Community Integrated Care

Norwood Drive

Inspection report

2 Norwood Drive
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Altrincham
Cheshire
WA15 7LD

Tel: 01619049228

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service: Norwood Drive is a residential care home that can accommodate up to six people. The home was providing support with personal care to five people with a learning disability at the time of our inspection.

People's experience of using this service:
• Staff treated people with care and respect. There was a small, consistent staff team, which helped staff build positive relationships with people living at the home.
• Staff had a good understanding of people's needs and preferences. Care plans were person-centred and contained a good level of detail about how people preferred to receive their care.
• Whilst the home was adequate to meet people's needs, the provider and relatives recognised that the premises needed refurbishment. Although the provider did not own the building, they were responsible under their registration for ensuring the premises met relevant requirements.
• We saw evidence that required servicing, checks and risk assessments relating to the premises and equipment had been completed. However, there was evidence that recommendations from the home's legionella risk assessment had not been acted upon. Legionella is a type of bacteria that can develop in water systems and cause Legionnaire's disease.
• There were some shortfalls in infection control procedures. We found some areas of the home were visibly unclean.
• Staff were aware how to identify and escalate potential safeguarding concerns. However, we were aware of one instance prior to the inspection when concerns had not initially been adequately investigated.
• There were systems in place to help ensure people's medicines were manged safely. However, staff had not always followed safe practice when giving people their medicines.
• We observed some activities taking place during the inspection, and some people attended day centres. However, activities did not engage everyone living at the home, and reports from relatives and staff indicated perceived barriers such as the weather, finances and transport could prevent people from accessing the community as often as they would like. We have made a recommendation about activities.
• Staff received a range of training relevant to their roles and the needs of the people they supported.
• The registered manager had recently left the service. The deputy manager was receiving support from the area manager to run the home day to day.
• The provider had systems and processes in place to help them monitor the quality and safety of the service. However, these systems had not always ensured the issues we found had been addressed and the service continues to be rated requires improvement overall. We found this to be a breach of the regulations.
• Relatives told us they felt the provider had not always acted openly and honestly in relation to previous incidents at the service. The provider assured us it was not their intention to withhold information from families, and that this had been due to a misunderstanding about which relatives had been informed of previous events.
• The service applied the principles and values of registering the right support and other best practice guidance, although this was not consistent. This guidance aims to ensure that people using services can live as full a life as possible, and achieve the best possible outcomes that include choice, control, inclusion and

independence.

For full details about the findings of this inspection, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection: We last inspected Norwood Drive on 4 and 5 October 2017 when we rated the service as requires improvement overall (report published 12 December 2017). This is the third consecutive time that the service has been rated requires improvement.

Why we inspected: This was a routine scheduled inspection. However, we were unable to inspect the service when we had originally planned in December 2018 due to an incident that raised concerns about the safety of people if they remained at the home. Whilst this incident was not directly related to the care people were receiving, there were concerns that people could be at risk of harm if they remained at the home. People were therefore supported to move to alternative accommodation for 12 nights whilst the provider worked with other agencies to assess potential risks to people's safety, and put in place measures to reduce these risks as far as possible.

At our last inspection of the service in October 2017, we identified a breach of regulations in relation to staff training. We found the provider had addressed this issue and the service was now meeting the requirements of this regulation.

Enforcement / Improvement action: You can see what action we have told the provider to take at the end section of the full version of this report.

Follow up:
We will:
• Continue to monitor the home.
• Ask the provider to send us a plan to tell us how they intend to improve the rating of the service from requires improvement to good or outstanding overall.
• Ask the provider and commissioners of the service to take part in a meeting to discuss how the service can be supported to improve.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our Safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our Effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our Responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our Well-Led findings below.

Norwood Drive

Detailed findings

Background to this inspection

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

Inspection team:
The inspection team consisted of one adult social care inspector.

Service and service type:
Norwood Drive is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Norwood Drive accommodates up to six people in one adapted building. At the time of our inspection there were five people living at the home. The service provides personal care and accommodation without nursing care to people with a learning disability.

