Eastern Healthcare Ltd

The Hollies and Hollies Lodge

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?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 4 July 2018 and was unannounced. The last inspection to this service was carried out on 19 December 2016 and was rated good throughout with no breaches of regulation. According to our inspection methodology this service did not require an inspection for thirty months. However due to concerns received about the service from a whistle blower and several concerning notifications we brought the inspection forward. During our inspection on 4 July 2018 we found this was no longer a good service and identified breaches of regulation around person centred care, consent, safe care and treatment, staffing, the premises and equipment and clinical governance. Since the last inspection the registered manager had left and a new manager came into post in November of last year. They told us they had made some significant changes to the service and had in place a detailed action plan they were working towards. We were confident in the manager's ability to identify and bring about positive change to the service. We were less confident in the overall management and oversight of the service by the registered providers.

The service is registered for up to 27 people who primarily have a mental health need. However, people might also have a learning disability, a diagnosis or autism or issues relating to alcohol and substance misuse.

The Hollies and Holly Lodge 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.

The service is divided into two separate units joined by corridors. The main house accommodates most people and has shared communal areas and communal showers. It offers single occupancy bedrooms and generous gardens and grounds. The second part of the building has fewer number of people and separate communal facilities and separate staffing.

During our inspection on 4 July 2018 there was a manager in post but they were not yet registered with the Care Quality Commission although they advised us they had put their application in and had been waiting at least twelve weeks.

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 this inspection we found people were receiving care that was not always safe or met their identified needs. The manager had taken actions to try and ensure people got their medicines as intended after a series of medication errors. This had resulted in either people not getting their prescribed medicines or medicines administered incorrectly. There had also been issues with accounting for medicines to make sure they were available as people needed them. The manager had put more robust procedures in place and had

supported staff to ensure they were competent and had accessed the right level of training.

The manager confirmed they had significantly increased the staffing levels since coming into post including the introduction of waking night staff. However, we were unable to see what people's assessed needs were as some people had not been reviewed for some years. Some people had high risk behaviours which could put themselves or others at risk. Staffing levels meant that people were not always supervised for their safety and were not sufficient for people to have personalised care around their needs. The service did not have a dependency tool in place to show how they calculated the numbers of staff they needed.

The environment was not safe for its intended use. We found during our inspection broken window restrictors, ligature risks, uncovered radiators, water that exceeded recommended temperatures, and exposed pipework. We also found the environment was excessively hot with little means to keep people cooler. The service had long, thin corridors which were inappropriate for people with a physical disability. Some people using the service were becoming more frail with reduced mobility. Should they need walking aids or be permanently in a wheelchair, the service would not be able to accommodate them safely. The service was not appropriate for people with sight impairment or cognitive impairment as there was nothing to orientate people. The communal areas were too small for everyone to use at once. It was a hot day so some people were outside but others were stretched out on sofas. There were not enough places for people to sit apart from their own rooms and at lunch time there was not enough space for people to safely move between the table and chairs.

Risks to people's individual safety had not been adequately considered. We observed people unsupervised during the day.This included people frequently accessing the kitchen to make themselves drinks. Staff were not in the vicinity to support people. The risks from cross infection had not been adequately considered and areas of the service were dirty. There were no separate domestic staff and although staff did clean the service they did not have time to do this continuously throughout the day.

Some people's needs outweighed what the service could provide and the service did not facilitate people's independence or autonomy. There was nothing in place around assessing people's capacity to make decisions about their everyday needs or more complex decisions where required. The manager was in no doubt that some people had fluctuating capacity and there were no systems in place to support effective decision making to ensure it was in people's best interest. The manager was in the process of getting everyone needs re reviewed and where necessary carrying out capacity assessments. They had reviewed lots of care plans to ensure they accurately reflected people's needs and provided evidence of how staff were meeting these.

However not all the care plans were up to date and it was difficult to establish what everyone's needs and risks associated with their care and support were. It was difficult to establish from their records how their health care needs were monitored and met by other professional staff.

There was nothing in place regarding end of life care, and people's preferences regarding this were not clearly established. Staff had not been given training and this was of a concern given a few recent deaths.

Activities for people were provided but it was difficult to assess if they were sufficient or around people's assessed needs and in keeping with their life experiences.

The meal time experience was poor and staff did not enhance people's wellbeing although we saw people did enjoy the food provided. Meal sizes did not consider people's preferences, neither were they proportionate in terms of those who had been steadily gaining weight. Weights were monitored but we

could see little recorded actions regarding weight gain and promoting healthier lifestyles where appropriate.

The manager was experienced and had set about bringing positive change to the service. They had a full staff team and had recently recruited a senior team to help improve the service. They had put in systems to help them measure the effectiveness of the service and identify anything where improvements were required. A new maintenance person was on site and focussing refurbishment and ensuring equipment and premises were well maintained.

Staff recruitment processes were adequate and the manager had improved training opportunities for staff and ensuring staff received adequate support and supervision for their job role.

Staff had sufficient understanding of protecting people from abuse and had received training. We had concerns about the management of incidents as records did not always tell us what actions had been taken and if risk assessments were in place and had been updated.

Overall although we have rated this service as requires improvement we found people were happy with the service and the staff that supported them. We were confident with the new management arrangements and felt given time this service could be turned around to become a good service. We have received assurances that the building is being completely renovated and the service is going to provide a second regulated activity of personal care in people's own homes. This would increase the scope of the service to provide care and support around people's assessed needs and become more personalised. We do however have reservations about provider oversight given the level of concern we identified. We also want assurances that the action plan continues to be met and plans for refurbishment and the rebuild go ahead as scheduled.

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 safe.

