County Care Homes Limited

Norwood House

Inspection report

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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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Norwood House provides accommodation and personal care for up to 71 older people. There were 41 people living in the home. The home was situated in a rural area of Middleton Moor on the periphery of the village of Saxmundham in Suffolk.

Norwood House 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. This inspection took place on 21 and 23 February 2018 and was unannounced.

There was a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our last comprehensive inspection in November 2016 we rated the home requires improvement. We recognised that whilst improvements had been made some of these were on going and not yet fully implemented, sustained and embedded into practice. We also found that further improvements were needed to ensure people are provided with their medicines safely at all times. Improvements were needed to show how people were provided with person centred care which was tailored to meet their specific needs. We also recommended that the service seek training for staff which was specific to the needs of the people using the service.

Prior to the inspection in November 2016 we carried out an inspection in April 2016. At this inspection we also rated the home requirements improvement, inadequate in well led and found that there were four breaches of the regulations. This inspection is the third comprehensive inspection since 2016 where we have rated the home requires improvement overall. We have also found nine breaches of the regulations. Due to this and the failure to make and sustain the necessary improvements we have rated the key question of 'well led' inadequate. You can read the reports from our previous comprehensive inspections, by selecting the 'all reports' link for Norwood House on our website at www.cqc.org.uk

We found that people were not always kept safe as there were insufficient staff deployed on shifts and whilst staff knew people well and were kind, they were not able to meet their care needs as they did not have sufficient time. People told us that staff were kind and caring but they often had to wait for care to be delivered due to the home being short of staff.

Notifications of events and incidents were not always submitted in accordance with statutory regulations. Registered managers and providers are required to submit to CQC statutory notifications in accordance with regulatory requirements however we found a number of safeguarding incidents that had occurred at the home which we had not been notified of.

Staff did not have a good understanding of how to safeguard adults from abuse and harm and who to contact if they suspected any abuse however they knew how to access this information should they have needed to.

The provider had not ensured they carried out their responsibilities to comply with the requirements of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS). Where people could not always make decisions themselves, mental capacity assessments had not been completed.

People received support from staff that were mostly kind and caring. However, people were not always treated with dignity and respect because staff were task focussed and care took place in a manner that was not centred on people as individuals and was at times hurried.

Care plans were not all reflective of people's current support needs; the information within them was not always detailed. We could not be confident that people always received the care and support they needed.

There were systems in place for managing medicines in the home. A medicine procedure was available for staff and staff had completed training in relation to safe medicine administration. Improvements were needed to the management of 'when required' medicines.

Referrals were made to external healthcare professionals and we saw involvement from district nurses, chiropody, dentists and GPs.

We found nine breaches in the legal requirements and regulations associated with the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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

There was insufficient staff on duty to meet people's needs.

The provider's recruitment processes were not robust and did not always ensure people were supported by appropriate staff.

People received support to take their medicines safely.

Essential safety checks had taken place.

Is the service effective?

Requires Improvement

The service was not always effective

Staff had not been provided with regular supervision and had not received all of the relevant training to support them in their roles.

The provider was not always acting in accordance with the Mental Capacity Act 2005.

There was no consistent approach being taken to ensure people received sufficient nutrition and fluid to meet their needs

People were referred to other healthcare services when their health needs changed.

Is the service caring?

Requires Improvement

The service was not always caring

Staff did not always have time to engage in meaningful interactions with people.

Whilst staff were kind they were not able to provide good care due to being rushed

People's privacy and dignity were respected.

Is the service responsive?

Requires Improvement

The service was not always responsive

Care records were not always up to date or robustly reviewed.

People did not always receive personalised care that met their needs.

There was a procedure to record and respond to any concerns or complaints about the service.

Is the service well-led?

Inadequate

The service was not well-led

The provider and registered manager had failed to identify the concerns we saw during our inspection.

Established systems were not always operated effectively to ensure compliance with the regulations.

There was a lack of oversight and ability to drive improvements within the service.

Some incidents which occurred at the home had not been notified to the Care Quality Commission in accordance with the regulations.