The service did not have a manager registered with the Care Quality Commission. A registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
This inspection took place on 23 and 31 January 2019. The first day of the inspection was unannounced.

What we did:
Before the inspection we:
• Reviewed statutory notifications sent to us by the provider. Statutory notifications are information providers must send us about certain significant events such as deaths, safeguarding, police incidents and serious injuries.

• Reviewed previous inspection reports.
• Asked for feedback from Trafford Council's quality and contracts monitoring team; the local authority infection control lead; commissioners of the service, Trafford Healthwatch and professionals the provider told us had recent involvement with the service. We used the feedback received to help plan our inspection.
• Looked at the information sent to us in the provider information return (PIR) the service sent to us in November 2018. Providers are required to send us this key information about their service, which includes what they do well, and improvements they plan to make.

During the inspection we:
• Spoke with one person who was living at the home.
• Observed the care and support people received in communal areas.
• Spoke with the relatives of two people by phone, and received feedback from one relative by email.
• Spoke with five staff members. This included two support workers, an agency care worker, the deputy manager and the area manager.
• Reviewed records relating to the care people were receiving. This included daily records of care, three people's care files, records of accidents, incidents and complaints, and three people's medicines administration records (MARs).
• Looked at other records related to the running of a care home, including: Records of servicing and maintenance of the premises and equipment, three staff personnel files and audits and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

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

Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse
• Systems and processes were in place to help ensure staff identified and escalated safeguarding concerns. However, information we held prior to our inspection showed these processes had not previously always been followed effectively.
• Prior to our inspection, CQC received allegations that staff members had allowed their partners to enter the home during the night shift. We raised these concerns with the service, but we were not satisfied they had been adequately investigated or acted upon.
• We therefore informed the local authority safeguarding team and the provider's nominated individual. The allegation was found to be substantiated, and the provider took appropriate action to address this matter.
• In December 2018, the provider decided in conjunction with the local authority to move everyone out of the home for 12 nights to alternative accommodation. This was due to concerns about people's safety that were not directly related to the care they were receiving.
• The provider worked with the local authority and other agencies, including the police to assess potential risks, and to put in place measures to safeguard people when they moved back in.
• Staff were aware how to identify signs of potential abuse and neglect, and how to report their concerns. We saw information on safeguarding procedures was displayed in the home for staff reference if needed.

Using medicines safely
• There were systems in place to help ensure medicines were managed safely. However, we identified lapses in these systems during the inspection.
• People's medicines were stored securely in locked cabinets in their bedrooms. Since our last inspection, the provider had installed a controlled drugs cabinet in case they needed to store any such medicines. Controlled drugs are medicines that are subject to additional legal requirements in relation to their storage, administration and destruction due to risks relating to their misuse.
• When checking people's medicines, we found staff had not administered one person's tablets, but had signed for them on the medicines administration record (MAR).
• This showed staff had not followed safe procedures when administering this person's medicines. The provider took appropriate action when we informed them of this error, including seeking medical advice. No harm occurred because of the error.
• We concluded this was an isolated error rather than standard practice. We observed another staff member administer medicines and found they followed safe practice. The stock of other medicines we checked was correct according to the records on people's MARs.
• Staff had received training in medicines administration and they had their competency assessed each year.

• We saw staff administered one-person paracetamol 'when required' (PRN). This had been administered routinely and records indicated the required four-hour gap between doses had not always been maintained. Staff told us they did ensure they left four hours between doses, and told us this was an ongoing issue with the times recorded on the MAR by the pharmacy. Staff consulted with this person's GP during the inspection to try and resolve this issue.
• In most cases there were protocols in place to inform staff when they should administer PRN medicines, and what their intended effect was. Staff had also recorded the reason for administration of these medicines, and the outcome of their administration when they were not being administered routinely. This was good practice.