People did not always receive their medicines as intended.

Risks from the environment were not carefully controlled. Risks to people's individual safety was not always reduced adequately.

Staffing levels were not adequately assessed to ensure they met people's individually assessed needs.

Arrangements in place to reduce the risks of cross infection were insufficient.

Staff understood how to keep people safe from abuse and report any concerns they might have both internally or externally where necessary. However, we could not see how staff learnt from adverse events or how the service was proactive in supporting its staff to manage incidents effectively.

Staff recruitment processes were sufficient to help ensure staff employed were safe and had the right skills and attributes to work in care.

Is the service effective?

Requires Improvement

The service was not effective.

There was poor recording of capacity assessments for those who had fluctuating capacity and might need support to make decisions or have decisions made in their best interest.

There was poor recording of how people's health care needs had been monitored or if people had adequate access to health care professionals.

People were supported to eat and drink sufficiently and the risks of unintentional weight loss were monitored. However, some people were putting on weight and this had not been considered in relation to increased health risks.

Is the service caring?

Requires Improvement

The service was not always caring.

People had privacy but the environment did not lend itself to people being able to have private space unless in their rooms and even then, their personal space could be compromised.

People were supported according to their wishes and needs but also according to the availability of staffing.

People were consulted about their wishes and needs.

Staff were observed talking to people in a respectful way and knowing people sufficiently well.

Is the service responsive?

Requires Improvement

The service was not responsive.

Peoples care plans were not always sufficiently up to date and did notreflect people's changing needs. Daily notes did not show how people's needs were being met or how people were encouraged to retain existing skills.

Activity during the day was limited according to people's interest and motivation to participate. However, we did not see sufficient opportunity for staff to spend time with people and encourage them to join in or participate in an activity of their choice.

There was an established complaints procedure and people could feed back about their care, support and treatment and concerns were acted upon.

Is the service well-led?

Requires Improvement

The service was not well led

The new manager was waiting for CQC registration. They were very experienced and had made a positive impact on the service.

Prior to them coming into post there were clearly some shortfalls which had not been recognised by the provider and had affected the safety and security of those using the service.

Some people's needs had not been assessed and we were not confident that the service had the necessary staff in place with the right skills to meet people's needs.

The service was not complying with all the regulations.

We had concerns about the safety and suitability of the premises and will be seeking assurances from the provider that this will be dealt with immediately.	

The Hollies and Hollies Lodge

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.

This inspection took place on 4 July 2018 and was unannounced. The inspection was undertaken by three inspectors, one of whom was an assistant inspector.

Before this inspection we considered information already held about this service, which included previous inspection reports, share your experience forms (feedback on our website,) notifications which are important events the service is required to tell us about and information from whistle blowers. Providers are asked to complete a provider information return (PIR) which tell us about the service and how it is managed in line with the key questions we inspect against. However, we did not have an up to date PIR for this inspection as we brought it forward. Before the inspection we spoke with the safeguarding team about recent concerns and have since spoken with the Local Authority who have offered to meet and support the new manager.

During this inspection we met with the manager, spoke with two relatives, seven people using the service, and four staff. We looked at three care plans and saw some examples of the revised care plans. We looked at staffing rotas, staffing records and other records relating to the safety and maintenance of the service.

Requires Improvement

Is the service safe?

Our findings

At the last inspection of this service on the 19 December 2016 this key question was rated as good. At our more recent inspection on the 4 July 2018 we have rated this key question as requires improvement.

Staffing levels were not always sufficient across the day to ensure peoples needs were adequately met. Inadequate staffing levels also had an impact on people's opportunity to go out when they wanted and the level of cleanliness at the service. Staffing numbers on duty did not include separate domestic staff or separate catering staff in the evening or weekends. This meant care staff spent considerable time preparing and serving food and cleaning the service. Some staff were trying to fulfil more than one role such as administration and care without sufficient time allocated to either.

Poor organisation on shift meant care staff did not always feel adequately supported and staff said not all staff pulled their weight. Care staff told us senior staff did not always assist on the floor when they were busy. We observed sometimes during the day when there were less staff available to assist people. For example, the mornings medication administration took two staff up to three hours to administer people's medicines. During this time there were no additional staff deployed to ensure people's safety and wellbeing. Lunch time was another example where people in the main house did not get a good meal time experience as staff did not have time to sit and chat with people.

Staff told us on long shifts they got tired. They said at weekends their time was more pressurised because there was no cook. This meant that one staff member would be in the kitchen, another two staff would be doing medication. They said if activities were being provided this would often take two staff out leaving potentially one member of staff to meet the needs of everyone else and ensure their safety. Staff said some allocated units were harder than others as some people were more dependent on support and needed more regular monitoring for their safety.

One person told us there had been a high turnover of staff. Another person told us there were not always enough staff but said night time was better than it used to be. One person told us there were not always enough staff to support them with things they would like to do. Some people required support to access the community and this was staff dependent and restricted people's choice to go out when they chose.

Throughout the day of our inspection staff were not visible and we found people were left largely unsupervised in communal areas with little occupation for them during the day. We observed some people sleeping throughout the day and people in their rooms received very little stimulation. Door guards were used to keep doors open which were for staff's convenience so they could check people as they walked past. Most people had their doors shut but for people who were not well their doors were open. We observed people going in and out of the kitchen to make themselves hot drinks but did not see staff prompting and supporting other people to drink on what was a very hot day. We did not observe any incidents between people but were told of an incident the night before which had unsettled some people using the service. Another person was unwell throughout the night and had returned home in the early hours of the morning and would have needed some additional support which we did not observe staff offering other than some

brief monitoring checks. At lunch time meals were served efficiently but staff were not in the dining room and were not encouraging people to eat/drink or just spending time with people.