Norwood 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 checked 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 21 and 23 February 2018 and was unannounced. The inspection team consisted of two inspectors and an expert by experience on the first day and one inspector on the second day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we requested that the provider 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 received from the provider.

Providers are required to notify the Care Quality Commission about events and incidents that occur including unexpected deaths, injuries to people receiving care and safeguarding matters. Before the inspection we reviewed information that we held about the service such as statutory notifications. We also contacted commissioners (who fund the care for some people) of the service and asked them for their views.

We looked at the care records of six people in detail to check they were receiving their care as planned. We also looked at records including staff recruitment files, training records, meeting minutes, medication records and quality assurance records. Over the two days we visited, we spoke with eight people who live in the home, nine members of care staff, the chef, the receptionist, two deputy managers and the registered manager as well as two of the directors of the provider company. We also spoke with relatives of six people currently living in the home and another visitor.

Requires Improvement

Is the service safe?

Our findings

At our last comprehensive inspection in November 2016 we rated this key question 'Requires Improvement'. We had concerns that whilst some improvements had been made in the safe management of medicines these needed further embedding into daily practices. We were also concerned that improvements were needed in how the service ensured people's safety on a daily basis. At this inspection we found that whilst improvements had been made in these areas we now have additional concerns around staffing levels, safeguarding people and the management of risk. As a result we have rated this key question 'Requires Improvement'.

On our arrival at the home the registered manager told us that they had no specific concerns about the current staffing levels and told us that there were between six and eight staff on each shift during the day. On checking staff rotas and after speaking with staff we found that this was not accurate. The registered manager was aware that, previous to this inspection, we had received some information of concern from an anonymous source about the staffing levels at the home. We asked the registered manager on these occasions to assure us that there were sufficient staff on duty. As a result, the provider also sent us an action plan of how they were addressing the staffing shortages. This action plan included a fairer distribution of staff between early and late shifts and a direction that the management team would work four hours per day 'on the floor' working alongside the care team, to provide additional support to staff. When we spoke with staff they told us they were aware that the provider had made this request however they told us this was not happening. A member of staff said, "Since [provider] told [registered manager] to be out working on the floor, I've seen her a little bit but not much." We saw that the staff rota's did include the registered manager and deputy managers on some care shifts, however this was not on a daily basis.

Despite the actions taken by the provider, during our visits people, their relatives, visitors and staff told us that staffing levels were not sufficient to provide the support that people needed. One person told us, "There are nowhere near enough staff." Another person told us, "They [staff] are always busy and don't have time to chat."

Relatives we spoke with were also concerned about the staffing levels at the home. One relative told us, "There is often a shortage of staff, especially at weekends, [people] seem to be left more, staff don't interact so much." Another relative was concerned and told us, "Today I think [person] been left in here [dining room] when they could have been helped to the lounge."

Staff told us they were very concerned about the staffing levels and the impact that this was having on people's care. One member of staff told us, "It's hell here at the moment. We're short staffed and I've had enough. Staff are all slowly leaving and they are not being replaced." Another member of staff said, "At the weekend it [staffing levels] was exceptionally bad. Three [people] were still in bed at 2pm. It's not uncommon for people to be getting up at lunch time." A third member of staff told us, "We've been really short staffed, staff have to rush people and we can't do our jobs properly. Weekends are just horrendous."

Our observations were that there were insufficient staff. Staff were extremely rushed and task focussed, we

saw they had little time to spend with people. We saw frequent times during both days of our visit where people were left for long periods of time with no interaction. Following breakfast and lunch we found several people were still sitting at the dining tables. Over two hours after completing their lunch time meal, we observed one person remained sitting at the dining table slumped over the table asleep with their head on a table placemat.