Assessing risk, safety monitoring and management
• Staff assessed risks to people's health, safety and wellbeing, and took reasonable steps to manage such risks. However, practice in relation to recorded risk assessments was variable.
• Staff assessed risks in relation to a range of potential hazards. This included medicines administration, moving and handling and use of equipment such as wheelchairs.
• Whilst one person had a risk assessment and care plans in relation to seizures, neither were present in another person's file when it was identified they had previously had seizures. Staff told us this was because the person had not had any seizures for many years. The provider told us they would have put a care plan and risk assessment in place if the person had had any seizures whilst living at the home.
• One person's care records indicated they were at potential risk of developing pressure ulcers. Although staff had taken steps to reduce this risk, there was no risk assessment completed in relation to this concern. Having a risk assessment would help staff monitor this risk and if required, prompt them to take further action to keep the person safe.
• Staff reported accidents and incidents, which were recorded on an electronic system. We saw a manager had reviewed any incidents and had made a record made of any actions taken to keep people safe, or help prevent the issue recurring.
• There had been no serious injuries notified to the CQC since our last inspection. Our review of the accident/incident reports confirmed there had been no accidents that would have required notification to the CQC.
• Required checks and servicing of the premises and equipment had been carried out. For example, hoists had received a thorough examination as required under LOLER.
• Risk assessments in relation to the safety of the premises and environment had been carried out. There were measures in place to help control the risks of legionella, such as monitoring of water temperatures. However, the provider had not received a copy of the legionella risk assessment completed on behalf of the housing provider. They got a copy of this risk assessment during the inspection, and we found not all recommendations made by the risk assessor had been acted on to reduce the risk of legionella developing in the water system. We discussed this issue with the provider who told us they would raise this with the housing provider that owned the building and discuss it with their facilities department.
• Legionella is a type of bacteria that can develop in water systems and cause Legionnaire's disease. Legionnaire's disease can be dangerous, particularly to people who may be more vulnerable due to factors such as old age or disability.
• The kitchen was freely accessible to people living at the home. We saw knives and other sharp objects were accessible. Staff assured us they did not believe this posed a risk to anyone living at the home. However, we asked that they consider this as part of the review of their environmental risk assessments.

Preventing and controlling infection
• Communal areas and people's rooms were clean and there were no malodours in the home. Staff had received training in infection prevention and control. However, we noticed some areas of uncleanliness and shortfalls in relation to practices that would help prevent and control the spread of infection.

• Some of the drawers and cupboards we looked at in the kitchen were visibly unclean. The floor was not sealed at the edges, which would make it more difficult to clean effectively. The provider acknowledged that the kitchen needed to be replaced, and they had raised this issue with the owner of the premises.
• Some of the bins in the home, including in the kitchen and wet-room were hand-operated, which increases the risk of the spread of infection.
• A grab-rail in the wet-room was rusted and there was a layer of visible dust on top of the hand-towel dispensers in the wet-room and a toilet. Hand-towels were stored on the top of toilet cisterns.

Staffing and recruitment
• There were sufficient staff to meet people's needs. The provider told us they worked out staffing levels based on the support commissioned by the local authority. They told us they would also vary staffing levels based on the needs of people using the service at that time.
• During our inspection we saw there were sufficient numbers of staff on duty to provide people with support in a timely way.
• Rotas showed shifts were covered, including through use of agency staff when required. There was one vacancy for a member of waking night staff at the time of the inspection. Staff told us it was usually a regular member of agency staff who covered these shifts.
• There were procedures in place to help ensure staff employed were of suitable character.
• The recruitment process included, obtaining a full employment history, exploring gaps in employment, obtaining proof of identity, carrying out an interview and requesting a disclosure and barring service (DBS) check. A DBS check provides details on any convictions, and dependent on the level of check, whether the applicant is barred from working with vulnerable people.

