Indigo Care Services Limited

Norfolk House

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?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection was carried out on 14 and 17 October 2016 and was unannounced.

Norfolk House provides accommodation and personal care for up to 30 older people. The service is a large converted property. Accommodation is arranged over three floors and a lift is available to assist people to get to the upper floors. There were 23 people living at the service at the time of our inspection. The service is situated next door to another care home service run by the same provider and shares staff and management with the other service.

The registered manager for the service next door was leading the service and had applied to the Care Quality Commission (CQC) to also be the registered manager at Norfolk House. The previous registered manager had resigned and had stopped working at the service a couple of weeks before our inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the care and has the legal responsibility for meeting the requirements of the law. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider and manager did not have oversight of the service. They had not supported staff to provide a good level of care and staff were not all aware of their role and responsibilities. Checks on the quality of care being provided had been completed but the shortfalls in the service that we found at the inspection and not been identified.

Safeguarding risks had not been identified and referred to the Kent local authority safeguarding team for their consideration or investigation. The manager reported their concerns to the Kent local authority safeguarding team during our inspection. Staff knew the signs of possible abuse, and how to whistle blow to the provider, Kent local authority safeguarding team and CQC.

Risks to people had not been consistently identified, assessed and reviewed. Action had not always been taken to reduce risks and provide staff with guidance about how to keep people safe while maintaining their independence. On one occasion a person had not been provided with prescribed pressure relieving equipment and this had caused them harm.

Plans were not in place to keep people safe in an emergency, including plans and equipment to evacuate people from the building. Following the inspection the manager contacted the local Fire and Rescue Service for advice.

Assessments of people's needs had not been consistently completed to identify their needs. Detailed guidance had not been provided to staff about how to meet people's needs. No guidance had been provided to staff about how to provide one person's care. People had not been supported to have regular health checks such as eye tests.

People did not always receive their medicines in the way they preferred to keep them comfortable. Medicines were stored safely and recorded accurately.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Applications had been made to the supervisory body for a DoLS authorisation when people were restricted. Staff did not know who applications had been made for. Care had not been planned to make sure restrictions to people's liberty were minimised.

Staff did not follow the principles of the Mental Capacity Act 2005 (MCA). When people needed to make a specific decision their capacity to do so had not been assessed. Staff disagreed about people's ability to make important decisions. Decisions made in people's best interests had not been recorded to demonstrate how the decision had been made and by whom. Care staff assumed people could make day to day decisions, however, guidance was not provided for staff about what decisions people were able to make.

People told us they would like more to do. Some people were not supported to participate in activities and staff did not spend time with people who chose to be in their bedrooms.

Accurate records were not maintained about the care and support people received. Information was not available to staff and health care professionals to help them identify any changes in people's needs. People's personal information was not always kept safe.

People and their representatives were confident to raise concerns and complaints they had about the service. However, action had not been taken to resolve people's complaints to their satisfaction and use them to continually improve the service.

People and their relatives were asked for their views each year. Many people did not return the survey they were sent. Action had not been taken to explore other methods of obtaining people's views and involving them in developing and improving the service. Staff did not have regular opportunities to share their experiences of the service. Suggestions they had made had not been considered and staff had stopped making suggestions until very recently.

People's needs had been considered when deciding how many staff were required on each shift. However, the provider had not taken action to make sure sufficient staff, who knew people, were deployed to meet their needs. Staff worked as a team to meet people's needs.

Safe recruitment procedures were followed for most staff. Gaps in employment had been questioned.

Staff had not regularly met with a manager to discuss their role and practice. Staff told us they had not felt supported and appreciated until very recently. They were confident to raise concerns with the manager and other senior staff.

Staff had completed the training they needed to provide safe and effective care to people.

Although people and their relatives told us that staff were kind and caring, people were not always treated with respect. For example, people did not always receive their laundry back from the laundry and their clothes were found in other people's wardrobes.

People told us they liked the food at the service. Meals were balanced and included fruit and vegetables. All

meals were homemade. People were offered a choice of food to help keep them as healthy as possible. Food was prepared to meet people's needs and preferences.

People were treated with dignity. Staff offered people assistance discreetly without being intrusive.

The manager had not notified CQC of some significant events that had happened at the service. Services that provide health and social care to people are required to inform the CQC, of important events that happen in the service like a serious injury or deprivation of liberty safeguards authorisation. This is so we can check that appropriate action had been taken.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. 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.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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.

Assessments of risks to people were not always accurate and action had not been taken to support people to be as safe as possible.

Detailed guidance and training had not been provided to staff about how to keep people safe in an emergency.

Staff knew how to recognise abuse, but concerns had not been referred to the Kent local authority safeguarding team for investigation.

There were not always enough staff to provide the support people needed.

Checks were completed on staff to make sure they were honest, trustworthy and reliable before they worked alone with people.