Staff told us, and the eight weeks of rota's we viewed confirmed, that the level of staffing was frequently below the stated numbers given by the registered manager. The registered manager showed us the dependency tool they used which identified how many people required two staff to assist them along with whom required staff support to eat and with their personal care. The dependency tool however did not give any weighting to the analysis of people's needs or provide any calculation of how this information was used to determine safe staffing levels. Despite concerns about the home being short staffed, the registered manager was continuing to admit people into the home. We raised our concerns about this with the registered manager. We asked them to tell us how they were balancing the risk of a staffing shortage against increased numbers of people living in the home. We received information after our visit from the provider who told us that with immediate effect staffing numbers had been increased to the appropriate levels on each shift.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always protected by robust recruitment procedures. Staff being employed to work in care settings must have a Disclosure and Barring Service (DBS) check. The DBS carry out a criminal record and barring check on individuals who intend to work with children and adults. This helps employers make safer recruiting decisions and also to minimise the risk of unsuitable people from working with vulnerable children and adults. One staff member's DBS check had showed they had received a number of police cautions. However, there was no evidence of the registered manager or provider reviewing these concerns with the staff member or considering any potential risks involved in employing them. The DBS code of practice states that registered persons must have a policy in place to assess such matters. There was no risk assessment in place to show how concerns identified would be managed to protect people from potential risk. The registered manager told us that any concerns identified on the DBS would be asked about at interview stage and records would reflect this. We checked the application form and interview notes for this member of staff and on both documents the staff member stated they had no convictions. Therefore the registered persons employing this person had not followed robust recruitment processes to ensure only suitable people were employed.

This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not protected from the risks of abuse because systems were not embedded to identify or report concerns to the local authority adult safeguarding team and to CQC. This meant that lessons were not always learned from incidents or concerns because these were not consistently raised or discussed with the staff team. The provider's safeguarding procedures were to notify the local authority of any safeguarding incidents and to keep them informed of any investigations into safeguarding concerns. However, the registered manager and management team had not always followed their own procedures, or informed CQC of safeguarding concerns at the home as they were required to do by law. For example, on two different occasions and dates there were altercations between people who were living with dementia. In both of these examples the altercation resulted in one person being assaulted. These had not been reported to the local authority safeguarding team or CQC. This meant that the safeguarding team had not been able to offer

advice or investigate the concerns and we had not been able to check that sufficient and appropriate actions had been taken at the time of these incidents to ensure risks were managed to prevent them happening again. We requested that the registered manager make the appropriate safeguarding notifications during our visit.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not supported by staff that were knowledgeable about safeguarding and how to raise safeguarding concerns externally of the home or provider. Despite staff having received training about safeguarding we found in discussion with them that they were not clear on the action they could take and who they could contact. However, all staff were clear that there was guidance on safeguarding within the home that they could use should they need to.

Another person told us they didn't feel safe. They often chose to spend time in their own bedroom in their bed, however once there; they told us they had no means of calling for assistance or help. The system of people calling staff for assistance at the home consisted of pressure mats on the floor. When stepped on, the pressure mats raised an audible alarm so that staff would be aware. Pressure mats are often used to alert staff when people have left a particular area so they are aware to check on the person and their safety. Once in bed, people had to get out of the beds and step on the pressure mats to call for help or assistance. Where people found this challenging, it meant they had no means of calling staff. The person told us, "I haven't got a direct link to the [staff], so if I had a disaster I don't know what I'd do; I've no way of getting help, that does worry me I have to admit." The person demonstrated to us by walking to the door and calling out 'is there anybody there?'. Hearing no response from staff they told us, "See it's not very safe."

We saw the carpet in the home's main dining area was dirty and heavily stained. Between breakfast and lunch there were no efforts to clean it and we observed if there were spillages staff did not routinely make efforts to clean it. One member of staff told us, "There are all sorts of stains on that [dining room] carpet, blood, food, drinks." The registered manager told us that there were plans to address the issue. "We are looking to review the carpet in the dining room; we're looking for quotes and a replacement." Following our visit the provider told us the carpet in the dining room was deep cleaned weekly with an industrial carpet cleaner and that they had no current plans to replace the carpet.

This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people and their relatives told us that despite their concerns about the staffing levels they felt safe living at the home because of the care staff who were looking after them and the environment which they considered secure. One person's relative said, "I do feel [person] is safe, much safer than when they were at home, here they can potter around which is really important for [person]."