When initially arriving at the service we could not see who was on duty and there was no information for visitors about who was in charge and which staff were working. This also meant people using the service did not know which staff were coming on duty.

There was an on- call system with an on- call phone. There was no rota in place but the manager and the deputy manager would take the phone home of an evening or weekend and if staff need them they rang the number and someone would answer.

The service was divided up into two different zones, the Lodge and the main building and both were staffed separately. Handover records were held. We could not ascertain if people got continuity of care and support because the handover notes were so brief and lacked meaning. I.e. 'person aggressive today,' 'Offered fluids today.' Staff confirmed there was sufficient overlap between shifts for handover.

There was no dependency tool which would help us to see what level of support and supervision every person required and a calculation of staffing hours needed to meet people's individual needs. We do not know what the rationale was for six staff on duty and this was at times during the day insufficient to meet people's assessed needs.

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

Since the inspection the manager has completed and forwarded us a tool which calculates people's needs and determines how many staffing hours were required to meet people's assessed needs.

On arrival at the service the manager told us they had increased the staffing ratios since coming into post in November 2017. They said there use to be three care staff and there were now six per shift which included a team leader. They also told us there had previously been no waking night staff, there were now two plus a staff member sleeping in who could assist where required. We looked at the staffing rota and saw staff were divided up so there were three staff in the main house, two in the lodge, and the team leader supporting both sides. There appeared to be minimal staff sickness and use of agency staff was limited to staff who knew the service well. The staffing rotas were done up to six weeks ahead if possible but always at least four weeks ahead. There were no vacancies but the manager was looking to recruit three extra staff as flexible workers to cover holidays and short days. The current shift patterns had been changed to include staff working from 8.00 am to 6.pm and 6.pm to 10.00 pm with night staff coming in at 9.30 pm for handover. The manager was looking to change shifts to a 12-hour shift.

The home was not clean in parts and there was an increased risk of infection spreading between one person and the next. This was due to some people's lack of personal hygiene and behaviours which could increase the risk of infection. However, it was also due to staff having insufficient time throughout the day to revisit the cleanliness of the service. For example, in the afternoon we found a few dirty toilets which were shared by individuals and on such a hot day could attract flies. People were going in and out of the kitchen to make hot drinks. They were not observed or encouraged to wash their hands first and were close to food preparation areas. They were not asked to put aprons on. Some people had poor hygiene so the risks of cross infection were increased. Hand gels were by the entrance doors and in the bathrooms/kitchen/office The service did not have allocated domestic staff which meant cleaning was done when staff had time and not necessarily when the service needed cleaning.

There were cleaning schedules both daily and weekly but the expectation was this was done mostly by night staff but also day staff with no separately designated domestic staff. We saw infection control audits were complete and limited in scope but referred to staff training in infection control, the use of personal protective equipment and no jewellery for staff such as rings which could harbour germs.

One staff member told us, "Communal areas are done in the evening. In the day support workers do the bedrooms in their section and check the toilets as you go. It is a difficult place to keep clean and you are supporting people and keeping up with the cleaning."

Staff tried their best to clean the service and there were daily room checks.
We asked staff about infection control. One staff told us, "We have training on it. Most cleaning is done through the night but we clean through the day as well. We tend to clean as we can. We have access to personal protective equipment. "

The lack of robust infection control measures constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

People did not always receive their medicines as prescribed and there had been a number of errors which included a recent hospitalisation of a person as a precaution after being administered someone else's medicines. The manager had worked hard to help ensure people received their medicines safely. They told us there had been discrepancies when accounting for medicines and said the numbers of tablets did not always tally with the number that should be in stock. The manager told us that since coming into post they had changed pharmacist and now most medicines came in blister packs and were ordered monthly rather than weekly which used to be the case. This had led to a reduction in the number of incidents occurring. The manager told us there were 22 reported medication incidents in June 2018, only five of these related to medication errors, the other related to errors in recording or accounting for tablets. All reported incidents were investigated and showed actions taken.

The manager confirmed and provided evidence that all staff had completed as a minimum an e-learning medication course and training from the pharmacist on using the blister pack system. Staff competency assessments have been carried out and new staff were supported until confident. Currently all staff administer medicines but several staff had been removed from administering medicines because of errors that had been made. They were being offered additional training and competency assessments were being redone. The manager told us staff had not been clear about reporting medicine errors but there was a robust system in place for this now so they did not feel there had been an increase in errors just more accurate recording of them.

We observed medicines being administered. Staff told us administering medication could take up to three hours depending on the day and how familiar the staff member was with the medication round. Staff countersigned medication to help reduce the number of errors. The manager told us they were currently contacting psychiatrists to ask them to review people's medication and they said ten people's medicines had recently been reviewed and in some instances reduced. The GP did an annual review of people's health/medication. Staff were situated in the medicines room and generally people came and took their medicines when asked to. Some people refused or would only take their medicines when they were ready. Some people slept late so did not take morning medication until later. Staff said this could be problematic because they would need to remember who had taken their medicines and, where refused, they offered it again within an hour's window. Staff said they needed to be mindful of having along enough gaps between medicines. Some staff were anxious about giving medication particularly when working a long shift, they found it hard ensuring everyone had what they needed.

Daily checks were in place where the team leader checked everyone's medication both in the blister packs and boxes. This was to ensure no medicine was forgotten or that staff had not forgotten to sign. Given the concerns staff raised this was a sensible approach to help reduce the risk of medicine errors.

