SHC Clemsfold Group Limited

Norfolk Lodge

Inspection report

9 Norfolk Road
Horsham
West Sussex
RH12 1BZ

Tel: 01403218876
Website: www.sussexhealthcare.co.uk

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Norfolk Lodge is a residential care home providing personal care and accommodation for five people with learning disabilities at the time of the inspection. The service can support up to eight people.

The service has been developed and designed in line with the principles and values that underpin Registering the Right Support and other best practice guidance. This ensures that people who use the service can live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence. These values were not always seen consistently in practice at the service. For example, some people could live independent lives and were supported to do so. However, other people were not receiving the assistance with communication they needed to be as independent as possible.
Norfolk Lodge is owned and operated by the provider Sussex Healthcare. Services operated by Sussex Healthcare have been subject to a period of increased monitoring and support by local authority commissioners. Due to concerns raised about the provider, Sussex Healthcare is currently subject to a police investigation. This does not include Norfolk Lodge; the investigation is on-going, and no conclusions have yet been reached .

People's experience of using this service and what we found
Risks were not consistently being managed safely, such as around people's health needs, and staff did not fully understand who to report to under safeguarding. People did not always receive their prescribed medicines when they needed them. Lessons were not learned when things went wrong.

People were at risk of not receiving the right amount to drink as fluid charts were not completed correctly. There were some gaps in staff training and competency checks had not happened when they were needed. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

People's privacy and dignity was not always upheld; we found personal medical details discussed in a staff communication book. People did not always have their care plans in the format they needed them. Staff treated people with kindness and people told us they liked their staff.

People' care plans were not personalised, and some had important information missing. Activities were not person centred and they were not tracked to see what people did or if they enjoyed it. People knew how to make a complaint and the service was helping people make decisions around how they wanted to be supported at the end of their lives.

The service was not well led as audits had not been effective in putting right issues we found at the last inspection. We had not been told about all serious incidents and the previous inspection rating was not

being displayed in the service. There was a new manager at the service who was registering with CQC and was working to change the culture in the service.

People told us that they liked living at Norfolk Lodge and that they liked their staff.
We saw some examples of kind and considerate support from staff who had a caring approach.
People knew how to complain and were confident they would be listened to.

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

Rating at last inspection
The last rating for this service was Inadequate (published 17 April 2019) and there were multiple breaches of regulation.

This service has been in Special Measures since April2019

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection.

Enforcement
We have identified breaches in relation to person centred care, dignity, mental capacity, safe care and treatment, safeguarding, governance, displaying ratings and notifying CQC of incidents at this inspection.

We imposed conditions on the provider's registration. The conditions are therefore imposed at each service operated by the provider. CQC imposed the conditions due to repeated and significant concerns about the quality and safety of care at a number of services operated by the provider. The conditions mean that the provider must send to the CQC, monthly information about incidents and accidents, unplanned hospital admissions and staffing. We will use this information to help us review and monitor the provider's services and actions to improve, and to inform our inspections.

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 request an action plan from the provider to understand what they will do to improve the standards of quality and safety . We will work alongside the provider and 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 remains 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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our caring findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

Norfolk Lodge

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.

Inspection team
The inspection was carried out on both days by two inspectors.

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

The service did not have a registered manager in day to day control of the service. At the time of the inspection there was a manager registered. This manager applied to CQC to deregister on 9 January 2019 and this application was being processed by CQC at the time of the inspection. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided. A new manager had started in April 2019 and was applying to be registered with the Care Quality Commission.

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.
We reviewed information we had received about the service since the last inspection. We spoke with the local safeguarding adults' team and reviewed information that had been sent to us by the provider,

including statutory notification forms.
We used all of this information to plan our inspection.

During the inspection
We spoke with five people who used the service and two relatives. We spoke with the manager, an operations manager, and four care staff. We reviewed a range of records including four people's care records, medicines records, and a variety of other safety related documents such as fire risk assessments and kitchen safety records. We reviewed the providers' policies and procedures and staff records related to recruitment and day to day staff management.

After the inspection
We continued to seek clarification from the provider to provide further evidence. We looked at training and staff rota data and requested a safeguarding referral was made.

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 inadequate. At this inspection this key question has remained the same and continues to be rated inadequate.

