liked living at the home and described positive relationships with staff members. Staff knew people well and people appeared to be comfortable and happy with staff. They told us the staff were kind and caring, one person described a staff member as "My angel."

People were supported to have enough to eat and drink and told us that they enjoyed the food on offer. People were able to access the health care services that they needed and staff supported them to attend appointments. Staff described positive working relationships with a range of health care professionals who were involved in people's care and support.

People were receiving their medicines safely. Infection control arrangements ensured that people were protected from infections. People were able to access the local community facilities regularly and were supported to be as independent as possible. Staff supported people to maintain relationships that were important to them. People and their relatives were confident that any concerns or complaints they had would be listened to and resolved.

There was a clear management structure and staff were clear about their roles and responsibilities. People, their relatives and staff spoke highly of the registered manager. The model and scale of the home are in keeping with the principles of Registering the Right Support. The home is small and provides a homely environment. People have access to local amenities and were supported to participate in the community. People were able to use local health and social care services and staff supported people to be independent.

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.

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.

People were not always safeguarded from abuse.

Risks to people were not always assessed and managed effectively. There were not always enough suitably trained staff to care for people safely.

Medicines were managed safely. The home was clean and people were protected from risks of infection.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Care, treatment and support was not always planned and delivered in line with best practice to meet people's needs in a personalised way.

Staff did not always have the training they needed to support people's individual needs.

Consent to care and support was not obtained and documented in a consistent way.

People were supported to have enough to eat and drink and they were supported to access health care services.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's dignity was not always promoted and protected.

People were supported to express their views and to be involved with decisions about their care and support.

People were able to be as independent as they could and staff treated people with kindness.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were not always supported with their communication needs in a consistent and personalised way.

People were supported to follow their interests and to maintain contact with people who were important to them.

There was an effective complaints system in place.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Management systems were not always effective in identifying shortfalls in the quality of the service.

Risks were not always identified and managed effectively and records were not complete and accurate.

There was a clear management structure and staff understood their roles.

Staff supported positive connections within the local community.

Norfolk Lodge

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 took place on 28 and 29 August 2018 and was unannounced. On the first day of the inspection the inspection team consisted of 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. On this occasion the expert by experience had personal experience of caring for people with learning disabilities. The second day of the inspection was attended by two inspectors.

Prior to the inspection we reviewed the information we held about Norfolk Lodge. This included information from other agencies, any complaints, concerns or feedback received and statutory notifications sent to us by the manager about events that had occurred at the service. A notification is information about important events which the provider is required to tell us about by law. Before the inspection the provider had submitted a Provider Information Return (PIR). 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 used all this information to decide which areas to focus on during our inspection.

During our inspection we spoke with five people and two relatives by telephone. We spoke with five members of staff, the Registered Manager and the Regional Operations Director. We observed staff interactions with people. We reviewed a range of records about people's care and how the service was managed. These included the care records for five people, medicine administration record (MAR) sheets, seven staff training, support and employment records, quality assurance audits, incident reports and records relating to the management of the service.

The service was last inspected on the 19 September 2016 and was awarded the rating of Good overall.

Inadequate

Is the service safe?

Our findings

People were not always safeguarded from abuse and improper treatment. . An incident was witnessed by inspectors when a person was leaving the home to go out. The incident involved both physical and psychological abuse and resulted in harm to the person. The registered manager confirmed that particular circumstances were a known trigger for the person's behaviour which led to the incident. Staff told us that there had been other incidents previously. A staff member said, "It's not unusual," another staff member told us, "Yes, that has happened before." Records confirmed that similar incidents had occurred previously. The registered manager said, and a social care professional confirmed, that previous incidents had been less serious in nature. The person's care plan had been adjusted following a similar incident but guidance for staff did not provide a clear strategy for managing the identified risks to ensure that the person was protected from abuse. This meant that there had been a failure in the provider's systems to ensure that people were safeguarded from the risk of further harm or abuse.