People were not always given their medicines at the times they needed them. People's medicines were stored safely and recorded accurately.

Is the service effective?

Requires Improvement

The service was not effective.

Staff did not have the opportunity to meet regularly with a manager to discuss their role, practice or any concerns they had. Staff had completed the training they needed to meet people's needs.

The advice of health care professionals had not been consistently followed. People were not supported to have regular health checks.

Staff did not always follow the principles of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards. Guidance had not been provided to staff about how to support people to make decisions.

People told us they liked the food at the service and were offered a balanced diet. People were involved in planning the menu.

Is the service caring?

Requires Improvement

The service was not always caring.

Some people told us they were lonely as staff did not have time to spend with them.

People were not always treated with respect. For example, people's clothes were not always returned to them and were found in other people's wardrobes.

People's confidential information was not always kept securely.

Staff knew people's likes, dislikes and preferences and information about some people's life before they began to use the service. This helped staff get to know people and how they preferred their care provided.

People said that staff were kind and caring to them. People were given privacy.

Is the service responsive?

Inadequate

The service was not responsive.

Assessments of people's needs had not been completed. Detailed guidance had not been provided to staff about how to meet each person's needs.

People told us they wanted to take part in more activities at the service.

People's complaints had not always been resolved to their satisfaction People and their relatives told us they were confident to raise any concerns they had with the staff.

Is the service well-led?

Inadequate

The service was not well-led.

The registered manager had resigned. The provider had appointed a new manager with the skills and experience they needed to lead the service.

Staff did not have clear responsibilities and were not always held accountable.

Checks completed on the quality of the service were not effective. Action had not been taken to regularly obtain the views of staff, people, their relatives and health professionals.

Records about the care people received were not consistently accurate and there was a risk that action would not be taken to provide the care people needed.

Norfolk House

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 14 and 17 October 2016 and was unannounced. The inspection team consisted of three inspectors.

Before the inspection, we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This was because we inspected the service sooner than we had planned. We looked at notifications received by the Care Quality Commission which a provider is required to send us by law. Notifications are information we receive from the service when significant events happen, like a death or a serious injury. We spoke with staff from the local authority about what they had found when they visited the service and a clinical nurse specialist for older people who had been supporting the staff to make improvements at the service. We reviewed information we had received from people's relatives and whistleblowers.

During our inspection we spoke with six people living at the service, five people's relatives and friends, three health professionals, the manager, a deputy manager, the operations manager and staff. We visited some people's bedrooms with their permission; we looked at care records and associated risk assessments for six people. We looked at management records including staff recruitment, training and support records, health and safety checks for the building, and staff meeting minutes. We observed the care and support people received.

Some people were unable to tell us about their experience of care at the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We looked at medicines records and observed people receiving their medicines.

This was the first inspection of Norfolk House under the ownership of Indigo Care Services Limited.

Inadequate

Is the service safe?

Our findings

People told us they did not always feel safe at the service. One person told us, "They leave my buzzer behind the television so at night time I have to slide along to get it. What would happen if I needed them in an emergency?"

One person told us about an incident when an agency member of staff had caused bruising and scratches on their arm. They said that the staff member had been rough with them, and this had caused them some distress. Their relative told us, "My [relative] was scared. They [the staff member] was very heavy handed". They had reported the issue to the manager.

The manager had not considered this incident to be a safeguarding concern. They had not reported it to or taken advice from the Kent local authority safeguarding team as they should have done. They managed the incident as a complaint, informed the staffing agency of the issue, and requested that the staff member did not return to the service. They had not notified the Care Quality Commission (CQC) of this incident, as required by law. The manager notified the Kent local authority safeguarding team and CQC of the concerns during our inspection.

The manager was aware of safeguarding procedures but had not always adhered to them. Staff knew the signs of possible abuse, such as changes in people's behaviour or bruising. They supported people to raise any concerns they had and reported their concerns to the manager. Staff told us they had completed training on keeping people safe and this was confirmed by the training records. Staff felt confident to whistle blow to the management team or to the CQC when they had concerns about their colleagues' practice.

The provider had failed to effectively operate systems and processes to investigate any allegation of abuse. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people had not been consistently identified, assessed and reviewed. Action had not always been taken to reduce risks and provide staff with guidance about how to keep people safe while maintaining their independence. For example, when people were at risk of self-neglect there was no guidance for staff about how to manage people refusing support with their personal care or when to contact health professionals for advice and support.

Risks to peoples' skin health, such as the development of pressure ulcers, had been assessed. However, the assessments had not been completed accurately and risks were not correctly identified. For example, one person's assessment had not been completed correctly in September and October 2016 and stated they were at medium risk. The operations manager reviewed the assessment during the inspection and confirmed the person was at high risk of developing pressure ulcers. The person had developed pressure ulcers.