This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

●At our last two inspections we found a breach of regulation relating to keeping people safe from abuse. At this inspection we found insufficient action had been taken and the breach had still not been met .
● During our inspection in January 2019 we found several incidents relating to unexplained bruising for the same person. These had not been reported to the provider or the local safeguarding adults' team, in line with the safeguarding policy.
● Following our last inspection, the incidents were reported to the local safeguarding team and recommendations were made including the reporting of unexplained bruising and that any concerns identified in full audits of the service should be reported to the safeguarding team .
● At this inspection we found entries in the staff communication book relating to an incident in April 2019 relating to a person having unexplained bruising and swelling of the knees. These incidents had not been reported to the local adult safeguarding team or to the provider's management team.
● We checked to see if an incident form had been completed for the incident, but it had not. We checked the monthly accident/incident audit and the behaviour recording forms but there was no record of any follow up or reporting, under safeguarding. Staff had called the person's GP and had been advised to monitor the swelling.
● We raised this as a concern with the manager who confirmed that no follow up had been completed. The manager acknowledged that this incident met the criteria for a safeguarding alert and raised one with the local safeguarding adults' team.
● The communication book contained reference to staff borrowing money from a person's wallet to buy milk and cheese for the service. This was inappropriate. We raised this with the manager who assured us this practice was not continuing and that any monies were paid back immediately.
● Staff had received training in safeguarding adults and were able to recognise the signs of abuse. However, we spoke with four care staff who did not know who specifically to report concerns to outside of the organisation. We raised this with the manager as a training issue.
● The failure to report safeguarding concerns as per the provider's policy is a continued breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

● We also found an incident where a person had not received a prescribed medicine. This had been flagged to the person's GP and it had been confirmed that no harm had been caused to the person. It had been decided that this would not be referred to the local safeguarding adults' team. However, we discussed this

with the local safeguarding team who felt it should have been reported as part of a trend and theme of medicines errors in Norfolk Lodge. The manager agreed for all future medicines errors to be reported to local authority and CQC. The Local Authority will then decide whether to progress with a safeguarding enquiry or not.

● Other concerns had been reported to the local authority safeguarding team in a timely manner.

Assessing risk, safety monitoring and management, and using medicines safely
At our last two inspections we found a breach of regulations relating to the safe management of risk. At this inspection we found insufficient action had been taken and the breach had still not been met .
● One person had a behaviour plan that referred to a self-injurious behaviour in the past. The person's behaviour plan stated that cleaning products must be kept locked away, so they could not be ingested. However, during a walkaround of the building with the manager on the first day of the inspection we found the cleaning cupboard open, with cleaning chemicals inside. We also saw there was a full bottle of cleaning fluid left out on a shelf in the lounge. This placed the person and others at risk of avoidable harm.
● We bought these issues to the attention of the manager who acted to ensure cleaning chemicals were kept safely locked away.
● At our previous inspection in January 2019 we identified risks to one person from choking. At this inspection we found that a referral had been made to the local speech and language therapy team and the person was due to have an appointment. However, care documents were not clear about the correct support the person needed to eat safely and contained contradictory instructions about the person's diet.
● There were three different descriptions of the person's diet across four care plan documents. This left the person exposed to the risk of not having their food in a safe way. New staff, or staff working in another care setting supporting the person, such as in hospital, may not know how to safely prepare food.
● The person's care passport referred to food needing to be liquidised for them to eat safely. The guidance from the provider's speech and language therapist in 2017 referred to the person eating a normal diet. The choking care plan had liquidised food crossed out in pen and had a hand-written note to state the person required chopped up food that was moist. The choking risk assessment stated the person needed a chopped-up diet but did not mention food needed to be moist.
● We raised these concerns with the manager who confirmed the person's correct diet with the speech and language therapist. The manager informed us that they would ensure all documents around the person's food were consistent.
● During the inspection we observed the person eating food cut up in to small pieces and with staff supervision. After our inspection the manager sent us an updated risk assessment that stated the persons food should be cut up small and they should have constant supervision when eating. The risk assessment had been reviewed and agreed by a speech and language therapist.
● Another person had a history of weight loss and refusing to eat. The person had lost weight in the two months up to May 2019 and then had a significant weight loss recorded in June 2019 with no follow up action.
● When we queried the significant weight loss the manager weighed the person and confirmed that the previous weight recorded in June 2019 was a false reading. However, staff were unaware the reading was false and there had been no action taken in relation to what had appeared to be a significant weight loss. This put the person at risk of not having the correct support if they lost more weight.
● There had been previous entries in a staff communication book in March 2019 and April 2019 stating the person was to be weighed weekly, and they needed a food chart to record their food intake due to weight loss. These actions had not happened.
● The same person had a nutrition care plan which referred to weight loss and food refusal as being historical issues. This was not reflective of the person's presentation in the months leading up to May 2019.