The provider's systems were not always operated effectively to identify, investigate and prevent abuse. There was a lack of consistency in how incidents were recorded and reported. For example, staff had identified and recorded injuries that could indicate that physical abuse had taken place. However there had been a lack of consistency in reporting all such injuries in line with local safeguarding arrangements. Staff had received training in safeguarding people and told us that that they understood their responsibility to report any concerns. Some incidents had been notified as safeguarding alerts to the local authority. However, the lack of consistent practice in this area meant that potential safeguarding incidents had not always been escalated and investigated in line with safeguarding procedures and local practice. Some people had behaviour that could be challenging to others. Staff had completed charts to monitor, assess and review incidents and recorded details within people's daily care records. Some records included details of incidents that had resulted in physical and psychological ill-treatment of people living at the home. These incidents had not always been identified, reported and responded to as potential safeguarding incidents. This meant that the provider could not be assured that people were always protected from abuse and improper treatment.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We discussed these concerns with the Registered Manager and the Regional Operations Director and following the inspection we raised safeguarding alerts with the local authority with regard to specific incidents that we had identified.

Risks to people were not always identified, assessed and managed effectively to keep people safe. People living at the home had learning difficulties and some people needed support with behaviour that could be physically and or verbally challenging to others. Some risks had been identified and assessed but there was a lack of detail to guide staff in how to assist people in a personalised way. For example, one risk assessment identified that a person had behaviours that could be physically challenging to others. There was some guidance for staff but a lack of detailed step-by-step strategies for staff to follow. Another risk assessment identified risks of verbal behaviour that could be threatening towards others but there was no guidance for staff in how to respond to such behaviour. A third risk assessment identified how a person needed support

with personal care but could use aggressive behaviour towards staff who supported them. There was a lack of functional assessment to identify why the behaviour might be happening and no clear step-by-step guidance for staff in how best to support the person. The lack of personalised, clear guidance for staff meant that risks to people were not always being mitigated and managed effectively. This meant that some people had continued to experience incidents that were verbally and physically threatening. People who needed support with behaviour that could be challenging were not receiving the help they needed to prevent such incidents from happening.

The provider had a system in place for recording incidents, accidents and untoward events. Some incidents had been recorded and reports were detailed and included the actions taken such as reporting incidents to the local authority under safeguarding arrangements. However, not all incidents had been recorded and reported in this way. Staff had recorded some incidents within people's daily records and within monitoring charts. There was inconsistent practice in identifying when such incidents should be escalated through the provider's reporting systems. This meant that incidents were not always escalated in an appropriate way to ensure that there was proper scrutiny of risk management and that lessons were learned and improvements made when things went wrong. For example, incidents involving physical and verbal altercations between people were not always fully reported, investigated and reviewed to ensure that risks to people were being effectively managed. This meant that people were not assured that they were always safe at the home. Whilst some people told us that they did feel safe at the home this was not consistent for every person. Our observations during the inspection confirmed that sometimes people did not feel safe. One person was present when an incident was taking place near them. They appeared to be shaken and frightened and asked for support saying, "Please don't leave me, please talk to me."

There was a lack of effective risk management, inconsistent monitoring and analysis of incidents and a failure to ensure that suitable actions were taken to make improvements and prevent further occurrences. This was identified as a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

There were not always enough, suitable staff on duty to keep people safe. During the inspection we noted that some people needed support from more than one staff member at times, for example when people needed support with behaviour that could be challenging. We observed that when more than one person presented this type of behaviour at the same time, and required support, staff were not able to continue to support the other people at the home. Some people were visibly upset by an incident, however they were not receiving emotional support from staff because they were occupied supporting other people. One person was upset by the noise from an incident, staff told us that noise was a known trigger for this person. Staff were not able to support this person as they were occupied with another incident. This meant that there were not always enough staff to respond to emergencies or incidents and ensure that people received care safely. We discussed our concerns with the registered manager and the regional operations director, who agreed that following the incident we had witnessed, staffing levels would be increased immediately to ensure that people's safety was maintained.

