Norfolk Care Homes Ltd

Iceni House

Inspection report

Jack Boddy Way
Swaffham
Norfolk
PE37 7HJ

Tel: 01760720330
Website: www.zestcarehomes.co.uk

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Iceni House is a residential care home providing personal care and support to 60 people aged 65 and over at the time of the inspection. The service can support up to 75 people. The care home consisted of two units, one on the ground floor and one on the first floor of the building. Each floor providing single accommodation for people requiring residential or more specialist dementia care.

People's experience of using this service and what we found
People were not supported to maintain their safety, and to prevent risk of harm. There were not sufficient numbers of suitably trained and skilled staff on each shift to respond to people's assessed needs and risks, including where people's call bells and sensor mats had signalled the need for assistance.

People were not being protected from the risk of the spread of infection, with concerns identified regarding infection prevention control and COVID-19 standards by the staff team.

People were not protected from access to risk items, including teeth cleaning tablets, razors and drinks thickener. Staff were not ensuring rooms and people's individual storage units were being kept secure.

People did not all have access to a call bell to enable them to source support from staff where this need had been identified in their care plans. People were not being supported to eat in a safe posture when in bed. People's breakfast was not being stored hygienically or at suitable temperatures to maintain food hygiene standards.

The provider was not maintaining consistent standards of oversight of the care provided to ensure people led safe and meaningful lives. The provider was not taking timely action to reduce the risk of incidents and accidents such as falls from reoccurring to keep people safe.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection (and update) The last rating for this service was Requires Improvement, (published 15 October 2020).

Why we inspected
The inspection was prompted in part due to concerns received about the security and safety of the care environment, and the management of people at risk of experiencing falls. A decision was made for us to inspect and examine those risks.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the Safe and Well-led sections of this full report.
We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from Requires Improvement to Inadequate. This is based on the findings at this inspection.
You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Iceni House on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment, staffing and the governance and oversight of the service at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures:
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Iceni House

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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
Consisted of two CQC inspectors.

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

The service had a manager registered with the Care Quality Commission and a nominated individual. This means that they 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 was unannounced.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with six people who used the service and observed care being provided in communal areas and spoke with one person's relatives. We spoke with the registered manager, nominated individual, quality manager, seven members of care and ancillary staff, including two members of night staff.

We reviewed a range of records, including four people's care records and two medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed. Inspectors observed the morning shift handover meeting and spoke with some night staff at the start of the inspection visit.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We provided final inspection feedback to the manager and provider team on 23 December 2021. We liaised with the local authority quality assurance team and made referrals to the local authority safeguarding team to alert them to concerns identified during the inspection site visit.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- The care environment was not keeping people safe. Doors were unlocked giving access to risk items such as cleaning and personal care products in the sluice and hairdressing rooms.
- Risk items were not being stored safely. Doors to lockable cabinets, containing razors, teeth cleaning tablets and prescribed creams were found with either keys in the locks or keys stored on top of the cabinets.
- Drink thickener was left on the drinks trolley. This did not protect people from risk of unsupervised consumption.
- Breakfast foods such as porridge and cooked foods were being left to go cold, rather than being kept at safe temperatures for people to consume.
- People did not all have access to call bells to enable them to seek staff assistance when required; two people asked inspectors for assistance in the absence of being able to contact staff.
- Staff were not ensuring people were correctly positioned prior to supporting people with eating and drinking to prevent risks of choking.

Risks relating to the health and welfare of people, and the safety of the care environment were not assessed and well managed. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection visit, we received assurances from the registered manager that these concerns were being addressed, and improvements made to staff practice. However, these concerns had not been identified through the provider's own audits and checks in place, therefore were only happening as a result of concerns found during this inspection.

Staffing and recruitment

- There were insufficient numbers of staff on shift to maintain people's safety or meet people's individual needs, risks and dependency levels. One person told us they chose to stay in their room rather than go to eat in the communal dining room due to a lack of staff to support them moving in their wheelchair.
- Dependency assessments were completed, but people's individual support needs were not reflected in the staffing numbers in place on each shift.
- Staffing rotas, as well as from speaking with staff and people using the service, identified there were insufficient staff on shift to meet people's needs, and provide individualised care.
- We identified people's call bells and sensor mats rang for long periods of time, unanswered.
- People were experiencing a high number of unwitnessed incidents, including falls. The local authority was

investigating the number of falls happening at the service, at the time of the inspection.
● The service's records showed staff had not received formalised supervision in three months, and there were gaps in staff training. This did not ensure staff had the necessary skills in place to meet people's needs.