There was a handwritten note on a care plan in April 2019 that said food intake should be monitored. However, this had not happened, and the person's food was not being recorded and monitored until the first day of our inspection, two months later.

● Another person was diagnosed with constipation. One staff told us that they ask the person if they had 'used the toilet'. The elimination care plan stated that the person would not tell staff if they were constipated. However, staff were asking and one of the actions recorded on the elimination plan was to ask the person if they were constipated.

● There were instructions for staff to contact the GP and a reference had been made to 'as required' medicines to help constipation. However, there was no guidance on when to give the medicine, or when to contact the GP.

● We spoke to staff about the person's bowel charts and how staff monitored the risk of constipation. One staff told us there were bowel charts and these had been in place for about 3 weeks. The staff also said that when the person complains of another ailment it probably means they are experiencing constipation. This important information was not contained in any of the person's care documents.

● We reviewed the person's bowel charts and found there were two different formats used. The charts were not being completed effectively. Most days the charts were blank. The lack of clear care planning and effective monitoring placed the person at risk of not receiving the correct care around constipation.

● Medicines had not been managed safely. There had been several medicines incidents, in the months preceding the inspection, where people had not received their prescribed medicines as directed or had been overdosed.

● There was a 10-point check of the medicine's administration records, introduced in February 2019. However, there had been several medicines errors since this check had been introduced.

● One person had a protocol for 'as required' medicines for constipation. However, it failed to state when to give the medicine and did not include important information related to how the person told staff they were suffering from constipation.

● The failure to ensure effective risk management, to monitor and analyse incidents and to ensure that suitable actions were taken to make improvements and prevent further occurrences is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● At our inspection in August 2018 we found a breach of regulations relating to deploying enough staff with relevant skills, competence and experience to care for people safely. At the next inspection in January 2019 we found the breach had not been met. At this inspection we found that action had been taken and the breach was met.

● At our last inspection staff told us there were not enough staff and we found a lack of permanent staff. At this inspection new staff had been recruited and staff spoke positively about staffing levels. We observed that staff were deployed safely to support people.

● One relative told us, "There are always staff around when we've visited." The manager told us that there would be a full complement of staff in the week following our inspection. The staff rota confirmed that any agency staff used were consistent and worked night shifts with another permanent staff sleeping in.

Learning lessons when things go wrong

● Lessons had not consistently been learned when things went wrong. For example, we found an instance of unexplained bruising that had not been reported correctly at this inspection, after finding the same issue for the same person at the previous inspection.

● There had also been repeated medicines errors in the service in the four months prior to our inspection. Lessons around medicines errors had not been implemented to ensure they did not happen again.

● Risks around choking, constipation, safeguarding and fluid intake had been highlighted in some of the

provider's other services, and despite this we found the provider had not managed choking risks at this service.

● Some staff told us there had been improvements recently with the new manager. One staff told us they had time to read incident reports and other information now. The staff said, "[Manager] will let me know and give me time to read stuff. That's a really positive thing."

● The manager was starting to take a proactive approach to learning from incidents. For example, a staff meeting had been scheduled to discuss outcomes, following a visit from the local authority safeguarding team.

Preventing and controlling infection

● There was an infection control champion at the service in line with national guidance.

● Regular infection control audits were taking place. Action points from the last audit had been identified but not reviewed, such as purchasing a fly screen for kitchen. The manager completed the audit on the day of our inspection.

● There were also kitchen audits with action points like purchasing a new fridge that had been completed.

● Staff used personal protective equipment when required and the service was cleaned regularly.

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.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same continues to be rated requires improvement.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience
At our last two inspections we found a breach of regulations relating to training and competence of staff. At this inspection we found insufficient action had been taken and the breach had still not been met.