Learning lessons when things go wrong
• Staff recorded accidents and incidents on an electronic system. This allowed the area manager to have an overview of incidents that occurred in the service so they could take appropriate action to investigate or escalate any concerns if needed.
• The manager or representative of the provider investigated incidents. Serious incidents were escalated to the company's board for their consideration and oversight.
• We saw the former registered manager had completed a summary of accidents/incidents that occurred in the service annually. This helped identify any potential trends or emerging concerns.
• The area manager told us that for certain incidents, such as medicines errors, they would ask staff to complete a 'reflective account' of what had gone wrong. They told us they found such an approach encouraged learning and identification of ways a repeat incident could be avoided.

Requires Improvement

Is the service effective?

Our findings

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

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

Staff support: induction, training, skills and experience
• At our last inspection in October 2017 we found low completion rates for some training courses that were important for staff to be able to support people using the service effectively. This was a breach of Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found the provider had made improvements and the service was now meeting the requirements of this regulation.
• Relatives told us they felt staff were competent to meet the needs of their family members. One relative told us, "We're generally quite happy and don't worry about them looking after [person]".
• Staff had completed a range of training that would help provide them with the skills and knowledge they needed to provide people with safe and effective care.
• Training courses included mandatory courses that the provider required staff to complete across all their services such as training in the mental capacity act, safeguarding and infection control.
• Staff had also completed courses specific to the needs of the people they were supporting. These included dementia awareness, moving and handling and dysphagia (swallowing difficulties).
• The provider told us learning disability awareness training was included as part of the induction for new staff, but at that time was not provided to existing staff.
• Staff had not received training in active support or positive behavioural support, although the provider told us this would be rolled out to this service soon. These courses would further staff member's skills in supporting people with a learning disability effectively.
• Staff felt they received sufficient training to allow them to care for people competently, although one staff member commented that they would like additional training in dementia care. A proportion of the training courses were delivered by e-learning, and they also told us this did not suit their learning style.
• Staff new to the service were supported to complete the care certificate. The care certificate outlines standards that all staff new to health and social care are expected to meet as part of their induction. It helps ensure they have the required skills, knowledge and behaviours to provide safe and effective care.
• Staff received regular supervisions, which were recorded in a 'You Can' booklet. We saw topics discussed included safeguarding, attendance, making a difference and training.

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

appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).
• We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.
• Whilst we found some evidence of good practice in relation to implementation of the MCA, we also found shortfalls in this area.
• Staff had assessed people's capacity to consent to their plan of care. If the person was found to lack capacity, staff had recorded a best interest decision that involved discussion with relevant persons, or had submitted DoLS applications to the local authority.
• People's care plans outlined how staff should support them to make decisions, and who else should be involved in making decisions in relation to areas such as medicines, relationships, finances and eating and drinking.
• Staff had assessed whether people were subject to any potentially restrictive practices. Where people were found to lack mental capacity, and be subject to restrictive practices, they had made DoLS applications to the supervisory body (local authority).
• Staff administered one-person's medicine covertly (without their knowledge). Whilst staff assured us this decision had been made in the person's best interests, and agreed with their GP, this was not clearly documented within their care records. During the inspection, staff recorded a mental capacity assessment and best-interest decision, which included consulting with the person's GP and family member. They told us they would also seek advice from a pharmacist.
• Care staff received training in the MCA and DoLS, but were not always able to explain how they applied to people living at the home. However, during the inspection we saw staff involved people in decisions about their care and support and asked for their consent when appropriate.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• Staff had assessed people's needs in relation to a range of their health and social care support needs.
• We found care plans provided staff with sufficient information to allow them to meet people's holistic needs in accordance with their preferences.
• However, multiple care plans were in many cases combined into one description of people's needs. For example, there were no separate care plans in relation to activities, oral hygiene, sleep or eating and drinking. This could make it harder for staff to find relevant information.
• Where possible, we saw people were involved in developing their care plans. Relatives told us they had been involved in assessments.
• Staff were kept informed of changes to guidance to help ensure people received safe and effective care. For example, we saw staff had been briefed about the standardisation of descriptors used to inform staff about the textures of food and drink people required.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
• People had health action plans in place. These provided details about how staff should support people to meet any identified health care needs, including through regular reviews and involvement of other health professionals.
• However, we found health action plans were not always accurate or up-to-date. One person's health action plan referred to a when required medicine that they were no longer prescribed. A second person's plan referred to a mental health condition that there was no care plan in relation to, and which staff told us they did not have. They told us they thought the entry in the health action plan had been made in error.
• Records showed staff supported people to access health and social care services that would help ensure their needs were met. For example, we saw district nurses, GPs, speech and language therapists and the community learning disability team had been involved in people's care.