Staff did not always have the skills and experience they needed to care for people safely. Not all staff had completed training in supporting people with behaviour that could be challenging. We discussed this with the registered manager who told us they had a clear understanding of good practice and techniques for supporting people with behaviour that could be challenging. They said that staff had received relevant training through the provider's training academy. Records showed that 6 out of 15 staff had completed training in how to support people who had behaviour that could be challenging within the last two years. The registered manager and one other staff member that we spoke with had completed this training. Agency staff were used on a regular basis and the registered manager had received a profile from the agency

showing the recruitment checks that had been completed and providing training details. None of the agency profiles that we looked at included training in supporting people with behaviour that could be challenging, such as Positive Behaviour Support training.

Staff we spoke with did not demonstrate a clear understanding of de-escalation techniques or positive behavioural support methods. When asked about how they would support someone who had behaviour that could be challenging, one staff member said, "We give them space," another said, "We tell them to calm down. "A third staff member said, "I would call for help." One staff member told us about how they would support people by diffusing the situation, they said, "There's no training to help because a lot of the time it is common sense, like working with children." This showed that there was an inconsistent approach to supporting people with incidents of behaviour that could be challenging. This was not in line with best practice and showed that staff did not have the training and skills they needed to support people safely.

The rota showed that there were regular occasions when none of the staff on duty had been trained in techniques for supporting people with behaviour that could be challenging, including the person in charge. Care plans did not provide detail and analysis of behaviour and the possible reasons for it. There was a lack of clear, step by step guidance for staff in how to support people. This meant that people were at risk of not receiving the support they needed with behaviour that could be challenging. We observed that failing to respond appropriately to one person's behavioural needs led to an incident of harm.

The registered manager said that staffing levels were adjusted when respite care was being provided to ensure that people received the support they needed. However, staff told us that there were not always enough staff on duty. Care plans identified regular activities that required one to one support. A staff member explained that one to one support had to be planned in advance, for example to support people to attend planned appointments or to go out. However, they told us that staffing levels did not always allow this to happen. One staff member told us, "When there are two staff on we have to say no if someone wants us to go shopping with them. This has been going on for some time now." During the inspection one person told us they wanted to go out but they needed support from a staff member. We heard staff discussing this and deciding that they could not go until later as it would mean there were not enough staff left at the home to care for people.

The provider used a tool to calculate how many staff were needed. Records of staff rota's confirmed that the staffing level had been consistently maintained and agency workers were used to cover any vacancies. However, the staffing levels were not always adequate to support the needs of people safely. There were not always enough staff with relevant skills, competence and experience to care for people safely. This was identified as a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that staff supported them with their prescribed medicines. One person said the staff, "Makes sure I get them everyday.' Another person told us that a staff member had explained what their medicines were for. People's medicines were stored and managed safely. Staff had received training in how to administer medicines and systems were in place to check that they remained competent. Some people were prescribed medicines as required (PRN) and protocols were in place to guide staff in when these medicines should be offered. Audits of medicine administration were undertaken each month and any concerns were identified and addressed through this process.

Environmental risks were managed effectively. A fire risk assessment had been completed and regular checks were maintained to ensure systems were working properly. Fire drills were recorded regularly and people living at the home had taken part. Infection control procedures were in place and ensured that the

environment remained hygienic, for example, regular checks were made to maintain the cleanliness of people's bedrooms. Audits had identified improvements that were needed to the fabric of the building and the registered manager told us that plans were in place to replace worn floor coverings and to repaint the hand rails on the stairs.

Staff were consistently recruited through an effective recruitment process that ensured they were safe to work with people. Appropriate checks had been completed prior to staff starting work which included checks through the Disclosure and Barring Service (DBS). These checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. Staff had obtained proof of identity, employment references and employment histories. We saw evidence that staff had been interviewed following the submission of a completed application form.

Requires Improvement

Is the service effective?

Our findings

Initial assessments were carried out prior to people coming to live at the home to ensure that the provider could meet their needs. Assessments had been completed that considered people's physical health, mental health and their social needs. People's needs and choices were included within the assessment process however care and support was not always planned and delivered effectively and did not always reflect current evidence based guidance. For example, current best practice approaches to supporting people with behaviours that may challenge, such as Positive Behaviour Support (PBS) advocates considering all aspects of a persons' physiological, psychological and social needs. PBS is a person-centred approach to support people with a learning disability and/or autistic people, who display, or who are at risk of displaying, behaviours which challenge. It involves understanding the reasons for the behaviour and considering the person as a whole, including their life history, physical health and emotional needs. This information is then used to deliver effective support that prevents rather than reacts to challenging behaviour. Care plans and risk assessments had not been developed in line with current best practice and did not include the detail and depth of analysis needed.