Pressure relieving equipment was available to people who needed it. However, accurate checks were not

completed to make sure equipment was used safely. A visiting health professional told us that the mattress for one person with pressure ulcers should be set at 60kg. Their mattress was set at 30kg. Guidance had not been provided to staff about the correct use of pressure relieving equipment, including the settings for pressure mattresses and cushions. Using a pressure relieving mattress or cushion that is too firm or soft may not give people the best protection from developing skin damage.

The risk of people becoming malnourished had been assessed; however some assessments had not been fully completed and so risks to people had not been identified. Action had not been taken to plan and review the care people received to support them to eat and drink enough. For example, one person's risk assessment said they needed a 'high fat diet and fortified foods' and they 'must be weighed regularly'. The person had not been weighed for over a month and no guidance had been provided to staff about how to support the person to eat and drink enough to keep them healthy and aid healing of pressure ulcers. The person had been offered high calorie foods but had lost weight. Action had not been taken to monitor what the person was eating and drinking and support them to eat more.

One person was at risk of developing infections. Staff were not able to tell us the action they took to reduce the risk of the person developing an infection and guidance had not been provided for them to refer to. During our inspection staff contacted the person's doctor as the person was 'more confused than usual' and they thought the person had an infection. No changes had been noted in the person over the previous 48 hours and staff were not able to tell us what changes in the person had been observed. When people had health conditions which were contagious protective measures were not consistently taken to make sure other people stayed safe and healthy.

Some people smoked and a smoking area was provided for people and staff in the garden. People were not permitted to smoke anywhere in the building. The manager told us that one person smoked in their bedroom at times. Risks to the person, other people and staff had not been assessed. A process was in place to reduce the risks, including staff holding the person's cigarettes and lighter, but this was not always followed and the person continued to smoke in their bedroom.

A fire evacuation plan was in place, but was not available to staff. There was no separate evacuation plan for night time when there were less staff on duty. Evacuation equipment was available to evacuate people safely but staff had not been trained to use it. Staff told us that some people were able to walk but "Would not make it down the stairs". Plans to keep people safe in an emergency did not include guidance to staff about how to move people to keep them safe in the event of a fire and had not been reviewed and amended as people's needs changed. For example, one person's personal emergency evacuation plan (PEEP) stated they were 'independently mobile' and would 'need support' to leave the building. The person's needs had changed and they were no longer able to walk and needed at least two staff to assist them into a wheelchair. Staff were not able to tell us how they would safely evacuate people from the building. Following our inspection the manager contact the local Fire and Rescue Service for support to improve fire safety at the service. The provider told us that everyone would have an accurate PEEP by the end of October 2016.

Regular tests were carried out on extinguishers, emergency lighting and fire doors. Some risks posed to people from the environment had been identified and assessed.

The provider had failed to assess and mitigate risks to people. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not always receive their medicine at the right time. One person told us before moving into the

service they had always administered one of their medicines at 10pm. Night staff were not trained to administer the person's medicine at the correct time of 10pm. During our inspection the manager arranged for staff from the next door service to administer medicines at night. We checked with the person, in the second day of the inspection, that they had received their medicines at the time they preferred since the change was made. They told us that they had not and they were "very angry about it". They also told us not having the medicine when they preferred made them uncomfortable each night. Another person needed their medicine early in the morning so day staff came in early to administer this.

Most medicines were stored securely. One person kept their medicines in their bedroom at their request. They had been provided with a locked storage space but did not keep it locked. Risks to the person and others had not been assessed and action had not been taken to make sure their medicines were always secure. The ceiling of the medicines room was damaged and the manager had arranged for medicines to be stored securely in another part of the service.

Guidance was not provided to staff, including agency staff who did not know people, about where to apply prescribed creams to keep people's skin as healthy as possible. One staff member who had recently returned to the service told us they had asked to look at the 'cream charts' and had been told there were not any. Staff told us they needed easy access to this information and without it there was a risk that people would not have their creams applied correctly.

Some people were prescribed medicines 'when required', such as pain relief and inhalers to help them breathe more easily. Guidance was provided to staff about each medicine including the signs that they needed it. However, staff were not aware of what to do if someone needed medicines during the night. Some staff told us they rang a senior member of staff and others rang the on-call manager. The manager told us the process should be to contact the service next door for a medicines trained staff member to assist. There was a risk people may not receive their medicines when they needed it.

Regular checks were carried out on medicines and records to make sure they were correct. These had not identified the shortfalls we found.

The provider had failed to operate proper and safe medicines management processes in relation to the administration, storage and recording of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some medicines needed to be kept cool and were stored in a locked medicines fridge. The temperature of the fridge was checked every day to make sure that medicines were always held at the correct temperature. Community nurses told us that people's insulin was stored correctly and staff made sure that the dose to be administered was at room temperature to reduce pain for the person.

