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The Lodge Care Home

Inspection report

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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

The inspection took place on 20 June 2016 and was unannounced.

The Lodge Care Home can provide accommodation and care to a maximum of 20 older people, some of whom may be living with dementia. Due to concerns about the quality and safety of the service, the local authority was not funding placements. At the time of this inspection there were eight people living in the home.

The home is operated by a partnership, with one of the partners being the registered manager. 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 the last full inspection of this service on 21 August 2015, we found widespread and serious issues throughout the service. The registered persons were in breach of nine regulations. We issued warning notices in respect of three of these, telling the registered persons that they must make improvements in those areas. The warning notices set out improvements that were required to staff training, person- centred care, and to systems for leadership and governance. We inspected the service again on 1 December 2015 and found that the warning notices had been complied with but we did not reassess the overall rating from 'Inadequate.'

The provider told us how they were going to improve to meet the remaining six breaches of regulations. These included protecting people from abuse, recruitment practices, safe care and treatment, and dignity and respect. Improvement was also needed because the provider had not notified us of deaths or other incidents happening in the home as required by law. At this inspection, we found that some improvements had been made. However, there remained concerns about the way the service was operating and the safety of people using it. Improvements were not always consolidated and sustained.

People's safety within the home was compromised. Risks to their welfare were not always properly assessed and mitigated. They were exposed to risks in the way the premises was operating, for example in relation to fire safety and from inadequate measures to reduce risks associated with the spread of infection. They received their medicines safely and as the prescriber intended. However, arrangements for disposing of medicines no longer needed were unsatisfactory and presented a risk of misuse or misappropriation. They were not in accordance with the provider's expected systems.

Improvements had been made to staff understanding and awareness of the risk of harm or abuse. The way that staff were recruited had improved so that there were better checks to ensure they were suitable to work in care services. People were satisfied that staff were able to attend to them promptly although there were consistent concerns from some family members that they were not always deployed appropriately.

The effectiveness of the service had improved. There were significant improvements to the training staff had received to ensure they were competent to meet people's needs. This included an improved awareness of how they needed to seek people's consent and what to do if people found it difficult to make decisions so that their best interests were taken into account. Concerns about people's health and welfare were referred to health professionals for advice but the guidance given to staff was not always consistently implemented.

Staff were aware of the importance of respecting people's dignity. However, there was a lack of consideration given to easily avoidable triggers for people experiencing distress and anxiety. Improvements had been made to the way that people's choices and preferences were taken into account in the way their care was planned and delivered. Staff made efforts to support people with their hobbies and interests. The way people's likes, dislikes and backgrounds were recorded was improving so that staff were able to engage more meaningfully with people.

Most people were experiencing a degree of memory loss and needed assistance from staff or family members to raise complaints or concerns about their care. There was a lack of confidence in family members regarding the approach of staff and the registered manager in responding openly and transparently to concerns or queries.

There was a lack of leadership within the service. The registered manager had improved some of the systems for assessing the quality and safety of the service but had not sustained these. Clearly identifiable risks to people's safety and welfare were not assessed and mitigated. They had failed, despite previous requirements, to tell us about events happening in the service as required by law. They did not have a good understanding of best practice in residential care and were struggling to maintain standards of care.

The service remained in breach of two regulations and had not sustained improvements in complying with a third one. People were still not consistently receiving safe care and treatment. The registered persons had again failed to tell us about events happening in the service. Previous improvements to systems for monitoring the quality and safety of the service were not sustained. This meant they did not effectively identify failings, manage risk and ensure prompt action to make improvements.

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

The service people received remained 'Inadequate' in safety and leadership at this inspection. The overall rating of this service is 'Inadequate' and therefore it remains in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take

action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks to people's safety and welfare were not robustly assessed and managed.

Medicines were administered safely but practices for disposing of medicines no longer required presented a potential risk.

Staff had an improved understanding of what might constitute a risk of abuse or harm. Recruitment processes had improved to contribute to protecting people from staff who were unsuitable to work in care.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were referred appropriately for medical advice but guidance from health professionals was not always implemented.

Arrangements for staff support, training and induction had improved so that staff were better able to meet people's needs.

Staff had an improved understanding of the importance of seeking consent and, if people were not able to understand decisions needed, how to consider what was in their best interests.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were sometimes exposed to easily avoidable triggers which caused them distress and anxiety.