People's individual medicine records included details of medicines people were taking and any special instruction or known allergies. There were prescribed when necessary protocols in place so staff would know when medicines could be offered. Some of the guidance was lacking in sufficient detail to help support staff when administering medicines.

No one self-administered their own medicines and the manager had expressed concern that until they had more robust systems in place to manage people's medication safely this should not be introduced but they would be looking at this. Although significant improvements had been made we still considered there to be enough evidence to support a breach.

This constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014

We reviewed the accidents/incidents which had occurred in the last three months. These were put on the shared drive so the registered provider could check them at any time and see if actions taken were appropriate. The manager said they only reported things to CQC if they met the safeguarding team's threshold. The log did not clearly illustrate actions taken by staff to safeguard people or to try and reduce further incidents. We could not always see who the service had contacted to report the incident or any lessons learnt. For example, some referred to disagreements between people resulting in verbal or physical altercations. Some resulted in police involvement and some resulted in other professionals being notified including social workers and the multi-agency safeguarding hub However, for other incidents follow up action was inconclusive and did not say if risk assessments and care plans had been updated to show what actions had been taken to try and safeguard people. For example, we saw people throwing hot drinks at others, one person trying to open the car door when it was on the move, several assaults between people using the service, one of whom wanted the police called but this did not happen because their behaviours deescalated. There was an incident when a person was found in the community, and the member of public was sufficiently concerned to bring the person back to the service.

We were concerned about the potential vulnerability of some people given the wide range of needs and previous risks associated with unwanted behaviours. The dynamics between people were sometimes fraught and people lived in close proximity with others.

Risks to people's safety were assessed on an individual basis but did not always consider risks from the immediate environment. We saw at each fire door there was a list of people using the service. There were individual evacuation plans which considered support people might need. There were policies to describe what action staff should take in the event of a fire. The last practice fire evacuation was in March of this year and there was regular testing of both the alarms, emergency lighting and fire doors. The fire risk assessment was reviewed in July 17. We spoke with the fire authorities who had not visited the building for some years but had raised several concerns several years ago. They felt it was a low risk building in the sense that it was mostly one storey but a high risk in terms of people's behaviours and previous incidents of small contained fires. Fire risk assessments should be reviewed regularly in line with best practice and on an ongoing basis considering the changing client group.

Lone working posed a risk to staff as there were no panic buttons although staff did have mobile phones. Staff said if there was an emergency they would use the fire alarm. We saw incidents where staff had been put at potential risk. For example, there were incidents in the medicines room and people throwing things. It

was not clear from recording what control measures had been put in place.

With regards to finance we saw in one instance a person lacked capacity to manage their own financial affairs and money was deposited into the providers account. This had been assessed. The person had access to their personal allowance but were unable to sign to draw out money so this was done by staff. We could not see that there were sufficient safeguards in place to ensure this person was protected from possible financial abuse. There was a note in their care plan to say they were restricted to £10.00 a week because in the past they had either lost money or someone was taking it. This is unacceptable because it means the person was not supported to keep their money safe so it could be accounted for. We could not see if the service had approached the local authority about support with the person managing their own finances

People spoken with told us they felt safe within the service. Staff confirmed they had received adequate training and were able to give clear examples of what might constitute abuse and who they should refer it to including external agencies. All were confident that the manager would respond to concerns.

We reviewed the safeguarding concerns and were not assured that these were always dealt appropriately. For example, we saw an incident which had occurred in the community where an accusation had been made by a member of the public, this had involved the police and the person had been warned about their behaviour but not charged. From the service's point of view there had been no follow up and no review of their care plan to highlight any risks either to themselves or members of the public when out independently.

There was evidence that police were often asked to intervene at the service but there was no agreed or working protocols between the service and the police which might help ensure a consistent approach and help better working relationships between the police, the service and individuals that used it.

We saw assaults had occurred between individuals which had not been reported to CQC and we could not see from the records what had happened as a result both in terms of individual responsibility but also how staff should intervene and try and prevent further incidents.

This was further evidence of a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014

Staff recruitment was adequate. We looked at two staff records. These included application forms which showed staff's relevant experience and job history. There were no employment gaps for the staff we looked at. There was an interview record to show what was discussed at interview and how the candidate met the shortlisting criteria. There was a fit to work form and copies of identification (passport and driving licence), copy of contract. Disclosure and barring checks were completed to ensure staff had not been barred from working in care of had committed an offence which might make them unsuitable to work in care.

Requires Improvement

Is the service effective?

Our findings

At the last inspection to this service on the 19 December 2016 this key question was rated as good. At our more recent inspection on the 4 July 2018 we have rated this key question as requires improvement.

The building was not suited for the needs of people using the service as it was neither comfortable nor safe. We found in the main house the dining room was too small for the number of people expected to use it. At one point 14 people were sat down for dinner and there was little space for people to get past one another. Staff did not have the opportunity to sit with people and join them which may have enhanced their meal time experience. The lounge in the main house was not large enough and four people were stretched out on sofas so other people had nowhere else to sit. People were either in their rooms or at the smoking area which was immediately outside the house and in close proximity to the building which might increase the fire risk. There was nowhere to meet visitors in private other than people's bedrooms. The corridors leading from one part of the service to another were long and narrow and not accessible for anyone with a physical disability who might require a wheel chair or walking aids. There were also some internal steps to navigate. There was limited signage and not every room had a number on it or anything to help them distinguish their room. The service was not registered specifically for people with dementia but at least one person had early onset dementia. There was nothing to help them orientate round the building.