Senior care staff had completed medicines management training and their competence was assessed regularly to make sure their practice remained safe. We observed people receiving their medicines. This was done in a caring and respectful way and staff stayed with people to ensure they took the medicines safely.

Before our inspection we received concerns about low staffing levels, including that people had to wait a long time to receive the care they needed.

People and their relatives told us, "I might ring the bell at 9:40pm to say I want to go to bed and staff tell me, 'You've got to be patient'", "I sat on the commode for half an hour waiting for them to take me off. I rang at 7 o'clock and I waited 10, 15, 20 minutes then [staff member's name] came and said they were hoisting

someone so I had to wait longer. This happens very frequently", "I have to wait 10, 15 minutes [for support to the toilet] so I don't drink because I'm worried about holding on", "There is a shortage of staff. When my relative goes to the toilet sometimes they have to wait forever" and "I couldn't sit there and ignore it if I saw someone lurch or fall over. I've seen it being close and it's visitors that have to step in".

The manager decided how many staff were needed at different times of the day. The manager told us, "I am really concerned about the number of agency staff being used". Shortly before our inspection staffing numbers at night were increased from two to three. There were several staff vacancies which were covered by agency staff. However, staffing numbers fell below the number the manager had assessed were needed at times. During our inspection staffing levels were low between 2pm and 8pm because a staff member did not work their shift. They had not worked other shifts in the weeks before the inspection. The manager had not identified the risk that the staff member would not attend their shift and had not planned cover for them.

Staff told us when there were less staff on duty they didn't have time to spend with people and people had to wait for the care and support they needed. People told us, "Staff can't sit down and have a chat with me" and, "Staff don't come for a chat". One staff member said, "Sometimes I think we could use another person. I feel really bad telling people they will have to wait". The activities coordinator took people to appointments when the number of care staff was reduced. They told us, "It only happens when they're short and there's no one else to go. I feel bad as it takes me away from the residents. What about the people left here?" During the inspection staff were rushed and did not have sufficient time to spend with people and there was little interaction and engagement by staff.

People's relatives told us they were concerned about agency staff who did not know their relative, providing their care. Their comments included "There always seems to be different staff when I come and then I worry that they won't know [my relative]" and "At key times, such as putting [my relative] to bed, it worries me that they might not know the staff".

The manager told us an on call system was in place to provide management cover at weekends and in the evenings. The system had changed before the inspection but staff, including staff who had previously been on call had not been informed about the changes.

The provider had failed to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet people's needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had recruitment and disciplinary policies and procedures which were followed by the manager. Checks had been completed on new staff to make sure they were honest, trustworthy and reliable, including police background checks. Information had been obtained about staff's conduct in their last employment and their employment history, including gaps in employment.

Any accidents were recorded and monitored by the management team so they could identify any patterns or trends and take action to prevent further incidents. When a pattern or theme was identified action was taken to refer people to health professionals to reduce risks and keep people safe.

Requires Improvement

Is the service effective?

Our findings

Care had not been provided to keep people as healthy as possible. Before our inspection one person had developed pressure ulcers. Staff had contacted the local community nurse team, who prescribed care and treatment to heal the ulcers, including a requirement for special equipment and two hourly position changes. The registered manager had not provided the equipment for several days and the person had not been repositioned for over 12 hours one night. The person's health care professionals told us they thought this had contributed to the person's pressure ulcers deteriorating. The operations manager had taken action to make sure that the person received the care they were prescribed and the ulcers were healing.

One person's relative told us, "My [relative] was very ill and a senior carer wanted to call an ambulance. The previous manager said 'don't, there's no need'. The senior called me and I told them, 'you call an ambulance'. They did and my relative was taken into hospital with a chest infection". They also told us that they felt their relatives care had improved since the new manager started working at the service. They said, "My relative had to have the GP out and they just did it and let me know straight away".

Detailed guidance had not been provided to staff about how to support people who were living with diabetes. For example, one person's care plan stated they were at risk of their blood sugar levels becoming very low. Guidance had been given to staff about the signs they may see if someone's blood sugar levels dropped, for example, inability to concentrate, morning headache and sleep disturbance. However, guidance had not been provided about what they should do if the person showed signs that their blood sugar levels were low and what their usual blood sugar range was. This was important as many staff including the manager and agency staff did not know the person well and there was a risk that they would not identify changes in the person's needs and respond appropriately.

Referrals had not always been made to health care professionals when people's needs changed. One person was assessed in September as being at risk of malnutrition and the assessment stated 'referred to dietician'. The person had lost weight and no referral had been made to a dietician. The person was referred to the dietician during our inspection.

People were not supported to access regular health checks, including eye or dental checks to make sure any changes in their needs were identified. People were supported to attend health care appointments by their family or staff. During our inspection a staff member accompanied one person to hospital in an emergency. This was to offer the person reassurance and support them to tell their health care professional about their health and medicines. A chiropodist visited some people regularly.