People were supported in a way that reflected improvements in the way staff upheld their privacy and dignity.

Staff interacted with people in a warm and polite manner.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's family members who raised concerns were not confident that there was an open and transparent approach to dealing with these.

The service had improved the way that they considered people's preferences and wishes in the way that staff delivered care for people.

Is the service well-led?

Inadequate

The service was not well-led.

Systems in place for monitoring and improving the quality and safety of the service people received were not robust and some improvements were not sustained.

The registered manager did not display an awareness and understanding of good practice, leadership and the standards with which the service needed to comply.

The Lodge Care Home

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.

The inspection took place on 20 June 2016 and was unannounced. It was completed by two inspectors.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the content of this. We also looked at all the information we held about the service. This included information about events happening within the service and which the provider or manager must tell us about by law, as well as complaints and concerns that were raised with us by family members. We reviewed feedback from the local authority's infection control team.

We spoke with three people who used the service, the registered manager, a senior carer, member of the domestic staff and a health professional. We also reviewed the records of care associated with three people and medicines records. We reviewed recruitment checks for three members of staff and checked a sample of records associated with the management and safety of the service. We looked around the premises.

Inadequate

Is the service safe?

Our findings

At our last full inspection of this service on 21 August 2015, we found that the service was not safe. Risks to people's safety and welfare were not properly assessed and managed. The provider told us what they were going to do to improve. At this inspection we found they had taken some appropriate action but the safety of people living in the home remained a concern.

The registered persons were not managing risks within the environment in a way that promoted people's safety. Health and safety audits were not robust and did not identify the concerns that we found.

We found that first floor windows were open wide and brackets designed to restrict their opening were unlatched. Restrictors were not of a suitable locking type to ensure they could not be removed. One of the windows we checked was only about one foot from floor level, had the key in it and gave potential access onto an adjoining roof. Although this window was in an unoccupied room, the room was not locked, meaning that anyone living in the home and mobile had easy access to this room. This presented a risk of falls and serious injury to people.

In one person's room we found that a cable was detached from above a doorframe and hanging down the wall. This still had the cable clips and fixing pins hanging from it, presenting a risk of injury to the occupant. The carpet on the upstairs corridor had a hole in it presenting a risks of trips and falls to both people living on that floor of the home and to staff.

The provider's pre-inspection information return (PIR) sent to us stated that a detailed fire risk assessment had been carried out by a fire safety company. The PIR said that fire doors were checked weekly as part of the health and safety audit. We found shortfalls in this process.

The fire safety officer raised concerns with the provider after our last inspection, in relation to one fire door where there was an unsuitable lock and a hole drilled right through the door. This compromised the way the door would function to help prevent the spread of a fire. The provider took action to ensure it was rectified. However, at this inspection, we found other fire doors to people's bedrooms presented the same concerns, having had holes drilled through them. The provider had not taken action to ensure they checked and made improvements or suitable repairs to all doors.

In one bedroom, we found a wedge behind the door of the type used to hold doors open. A fire door to another bedroom, fitted with a device intended to close it automatically if the fire alarm sounded, was wedged open. This meant that it would not close automatically to offer the required protection should a fire break out. This directly conflicted with the fire risk assessment for the home, which said that fire doors must not be wedged open. The checks in place did not identify that people's safety in the event of fire was compromised and ensure action was taken to address concerns.

Risks to which people were exposed were better assessed within their plans of care. For example, people's care records contained assessments of their risks associated with using bed rails, with mobility and of

developing pressure ulcers. A staff member told us that there was no one at the home who had a pressure ulcer or who needed staff assistance to change their position to minimise the risk of developing one. However, assessments did not always take into account increasing risks to people, their skin beginning to break down and the additional precautions staff needed to take.

For example, we found that one person's risk of developing pressure ulcers reflected that their skin condition was good. When we reviewed their records further, these showed that their skin condition had deteriorated. The person's care records directed staff to use a 'body chart' if the person became red or sore on their pressure areas. There were no body charts on file since February 2016 despite their records showing their skin condition had deteriorated since that time. Staff recorded this as healthy in February 2016, discoloured in March and April, and having developed a broken spot in May and June 2016. The person's assessment of risk remained unchanged despite this deterioration, showing no changes at each monthly review from 3 February 2016 to 12 June 2016. It should have reflected the person's increased risk 'score' to show they were at very high risk. This meant they would require additional precautions, support and advice to reduce further deterioration and promote recovery.