It was a hot day and some of the rooms were very hot and people were having difficulty sleeping. The manager was in the process of buying fans but the hot weather had been going on for some time. People were opening their doors and windows. However, we found some windows were fitted with restrictors which were broken and poorly maintained. There was an ongoing problem with hot water both from people's individual taps and temperatures coming out of the shower. One shower had been taken out of use. Some temperatures were reported above 60 degrees and we were told the circulation pump had failed. We saw from some people's care plans that they would be at risk from scalding yet no individual action had been taken to warn people that water may be too hot and no individual safeguards were put in place. We spoke with the maintenance person who had been in post two months and was trying to get to grips with some of the issues posed by the building. It was clear the thermostatically controlled valves had not been maintained adequately and the risks from water exceeding recommended temperatures had been poorly managed.

We found pipe work exposed both in people's rooms and along the corridors. Radiators were uncovered. The manager said these did not get excessively hot when on. However, in the homes literature it stated all radiators and pipes were covered which simply was not the case and the risks of this had not been considered. We found windows in a poor state and requiring painting.

Some people had exhibited behaviours which could put themselves or others at risk and we saw some recorded incidents where people had been violent or threatened self -harm. However, there were no generic risk assessments for the environment and ligature risks had not been considered.

The manager has since confirmed how the immediate risks have been addressed to help ensure people's

safety.

The service did not have sufficient systems to request back up if required or how people would ask for help in an emergency. Staff did carry mobile phones. This did not fill us with any confidence in how the service managed potentially difficult situation when there were less staff on duty in a home that was very spread out.

This constituted a further breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014

The manager told us the service was to be renovated and bathrooms overhauled and a wet room to be created. Bedrooms were to be refurbished.

We noted there were sufficient checks for legionnaires disease with water being analysed regularly for the presence of the disease and water being flushed through the system. We asked about asbestos and saw there had been an assessment and some asbestos had been identified and actions were in place to minimise risk and exposure from this.

We were not assured that people's health care needs were met in a timely way as there was poor recording around this and records were ambiguous. For example, when we looked at people's care plans there was not a separate section around people's health care needs and when they last accessed medical services. Medication reviews were taking place but we could not see if these had happened regularly in the past. We could see that people had been referred to other agencies but we could not see what advice had been given and how this was incorporated into the person's plan of care to ensure staff knew what to do. For example, we looked at a person's records, they had recently been taken to hospital and found to have an infection. We are not clear why this could not have been identified by staff via the GP route rather than a referral to hospital. Their notes showed they had experienced some recent weight loss but their records did not show how the service was clearly monitoring the changes to their needs.

People had seen the dentist, optician and other services but some records were old dating back a number of years and we could not see that people had been seen this year or at least annually.

Staff confirmed that if people went to hospital, depending on the person's needs, a staff member would go with them or they would go on their own with the relevant information. They said staff supported people with their health care appointments. On the day of our inspection a person had been discharged and returned to the home in the early hours of the morning, which was not good practice and we suggested the manager raise it with the hospital discharge planning team.

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

People were supported to have regular access to food and drink and people were complimentary about the food. One person said, "The food is very nice, my favourite is roast pork. We have a take out every Friday night."

Staff were observed supporting people around meal times. Most people ate together in the dining room. There was limited space for everyone to sit together and no room for staff to join people. Meal time was functional with little engagement between staff and people using than service, other than people asking for condiments which were not automatically on the table. The food was served promptly, looked appetising and we observed very little waste. We noted picture menus up on the wall and people provided appropriate

choice. The two menu options were toad in the hole, with roast potatoes. Gravy was added without first confirming people wanted it. The other healthier option was chicken wrap with salad. However, we noted everyone was served a large plate and very large portions without any variation. When we reviewed people's weights we saw a number of people were steadily gaining weight to excess and the known health risks of obesity had not been considered by staff when considering portion size. Puddings followed the main course and we did not observe people having a lighter option or fresh fruit.

We reviewed people's care plans. One showed the person to have exceptionally high blood sugars and had a risk management plan in place to state they needed a healthy diet. However, the guidance was not specific to support staff in knowing what foods were more acceptable. We saw from their weight record that this was increasing steadily which did not assure us they were receiving a healthy diet.

Lunch was busy and in addition to staff serving meals other staff were also giving out lunch time medication which reduced the number of staff available to support and create a positive meal time experience.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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 and whether any conditions on authorisations to deprive a person of their liberty were being met.

People's capacity to make specific and individual decisions, were not always clearly documented. Care records did not clearly demonstrated processes consistent with the MCA and associated code of practice. We asked staff what the Mental Capacity Act meant to them. One said, "I know it is about giving people choice and not making them do things they do not want to do." They were not able to expand on this. Another staff member said, "To make sure needs are met, cared for, ensure privacy and dignity." This demonstrated that staff did not have sufficient understanding or know how to support people lawfully.

Peoples records were not clear about who should be involved in the persons care or consulted should there be a concern. For example, one person's records said on the front sheet that their brother was named as their next of kin but there were no contact details for them. However further on in the care plan it named three brothers as people they would like to be involved in their care and people they wished for information to be shared with.

We could not see any deprivation of liberty safeguards applications made to the Local Authority. We were not assured everyone could fully consent to their care and treatment and place of residence. People's needs in this respect had not been assessed by an independent assessor so a judgement could be made about what was in the persons best interest.

This constituted a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Since the inspection the manager has provided evidence of how they are assessing and tracking whether

people have capacity and where they have made a DoLS application. They said five people they support were supported by Norfolk county council to manage their finances and another was currently being assessed for capacity to manage their finances.