People's needs had not been fully assessed to include detailed functional analysis of the person and their behaviour. Although possible triggers for some behaviours had been identified the rationale behind preventative strategies was not always clear and did not identify clear step-by -step interventions that staff should adopt to support the person. For example, care plans for supporting people with their behaviour described the types of behaviour that they might display and listed possible triggers that might lead to these behaviours. However, guidance for staff lacked detail, one care plan described how a person needed support to be calm but was not specific about how to achieve this. There was no detail about the approach to take, the language to use, any communication tools that might help, known strategies that might help to distract or reassure the person and what to do if they did not respond and their behaviour escalated.

Care plans and risk assessments did not identify effective preventative strategies and ongoing support styles that might avoid the behaviour from occurring. Staff told us that incidents of behaviour that could be challenging occurred regularly and they accepted this as the norm. They spoke about some people being threatening towards staff and other people living at the home. We asked staff how they supported people when such incidents occurred. One staff member described giving people space, offering PRN medicines, making sure they were in between people to avoid altercations. Another staff member said they would try and diffuse the situation by staying calm and talking to the person. A third staff member told us that they were not clear about what they should do. Their comment was, "I don't know the best thing to do, like do you talk to them when they are agitated or not?" Staff did not describe clear and consistent strategies, step by step approaches, or planned interventions. Lack of clear and consistent assessments and care plans increased the risk that people would not receive the support and care they needed.

The failure to ensure that assessments of people's needs and subsequent support was appropriate, met their needs and reflected their preferences is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staff did not always have the right competence, knowledge and skills to carry out their roles. All the people living at the home had a learning disability but not all staff had completed learning disability training. One staff member said, "Some of the staff don't understand that people need to stick to their routines, more training in learning disabilities is needed for staff to have a better understanding." Some people used Makaton to communicate. Makaton is a type of sign language that uses, signs, symbols and the spoken word to help people to communicate. Records showed that a third of the staff had completed Makaton training. One staff member spoke about how frustrating it had been for one person when staff did not understand Makaton and they had struggled to communicate effectively.

Some people were living with severe and enduring mental health problems. Seven staff had attended mental health training however staff told us that it was generic training that was not tailored to the specific needs to the person they were supporting. One staff member said, "People have different traits and personalities, the training wasn't tailored to the needs of the person we look after." Another staff member said that having generic training had been useful because, "Sometimes we don't know what to do when the person's mood changes. They need a lot of reassurance." They told us that having some training had helped. A staff member who had not received this training told us that they had obtained information about the person's mental health condition by using the internet. This meant that not all the staff had received appropriate training in how to consistently support the person with their mental health needs. Lack of clear guidance in care plans meant that staff did not have the information they needed to provide effective care and there was a risk that the person would not be supported to manage their symptoms.

The registered manager told us that training in methods for supporting people with behaviour that could be challenging was provided. Six staff members had attended this training. During the inspection the registered manager took action to book the remaining staff onto this training. However, staff were not providing support in line with best practice and this showed that the training had not been effective. For example, staff were not aware of the importance of providing a consistent approach when supporting people with complex behavioural needs. They described a reactive approach that did not provide clear consistent strategies to avoid behaviour that could be challenging. Care plans did not provide the detail that was needed to guide staff. This meant that people were not receiving the support they needed in line with best practice.

Training records showed that a range of training was available to staff and that new staff members completed an induction programme. However not all staff had completed training that was relevant to the needs of people they were looking after. We discussed this with the registered manager and the Regional Operations Director and identified this as an area of practice that requires improvement. Staff had not received the training and support they needed to be effective in their roles. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, the registered manager has provided further information showing that all staff have now been booked to attend future training in relevant subjects with the provider's Training Academy. Staff told us they felt well supported and records showed that staff had attended supervision meetings regularly.