Risk assessments were in place in areas of care such as risk of falls, prevention of pressure ulcers and medication. We also saw there were additional person specific assessments, for example for the risk of poor nutrition or fluid intake. The risk assessments were legible and up to date however they were not always followed up with effective record keeping. For example people who had a nutritional risk assessment in place did not have the necessary follow up and monitoring of their care.

At our last inspection we were concerned that whilst there were improvements in the completion of medicine administration and for medicines that were prescribed for administration 'when required' (PRN)

we found that these improvements were not yet fully implemented to ensure that people were provided with their medicines safely at all times. We found at this inspection that improvements were still needed to the protocols around as required medicine to reduce anxiety. One person was receiving a PRN sedative when they became anxious and agitated. However this was not supported by a detailed care plan of when this medicine should and should not be used and the strategies that staff could attempt first.

Other people received their medicine as prescribed. Staff had completed training in the safe management of medicines which was followed by a competency assessment which included observations of them administering medicines. An audit took place to ensure that people received their medication as prescribed and staff carried out checks on each other's recording of medicine administration after every medicine 'round'. Medicine administration records (MAR) were completed. We checked the MAR charts and saw that these had been completed appropriately.

We saw staff wore gloves and aprons and used hand gels before delivering personal care. This protected both people and staff from potential cross infection. An infection control audit was completed to identify if standards were not being maintained and housekeeping staff had team meetings to review cleanliness and hygiene practices.

Certificates showed equipment within the home, such as hoists, hot water and central heating boilers, fire detections system and electrical appliances were maintained safely.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in November 2016 we rated the key question of effective requires improvement. We were concerned that staff did not receive training which was specific to the needs of the people who lived at the home to ensure that they were provided with safe and effective care at all times. At this inspection we found that whilst staff continued to receive and have access to training they told us it did not always meet their needs and enable them to provide people with effective care. We have rated this key question requires improvement again.

Training for staff was primarily undertaken by staff online using a computer based training system. The majority of staff told us that this platform for learning did not help them understand any changes to care practices and give them the skills and knowledge they needed to support people effectively. One member of staff told us, "If people are aggressive I personally let them calm down then I walk away and get them a new face [staff]. I've not had training in that so I don't know if that's what I should be doing." Another member of staff said, "We get basic dementia information on our training, however this is advanced dementia here. We need more training." A member of staff who spoke positively about the training they received told us, "Training is not refused if a need is identified. Face to face training would be provided if staff requested it." After our visit, the provider told us that training in how to support people whose actions may challenge themselves or others was provided to staff. However not all staff felt this was effective in providing them with the skills they needed.'

The majority of staff told us they felt they did not have enough training. Some staff had still to complete some of their training courses or refresh their knowledge of courses already undertaken. We spoke with the registered manager who stated there were a number of staff who had to complete their training courses and these were being planned in the near future.

The Care Certificate is a nationally recognised set of standards that health and social care workers new to care work should adhere to in order to deliver caring, compassionate and quality care. It should be completed within the first 12 weeks of employment and as part of staff induction. There was some confusion about whether staff completed the Care Certificate at the Home. The registered manager told us staff did not undertake, however the provider told us they did. There were no records to confirm that staff did undertake this. After our visit the provider told us new staff did undertake the Care Certificate at the home and that two recently recruited members of staff had commenced this learning.

We had mixed feedback from staff about whether they had been receiving supervision and support and how effective it was when they did. One member of staff told us, "I've rarely had supervision." Another member of staff said, "I've had one or two supervisions but not what I should do." A further member of staff was positive about their experiences of supervision at the home saying, "I have supervision once every six months, and I can discuss anything I like in that time." The registered manager had put in place a clear structure whereby senior care staff had a group of staff to supervise as did the management team. We saw a tracker with recorded and planned supervision dates. Whilst we didn't read specific staff supervision records we did look at the dates that supervisions were held for six staff members. We saw that supervisions had been held for

most staff twice a year. We also found that, in line with the providers policy, newly employed staff had received regular probationary review meetings instead. Supervision is dedicated time for staff to discuss their role and personal development needs with a senior member of staff or manager. Staff should receive appropriate support, training, supervision and appraisal as is necessary to enable them to carry out their role. Feedback indicated that not all staff felt consistently supported and or able to work effectively with people living with dementia.