Staff responsible for administering medicine confirmed that they had received training to do this safely and that an experienced member of staff assessed their competence. We found that there was clear guidance about the use of medicines prescribed for occasional use, for example for pain relief. Records showed that staff had received training recently to administer insulin safely to one person. Checks on the competency of staff to administer medicines were completed regularly and recorded.

One bottle of eye drops, needing disposal four weeks after opening to avoid contamination, was not dated when it was opened but had only been supplied by the pharmacy on 27 May 2016. However, creams used for applying to people's skins were dated when they were opened, to ensure they remained safe and effective for use. This represented an improvement since the last full inspection of the service.

However, systems for managing medicines still did not adequately protect people. Medicines were not promptly disposed of and in accordance with the provider's guidance. Some medicines due for disposal were not properly and safely stored to prevent them being accessed by people living in the home or by unauthorised staff.

Staff said, and the registered manager's audit stated, that medicines no longer needed were returned to the pharmacy for proper disposal each month. We found that this was not happening. There was a large, round, plastic chocolate box approximately ten inches in diameter, secured in the medicines cupboard; staff used this to store medicines pending their return to the pharmacy. When we checked, some of those due for disposal were in small plastic packets labelled and dated back to February 2016. These were on top of many others, which were loose, unlabelled and the box was full, despite low levels of occupancy at the home.

We found two plastic storage crates containing medicines for disposal, stored in an unoccupied bedroom. In the interests of people's safety, we took immediate action to ensure the room was secured and a reminder to keep it locked was displayed on the door. Neither the crates, nor the room, were secure at the time we found the medicines. This meant that the medicines stored there were not protected from misuse or misappropriation and were potentially accessible to people using the service. We were concerned, given the amount of medicines and occupancy of the service, that the registered manager had not followed proper and safe arrangements for disposing of them for some time.

The registered manager's audits of medicines did not identify that the arrangements for disposal of medicines were not working as intended. Staff told us that the medicines were due for collection during the

afternoon of our visit but this had not happened by the time we left the service at 5.40pm.

We found that the medicines storage cupboard contained a plastic cup of yellow liquid with a small syringe in it. A staff member informed us that it was olive oil for people's ears. It was unlabelled with the nature of the contents or the name of the person for whom it was intended. We asked the staff member to dispose of it to avoid contamination or spread of infection.

The temperature of the fridge used for storing medicines that were affected by heat, was monitored. However, there was no guidance in the record about what the temperature should be and what staff should do if it fell outside this range. This presented a risk that these medicines would be adversely affected and not effective for use.

Before we visited the service, we received a complaint from a visitor about standards of cleanliness and odour within the home. The infection control team from Norfolk County Council completed an audit of infection control measures when they visited the home on 4 May 2016. The report from this raised concerns in all areas checked, that control measures were not adequate to protect people against the spread of infection.

At our inspection, we found that the registered manager had taken some appropriate action. In occupied rooms, there was better provision of soap dispensers and paper towels. Antibacterial hand gel stations were fitted at various points throughout the home. We accepted that some of the action needed was part of a long-term plan to improve the building and that the infection control team were aware of this. However, people remained at risk because there were outstanding actions needed more urgently, to manage the risk of infection spreading.

Since the infection control audit, the registered manager had reduced the hours available for dedicated support. A domestic staff member was working only two days each week. The cleaning schedule lacked detail, for example just stating that staff needed to, "clean mattresses." This was not practicable given the hours available for cleaning tasks. The cleaning schedule was not completed on the days the cleaner was not available.

We found that maintenance and décor within the service compromised the way that infection could be controlled and equipment cleaned. For example, the chipped surface of a bath and a cracked toilet seat and could not be properly cleaned. The infection control team's audit indicated that the bath should be repaired or replaced and toilet seats should be checked for damage and replaced within four weeks. This had not happened since the audit was completed, more than six weeks before our inspection.