- Staff had been trained in medicines administration, but competency assessments had not been completed for all staff giving medicines. Some staff that had been involved in medicines errors had not had their competency re-checked.
- Not all staff had been trained to use an airway clearance device; which the provider had installed at Norfolk Lodge. This is a device to clear a person's airway if they were choking. Although some staff had completed the training to use this device some staff who worked regularly at the service had still not been trained .
- Other courses had not been completed by most of the staff, such as fire safety awareness training and equality and diversity training.
- Areas of training we highlighted as lacking at the last inspection, such as learning disability training and positive behaviour support training, had been booked for the month following our inspection. Although action had been taken to arrange this training, staff still had not received it .
- We spoke to the manager about the training and competencies of staff. The manager told us that they were aware of the issue and were addressing it. The manager said, "I'm still addressing this…autism training is under 40% and epilepsy is 50 %."
- The failure to provide staff with the training and support they needed to be effective in their roles is a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- Staff told us that they were having supervision with the new manager. One staff told us, "We had supervisions and [manager] has asked each of the staff to take on an area like a champion…its brilliant"

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 when this is in their best interests and legally authorised under the MCA. 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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● At our last two inspections we found a breach of regulations relating to MCA and DoLS. At this inspection we found insufficient action had been taken and the breach had still not been met.

● One person had a sensor mat on the floor to help keep them safe at night times. The manager had spoken to the person's relative about this. However, there had been no MCA assessment, or best interest meeting, to see if the person could decide for themselves if they wanted this restriction. The manager confirmed, "I had a discussion with [relative] but still need to document it."

● Another person was at risk of not receiving their medicines as they could refuse them when they become unwell and potentially lacked capacity to decide whether to take their medicines. There was no MCA assessment in place for when they became unwell and may lack capacity and refuse medicines. The person had a behavioural plan, but it did not reference what to do if they refused their medicines when they may lack capacity. The person had a mental health care plan, but this did not reference their possible refusal of medicines.

● A third person was identified as being at risk of fluctuating capacity. Fluctuating capacity is when a person's ability to make decisions changes, usually as a result of changes in their mental state. This person had restrictions in place around their money. However, there was no MCA assessment or best interest decision in place about how staff should support them when they may lack capacity.

● Other people also had restrictions in place around how they accessed their money, but no MCA assessments had been carried out to ensure these restrictions were lawful.

● The lack of consistent practice regarding obtaining and documenting consent for care and support is a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Supporting people to eat and drink enough to maintain a balanced diet

● We saw drinks being made available to people during the inspection but there was a risk to people who needed their fluid monitoring.

● People were at risk of not receiving the correct amount of fluid. One person had their fluid intake monitored with fluid charts. However, there were no recommended daily allowances recorded on the charts to enable staff to know if the person had had enough to drink.

● Fluid charts had not had the amounts drunk each day totalled, so staff would be unsure if the person had received enough fluid. We checked 15 charts for June 2019 and only five had the total amount recorded.

● Fluid charts had not recorded consistent amounts of fluid drunk. For example, one chart in June had 2400mls recorded as drunk in a day; another chart in June 2019 only had 550mls recorded as drunk, but no action or reason for this small amount was recorded.

● We spoke to the manager about this and were told the fluid charts were used to monitor the amount of tea the person consumed as this affected another medical condition. However, the fluid charts did not direct staff to do this.

● We asked the manager how these charts were being audited and what would be the desired level of tea for the person to drink in one day. The manager confirmed that the charts had not been audited and that they would need to speak to the person's GP to find out how much tea the person should be drinking per day. This left the person at risk of their health condition not being effectively managed in relation to their drinking.

● We have also reported on the use of food charts in the safe domain.

● Other people were eating and drinking enough to maintain good health. One relative told us, "Yes, [name] certainly gets enough to eat and drink whenever I'm there."

Supporting people to live healthier lives, access healthcare services and support

● People were at risk of not having their health needs met. One person had previously had a diagnosis of a bacterial infection that can recur in people. However, their skin integrity care plan did not reference the condition or the risk that it can recur. There was reference to the condition in their medical health plan, but it only mentioned to monitor the person's leg. It did not state what signs to look for and what action staff should take.