People had not consistently been protected against the risk of malnutrition or inappropriate care because accurate records were not being maintained. There were gaps in the nutritional and hydration records where staff should have documented the care they had provided and people's intake. For example one of the people whose care we tracked and who was losing weight did not have the necessary monitoring of their nutritional intake in place.

We found that since admission to the home three months ago they had lost 7.6kgs of weight. The nutritional care plan in place stated that if the person was to lose weight fortification of their food should be commenced. The care plan however failed to describe to staff how this was to happen. A food and fluid chart had been put in place for this person however the recordings on it were intermittent and variable in detail. We saw numerous gaps and a failure to offer the person additional choices where they may have refused their meals. The food recording chart also failed to state if food had been fortified and we also saw that where people who were at risk of weight loss had not eaten their meal staff had not recorded any attempts to go back later in the day to prompt the person to have something to eat.

There was no evidence the fluid balance charts were being reviewed, recording was also variable. and there was no target fluid intake specified so staff could not be clear when further action was needed to prevent the risk of dehydration. Staff told us that they didn't always have the time to help people with their nutrition and hydration needs and complete records appropriately. One member of staff told us, "We are so short staffed it means pushing fluids is just not possible. I suspect most [people] are getting dehydrated."

We were told by the home manager that there were people living at Norwood House who were diabetic. We looked one of these people's care plans and found that there was no diabetes care plan in place. This meant that care staff could not be clear whether there were any restrictions on what the person could or could not eat.

All of these concerns amounted to a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed lunchtime and the mealtime experience. Most people ate in the large dining room adjoining the kitchen. We saw the tables were set with table cloths and condiments were available. People were positive about the meals provided. One person told us, "Every morning I have egg and sausages." Another person said, "The food is good, top notch. The chef is very good. Mostly it's just bought to me but sometimes they ask me what I want." A third person told us, "At night time you get a drink of your choice, I have Horlicks made with water. You have a choice at meal times, staff get to know what you like, what cereal you like, and you get to know them."

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

interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

During this inspection, we found consent to care was not always sought in accordance with legislation and guidance. The service had sought consent from relatives who did not have the legal authority to agree to care and support on a person's behalf. Where people did not have the capacity to consent to their care a letter had been put in their care plan asking a relative to sign to consent to their care being completed. Where people could not make decisions for themselves, records did not show who had been involved in making decisions for people. They did not show decisions had been made in their 'best interests' in consultation with people who were important to them, advocates and health and social care professionals as appropriate. A member of staff we spoke with was concerned about MCA practices in the home. They told us, "We [staff] are told to get people to sign to consent to their care. They [people] have all had DoLS applied for so therefore they don't have capacity to consent to their care so why are we being asked to get them to sign consent?"

DoLS applications were being systematically processed for everyone who used the service without a proper capacity assessment always being carried out. Some of these applications however had been approved by the local authority following the DoLS assessor's assessments. 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. We looked at the DoLS authorised for two people and the conditions. We found that in both cases the conditions had not been complied with. For both people, specific care plans and guidance should have been written covering some of their individual support needs; however neither person had these in place.

We discussed this with the registered manager, who did not have a clear understanding of the MCA and was not clear whose responsibility it was to carry out any MCA assessments. The registered manager agreed to review their understanding of the principles of the MCA.

All of these concerns amounted to a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives told us staff helped people to access healthcare services when they needed to. We saw evidence of the involvement of community healthcare professionals in people's care records. People and their relatives told us that their health care needs were met. One person said, "[Family member] has been here 18 months. When they first came they were [very unwell} and were very vulnerable. They [staff] were brilliant from the start and [family member] settled easily."

We looked at how people's needs were reflected in the adaptation, design and decoration of the premises. Many people at the home were living with dementia and as such the provider had sought to make the environment dementia friendly with reminiscence items available on the walls and within the lounge areas. Accommodation was provided over two floors with two passenger lifts available for access to the first floor. As well as a main dining room on the ground floor, there were two main lounges along with some additional smaller lounge areas. This meant there was space available if people wanted to spend quiet time or to talk privately with any visitors. Toilets and bathrooms were clearly marked to encourage independent use and help people who might have difficulties orientating around the premises. We saw there was signage around the building to assist people to locate different areas of the service.