Staff were supported in their job and the manager had organised a lot of additional training to help improve the service being provided. We saw copies of inductions packs for new staff and these had been dated and initialled. We saw from the training matrix that most staff training was up to date with 80% compliance rate. Training included: Moving in handling, Fire, Infection Control, Medication, First aid, Deprivation of liberty safeguards, (DOLS), Mental Capacity Act, (MCA), Dementia, safeguarding of vulnerable adults, (SOVA), Food safety, Health and safety, Equality and diversity, Person centred care, Care planning, Challenging behaviour, Diet and nutrition, Diabetes awareness, COSSH and De-escalation training to help staff manage conflict in a non-confrontational way.

The manager told us other training was available to staff but there had not been much take up and they were going to try and promote this. For example, training around: Drug use and alcohol misuse, Personality disorder, Continence, anxiety and depression, Bi-polar, Self- harm, Autism, Epilepsy, Learning disability awareness. We were not confident that all staff had the necessary skills and competent to meet the assessed needs of people they were supporting without having first completed the necessary training. Some staff did not feel confident giving medicines.

The manager told us they did staff supervisions every 6 to 8 weeks or as required. They said annual appraisals of staff performance were still being established and the manager was still trying to get to know the staff. Several staff had received an appraisal and more were planned. There were some staff whose performance were being monitored, for example due to medicine errors, and were being supported to improve their practice.

We asked if staff had specific responsibilities and were told there were medication champions and staff were booked on to do an advanced medication courses. They were also identifying an infection control champion which are staff with a specific interest or relevant experience to take a lead in infection control. There were no other champions but the manager had appointed a deputy manager and team leaders so had put into place a better staffing structure. This helped ensure the work was organised more effectively. Shifts had been reviewed to show us which staff had been allocated to support which people. This made them more accountable for the care and support provided and the manager could follow up with individual staff members if something was missed. The team leaders had overall responsibility to ensure things were done.

Staff completed an induction and there were records to evidence this. One staff member told us when they started they worked alongside the other member of staff who ticked things off on the induction plan when they had done each task. When they moved to care work, they completed the Care Certificate and had three months to complete it. The care certificate is a universal induction framework for staff working in the care industry. The staff member told us they were already familiar with care and had been shown how to complete the paperwork. Some staff had completed or were signed up to do advanced qualifications in care.

Requires Improvement

Is the service caring?

Our findings

At the last inspection to this service on the 19 December 2016 this key question was rated as good. At our more recent inspection on the 4 July 2018 we have rated this key question as requires improvement.

Although people all thought the staff team were nice and helpful we had concerns about the care and support we observed. One person said some of the staff could be quite bossy and they were concerned about this. However, we observed staff talking to people appropriately and regularly chatting with them.

Not all parts of the service were accessible to people or helped people stay independent and carry out their daily routines. For example, the laundry room was set back from the main building and was not accessible. The kitchen was open and accessible but the risk of individuals accessing it and making themselves hot drinks had not been fully assessed. There was insufficient space for people to sit quietly in communal rooms or at other times of the day. The space was insufficient for everyone to share. We found instances where people in their rooms, had their door open all day and staff said it was because they were unwell so they could keep a check of them. It did not consider if the person wanted their door open. Another person had expressed when in their room they wanted their door shut. This was respected by staff but they told us it made it difficult for them to monitor them in terms of their safety.

Most people were observed moving around freely in the least restrictive way. People confirmed they could get up/go to bed as they pleased and people had their own televisions, and access to the internet. There was a pay phone people could use which was in the communal area but was screened off to give people a little more privacy. We felt people had little privacy in their rooms as all the windows were open due to the hot weather. People did not have net curtains or blinds and we were able to see directly into people's rooms. Some people chose to stay in bed during the morning and their privacy was compromised.

The manager agreed care plans were not sufficiently personalised and people were not always encouraged to be as independent as they might. However, there were subtle differences between the main house and the lodge. The lodge worked better regarding its size as it only has four residents, described as younger and more independent. It also had a higher ratio of staff, with two on duty so more opportunity to go out and be more independent. We noted lunch time observations were more favourable than we had noted in the main house. Staff knocked on people's doors before entering and asked what time they would like lunch and what they would like for lunch. One person requested a melted cheese sandwich for lunch, another was out and another said they had a late breakfast so were not hungry. In the lodge they had their own kitchen where they have a sink, cupboards and oven each and share a fridge and freezer. They could help them self in their kitchen and staff assisted them in cooking and cleaning whilst encouraging their independence.

People confirmed they had keyworkers who supported them to ensure they had everything they needed. One person told us there were residents meetings and changes were implemented on the back of these. The example they gave was more trips out. They told us the new manager was great and they had been involved in their care plan review. There was little information around the service to help us confirm what they had said. We could not see planned meeting dates or minutes of meetings available to people that use the

service. We spoke with relatives who were not aware if family meetings took place. They said they use to but these had stopped. They had not been invited to reviews about the care provided and despite being at the service regularly did not really know what was going on at the service. They did say however that staff kept them informed about changes to their family member's needs.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection to this service on the 19 December 2016 this key question was rated as good. At our more recent inspection on the 4 July 2018 we have rated this key question as requires improvement.

The manager told us that care plans had previously been poor, not personalised and did not show how people were supported to retain their skills and develop new ones. They said as a priority they had been reviewing care plans and had done over half. We reviewed three care plans. We selected them based on feedback from staff that they were for people with currently changing and high needs. We later found out these care plans had not been reviewed and considered this needed to be done as a matter of urgency.