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 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 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 or authorisations to deprive a person of their liberty were being met.

We found that there was inconsistent practice and understanding with regard to obtaining consent, MCA and DoLS. Staff had received training in the MCA and DoLS and were able to describe the principles of the legislation and their responsibilities with regard to obtaining consent from people. Some care plans had been signed by people who had capacity to consent to their care and treatment. Staff were observed to be checking with people before supporting them.

Some care plans included risk management strategies that potentially imposed restrictions on people. For example, one person was usually able to go out independently. However, a risk management plan identified additional restrictions including close supervision. This was in place to keep the person safe at times when there was an increased risk to their safety, such as after dark. There had been a failure to obtain consent for these strategies or to identify other less restrictive options to support the person's safety. We discussed this with the registered manager who told us that the person had fluctuating capacity and the restrictions were only needed at certain times. However, there had not been a mental capacity assessment to confirm that they had fluctuating capacity and the process for making a decision in the person's best interest had not been documented. This showed that there was inconsistent practice and understanding with regard to obtaining consent for care and treatment.

Where people were unable to make decisions for themselves staff had considered the person's capacity under the MCA. Referrals had been made for Deprivation of Liberty Safeguards (DoLS) and DoLS authorisations had been granted for some people, staff knew this and were aware of their responsibility to comply with these authorisations when providing care. For example, a DoLS authorisation had been agreed for one person with a condition that the provider arrange for their medicine to be reviewed with the GP. Records confirmed that the Registered Manager had complied with this condition. However, some DoLS applications had not been granted because assessments had shown the person did not lack capacity. Despite this, the registered manager had submitted further DoLS applications for these people. This showed that there was inconsistent understanding about when a DoLS application was appropriate.

The lack of consistent practice with regard to obtaining and documenting consent for care and support was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People and their relatives spoke positively about the staff. One person told us, "They are wonderful." A relative told us that staff were effective in communicating with their relation, they said, "I think the staff do a good job." Another relative said, "There's the occasional issue with agency staff, but on the whole it's ok." Staff reported that communication was effective at the home and there were systems in place to ensure this. Staff told us that they worked together well, one staff member said, "We are a good team." Another staff member described the value of having a staff handover meeting twice a day to ensure important information was passed on. The registered manager described positive working relationships with other agencies including social workers, mental health professionals and the GP.

People were supported to have enough to eat and drink. They told us they were happy with the food on offer. One person said, "It's very good, you have a choice everyday." Another person said, "You can have an alternative if you want it." The food looked appetising and portions were generous. Staff checked if people were enjoying the food. People told us, and we observed, that people were able to make a drink themselves or with support from staff when they wanted one. Risks associated with nutrition and hydration were assessed. For example, one person was at risk of malnutrition and staff monitored their weight regularly to

ensure they maintained a safe weight. Another person had swallowing difficulties and had been referred to a Speech and Language Therapist (SALT). Their care plan included advice from the SALT about the assistance they needed and there was clear guidance for staff about how to support the person. People were able to choose where they had their meals and staff told us that they implemented a protected meal time policy to ensure that people were able to eat their meals without distractions.

People's health care needs were assessed and care plans were in place to guide staff in the support they needed. For example, one person had a history of epilepsy and there were clear guidelines for staff to follow if they were to have a seizure. Staff demonstrated awareness of people's individual health needs. Records showed that staff monitored people's health needs effectively. People and their relatives told us that they had support to access the health care services they needed. One person said, "I see the chiropodist and the dentist and the optician sometimes." People's relatives told us that staff supported people with their appointments. One relative said, "They were concerned about weight loss and brought the SALT team in." Records confirmed that people had involvement from a range of health care professionals.

The premises was made up of two houses converted into one building. The premises was suitable to meet people's needs. People who were able to move around independently or with support, and people told us that they could access the garden when they wanted to. We observed that people were spending time in the garden and moved around the home freely during the inspection. Adaptations had been included to meet people's needs. For example, hand rails had been fitted to support people's mobility. Some signs were provided in an easy read format to make the information accessible for people with learning difficulties. Staff told us that people had been included in choosing colour schemes around the home and for planned improvements.