Supporting people to eat and drink enough to maintain a balanced diet
• People were supported to eat and drink enough. However, there were shortfalls in procedures relating to meeting people's dietary needs.
• Staff told us they developed menus based on their knowledge of people's preferences. We saw a list of 'alternatives' had been developed for one person who did not enjoy many of the same foods as other people living at the home.
• We saw the provider had identified an action in their last audit indicating staff were to discuss the menus with people living at the home, and consider more home-made, rather than shop-bought meals. During the inspection we saw staff supporting one person to make a home-made soup.
• Staff monitored people's weights if required, and referrals were made to relevant professionals if there were concerns about unplanned weight-loss.
• People's dietary requirements were recorded in their care plans. However, this information had not always been kept up to date. One person's care records indicated they should receive dietary supplements. Staff were aware of advice of the dietician, which was that this person did not need supplements if their weight was maintained above a certain level, which it had been. However, this information was not contained in the care plan or risk assessments.
• Staff were aware of, and followed advice from speech and language therapists in relation to the support people needed to eat and drink. However, whilst staff monitored what people ate and drank, they had not recorded the quantity of food and fluids they had offered and people had consumed as recommended.

Adapting service, design, decoration to meet people's needs
• The home was a small bungalow in a residential area. There was level access to all areas of the home. However, a relative informed us the garden area was not fully accessible to wheelchair users.
• Rooms and corridors were large enough to accommodate any specialist equipment people needed, including profiling beds and hoists.
• Some adaptations had been made to make the home more accessible to people. This included the use of memory boxes outside people's bedrooms, and pictures on the kitchen cupboards to help people identify what they contained.
• The provider acknowledged that some areas of the home, including the kitchen, required updating or redecorating. The provider was working with the owner of the building to try and ensure these updates were made. Relatives and the provider also made us aware there had been previous problems with the heating system, although the heating was working adequately during our visit to the home.

Good

Is the service caring?

Our findings

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

People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; equality and diversity
• During the inspection we observed positive and respectful interactions between staff and people living at the home. We observed staff talking socially with people.
• People were smiling and relaxed in the presence of staff and when receiving support. The person we spoke with told us they knew and got on well with the staff supporting them.
• We received positive feedback about the kind and caring approach of staff from relatives. One family member told us, "We want to mention how welcome staff make us feel when we go to visit. It does seem quite a happy place" and another relative said, "The staff are wonderful with [person]. The general ambience of the place is nice."
• People knew the staff supporting them. Regular agency staff were used to cover a waking night shift. Staff told us, "The regular agency staff are really good with the residents."
• We spoke with a member of agency staff working on the second day of our inspection. They told us they had worked at the home previously, and had received a good induction and handover in relation to people's support needs.
• One relative told us, "They rarely use agency staff which impressed me as staff seem to stay there."
• Staff told us they would be happy for a friend or loved one to receive care at Norwood Drive.
• Staff received training in equality and diversity and that covered topics including human rights and dignity and respect. The provider had policies in place to support procedures aimed at ensuring people were treated with respect and their individual needs were met.

Supporting people to express their views and be involved in making decisions about their care
• Staff arranged six monthly reviews of people's care. When possible, the person was involved in these reviews, or a representative such as a relative.
• People's expressed preferences were considered as part of the review process. Other ways of understanding what was or was not working for people who were unable to express this verbally, included reviews of their daily care records. A member of staff reviewed these records each month and recorded any learning.
• Staff spoke with people and supported them to make choices in relation to their daily routines when possible.
• Information about the service was displayed on notice boards in communal areas. This included information about safeguarding and complaints. In addition, the deputy manager had placed information she thought might be useful for staff or people's visitors on the notice boards. This included information on activities for people living with dementia and different health conditions.