Requires Improvement

Is the service caring?

Our findings

At our last inspection in November 2016 this key question was rated good. At this inspection we found that improvements were needed. This key question has been rated as requires improvement.

People gave us mixed views about the care provided in the service. One person told us, "Staff are very kind, we all have a special carer, mine's very good, she comes and makes sure I'm alright."

Before we carried out our inspection we received information from a number of sources which indicated that some people living at the home might not be receiving appropriate care due to the levels of staffing. We found that this was the case during the two days of our visits. Whilst we observed some kind and caring interactions between staff and people who lived at the home, staff were busy and often task focused. Several people and their relatives also said staff were too busy to have any meaningful engagement with them. One person said, "Staff help out, they are kind. They help me dress if they are free, if they can't I sit down here in my chair and wait." We viewed a management audit carried out in the home during February 2018. This document highlighted that people were only being offered baths and showers when staffing levels permitted.

We received mixed feedback from relatives about their family members care. One relative told us, "The care my [family member] gets is not what they deserve. They lived through the war, I'm actually glad they have dementia now so they are not aware of what it's like there." Care staff we spoke with confirmed that they did not have the time to offer people the care they wanted and needed due to the staffing levels. We also received some positive and complimentary feedback from other relatives. Another relative told us, "The staff are really lovely to [family member], very attentive, want to know about them. They always have clean clothes."

We also observed some actions by staff that were not caring or respectful of people. During the morning we sat in a lounge area with several people. During this time the homes fire alarms were tested. Whilst we were pre-warned of the test we observed several people at the home had a very negative reaction to the sound of the fire alarms. One person started crying loudly and another person appeared very frightened and anxious. No staff member came to check on people or to reassure them that they were okay and what the loud noise had been.

Staff were confident when talking about how they promoted people's rights to privacy and dignity. They told us they always shut curtains and doors when assisting people with personal care and made sure people were covered up as much as possible when having personal care. A member of staff said, "I always make sure I close people's bedroom door before helping them with personal care. I ask, would you mind if I help you?"

We asked relatives about the staff's approach to their relations privacy and dignity. One relative told us, "They [staff] are very kind and caring." Staff told us they were committed to providing high quality care but did not always have time to get to know the people they were supporting.

We also observed interactions between staff and people who lived at Norwood House which were kind and gentle. Many people seemed comfortable with staff and staff clearly knew people well. Staff gave examples of respecting people's privacy and dignity and demonstrated their awareness of the importance of protecting people's confidentiality. People's personal information was held securely in locked filing cabinets when not in use. One member of staff told us, "I always make sure I close people's bedroom doors before helping them with any personal care. I ask, 'would you mind if I help you?' we [staff] all say that."

The home held a 'resident of the day' scheme which the registered manager told us aimed to involve people in their care. The scheme ensured that once a month each person would have a full care plan review as well as a review with other departments in the home such as housekeeping and the kitchen staff. One of the kitchen staff told us they spoke to whoever was resident of the day in order that they could make a decision about what special meal they would like for their day. Staff communicated with relatives so that they could also be involved in reviews. One relative said, "I brought in very comprehensive care notes that I had, the manager said they would build a care plan from that."

Visitors were encouraged and welcomed by the staff and people could visit their relatives in the privacy of their room or in the communal areas of the home. A relative of a person who used the service said, "They ring me if they are not sure of anything, which encourages contact. If you come in and ask staff always know how [family member] is." Another person's relative told us, "They [staff] are good at communicating, they pass information onto me. If [family member] has any falls they get the paramedics."

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in November 2016 this key question was rated requires improvement. We had concerns that necessary improvements to care plans had not yet been fully implemented and embedded in practice. We found that care plans needed to be more person centred and reflect the care and support each person required to meet their individual needs. At this inspection we found that the necessary improvements had still not been put in place. This key question has been rated as requires improvement again.