There was damage to coverings of a plinth under a toilet. The infection control team's audit identified this needed repair, so it could be properly cleaned, one week from their audit. A frame around one toilet, to assist people with mobility difficulties, was rusty and a sink was cracked. Neither of these could be properly cleaned and so would harbour germs. There was no soap for hand washing in the ground floor bathroom. The floor covering to one toilet was badly stained and there was no lid for the toilet seat. One person's en-suite WC had a loose toilet roll not in a covered holder presenting a risk of contamination. The flush handle to this toilet was corroded where it fitted the cistern and in one person's room there was a leather (or mock leather) pouffe that was split and so could not be properly cleaned

We also noted rooms in use where there was a strong smell of stale urine, which we could trace to the duvets in use. These were not wet at the time of our inspection, but dried, suggesting staff re-used them without laundering or replacing them.

These concerns represented ongoing breaches of Regulation 12 of the Health and Social Care Act 2008, (Regulated Activities) Regulations 2014.

At our last full inspection of this service on 21 August 2015, we found that staff were not trained to recognise and respond to suspicions of abuse. The registered manager had not cooperated openly and fully with the safeguarding team in investigating allegations and had not adequately protected people from the risk of abuse or harm. Recruitment processes did not contribute to safeguarding people living in the home. The registered manager told us what they were going to do to improve. At this inspection, we found that appropriate action had been taken.

Staff had received updated training in recognising and responding to suspicions that people may be at risk of harm or abuse. One staff member spoken to was clear about what they would report and told us they were confident that the manager would deal with concerns. However, the telephone number staff could use to make a referral of safeguarding concerns directly, was not up to date.

However, we found that one person's body chart indicated they had five bruises in February 2016. We saw that another person had a bruise to the corner of their mouth. A relative raised concerns with the manager that the person had sustained this when staff tried to get the person to drink. The records relating to this reflected that the cause was unknown. The registered manager had not recognised that they may need to seek additional advice from the local authority's safeguarding team about investigating.

The lock to one bedroom door was changed after our inspection in August 2015. This had been replaced with a type that the occupant could lock if they wished to prevent other people from walking in if they became disorientated. It unlocked from inside when the occupant turned the handle. It was the only lock of this more suitable type fitted. The manager told us after our last inspection that this one had been a priority because the person wanted their room locked at night. They said they would fit others over time.

One person told us, "Staff are always around when you need them." Staff told us that there were enough of them to meet the needs of the eight people living at the home at the time of our visit. We could see that people were not waiting long for assistance and that staff were available to sit with people chatting or playing games during our visit.

Following our inspection in August 2015, the registered manager confirmed that she had spoken with staff about the arrangements for their breaks. This was because we had concerns that there were periods of time when people received very limited staff support. Before this inspection, we received two separate complaints about staffing, one including that staff took cigarette breaks together. This concern meant that staff were not available to support people living in the home or to intervene promptly if necessary. This did not happen during our inspection, but may need further monitoring by the manager to ensure that staff are consistently deployed in a way that meets people's needs safely.

Staffing levels at the time of this inspection were maintained at two staff on shift for the eight people living in the home. The cook was working on an afternoon shift as a carer. Another member of staff, who had worked the early shift and did not leave until mid-afternoon, was due to return just over four hours later in order to complete the night shift. They told us that they were satisfied with this arrangement but had intended to leave earlier. The registered manager explained that they had recruited additional staff but were not able to use them temporarily because of falling occupancy levels.

We reviewed the recruitment records for three members of staff and found that improvements had been made. These showed that the registered manager acted to ensure the required checks were completed and

references taken up before staff started working in the service. This contributed to protecting people from the employment of staff who were unsuitable to work in care.

Requires Improvement

Is the service effective?

Our findings

At our last full inspection of the home in August 2015, we took enforcement action due to our concerns about staff training. Staff were working without appropriate training and assessment of their competence. This included a lack of essential training in first aid, safe moving and handling practices and medicines management. We inspected this service on 1 December 2016, to check that the provider had complied with the warning notice to ensure staff deployed received proper training to support people effectively. We found that the provider had made improvements to the training available and completed by staff.

At this inspection, a staff member told us that training continued. We discussed with the registered manager that, having made improvements, they now needed to sustain these and ensure that training was renewed promptly when it expired.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals 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.

We know from our last full inspection of this service that the manager had applied for these authorisations, where people's freedoms were restricted in the interests of their safety. They were still awaiting outcomes of applications for people currently residing in the home.