A doctor held a surgery at the service twice a week. Visiting health care professionals told us the provider's staff identified changes in people's health and contacted the doctor's surgery for advice and support.

The provider had failed to ensure people were safe and had the support they needed to manage their health needs. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff had completed training in MCA but some staff did not follow the principles. One staff member who was responsible for planning people's care told us, "[Person's name] has capacity [to make decisions] but we have to involve their family". They did not understand that people with capacity can make decisions, including unwise decisions without the involvement of others.

People's capacity to make decisions had not been assessed. One person had bedrails on their bed to reduce the risk of them falling out. The manager and deputy manager disagreed on the person's capacity to make the decision about using the bed rails. A capacity assessment had not been completed to check if the person could make the decision for themselves or if a decision needed to be made in their best interests. The person's family had agreed to their use. There was a risk that the person had not been supported to make the decision.

Detailed guidance had not been provided to staff about how to support people to make decisions. For example, one person's care plan stated 'Can make simple decisions. A visual choice is better'. Further guidance was not provided to make sure the person was offered choices in ways they understood.

The provider had failed to assess and plan people's care in accordance with the Mental Capacity Act 2005, including best interest decision making. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Due to a restriction, one person was the subject of a DoLS authorisation and others were waiting to be assessed by their local authority. Staff did not know who had a DoLS authorisation in place and who was waiting for an assessment. Care had not been planned to make sure restrictions to people's liberty were minimised. One person told us, "I can't go for a walk when I want as the doors are locked." Another person could not go out as often as they wanted to, to buy things they needed as staff were not available to support them. This made the person angry.

The provider had failed to protect service users from the risks of being deprived of their liberty without lawful authority. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us the food at the service was "very nice" and they were offered foods which they liked. Their comments included, "I like everything", "I like the food" and "The food is lovely, I quite like the curry, chicken and rice." The cook knew people's preferences and made sure these foods were available for them. For example, a sandwich with a particular filing was prepared for one person's supper every night as this is what they liked. One person told us, "The food is spot on. I love corned beef hash and chocolate sponge with custard. I always get custard".

Menus were varied and meals were balanced, with fruit and vegetables. All meals were homemade. Communication between care staff and catering staff was good, catering staff were aware of any changes in people's likes, dislikes and needs. The cook asked people what foods they would like added to the menu and was considering 'taster sessions' when people could try new foods.

Meals were prepared to support people to stay as healthy as possible. People who were at risk of losing weight were offered milkshakes and meals fortified with full fat milk, cream and other high fat products. The cook knew who did not like milkshakes and offered them alternatives. One person enjoyed a milky coffee with extra cream. People who required a low sugar diet were offered the same foods as everyone else but made with sweetener rather than sugar.

Staff worked through an induction when they started work at the service to get to know people, the care and support they needed and to understand their roles and responsibilities. This included shadowing more experienced staff. New staff had to complete basic training as part of their induction and the manager checked they were competent before they worked alone with people.

Some staff responsible for planning people's care did not communicate effectively with other staff. One staff member assessed at the weekend that a person was at risk of losing weight and needed three fortified milky drinks each day. They added the person's name to the list of people who needed fortified drinks in the kitchen. They had not told care staff that the person needed the drinks and the person had not been offered them.

There was an on going programme of training which included face to face training and e-learning. The manager tracked training staff had completed and arranged refresher training when it was due. The range of training completed by staff included subjects related to peoples' needs such as dementia awareness and managing behaviour that challenge. The operations manager identified during our inspection that staff required further training and development around assessing risks to people's skin. Most staff held level 2 or 3 qualifications in social care, other staff were working towards these qualifications. Staff were knowledgeable about people's needs and health conditions.

Staff told us they had not met regularly with a manager on a one to one basis for supervision and coaching. They had not had the opportunity to discuss their practice and development needs. Records showed that some staff had received one to one supervision and others had not. The provider's supervision policy noted, 'Staff will have the opportunity to attend a supervision session at least four times a year'. However, the manager told us supervision should be every two months and the deputy manager said it should be completed monthly. The manager agreed this was an area for improvement.

Staff had an annual appraisal of their practice and development over the previous year. They agreed goals for the next year with a manager. These were reviewed during the year to check staff's progress to their goals. Senior managers had recognised the skills and strengths of their staff and had put plans in place to develop staff, including developing senior carer's leadership skills.

Requires Improvement

Is the service caring?

Our findings

People and their relatives told us the staff at Norfolk House were 'nice' and 'friendly'. Their comments included, "The attendants are very good and very kind", "Everybody is lovely" and "My relative has been ever so happy since they have been here".