People's needs were not appropriately assessed or planned for and this had the risk of potential impact on their health and wellbeing. We looked at the care files of three people who used the service. Specific care plans were not in place for every area of people's support need. For example two people living at the home had diabetes. We found there was no diabetes care plan available and insufficient detail in the rest of their care plan about how they needed staff to help them monitor and manage their diabetes. This meant staff did not have sufficient information about people's needs to guide them in supporting people safely. Another person had a 'when required' medicine prescribed for if they became agitated or upset as a result of them living with dementia. However they did not have a care plan in place that sufficiently guided staff as to when to administer the medicine. Another two people had a condition on their DoLS authorisation that meant a specific plan of care should be in place. We found that neither of these plans had been developed. Some people needed records to be maintained to demonstrate how much they had eaten and what drinks they had taken; other people needed records to be completed to demonstrate how they had been supported throughout the day. We saw these had not always been completed to demonstrate people had received the care they needed. The registered manager acknowledged that improvements were needed to the care plans and records to accurately reflect people's needs.

People had mixed views about the opportunities they had to pursue their hobbies and interests. During our inspection visit, we saw people mainly sat quietly, watched the television or listened to music. Apart from a baking session involving several people early in the morning and a visit from a 'pat dog' during the afternoon on the first day of our visit there were no organised activities arranged. There were no opportunities for people to go out. One person told us, "I sit around all day, nothing much else to do." Another person said, "I sit around a lot. We go out sometimes, they arrange outings and I always make sure I go on them." A third person commented, "The sofas are made to take wear, you sit in them a long while." Some other people were more positive and made reference to some entertainers that performed in the home on occasions. One person said, "Through the day I'll have a chat with somebody or other, read the paper, might wander about. People come and entertain us, someone might come and play the organ for a couple of hours and then they go home." One person's relative told us, "They don't very often do activities when we are here. I know that they do sometimes do baking, painting, they have visiting animals and entertainments, and they do outings, afternoon tea for the women, and pub lunch for the men." Another person's relative told us, "The activities used to be amazing. Now there is nothing going on, nothing at all. They [people] just sit in the lounge and look at each other, it's pitiful."

We found that the home employed activities co-ordinators however when we looked at the staffing rota's to

see when they were working we found there were frequent days when no activities co-ordinators were at the home. We were also told by staff that at times the activities co-ordinators were taken away from delivering activities to carrying out care tasks. Staff also told us that there were minimal opportunities for people to be involved in activities and follow any interests. One member of staff said, "I don't see much going on, there are days when there is more than others, but no not much."

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's relatives told us that they had been consulted about the initial development of the care plan. A relative told us, "We haven't discussed a care plan, but [family member] has one, they have discussed [family members] medication with us."

Policies and procedures were in place to respond to complaints. The provider had a complaints policy, which set out how complaints would be investigated and the timescale for responding. The relatives we spoke with were aware that they could raise a concern. We saw concerns that had been raised had been investigated and outcomes communicated.

Some people and their relatives had discussed preferences and choices for their end of life care including in relation to their spiritual and cultural needs. This was clearly recorded and kept under review. This meant people's end of life wishes were clearly recorded to provide direction for staff and ensure people's wishes were respected. The registered manager told us no one living at the home at the time of our inspection was being supported at the end of their life.

Inadequate

Is the service well-led?

Our findings

At our last inspection in November 2016 this key question was rated Requires Improvement'. At two previous inspections the rating was also 'Requires Improvement'. Whilst some improvements had been made, not all of these had been fully addressed and were still ongoing. We have concerns about the history of non-compliance and the failure to ensure that improvements are made, sustained and embedded into practice. We have rated this key question 'Inadequate'.

The governance of the service was not effective or robust and this was evidenced by the lack of oversight. Whilst staff were aware that some people were at risk of weight loss and dehydration we identified that the corresponding records and charts were not always completed. It was not clear who checked that nutritional records were in place and that these were completed regularly and in detail. The wellbeing of those people who required this support was dependent on staff to ensure they received adequate nutrition and hydration. Accurate record keeping was an important part of these processes that was not always well managed.