Risks relating to staffing numbers, supervision and appraisals were identified. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection visit, we received assurances from the registered manager that additional staff have been appointed and are due to start working in January 2022. However, these concerns had not been identified through the provider's own audits and checks in place, therefore were only happening as a result of concerns found during this inspection.

Systems and processes to safeguard people from the risk of abuse
● People were not being kept safe due to poor care and environmental standards. Incidents, accidents and safeguarding concerns were not consistently being reported to the local authority safeguarding team, or to CQC.
● There was poor understanding and oversight of safeguarding practices by the provider and management team. This placed people at risk of harm.

Preventing and controlling infection
● We were not assured that the provider's infection prevention and control policy was up to date. Their policy was out of date, did not make reference to COVID-19 or associated safety practices.
● We were somewhat assured that the provider was preventing visitors from catching and spreading infections. Inspector's vaccine status was not checked on arrival, or when this was double checked with the registered manager, this contradicted the guidance in place on the premises.
● We were somewhat assured that the provider was admitting people safely to the service. The provider's policies required updating to reflect current government guidelines regarding enhanced testing and the management of isolation, in relation to those people living with dementia.
● We were somewhat assured that the provider was using PPE effectively and safely. Some staff were observed to not wear masks correctly.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. Staff were completing testing while seated with other staff in the main reception, rather than washing their hands and completing testing hygienically.
● We were somewhat assured that the provider was making sure infection outbreaks can be effectively prevented or managed. Staff were not all dressed bare below elbow, were observed to be wearing jewellery and nail varnish, which did not support maintenance of good hand hygiene standards. The provider did not plan to implement use of uniform in the event of future COVID-19 outbreaks to maintain people and staff safety.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.
● We were assured that the provider was meeting shielding and social distancing rules.

Learning lessons when things go wrong
● Lessons had not been learnt from recent serious incidents.
●The provider team were not found to be receptive to inspector's feedback as a means of adjusting and improving standards of practice.
● Actions remained outstanding for the provider's service improvement plans including one relating to a

recent review completed by the local authority. This did not demonstrate that timely action was being taken in response to feedback or findings.

Using medicines safely

- Improvements to the safe storage of prescribed creams was required, to maintain people's safety.
- We identified an example of discrepancies in allergy information recorded in a person's medicine records, and care plans; this had not been identified by staff during the checking systems they had in place.
- Medicines were being given to people as prescribed.

Inadequate

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.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to rating of Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Continuous learning and improving care

- The nominated individual and registered manager did not recognise or understand their regulatory responsibilities. Notifiable incidents had not all been submitted to CQC.
- There were signs of a closed culture within the service. When significant incidents occurred, including those that led up to the inspection being completed, these were not openly discussed or the seriousness recognised by the nominated individual.
- There was a lack of learning from incidents, accidents and advice from external professionals. This was reflected in the deterioration in rating, and breaches of regulations.
- The service required greater standards of provider level oversight and formalised auditing to ensure areas of risk were being identified and addressed. The checks in place had not identified environmental risks found by inspectors.
- Written records were not in place for all relevant checks and audits in place. Inspectors were told this was due to the impact of the COVID-19 pandemic had on the management team's workload. As a result, standards of care and the condition of the environment had deteriorated since our last inspection.
- A number of key policies and procedure required updating to reflect current government guidance and recognised best practices relating to infection prevention and control, including COVID-19.
- Staff were observed not to make any notes of risk information or actions required which were discussed during the morning shift handover meeting. Some staff were also late and missed the start of the handover meeting.

The provider demonstrated a lack of understanding and recognition of their own regulatory responsibilities and accountability to maintain standards of safe care at the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection visit, we received assurances from the nominated individual that they were implementing a service development plan. However, these concerns had not been identified through the provider's own audits and checks in place, therefore were only happening as a result of concerns found during this inspection.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good

outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● Where feedback of concern was identified during the inspection, the response from the nominated individual did not provide required assurances.

● Improvements to working relationships with external professionals were required to ensure positive outcomes for the people using the service.

● Staff were task focused, rather than focusing on the individual needs and meaningful quality of life for people living at the service.

● Staff were not working as effective teams, ensuring that mistakes in practice were identified quickly and confidently brought to the attention of their colleagues or members of the management team where required.

● Staff were unclear of the rationale for the service have closed circuit television in place on the ground floor unit, and what was being recorded. This impacted on their confidence to speak openly with inspectors.

The provider had poor governance arrangements in place to drive improvements and standards of safe care at the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection visit, we received assurances from the registered manager and nominated individual that these concerns were being addressed, and improvements made to staff practice. However, these concerns had not been identified through the provider's own audits and checks in place, therefore were only happening as a result of concerns found during this inspection.