Requires Improvement

Is the service caring?

Our findings

People told us that staff were kind and caring. One person said, "They are great," another said, "I get along with them all." A third person referred to a member of staff as an angel, saying "She's very caring." A relative told us that staff were kind and said, "It's the little things, they make her a cup of tea and that's nice." Another relative said, "They do a really good job." They described their relative as being, "Well-looked after and happy." However, despite these positive comments we found areas of practice that required improvement.

People were not always supported to maintain their dignity. We observed the lunchtime meal and noted that one person was having difficulty with keeping food in their mouth. Their care plan had clear guidance for staff in the support that was needed at meal times. This included being positioned close to the table and prompted to sit up straight to prevent food falling. Staff did not check the position of the person and did not remind them to sit up straight. Food continued to drop from the person's mouth onto their clothes protector, the table, floor and into their drink. This did not protect the person's dignity at the meal table.

Another person told us they were going out into the town. They were dressed in clothes of their choice but there was a hole in their trousers exposing their underwear. Staff appeared not to have noticed this and it was only when the inspector pointed this out to a staff member that they offered to support the person to change their clothes so their dignity was protected. A person needed support with wiping secretions from their mouth, a staff member noticed and prompted the person to wipe their mouth but when they were not successful the staff member did not offer further support. On two further occasions during the inspection it was noted that staff did not support this person to wipe their mouth and this had a negative impact upon their appearance, their dignity. Failing to support people to maintain their dignity and to treat them with respect is a Breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Some people had communication difficulties and used Makaton signs and symbols to help them with communication. We noted that some signs around the home had been produced in an easy to read format with symbols to support people to understand. However, this was not consistent, for example, the menu in the dining room was written on a white board but there were no symbols, pictures or photos to support people with communication difficulties. The notes from resident's meetings were not in an easy to read format and this meant that some people would not find them accessible. This is an area of practice that needs to improve.

People's privacy and confidentiality were respected. Staff knocked on people's doors before entering and we saw that people were able to spend time on their own if they wished. Care records were kept securely to protect people's personal information.

Staff knew the people they were supporting well and were able to tell us about their needs, preferences and backgrounds. A key worker system was in place, which enabled people to have a named member of staff to take a lead and special interest in the care and support of the person. One staff member described how they supported a person to shop for clothes as part of their key working role. Another staff member said they

enjoyed spending individual time with the person they were key working and described activities that the person enjoyed.

People's differences were acknowledged and respected. People were able to maintain their identity, they wore clothes of their choice and their rooms were decorated as they wished, with personal belongings and items that were important to them. One relative told us how staff had supported their relation to be involved and choose the colour scheme for their bedroom which had been redecorated. They described how staff had worked with the person at their own pace to implement the changes.

Staff told us that people were supported to make decisions about their care and support. One staff member described offering choices to people such as what they would like to wear, what food they would like to eat and activities that they wanted to do. People's relatives said they were included in planning people's care and support. One relative said, "The staff always phone me." Another relative told us they were invited to attend meetings to review their relation's care and support. Notes from resident's meetings showed that people were encouraged to be involved in making decisions about the home including adjusting the menu and discussing trips and activities.

We observed positive interactions between staff and people. We observed staff offering support and acknowledging one person's feelings when they described feeling sad. The staff member was kind and offered appropriate reassurance to the person. Another staff member was supporting someone to make a cup of tea and we saw that the person was relaxed and appeared happy in their company, chatting and making plans with the staff member.

People told us they were able to be as independent as they could be. We noted that some people were able to access the local town and facilities and did so independently during the inspection. One person said, "I can go out every day." Another person told us they enjoyed going to the local café for a drink and cake independently and a third person said, "I go to church on my own." One person told us they could make snacks for themselves if they wanted to. Another said that they enjoyed doing their washing up and liked to do their housework. A relative confirmed that their relation had independence saying, "Yes they enjoy going to the coffee shop so they have got a bit of independence."

Requires Improvement

Is the service responsive?