Some people were isolated and lonely at times. One person told us, "I spend all my time in my room. Staff don't come for a chat, so I sit here and look at the stripes on the mattress and the leaves on the wallpaper". Staff did not regularly visit people who chose to stay in their bedrooms. People who used the lounge were not supported to chat to other people or take part in activities together and many people sat on their own. We observed a couple of people chatting and spending time with each other at meal times and in the smoking area.

People were not always treated with respect. One person's relative told us, "I check [my relative's] wardrobe and there are quite a few clothes that are not theirs. It's hard to identify who their keyworker is to help us sort this out". A key worker is a member of staff who is allocated to take the lead in co-ordinating someone's care. Staff responsible for doing the laundry told us that everyone's clothes were marked with their names so they could be returned to the correct person. This system was not working well and people did not always receive their clothes back from the laundry.

Staff did not always give people choices or provide information in ways they understood. For example, staff did not offer people a choice of biscuits with their morning drink, biscuits were just given out. Staff told us previously people were shown two meals at lunchtime to help them make a choice and this had worked well but no longer happened. Alternative ways of supporting people to make choices had not been explored and people were now told what the menu choices were. Staff told us some people found it difficult to make a decision in this way.

Before our inspection we received concerns about the confidentiality of people's information. Information about people was not always kept securely, for example, we found people's personal information being stored on a windowsill and it was visible from outside the building. The manager removed this immediately.

Staff used people's preferred names and people were relaxed in the company of staff. Staff knew about people's preferences, likes, dislikes and interests. Some people and their families had shared information about their life history with staff to help staff get to know them. Information about some people's backgrounds was available for staff to refer to in people's care records. Staff had used this information to plan people's care.

Staff offered people reassurance when they were upset or worried. Staff told us that one person became confused at times and this made them anxious. They chatted calmly and sung to the person and this reassured them. Another person liked to look after a 'baby boll'. Their relative told us they were not sure the person would like the doll when staff suggested it but that it gave them comfort.

Some people's bedrooms were decorated to their taste and plans were in place to involve everyone in planning the redecoration of their bedroom. Some people had brought personal items into the service, such as pictures and ornaments to decorate their bedroom.

People were treated with dignity and received as much individual support and attention as staff had time to provide. Staff offered people assistance discreetly without being intrusive. A hairdresser visited weekly and people were supported to make appointments to see them. The service had a hairdressing salon where people had their hair washed and styled in private.

New staff, including the new manager and deputy manager did not know what each person was able to do for themselves and how much support they needed because people's care plans did not all contain this information. Care staff supported people to remain as independent as possible with personal care tasks such as washing and dressing. For example, staff told us that one person was able to wash their face but needed support to wash the rest of their body.

People told us they had privacy and staff always knocked on their bedroom door before entering. People decided how much privacy they had. Some people preferred to have their bedroom door open when they were in their room and other people chose to have their door closed.

People who needed support to air their views were supported by their families, solicitor or their care manager. No one required the support of an advocate at the time of our inspection. An advocate is an independent person who can help people express their needs and wishes, weigh up and take decisions about options available to the person. They represent people's interests either by supporting people or by speaking on their behalf.

People's religious and cultural needs and preferences were recorded and respected. Staff supported people to attend places of worship so people could follow their beliefs.

Inadequate

Is the service responsive?

Our findings

Before moving into Norfolk House people and their families had met with staff to complete an assessment of their care needs. The assessments had not been fully completed and did not detail all the support people needed, including their preferences. Health care professionals told us that on occasions staff had admitted people whose needs they could not meet. The new manager and operations manager had recognised that staff did not have the skills to meet several people's needs and had given them and their case manager notice to find an alternative service. New people were not being admitted to the service at the time of our inspection.

Assessments of one person's needs had not been completed since they moved into the service in July 2016 and they had no care plan for staff to follow. No guidance had been provided to staff about how to meet their needs and staff relied on the person telling them. The person told us they did not always receive the support they wanted.

People's relatives had different views on their involvement in planning their relatives care, one person's relative said, "I filled in a booklet for hospital, about [my relative's] likes and dislikes and medicines before, but I don't know what they did with it". Another person's relative said, "We were involved in drawing up [my relative's] care plan". Some people had been encouraged to tell staff about their care choices and preferences, other people had not. Staff had very little information about some people.

People's care plans contained brief detail about people's care preferences, such as 'enjoys a shower with support from two staff'. Detailed guidance was not provided to support staff to provide consistent care to people in the way they preferred. Agency staff said they did not have time to refer to people's care plans and relied on other staff to tell them how people liked their care provided. One agency staff member told us, "I ask around, I sit with people. Staff will give me a verbal handover".

People's personal choices were not consistently reflected in their care plans to help staff provide people's support in the ways they liked. For example, one person told us before they moved into the service they always bought a television listing magazine on a Saturday so they could plan what they wanted to watch. They told us they relied on another person to buy the magazine for them each week as staff had not ordered the magazine to be delivered as they had requested. The person told us it was very important to them that they had the magazine each week.