● Another person had an historical diagnosis of diabetes. The manager informed us that the person was diabetic but was not on any medicines for this condition. The person had health passport that stated their diabetes was medicines controlled and a nutrition care plan that stated the diabetes was historical. When we spoke with care staff they were not clear around whether the person had diabetes and what support they required.

● For example, one staff told us the person's diabetes was medicines controlled, another staff said it was controlled by tablets and a third staff told us the person no longer had diabetes. Staff were not aware of the signs of diabetes and told us they had not been trained. We raised this with the manager and was told that the person previously had a diagnosis of diabetes. However, the person was at risk of staff not being able to spot the signs of the condition returning.

● The same person was also prone to urinary tract infections (UTI). We found references to the person showing signs of having a UTI but there was no evidence this had been followed up with a medical professional. We spoke to the manager about the episodes of possible UTI, but they were not aware of them. The manager was unable to show how these concerns had been followed up.

● The failure to safely manage risks around hydration and health conditions is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

Adapting service, design, decoration to meet people's needs

● At our last inspection in January 2019 we made a recommendation that the provider implements a decoration and maintenance plan to address the issues with the building. At this inspection we found that the provider had made plans and was acting to address these issues.

● The provider had carried out work to the external walls to make the building water tight. The operations manager told us that once the work had been completed and the walls were dried, the re-decoration work could start.

● People had appropriate access to the garden. One person liked to go in the garden to smoke and there was a special smoking area for them that was covered.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law and staff working with other agencies to provide consistent, effective, timely care.

● People had care plans that used nationally recognised guidance such as Waterlow charts that check their skin is in a good condition.

●People had assessments of their needs prior to joining the service. Nobody had joined the service in the previous 12 months.

● The manager was able to effectively describe the process for assessing people prior to their move, including how their needs would be matched to staff skills and current people living at the service.

Requires Improvement

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.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same continues to be rated requires improvement.

This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence
At our last two inspections we found a breach of regulations relating to dignity and respect. At this inspection we found insufficient action had been taken and the breach had still not been met.

- People's privacy and dignity was not consistently upheld. We found entries in the staff communication book relating to people's intimate medical conditions. This information was not kept secure and other people could have read it.
- People were not being supported to be as independent as possible. For example, all people living at the service had restrictions in place around their money. People would collect daily money from the office. Staff had not explored the option of some people managing their own finances. This could give people much greater independence.
- We spoke to the manager about this and were told that they would review this historical arrangement, as part of their review of the service.

Ensuring people are well treated and supported; respecting equality and diversity

- People with a disability who required additional measures to help them to communicate did not always receive them.
- For example, one person had a communication plan. They had not signed the plan as they had poor eyesight. However, the communication plan had not been made available in large print format.
- Other care documents had also not been made available to the person in large print versions.
- Failing to support people to maintain their dignity and to treat them with respect is a continued Breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014

- People were treated with compassion and kindness. Staff spoke with people in a respectful way, and at a pace that suited people.
- One person told us, "She's lovely [looking at staff]. How many years have I known you?" The staff thanked the person, returned the compliment, and explained they used to work bank shifts and have known the person a long time.
- Staff were kind and thoughtful. One person wanted to have a barbecue party for their birthday during our inspection. Despite the rainy weather staff still provided this for the person. We observed one staff cooking on the barbecue under an umbrella to ensure the person had the party they wanted.
- We saw some examples of kind and caring support. Staff spent time with people and spoke to them respectfully. We observed a newly implemented scheme the manager introduced on the first day of our

inspection called 'planning future events'.
One person spoke about the type of party they wanted to plan for their next birthday and staff helped them to make a plan.
● Another person was speaking about the things they would like to do. Staff noticed that the person was becoming overloaded. Staff redirected the person in a way that left them calm but feeling listened to.
● People's needs were respected under the Equality Act. One person had a sexuality care plan and staff were directed to support the person in a discreet and respectful way if they were to ask for support in this area again. The plan stated the importance of privacy and any sexualised behaviour being respected.