Respecting and promoting people's privacy, dignity and independence

• During the inspection we observed staff take positive steps to encourage and support people's independence. For example, we observed a staff member move a person's bowl towards them so they could eat more easily without direct staff assistance. After their meal, they encouraged them to use a napkin to wipe their face.

• Staff were aware of what people could do independently, and encouraged them to take part in tasks such as making drinks and meals when they were able. During the inspection we observed two people who helped clear up after their meals, and staff supported one person to cook a meal.

• The person we spoke with told us staff supported their independence, but provided them with the support they felt they needed to stay safe.

• Staff told us they would help respect people's privacy by ensuring doors and curtains were closed when providing any personal care. During the inspection we saw staff knocked on people's bedroom doors before entering, and closed them behind them.

Requires Improvement

Is the service responsive?

Our findings

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

People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
• Care plans were person-centred and contained detailed information about people's preferences, likes, dislikes and social history. This would support staff to get to know people and deliver care that met individual needs and preferences.
• People's communication support needs were identified and recorded in their care plans. This included information about how people communicated non-verbally, and how staff should respond to such communication.
• Information on people's communication support needs was recorded in their hospital books, which were sent with them if they were admitted to hospital. This would help other professionals understand how to communicate effectively with people.
• Staff had identified people's goals and aspirations and identified the steps that needed to be taken to achieve their goals. Staff considered what progress had been made towards meeting people's goals at the six-monthly reviews.
• Staff we spoke with knew the people they supported well. They were able to talk in detail with us about people's needs, interests and preferences. We observed staff provide support to meet people's preferences as recorded in their care plans.
• We found mixed evidence in relation to the support people received to take part in meaningful activities and their communities. One person we spoke with told us, "I do my crayons and sometimes play a board game. I go out with staff to do shopping for personal things. Sometimes I go out with my sister. I go to [day centre] and did my own cooking today.
• There was an activity planner displayed within the house, and staff recorded people's preferences in relation to activities. During the inspection we saw staff put on films for people, one person took part in a cooking and baking session, and some people attended day centres. However, these activities did not engage everyone living at the home.
• We saw limited evidence from the records we reviewed that staff supported people to access the local community or go on trips out. Whilst staff assured us such activities did take place, comments from staff and relatives indicated they were limited.
• One staff member told us, "We try with what we have, it's mainly in-house activities. There's not always a lot we can do with weather, money and drivers." One relative told us they felt there was 'little commitment' to supporting their family member to go out on a regular basis. They commented that they sometimes had to ask staff to get their family member up, rather than leave them in bed all day. A second relative also recognised that staffing levels and individual's available finances could have an impact on the activities staff could support them to take part in.
• We recommend the provider reviews and implements best practice guidance in relation to supporting people with dementia and learning disabilities to engage in meaningful activities and occupation.

• Staff supported people to maintain relationships with people who were important to them. For example, they supported one person to visit their brother in the community. People's families could visit without restrictions.

Improving care quality in response to complaints or concerns
• People, including relatives we spoke with told us they would feel confident to raise a concern or complaint with staff.
• The service had received one formal complaint since our last inspection. This resulted in the provider issuing an apology to the person raising the complaint.
• The provider acknowledged in their response to this complaint that they had not correctly followed their complaints process, including how they acknowledged the complaint and the timescale for providing a response. After the inspection, the provider told us they had in fact followed the correct procedure, but that the complaints policy referred to when handling this complaint had been an old version that had been replaced.

End of life care and support
• The service was not providing end of life care to anyone at the time of our inspection.
• Staff had received training in end of life care. The area manager told us they would review staff training needs if anyone using the service required end of life care support.

Requires Improvement

Is the service well-led?

