County Care Homes Limited

Norwood House

Inspection report

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Suffolk
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14 September 2016

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Ratings

Overall rating for this service	Requires Improvement
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Norwood House provides accommodation and personal care for up to 71 people, some living with dementia. There were 50 people living in the service when we inspected on 14 September 2016.

We undertook an unannounced focused inspection of Norwood House on 14 September 2016. This inspection was done to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection of 11 April 2016 had been made. The team inspected the service against one of the five questions we ask about services: is the service well-led? This is because the service was not meeting some legal requirements.

We undertook this focused inspection to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Norwood House on our website at www.cqc.org.uk.

Following our last inspection we issued a warning notice in which we told the provider the areas they needed to improve on relating to the Duty of Candour. This included the actions they should have taken following an incident including investigating it, keeping the person, or their representatives where appropriate, informed of the investigation outcomes and providing an explanation and/or apology for the incident. The purpose of this focused inspection was to check that the provider had made the required improvements. We found that the provider was working to the requirements of Regulation 20 Duty of Candour and the appropriate improvements had been made.

We have changed the rating for well-led from inadequate to requires improvement, this is because the provider has made the improvements required as identified in our warning notice in relation to the Duty of Candour. The overall rating for the service has not changed. We will follow up on other areas of improvement identified at our last inspection in a comprehensive inspection in due course.

There was not a registered manager in post. 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. There was a new manager in post who had started working in the service 5 September 2016.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The service's quality assurance system was not robust enough to independently identify shortfalls in the service provided to people.

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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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The inspection team consisted of two inspectors. We did not speak with people using the service during this inspection, this was because the inspection focused on Regulation 20:Duty of Candour.

We reviewed information we had received about the service including the information sent to us by the provider regarding the improvements they had made and notifications. This is information about important events which the provider is required to send us by law. We also looked at information sent to us from other stakeholders, for example the local authority and members of the public.

We spoke with the manager and two members of staff. We looked at records relating to incidents and accidents and investigations undertaken.

Requires Improvement

Is the service well-led?

Our findings

Our last inspection of 11 April 2016 found shortfalls relating to how the provider demonstrated they were meeting the requirement of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 20: Duty of Candour. This was because we found that there were no records which showed that the provider nor the previous registered manager had investigated an incident. There were records in place which showed that relatives had been notified of the incident but no further information about how the provider had provided an apology and explanation of the incident.

We issued a warning notice in which we told the provider the areas they needed to improve on relating to the Duty of Candour. This included where the provider had not taken the necessary action and where they must make improvements. The purpose of this focussed inspection was to check that the provider had made the required improvements. We found that the provider was working to the requirements of Regulation 20: Duty of Candour and the appropriate improvements had been made.

Following our inspection the provider kept us updated with the improvements they had made, this included reviewing and updating their Duty of Candour policy and procedure, fully investigating the incident and meeting the person's relatives to explain what had happened and offering an apology.

During this inspection the new Duty of Candour policy and procedure was available for staff in the office. We spoke with two staff members who told us they had been updated with regards to the requirements of the Duty of Candour. The minutes from a head of department's meeting in May 2016 showed that the team were updated with information about the Duty of Candour.

The new manager, who had started working in the service 5 September 2016 was up to date with the requirements of the Duty of Candour regulation and the actions that they should take following an incident. They also told us about their plans for further improvement.

We saw the records of incidents that had occurred in the service following our last inspection, which required further action as identified in Regulation 20: Duty of Candour. The incidents had been investigated and the person's representatives had been kept updated. Once the investigations were completed these representatives were met with and they were provided with an apology and explanation of the incident. This showed that improvements had been made and the service had acted in an open and transparent way.