Supporting people to express their views and be involved in making decisions about their care
● People were not as involved in their care plans as they could be. One person told us, ""No I haven't seen my care plan." Another person said, "I haven't seen a care plan, but I have been to reviews." However, one relative told us that they had not been invited to attend reviews at the service.
● Staff reported that rotas and practical arrangements had improved since our last inspection and that they could spend more time with people. We observed staff spending time with people doing things such as planning a party or decorating a cake.
● One staff told us, "We get to spend time with each person."

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same continues to be rated requires improvement.

This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
At our last two inspections we found a breach of regulations relating to person centred care. At this inspection we found insufficient action had been taken and the breach had still not been met.
● Care plans were not person centred as there was conflicting and missing information in several care plans.

● For example, one person had a history of behaviours that may challenge others. The provider had arranged for their Autism and Positive Behaviour Support (PBS) lead to review the person's support. The autism and PBS lead had made several recommendations to help the person. However, the recommendations had not been pulled through to other care documents and staff were not actioning them.

● Other care plans contained conflicting information, such as around one person's choking risks or another person's guidance around medicines.

Meeting people's communication needs
Since 2016, all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● The provider was not meeting the accessible information standard. People had a one-page sheet in their care plans explaining what the AIS was and how it should be met. However, the actions to meet the AIS had not been carried out consistently for people.
● For example, one person with fluctuating capacity may require additional support to understand things when they are feeling unwell.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them.
● Activities were not consistently person centred and they were not being audited effectively to ensure people did the things they were interested in.
● One person had a condition on their DoLS that their activities should be reviewed to ensure they had a timetable of trips out to places other than a local café. The review and implementation of a new timetable had not happened.
● Other people had limited activities. For example, one person had their activities recorded on a form.

However, the two most frequent activities staff recorded were 'chat to staff' and 'watching TV'. There was a lack of structured activities for this person.
● Activities were not being tracked or audited effectively. We asked the manager how we could track which activities people were supported with. The manager told us that the only way to track activities was through people's daily handover sheets or their daily reports. This did not give the provider effective oversight of people's activities and was not easy to analyse.
● The manager had very recently introduced a new activities board. However, people were not using this yet. One person said when asked who used the board, "I don't, the staff use that." Other people confirmed they didn't use the activities board. Some staff said that activities provision was slowly improving with the new manager.
● The failure to provide person centred care is a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

● During the inspection we observed some activities taking place. One person was sat at the table and had baked a cake for another person's birthday. Staff supported people to decorate the cake and prompted them to remember what they had baked when asked about it.
● Staff used appropriate humour to engage people in their activities. Another person had made another type of cake for the birthday celebration. Staff placed the cakes on a cake stand and ensured they looked well presented, and people received good levels of praise and encouragement.
● We spoke to people about their activities. One person told us, "I go out when I want. Most days I go and get a paper and every day I go to the theatre café with my friend."
● Another person told us, ""I went to the Cinema and saw the Elton John one, it was good. It's a new thing to go to the cinema."
● People were supported to maintain contact with their families and loved ones. One person told us, "You can go out when you want. I go to church on Sunday."

Improving care quality in response to complaints or concerns
● There was an up to date complaints policy updated in February 2019. The service had recorded one complaint in the last 12 months, which was handled in line with the providers policy.
● There was an easy read version of the complaints policy displayed in the reception. It set out the process for how people could make a complaint to the provider and how long they would have to wait for an answer.
● People told us they knew how to make a complaint. One person said, "I would speak to [name] and they would help me to sort it out."

End of life care and support
● There was nobody receiving end of life care at the service.
● People had been asked to complete a plan about their wishes in relation to their final days.
● We reviewed one person who had a funeral plan in place and it contained personalised information.

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 inadequate. At this inspection this key question has remained the same and continues to be rated 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.