There were improvements in the assessment of people's capacity to make decisions about their care and protecting their rights. Staff understood the importance of seeking people's consent when they delivered care.

Records of assessments sometimes did not show the specific decision under consideration in each assessment. However, we found that care plans had a thread of information running through them to show people's ability to understand and consent to aspects of their care. For example, one person's assessment showed they were not able to understand the purpose of their prescribed medicines and the importance of taking them. A family member, staff and the person's doctor had been involved in determining it was in the person's best interests to take their medicines and to administer them covertly. For another person, we found that there was detail about the best way to communicate with the person to encourage them to make their own decisions.

Training for staff in understanding their responsibilities under the MCA took place in October 2015. A staff member showed us they understood the principles of gaining consent. They told us how, for one person, they were seeking additional advice because the person was refusing some aspects of their care. They were clear that people's capacity to understand and make decisions varied. They told us how, if someone refused assistance they would go back and a different time and try a different approach to see if the person agreed.

People told us that they were happy with the food provided for them. One said, "We have lovely food. It's always nice." People were assessed to determine whether they were at risk of not eating or drinking enough. A staff member spoken with explained that the staff team had recently started monitoring one person's fluid intake as they were not drinking well. We found that staff sought advice where they were concerned about people's nutrition.

Although people had access to support with their health and welfare, staff did not consistently act on the advice health professionals gave them. For example, on two occasions, staff sought advice from a health professional regarding concerns about one person's weight loss. The advice was first given on 6 January 2016. Notes showed that the health professional wanted staff to weigh the person each week. Records showed that staff weighed the person on 11 January and 18 January 2016 and then reverted to doing this monthly as before. Again, on 15 June 2016 the health professional repeated their advice to monitor the same person weekly. Staff had not done this promptly after getting the advice, and the person had not been weighed since 4 June 2016. The service could not show from these records, what they were doing to monitor the person's wellbeing and to act on the advice they had been given. There was a risk that staff would not be able to identify promptly whether the person's weight had stabilised or needed greater intervention to promote their health and welfare.

One person had confusing information within their plan of care about how often staff should monitor their blood sugar to assist in controlling their diabetes. We found that a review dated 14 May 2016 said their blood sugar needed testing before breakfast and their insulin was given, and a second time before tea. On 23 May 2016, advice noted from a specialist diabetes nurse was that the person was stable and no longer needed twice-daily checks. Notes indicated that staff should check on an evening or afternoon reading once each week. We found that the person's blood sugar had been tested twice on 24 May, the day after the advice was given. It was also tested on 1, 5 and 6 June 2016. On one of these days, staff tested the person's blood sugar twice but records did not indicate why this was needed. Staff had not identified this was not in accordance with the advice the diabetic nurse specialist issued regarding the appropriate time and frequency for testing.

We discussed with the registered manager the importance of updating care plans clearly in response to advice so that staff understood their responsibilities in relation to people's health and welfare. This would help to address the risk that staff were not monitoring people's welfare as often as health professionals intended or were subjecting people to unnecessary tests.

People's records showed that they had access to treatment by health professionals, including their GP, optician and for chiropody treatment. We also noted that the staff had sought advice with regard to caring for someone who was living with dementia and experiencing problems with their mental wellbeing. The registered manager told us, following our last inspection, how they were exploring options for improvement to dental treatment.

Requires Improvement

Is the service caring?

Our findings

At our last full inspection of this service in August 2015, we found that the service people experienced was not as caring as it should be. Staff did not support people in a way that was consistently respectful and promoted their dignity. The provider told us what action they were going to take and we found some improvements had been made. However, more could be done to support people's emotional wellbeing.

At this inspection, we found that a trigger for a person's anxiety or distress was easily avoidable but not being routinely addressed. When we arrived for this inspection, there was a notice on the door about a dog being present. The registered manager told us that two large and two small dogs owned by staff members spent some time in the home and sometimes there were two at once. Three people living in the home told us that they liked the dogs. Staff and one of the people we spoke with, confirmed that another person did not like the dog, and became anxious and tried to kick out at the animal because of this.

For most of the time we were in the home, a dog was confined either to an animal crate in the staff room, or in the garden. This meant that the person had not become anxious or distressed as a result of the pet's presence while we were there. However, it was loose on the ground floor of the home when we arrived for this inspection, so there were risks that the person would become agitated and distressed. Their dislike of the animal, and anxiety when it was present, was not properly taken into account.