Our findings

At the last inspection on 19 September 2016 we found that people were not receiving a service that was consistently responsive. This was because the support people received was not always accurately recorded. This put people at risk of receiving inconsistent care and support. At this inspection it continued that care records did not contain all the information that staff needed to care for people in a person-centred way.

People's needs and choices had been assessed in a holistic way to take account of people's physical and mental health and their social needs. Care plans included details of people's diverse needs such as their sexual preference, religious beliefs and disabilities. However, care plans were not consistently personalised. For example, some people had complex needs including behaviours that could be challenging to others. Care plans were not detailed and personalised to guide staff in how to support people in a responsive way.

From 1 August 2016, all providers of NHS care and publicly-funded adult social care must follow the Accessible Information Standard (AIS) in full, in line with section 250 of the Health and Social Care Act 2012. Services must identify record, flag, share and meet people's information and communication needs. People's communication needs had been assessed and identified together with tools that people needed to help them to communicate. For example, one person needed support with communication, their care plan identified that they used key words when talking to people and guided staff to use these words but did not state what the key words were. Another person needed information to be provided in an easy to read format, a third person used picture cards and Makaton signs and symbols. Although people's care plans identified this information their care records were not provided in these formats to make them accessible. This meant that people were not fully involved in planning their care and support. We observed that staff were not using picture cards or Makaton symbols with people, even though this was identified in their care plans, and not all staff had been trained to use Makaton signs. This meant that people were not being supported with their communication and information needs in a consistently personalised way.

The continued failure to support people in a personalised way, with care that was appropriate to meet their needs, is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

CQC's Registering the Right Support (RRS) and other best practice guidance, describes how people with learning disabilities and /or autism are as entitled to live an ordinary life as any other citizen. The values underpinning this policy include offering people choices, promoting independence and inclusion within the local community. Although Norfolk Lodge was registered before this guidance was published the model and scale of the home are in keeping with the RRS principles. The home is small and provides a homely environment. People have access to local amenities and were supported to participate in the community. People were able to use local health and social care services and staff supported people to be independent.

People's interests and hobbies were noted within their care plans and people told us that they were often able to access community facilities independently. Some people were not always able to access the community without staff support to accompany them. Staff told us that outings were planned to ensure people were supported to follow their interests. One person said, "I go to a club regularly that I enjoy."

Records confirmed that people were regularly going out. People were supported to maintain relationships that were important to them. For example, one person told us that staff helped them to buy Christmas and birthday presents for their loved-ones. Another person said that staff helped them to contact their relative on a regular basis to keep in touch.

Staff gave us examples of how they had provided support to meet the diverse needs of people using the service including those related to disability, faith and sexual orientation. These needs were recorded in care plans and all staff we spoke with knew the needs of each person.

At the last inspection on 19 September 2016 we found that the complaints procedure was not in a format that was accessible to all the people at the home and identified this as an area that needed to improve. At this inspection we found that the complaints procedure had been produced in an easy to read format to make it more accessible. People said they would feel comfortable to raise any complaints or concerns. One person said, "I don't think I have made a complaint but I think they would listen." A relative told us that had made a complaint previously and that the issue had been resolved. The provider had a clear complaints procedure and complaints were recorded together with actions taken to address the concerns. No complaints had been received in recent months.

Requires Improvement

Is the service well-led?

Our findings

People and their relatives spoke well of the registered manager and staff at the home. One person said, "She (registered manager) is very nice and all the staff are nice too." Another person said, "They look after me well here." Relatives told us, "The staff keep me abreast of things," and "On the whole, it's well managed." However, despite these positive comments we found some areas of practice that were not consistently well-led.

Management systems were not always effective in providing oversight and governance. For example, management systems had not identified inconsistent practice in recording and reporting safeguarding incidents. This meant that records were not accurate and complete and that risks to people were not being effectively monitored. Indications of abuse were not reported and had therefore not been investigated. Trends and patterns had not been identified and actions were not taken to manage emerging risks. This meant that people were put at risk of harm and abuse.