The registered manager and provider carried out some quality assurance checks at the service. However, these checks had not identified and acted on the issues we found at this inspection.

There was no effective process to determine staffing levels in the home which took into account the dependencies of people and the layout of the building. Despite the service being short staffed the provider and registered manager continued to admit people into the home.

Staff did not feel supported or valued in their role and told us that communication with management was not effective. They told us that it was a very challenging time at the service due to the lack of permanent staff and that morale amongst them was poor at the moment. One member of staff said, "They [home management team] see the staff rota, they see we are short staffed and yet they don't help us. Motivation is so low, I feel taken for granted." Another member of staff said, "We don't get a lot of feedback from the management, we [staff] are all so stressed with the staffing a little appreciation would go a long way."

Suitable arrangements were not in place to ensure people experienced person centred care. Staff were often task focussed and our inspection process found that people's choices and preferences were not always followed or respected. For example, in regards to personal care such as regular bathing and social care needs.

We noted two people's DoLS had been authorised with conditions. However, there was no evidence seen that action had been taken to meet the conditions. This meant the registered manager had failed to monitor and mitigate the risks to the welfare of the person.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had failed to notify CQC about all safeguarding allegations or incidents. This is a requirement

of the provider's and registered manager's registration so that where needed, CQC can take follow-up action. The registered manager was not clear on the regulatory requirement to report allegations of abuse to CQC.

This is a breach of Regulation 18 Care Quality Commission (Registration) Regulations 2009.

The registered manager told us staff meetings were held frequently. We found these were infrequent as only two meetings were held for care staff last year. We looked at the minutes from the last meeting which was held in October 2017 and was used to update staff about expectations within the home. Prior to this, the meeting before had been in April 2017. We saw that other departments within the home also had meetings such as housekeeping and that these had been held more frequently. We were aware that the provider also came to the home and met with staff in order to listen to them and seek feedback, staff confirmed that they had attended these meetings. After our visit the provider told us about the daily meetings held between key members of the staff team such as the registered manager and other 'heads of department'. The provider told us the purpose of these meetings was to raise issues relating to the daily running of the home such as staff numbers, people's welfare and catering arrangements.

The registered manager held regular 'coffee and catch up meetings' for people and their relatives however we saw that despite these being advertised people and their relatives did not attend. The registered manager told us that she held an 'open door' policy and was happy to speak to people or their relatives at any time. The service worked with other agencies in partnership. There was a good relationship with the local GP surgeries and the visiting nursing teams.

We found that not all staff understood and were confident about using the provider's whistleblowing procedure. Whistleblowing is where a member of staff can report concerns to a senior manager in the organisation, or directly to external organisations. They can do this anonymously if they choose to. We spoke to the provider who told us that there was a clear whistleblowing policy in place and they felt staff were aware of it. We also spoke to the registered manager who told us they were disappointed that staff told us they did not demonstrate awareness of whistleblowing and safeguarding. They told us that they often carried out 'on the spot' checks of staff understanding and were confident they were aware and had the necessary knowledge. They agreed to follow this up further with staff.

The staff team we spoke with also told us they were committed to ensuring that people received really good care. One member of staff told us, "Despite the staffing levels, I love this place [Norwood House]. It's so stressful with the staffing levels but I love the people who live here, that's why I stay." Another member of staff told us, "I stay here because I love the [people] who live here [Norwood House]. I only stay for them."

It is a legal requirement that the overall rating from out last inspection is displayed within the home. We found the provider had displayed their rating as required

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 CQC about all safeguarding allegations or incidents.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care provided did not meet people's individual needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Consent to care was not always sought in accordance with legislation and guidance.

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 People were not protected from the risks of abuse because systems were not embedded to identify or report concerns to the local authority adult safeguarding team and to CQC.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs

People's nutritional needs were not always met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The system of people calling staff for assistance at the home was not safe. Premises and equipment were not maintained to acceptable standards of hygiene.

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 implement effective systems to assess, monitor and improve the quality and safety of the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed People were not always protected by robust recruitment procedures.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not sufficient numbers of staff to meet people's needs safely.