People were not involved in reviewing their care. Reviews of people's care had been completed by the registered manager. People and their relatives had not been invited to take part in reviewing and updating their care plans to make sure their views were included. Changes in people's needs or preferences were not always identified in their care plan reviews. For example, one person's plan stated they were 'nursed in bed'. The person was supported to get up for meals during our inspection, staff told us the person liked to do this regularly. No guidance was provided about how often the person liked to get up, where they liked to sit and any special equipment that was needed to keep them safe.

A recent survey, completed by ten people, asked 'Do you know that you have your own care profile?' Eight people had responded, 'No' and two replied 'I don't know'.

Staff, including agency staff were able to tell us about some people's preferences and preferred routines but without a care plan for each person there was a risk people would not receive consistent care. For example, staff told us it was very important one person to have their bed made in a certain way or they became anxious. One person's relative told us, "I think [my relative] gets the care and support they need". The operations manager told us they were introducing 'daily flash meetings' to make sure a detailed handover was being completed and to make sure staff were aware of changes in people's needs.

People had different opinions about the activities provided at the service. Some people enjoyed some of the activities; other people did not. Comments from people and their relatives included, "We have sing songs, we have quizzes and do exercises. You can choose a film if you want" and "I don't feel there is enough stimulation. They do try, but I'm not sure if anyone checks what is happening". People and their relatives were not involved in planning the activities provided.

An activities coordinator worked during the week and spent time doing activities with individuals or small groups of people. On one morning of the inspection a person was supported to attend a local church service, while a film was on in the lounge for other people to watch. Two different people went out in the afternoon for a walk and to a local café and again a film was on for other people to watch. On another afternoon people took part in a quiz. We observed that many people did not engage and participate in the quiz. A staff member said, "The activities coordinator always takes the same people out." Some people went out with the support of external organisations or relatives but most people stayed at the service. A couple of people enjoyed going out regularly with the activities coordinator.

People were not supported to follow their interests and take part in social activities. An activities picture board was displayed in the corridor. This was not kept up to date and the choices of activities offered were not discussed with people.

The provider had failed to carry out with people an assessment of their needs and preferences and had failed to provide person centred care that met people's needs. The provider had failed to support people to be involved in their community as much or as little as they wished. The provider failed to make sure people were not left unnecessarily isolated. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A process was in place to receive and respond to complaints; however this had not been consistently followed. Before our inspection people and their relatives told us about complaints they had made that had not been listened to and resolved to their satisfaction.

The provider told us that all new complaints received would be investigated and the complainant would receive a written response in 28 days.

Inadequate

Is the service well-led?

Our findings

The manager had been managing the service for two days when we began our inspection, they had previously been the registered manager of the service and knew some staff and people well. Relatives told us they were "Pleased to see [the manager] back at Norfolk House" and said "I know [the manager] will do what is best for [my loved one]". The registered manager had resigned and had stopped working at the service two weeks before our inspection. The manager was also the registered manager for another care home service next door and had applied to the Care Quality Commission (CQC) to be the registered manager at Norfolk House as well. Another manager had spent at least two days a week at the service supporting the manager.

Staff told us they had not felt appreciated and were demotivated under previous management. They told us the new manager thanked them for their work and they now felt a valued member of the staff team. One staff member told us, "I feel appreciated now". Staff told us they were supported by the manager and supporting manager, who were approachable, listened to them and gave them advice when they asked. One staff member commented, "They are brilliant".

Staff told us they had previously been delegated management tasks, including being on call at night and at weekends. They told us this had put pressure on them and caused them stress. The manager had taken some management responsibilities back from staff to reduce the pressure on them and gave them more time to complete their role, such as managing people's medicines.

Staff were not fully aware of their specific roles and responsibilities, for example senior care staff had not been informed that they were no longer required to provide on-call cover at night . Staff had not previously been held accountable for the service they provided. For example, the new manager had stopped staff taking their breaks together to make sure there were always available to provide support people. The provider had booked a staff meeting for a couple of days after our inspection to support staff to understand what was expected of them.

The provider had purchased the service in April 2016. They had not shared their expectations with staff. Staff told us they had "Just been left to get on with it". The provider was not aware of all the shortfalls in the quality of the service that we found. Staff told us they wanted to provide a high quality service to people but had not been supported to do this. The provider had developed an action plan to address the shortfalls they had found before our inspection.

Care staff, including agency staff worked together as a team. Senior care staff led each shift and delegated tasks to staff. They told us they did not always have time to check that delegated tasks, such as supporting people to have a bath, had been completed and to check that records were completed correctly.