Where risks had been identified, actions had not always been taken to mitigate risks effectively. For example, the registered manager had recognised that the service was not able to meet the needs of one person and had communicated this to the local authority. However, they had not made adjustments to staffing levels to ensure that risks were effectively managed. This had put people at risk of harm.

Quality assurance procedures had not identified that care was not always delivered in line with care plans. For example, although care plans clearly described people's communication needs information was not provided in the formats that people needed.

A system was in place to monitor and plan staff training. Records indicated that not all staff had completed training that was relevant to the needs of people who were living at the home, including supporting people with behaviour that could be challenging, Makaton and learning disability training. This had not been identified through the provider's monitoring system. The registered manager took immediate steps to ensure that staff were booked onto relevant courses and since the inspection we have received confirmation of dates in the near future for staff to attend. The registered provider had not monitored the effectiveness of training for staff which meant that staff did not always provide safe or effective care.

Audits were undertaken regularly and some shortfalls had been identified through this process. We could see that some actions had been taken or were planned, for example, a health and safety audit had identified certain areas of the home that needed to be painted and the registered manager told us that a refurbishment plan was in place. However, not all quality assurance processes were effective in identifying shortfalls. The Regional Operations Director made regular visits to the home and completed a monthly report on behalf of the provider. The most recent report, dated 13 August 2018, had not identified the shortfalls that we have found during this inspection.

Failures in systems to assess, monitor and improve the quality and safety of services, to mitigate risks, and to maintain accurate records, is a Breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated

Activities) 2014.

There was a clear management structure with identified leadership roles. Staff demonstrated an understanding of their roles and responsibilities. Staff described positive leadership and told us that the registered manager was, "Very approachable, if ever I'm unsure I speak to her." Another staff member said the registered manager was, "Good with the service users, she manages people very well." The registered manager had oversight of supervision meetings and had ensured that staff received the support they needed. Staff meetings were held regularly and staff were asked to contribute to the agenda. Staff told us that felt included in developments at the home. One staff member said, "We are a good team, staff do step-up and go above and beyond." Another staff member told us, "The manager does listen and takes on board what the staff say."

Staff members and relatives described an improvement in the management of the home. A relative also told us that, "Things are better than 3 or 4 years ago." Another commented, "It has improved considerably. I'm very happy with them." Relatives were sent questionnaires on a regular basis as part of the quality monitoring process. The registered manager described how they used this information to make improvements. For example, one person's relation had been concerned about a lack of social activities and plans had been put in place to address this. They told us that there had been a noticeable improvement. Staff said they had regular contact with relatives to ensure they were up to date with any changes and to keep in touch.

Staff told us that they had made positive links with the local community including with local shops and businesses. For example, one person regularly used a local café and staff at the café knew what they liked to order. This made it easier for the person to communicate when out without staff support. One staff member told us, "All the people here are known and recognised locally. Shop staff will contact us directly if there is any problem so we can ensure people are supported." Other links included the cinema and theatre complex and with the local police, social services and mental health services. Staff described having positive contact with police officers, social workers and mental health practitioners who supported people living at the home on a regular basis. People told us that they had enjoyed a recent garden party event which had been attended by neighbours, friends and family. Staff said that this helped to build and maintain good relationships.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The manager had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken. The manager was aware of their responsibilities under the Duty of Candour. The Duty of Candour is a regulation that all providers must adhere to. Under the Duty of Candour, providers must be open and transparent and it sets out specific guidelines providers must follow if things go wrong with care and treatment.

The registered manager told us that they were committed to making improvements at the home and described several areas of practice that they were focussing on including care plans which they described as "Work in progress." They attended regular training events and the local provider's forum to keep abreast of local updates.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care There was a continued failure to support people in a personalised way with care appropriate for their needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect There was a failure to support people to maintain their dignity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Failing to obtain and document consent for care and support.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There was a lack of effective risk management, inconsistent monitoring and analysis of incidents and a failure to ensure suitable actions were taken to make improvements.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and

	improper treatment There was a failure to identify, investigate and prevent abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a failure to assess, monitor and improve the quality and safety of services, to mitigate risks and to maintain accurate records.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not received the training and support they needed to be effective in their roles. There were not enough suitable staff on duty.