Our findings

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

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

Continuous learning and improving care; Working in partnership with others
• The provider had worked alongside other agencies including the police and local authority following recent incidents. This helped ensure people continued to receive the care they needed, and that risks to people's safety had been considered in an open and transparent way.
• Commissioners of the service had visited and made recommendations to improve the quality of the service. Whilst the provider had acted to implement the suggested improvements, they considered other recommendations would not improve the quality of the service.
• For example, commissioners had recommended that staff names be displayed on the activity board so people and visitors would know who the staff on duty were. The provider had considered this recommendation and recorded that they did not think displaying this information in written form would be useful. When asked, they told us other methods of displaying this information had been considered, but also not thought to be of benefit to people using the service.
• The provider had systems in place to help them monitor the quality and safety of the service. However, these had not always ensured the shortfalls we found during our inspection had been adequately addressed.
• Staff recorded incidents, accidents and complaints on an electronic system that allowed the area manager to monitor the completion of actions and investigations, and to look for any trends.
• The registered manager had also completed analysis of records including daily records of care and accident/incident reports. This helped them identify any improvements that could be made to the service.
• Staff completed audits relating to aspects of the service including; medicines management, health and safety and infection control. The provider also carried out regular audits, with the most recent having been carried out in November 2018 and January 2019.
• The audits and quality assurance processes had not identified some of the issues we found. This included the finding that a DoLS re-application had not been made in a timely way, issues in relation to poor infection control procedures, inaccuracies or gaps in assessments and care plans and not having oversight in relation to all aspects of the safety of the premises. Full and accurate records of care were not always maintained, including in relation to records of food and fluid intake and records of seizures.
• This is the third consecutive time the service has been rated requires improvement overall. The provider had not supported the service to sufficiently improve the quality of the service it provided to people living in the home.

The provider's systems and processes were not sufficiently robust to ensure the quality and safety of the

service was adequately monitored and improved. Accurate and complete records relating to people's care were not always maintained. This was a breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

• The service did not have a registered manager in post. The registered manager had left the employment of the provider five days prior to our inspection. They had applied to cancel their registration with the CQC as of 18 January 2019. They had been registered with CQC to manage Norwood Drive since September 2016.
• In the absence of a registered manager, the deputy manager was managing the service day to day with the support of the area manager. One relative fed-back to us that they found the deputy manager to be 'excellent'.
• Staff were clear about the responsibilities of their roles. They described the purpose of the support they provided as making sure people's needs were met and providing person-centred care.
• Staff told us they felt the management team, including the deputy manager and area manager were visible and approachable.
• We cross referenced records held by the service with statutory notifications CQC had received. We found the provider had sent us the required notifications. Notifications are information that providers must send us about certain significant events such as deaths, safeguarding and police incidents.
• The service was displaying its' performance rating from the last inspection of the service both on-line and in the home as required.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

• Some relatives told us they felt the provider had not been open and 'up-front' with them. This related to an incident that had occurred at the service that ultimately led to people being temporarily moved to alternative accommodation.
• The provider told us it was not their intention to keep information from people's relatives. They identified that a misunderstanding had arisen due to confusion in relation to an acronym the provider used. This meant not all people's families had been informed of the incident, but this had not been identified when more senior managers were reviewing the incident paperwork.
• The provider had recently agreed that they would start to hold meetings with relatives of people living at the home every other month. Relatives saw this as a positive step. They hoped these meetings would help improve communication with the provider, and allow them to openly feed-back any concerns they had, and 'feel more involved' in the running of the service.
• Staff told us they would feel comfortable to act openly and honestly if they made any mistakes. They told us they believed they would be treated fairly by the provider, and would 'accept the consequences'' of their actions.
• The provider encouraged learning from incidents by asking staff to complete reflective accounts. This would help staff learn from any incidents and identify ways in which their performance, or the performance of the service could be improved.
• Staff told us they worked well together as a team. They said they would feel confident to discuss any concerns they had with their manager.

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 17 HSCA RA Regulations 2014 Good governance The provider quality assurance and audit systems did not identify, nor address shortfalls in the services quality and safety. Accurate records of care were not always maintained. Regulation 17(1)