People and their families were asked for their views and opinions about the service yearly. A quality assurance survey was sent to people and their relatives and some responses had been received. The feedback received was not collated to look for patterns and trends and feedback was not provided to

people and their relatives about any action taken to improve the service. For example, the most recent survey, completed by ten people living at Norfolk House, showed that eight people did not know they had their own care profile and that nine people did not know who their keyworker was. There was no action plan to address these concerns. Some people were not able to complete a questionnaire. Other ways of obtaining their views had not been tried to make sure that everyone's views were heard. Only one meeting for people and their relatives had been held this year, in January 2016. Health professionals were not asked to provide feedback on the quality of the service.

Staff had not had regular opportunities to share their views about the quality of the service and make suggestions about changes and developments. Staff told us suggestions they had made in the past had not been listened to and they had stopped making suggestions. They told us the new manager had asked them for information about people's care and listened to what they had to say. Staff were confident the new manager would listen to and consider any suggestions they made as they had done this when they managed the service previously.

Some audits were carried out to monitor the quality of the care. A senior manager had visited often and asked staff for their feedback. Staff said they had not felt confident until recently to share their concerns with the senior manager. Once they were aware of the concerns the senior manager had acted on staff's feedback.

Checks had not been completed on all areas of the service to make sure that it was of a good standard, such as activities and the amount of time people had to wait to receive their care. Checks that had been completed, including medicines management and infection control audits were not effective and the provider and manager had not identified the shortfalls we found at the service.

Staff practice had not been consistently monitored. The new manager had challenged staff practice since they came into post to make sure people received a good standard of care. They put plans in place during our inspection to check staff practice at different times of the day, including at night. Quality monitoring audits had been carried out in May and August 2016. No action plan had been completed following the audits to address the identified shortfalls. For example, the May 2016 quality monitoring audit noted, 'Mental capacity assessments had not been carried out for individual, specific decisions and had been completed generically'. This shortfall was still present during the inspection and had not been addressed.

The provider had failed to assess, monitor and improve the quality and safety of the service provided to people. They had failed to seek and act on feedback from relevant people, including service users, on the services provided to continually evaluate and improve the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had put plans in place to improve the quality of some areas of the service before our inspection. These included improvements to the building décor, staff training and induction and the day to day management of the service. Other areas of the service including the management of risks and people's health needs had not been identified and plans were not in place to improve them. The provider had stopped taking new admissions into the service before our inspection to reduce the pressure on staff and give them time to make the necessary improvements. The operations manager had developed new pressure ulcer prevention guidance for staff based on recognised good practice. They had requested feedback on the guidance from the local Clinical Commissioning Group (CCG) specialist nurse supporting the service before they introduced the guidance and trained staff.

Records in respect of each person's care and support had been kept, however they were not always

accurate and complete. Records did not contain all the information staff and visiting health care professionals needed to assess, review and plan people's care, such as what they had eaten and drunk and how much they weighed. Staff told us they had been told not to record some areas of people's care, such as when someone who was at risk of becoming constipated went to the toilet and this meant that they did not have important information to share with the person's doctor when they became unwell. Inaccurate or incomplete records could put people at risk of not receiving the care they needed quickly. The provider said they would review people's care records every week to make sure they were accurate and complete.

The provider had failed to maintain an accurate, complete and contemporaneous record in respect of each person, including a record of the care provided to them and of decisions taken in relation to the care and treatment provided. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Services that provide health and social care to people are required to inform the CQC, of important events that happen in the service like a serious injury or deprivation of liberty safeguards authorisation. This is so we can check that appropriate action had been taken. We had not been notified of some significant events that had happened at the service.
The provider had failed to notify the Commission (CQC) without delay of incidents that had occurred at the service, including safeguarding concerns. This was a breach of Regulation 18 Care Quality Commission (Registration) Regulations 2009.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify the Commission (CQC) without delay of incidents that had occurred at the service, including safeguarding concerns.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to carry out with people an assessment of their needs and preferences and design care to achieving their preferences and ensure their needs were met. The provider had failed to support people to be involved in their community as much or as little as they wish. The provider failed to make sure people were not left unnecessarily isolated.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to assess and plan people's care in accordance with the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to operate proper and

	safe medicines management processes in relation to the administration, storage and recording of medicines. The provider had failed to assess and mitigate risks to people. The provider had failed to ensure staff followed prescribed care pathways.

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 The provider had failed to effectively operate systems and processes to investigate any allegation of abuse. The provider had failed to protect service users from the risks of being deprived of their liberty without lawful authority.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to assess, monitor and improve the quality and safety of the service provided to people. They had failed to seek and act on feedback from relevant people, including service users, on the services provided to continually evaluate and improve the service. The provider had failed to maintain an accurate, complete and contemporaneous record in respect of each person, including a record of the care provided to them and of decisions taken in relation to the care and treatment

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to deploy sufficient

numbers of suitably qualified, competent, skilled and experienced staff to meet people's needs.