Continuous learning and improving care

- At our inspection in August 2018 we found a breach of regulations relating to auditing the quality of the service. At the next inspection in January 2019 we found the breach had not been met. At this inspection we found insufficient action had been taken and the breach had still not been met.
- Quality audits had not been effective in remedying some of the issues highlighted at the previous inspection such as those identified in relation to MCA, or people's care plans.
- Audits had not identified incidents such as unexplained bruising to ensure that people were safe.
- At our previous inspection in January 2019 we found seven breaches of regulation, of which six were continued breaches from August 2018. At this inspection we found only one of these breaches had been met and six of the breaches continued. We also found a new breach of registration regulations related to displaying the correct CQC rating.
- The manager had started to go through the service improvement plan and was ensuring that actions completed by others were completed. However, this process had not been followed through due to the new manager only being recently appointed.
- Other concerns highlighted at this inspection, such as around medicines and risk, had not been mitigated by an effective quality monitoring process.
- Concerns about choking, constipation, safeguarding and fluid monitoring had been highlighted to the provider on a number of occasions at others of their services. This information had not been properly shared or used to improve safety and care at Norfolk Lodge.
- The failure to assess, monitor and improve the quality and safety of services, to mitigate risks, and to maintain accurate records, is a continued Breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 .

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

- At our inspection in August 2018 we found a breach of regulations relating to notifying CQC about significant incidents. At the next inspection in January 2019 we found the breach had not been met. At this inspection we found insufficient action had been taken and the breach had still not been met.
- A statutory notification had not been submitted to CQC for unexplained bruising to one person in April 2019.
- The failure to ensure that the Care Quality Commission had been notified without delay of significant

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

● The registered provider was not displaying the most recent inspection ratings in the service. The old inspection rating on display was more favourable than the current rating. It is a legal requirement to display CQC ratings. The ratings are designed to improve transparency by providing people who use services, and the public, with a clear statement about the quality and safety of care provided.
● The failure to display CQC ratings in the premises is a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There was not a registered manager in post. It is a requirement of the provider's registration for a registered manager to be in post. The previous manager had applied to CQC to deregister on 9 January 2019 and this application was being processed by CQC at the time of the inspection. The provider had initially based a peripatetic manager at the service to oversee day to day management. A deputy manager from another service had then been brought in when the peripatetic manager left. Then a new manager had started in late April 2019. The manager told us they were in the process of registering with CQC.
● The manager told us they felt they were being given support in their new role. The manager said, "I have supervision booked next week and attend a manager's briefing every month." The manager told us they were able to speak to the area operations manager for support.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The manager described a vision of the service where people would oversee their own home. The manager told us that people should be active in the involvement of their own care, rather than just receiving the care, and that they should lead the service. The manager said, "The change of culture can only happen when the staff are supported so that they can lead the change and have my support. There was an old culture; as a new person to Norfolk Lodge I could see an inherited culture."
● The manager described a previous culture in the service where there was a lack of ownership from people in relation to their own home; and staff in relation to their duties. The manager spoke about creating a sense of equality between people and their staff and made a point of not wearing a badge that would separate them from people. The manager told us, "Uniforms are not a part of ordinary life and I will have a discussion with line manager about getting rid of the [staff] uniforms."
● The manager had explained the expected values of the service to the staff team in a meeting on their first day and told the staff that only things would only change where they could improve. The manager said the staff team bought in to the new values of the home and described the values as people having an ordinary life.

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
● The provider had not consistently reported all incidents under the duty of candour. An incident of unexplained bruising in April 2019 had not been reported correctly.
● The manager understood the duty of candour, and told us, "It's being transparent and reporting and recording and making sure clients are involved and have their say about it if an incident occurs."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
People were starting to be more involved in the running of their service. The manager told us, "There is tea party for service users to catch up and give feedback for what they want to do for the week. Menu was discussed, and [name] said they liked spicy food and staff implemented this."

● Staff were encouraged to make suggestions and there were champions for different areas of responsibility, such as infection control. The manager had implemented plans for senior carers to chair the staff meetings. The manager said, "We have planned for senior to supervise a support worker. It's part of action plan and we need to coach the seniors."
● People's relatives and their stakeholders were sent a request to provide information to help staff complete a profile for people with their background or likes. There were annual parties, such as summer BBQ and a Christmas party where relatives and others were invited.

Working in partnership with others
● The manager was working with the local safeguarding team and had been developing relationships with people's social workers. Other professionals such as psychiatrists, podiatrist, speech and language therapist and occupational therapists have all visited from the local health teams. A visiting optician and the local pharmacist are also involved in the service.
● The local authority finance team were involved with some people and the DoLS team had arranged visits. The manager told us the local authority had visited and had maintained oversight of the service through the safeguarding and review process.
● Information was being shared with stakeholders securely, using encryption. Unique identifiers were being used instead of people's names to protect people's identities.