We asked staff about people's care plans and if they contained all the relevant information. One staff member told us, "I do feel resident's needs are met? We could do with more one to one time to meet their needs. Care plans could be better they have enough information but they could be more personal, I would like to have my own care plans to work on. "

We found the information in care plans poor. There was an initial introduction of the person and a little background history but nothing about significant events or achievements. There was a section, goals and aspirations, but these described routine things like 'enjoys watching television' and 'likes a tidy room'. They were limited in scope and did not focus on clear goals and how the person could be supported to achieve them. Care plans were in place for the persons identified needs and although staff reviewed these monthly. There was no active summary of how the persons needs had been met or if they had changed over the preceding month. For example, we looked at a person's care plan regarding their mental health. There were some significant areas of concern and description of their previous behaviours. We could not see if these were still relevant or still posed a risk. We saw in the last ten months each monthly summary said no change to the person's needs. Looking through their daily notes we saw their needs had been changing significantly due to general cognitive decline but this had not been addressed within their current care plan. There was no evidence that the person had been consulted about their care needs. Daily notes kept by staff made very little reference to how the person spent their day, what activities they had engaged with or how staff had supported them to ensure their needs were met.

The care plans were not sufficiently personalised and would not enable staff unfamiliar with a person to meet their needs. The care plan for this person's mental health indicated positive and negative aspects of this person's mental health but did not include any strategies to support positive mental health or any potential triggers or activity which might affect the persons emotional wellbeing. Language used was generic and therefore quite meaningless. For example, with regards to self-esteem it said to promote the persons sense of self, to promote the person's personality and to maintain their interests. It did not then go on to say what the person's interests were and how staff should link in to these.

Changes to their physical wellbeing and mobility were documented but in a haphazard way which were difficult to track through and did not provide a clear timeline of actions from other agencies. We struggled to see how people's health care needs were met in a timely way and how subtle changes to health were

identified because of the poor records. We saw when referrals had been made to other health care professionals but little in the way of advice given or how staff should be acting on any feedback given. For example, a person's declining mobility and increased risk of falling had been considered in line with their cognitive decline and some concerns about the way they navigated around their environment. The care plan stated, "When taking [person]out its worth considering a wheelchair for [them]. "This is not clear advice and it was not clear if this person had a wheelchair designed around their needs, or any risks associated with taking them out in a wheelchair. For example, might they need a lap belt to ensure their safety.

In terms of physical care needs again it was difficult to establish what support they might needs. It listed things they found difficult but not what they could do for themselves or how staff had tried to adapt their environment to make it more accessible. Such as it reported they found taps difficult and were unable to regulate water temperatures, (it did not say they needed supervision around personal care and for what.) it did not say what was in place to prevent scalding or if adapted taps might facilitate greater independence for this person.

We reviewed another care plan for someone recently joining the service and could see that although a detailed assessment of their needs had been completed there were no care plans developed to look at either risk or their needs. This meant we were not assured that staff would work consistently with this person to ensure the best possible care outcomes. There were some risks associated with this person's care but they had not been fully explored. There was no consideration around their vulnerabilities and possible risks associated with sharing with other people.

A further care plan showed monthly reviews taking place which again asserted there was no change to this person needs over a long period of time. There were no plans to tell staff how to support this person with some of their negative behaviours and poor lifestyle choices. There was no guidance of how to provide emotional support particularly around suicidal thoughts or what might trigger these thoughts. There was no guidance about how to manage escalating behaviours from verbal to physical aggression and how to keep the person, other people and staff safe. It just referred to keeping your distance and if things escalated to call the police. There were no risk assessments about going out in the community despite a recent incident. There was an incident recorded regarding a fall but again nothing specifically about this in their record and how a further fall could be avoided. Health care plans were also poor and we saw an appointment had been cancelled but we could not see if this had been rearranged.

There was no specific support or guidance for staff to help them support people as they got older and became physically frailer. There had been some recent changes to people's health which were not clearly evidenced through records and there was nothing in place to show that people had been consulted about their advanced wishes should they become ill, require treatment or as they approached the end of their life. We therefore could not be assured people would be supported appropriately at the end of their life. Several people had recently passed away at the service and we were not confident that the service would have known their wishes.

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

People could participate in some group or one to one activities but we found these quite limited. We asked staff what people did yesterday and they said, "We played lawn bowls and people collected eggs from the chickens." We asked a person using the service and they said, "We go on trips to the shop. We hatched the chickens. We get a take away on a Friday." Another person said they went to Norwich once a week, got a taxi and went to the cinema. They described staff as brilliant.

One person told us that did not really have any interests or hobbies but then said they like art which they did on a Friday and wood work which they did with the handy man. Some of the art work was displayed around the service. They told us, and other people confirmed, that they could go to the shops each day, usually with staff to buy the things they needed whether it be cigarettes of snacks. One person said they regularly bought pork pies but when asked if they had access to a fridge they said no, (the service was exceptionally hot so this could pose a real health hazard if foods went off in the heat.) Another person told us there were trips out, they had been to Cromer and they went to Tesco's and in to the local town Long Stratton as well as Norwich. They told us there were no restrictions and they could do what they wanted within reason.

People could access different activities. For example, on the afternoon of the inspection there was a cooking class taking place. There was also a designated art room and weekly sessions took place. Music and other therapies were available. Some people had one to one support in which they could choose what they do. For example, one person went to the cinema recently. Staff said they also found out about local events and took people to these.

There was an activity board but this did not correspond with the activities we observed and was limited in scope. There was no newsletter and people did not have an activity schedule in their rooms.

There were adequate arrangements in place for people or stakeholders to raise concerns should they needs to and reviews were providing people the opportunity to raise concerns. People told us they had social workers and could speak with staff if they had any concerns. No recent, formal concerns had been recorded but we felt this might be reflective of the standard of record keeping from the previous management arrangement and the history of underreporting which the new manager was addressing.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection to this service on the 19 December 2016 this key question was rated as good. At our more recent inspection on the 4 July 2018 we have rated this key question as requires improvement.

Some of the concerns we found are indicative of an inadequate service. However, we had confidence in the manager and the actions they had already taken to identify and address some of the concerns we had. Despite this there are some significant failings and we could not be assured that prior to the appointment of the new manager the registered provider had sufficient oversight of these issues. We identified flaws with the environment which had been outstanding for many years and had a negative impact on people's health and safety. This has to be viewed in the context of people's getting older, and their needs changing. There had been a lack of assessment and reassessment to ensure everyone's needs could be met within the current environment. Staffing levels had been woefully inadequate and were still insufficient at times to ensure people received personalised care which focused on re-enablement where appropriate. The service was not progressive in terms of supporting people with existing skills or giving them the opportunity to develop new skills and sufficient opportunity to engage in meaningful occupation and activity.

The service was not currently complying with the Mental Capacity Assessment legislation. No one had a deprivation of liberty safeguards in place and there were no best interest decisions in place for people. There were some people who would not have capacity to make complex decisions and decision making could vary according to the persons mental wellbeing. They also confirmed the end of life planning at the service was poor and assured us they were addressing both.

Records were poor in some instances and we could not be assured people had access to the services they needed and in a timely way to promote their health and wellbeing. We were concerned about people's weight management and general health and felt staff did not provide enough support and guidance to people about healthy life style choices.

We had concerns about infection control and this was in part due to inadequate arrangements in place for the cleaning and general maintenance of the service.

There had also been a high number of medication errors not resulting in harm but significant in their potential to cause unnecessary harm.

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

Since the arrival of the new manager in November last year we found things were starting to improve and they themselves had recognised many deficits with in the service. They had responded by developing an action plan showing how they were systematically improving the service. In order for them to make improvements they had first got staff into senior positions to support them such as deputy manager, team leaders and administrative support. They had also appointed a replacement maintenance person. They carried out some audits monthly and reported these the provider who also carried out their own limited

audits three monthly but were at the service more often to support the manager. We saw as well as their action plan, they had replaced and renewed equipment carrying out audits of bedding and mattresses and replacing these. They also carried out audits on records, care plans, (four plans a month) infection control audits, health and safety and fire audits. The last provider audit was dated 1 June 2018 but had not identified the many issues we identified as part of this inspection but was mostly a positive report stating things were fine. They did however pick up gaps in care plans and did do some general sampling across the whole service.

The manager had increased the staff based on the perceived needs of people using the service, some of whom had not had a statutory review in years. Reviews had been taking place or planned. They had completed fourteen with the relevant agencies. Psychiatrist reviews were also being arranged to follow up on the prescribed medicines people took and whether these were still necessary. The manager told us some people were on a lot of medication and they intended to ensure people were on the correct medicines and dosage for their needs, They were also focussing on the safe administration of medicines so people were getting it as intended. They reported numerous medication errors and they had responded by retraining all the staff, assessing their competencies and changing the pharmacist provider.

The manager showed us evidence of care plans they had reviewed which were clearer. They had introduced health action plans as had recognised the health information was hard to find. They also recognised daily recording was poor and wanted to introduce a diary for everyone to record their day.

The manager spoke of their vision for the service and future to have a second regulated activity for domiciliary care. This would enable them to give people more choice in terms of what accommodation and level of support might accurately reflect their needs. People currently being supported might benefit from accommodation and support which offered them more independence. The manager spoke of re-enabling people and encouraging people to do more for themselves where this was appropriate. For others who were older and losing skills, the manager was considering if this was the right service for them and if it was still able to meet people's assessed needs. One person had been given notice as they had breached the terms and conditions of their contract. Another person's needs outweighed what the service could currently provide and this was being reviewed.

There was a renewed confidence within the service and people and relatives spoken with knew who the manager was and happy that they were sufficiently responsive. One person told us, "Since the new manager took over things have improved, there are more staff, a new car and more trips." Relatives told us there had been lots of different managers. They referred to three. They said they were happy with their family members care and liked the new manager as they were a person they could talk to. Staff told us there were lots of positive change and they were confident in the new manager.

We asked the manager how they gauged people's satisfaction across the service and they said they currently had regular staff meetings and feedback from people through care plan reviews. They had issued surveys to staff in the last month and residents in November of last year but not to relatives or visiting professionals so we could not be assured how representative this survey was. The results had not been collated so we could not see how this informed the action plan or clearly what people's experiences were apart from the little we gleaned on the day of inspection which is a snap shot on the day. However since the inspection the manager has confirmed they are currently sending out surveys to families, staff and professionals.

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 9 HSCA RA Regulations 2014 Person-centred care The care and treatment people received was not always appropriate or around their assessed needs or preferences. Records did not accurately reflect the support people were given or clearly highlight changing or unmet needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Consent to care and treatment was not always clearly established, particularly where people had fluctuating capacity or may not be able to make complex decisions. People had not been assessed as to whether they were being deprived of their liberty and we could not be assured people were supported lawfully by staff.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The needs of people had not been adequately assessed in relation to the environment they lived in and whether this was suitable for purpose. The service was not adequately cleaned and the risk of cross infection had not been adequately considered.

People had not always received their medicines as intended and this had not always been reported as such increasing the risk of potential avoidable harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes had not been fully implemented to enable the provider to clearly identify where they were meeting regulations and where the service fell short of expected standards and regulations. They had failed to adequately assess, monitor and improve the quality and safety of the service and mitigate risk from unsafe care and unsafe premises.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing staff were not always sufficiently deployed to ensure there were always enough staff to meet peoples assessed needs and ensure their safety.