People living in the home were not able to remember how long they had lived there and how long they had known established members of the staff team. However, we found that some records showed both people living in the home and some staff working there, had known one another for some years. This enabled people to receive support from a largely consistent group of staff. One person told us, "The staff are very kind." Another person echoed this view. Records of care delivered showed that staff better respected people's choices about the times they went to bed and got up in the morning. A third person told us, "The staff are lovely. They help you if you need them."

Although we had two concerns raised with us about staff attitudes since March 2016, these were not substantiated by what we saw during the inspection. During our inspection, we noted that staff spoke with people respectfully. They took prompt action to intervene when one person complained of pain, offering medicine for pain relief and reassurance. When the person refused the medicine staff respected their choice. We saw that they then asked whether the person would like to rest on their bed for a while. Staff assisted them to do so when the person agreed that this would help them feel more comfortable.

We heard staff addressing people by name and saw that they assisted people discreetly when they needed support with continence management. A staff member assisting someone with their meal sat alongside them and helped them to eat at their own pace.

We noted from people's care records that those who were able to do so had signed their records to show that staff had discussed their care with them. For another person, we saw that their next of kin had been involved in discussions about their care and welfare. Minutes from staff meetings confirmed that the

registered manager discussed issues about choice and privacy with the staff team. They also showed that the registered manager reminded the staff team of the importance of talking to people in the right way.

We observed that people were able to have family members or friends to visit freely. One person received regular daily visits from a relative who was able to join them for meals and drinks.

Requires Improvement

Is the service responsive?

Our findings

At our last full inspection of this service in August 2015, we took enforcement action because the service was not being delivered in a way that reflected people's needs and preferences. Institutional practices had developed, including assisting people to rise from 3.15am without regard to their preferred routine. People were not offered activities that took into account their interests and hobbies.

We inspected the service again on 1 December 2015 and found that the provider had taken appropriate action to comply with the warning notice. People's needs and preferences were better taken into account in the way staff provided their care. Changes to the staff roster allowed more flexibility for people to get up when they wished and no one was up out of bed when we arrived at 4.25am. There were improvements to the support staff offered people with activities so that they had more to do which they would enjoy.

At this inspection, we found that people felt improvements had continued. One person told us, "I can get up and go to bed when I like." Another person confirmed that this was their experience. People's preferred routines were better reflected in their plans of care.

We noted that, although staff were no longer recording specific times people got up or went to bed, there were regular daily entries showing that people who preferred not to get up early were still in bed when the day shift arrived for duty. Likewise, daily records showed that people who chose to stay up in the evening were not being assisted to bed straight after tea before the night shift arrived. The registered manager had reminded the staff team at a meeting about the importance of respecting people's preferences and of recording if the person was awake very early and wanted to get up.

Staff reviewed people's care plans regularly. However, care plans did not always show the action staff needed to take to address escalating risk, for example from poor nutrition or pressure ulcers.

One person told us that they liked to read. They said, "The cook brings me books and I've got a couple to read in my room." They told us that they preferred documentaries on the television but understood why a chat show was on in the lounge, as other people liked it. Two other people confirmed that they liked watching television and one told us they did not want to do anything else but did read their paper regularly. We saw that this was available next to them.

We saw that improvements had been made to the way people's life histories and backgrounds were recorded. The registered manager told us that this was work in progress but information meant that staff would be better able to engage people in discussions about things that interested them. We saw that one staff member supported a person to go through a book with photographs about Winston Churchill and engaged them in discussions about their memories. Later we saw that staff supported one person to play a board game.

Staff told us that they tried to fit in activities at quiet points in the day. The registered manager said that they had appointed a staff member to assist people with hobbies and interests. However, they were not working

at the home at the time of our inspection, due to reduced occupancy levels at this time.

Staff had taken care to ensure people were dressed in the way they preferred, with coordinating clothing and jewellery if they wished. They had ensured that three people needing glasses had these on so that they were able to see to join in activities, read or watch the television.

Most people using the service would need support of staff or family members to raise concerns. We had concerns about a lack of open and transparent processes for recognising and responding to complaints, particularly those people raised verbally. Three family members, who contacted us, were not all confident that staff and the registered manager had a constructive and open approach to dealing with their concerns. For example, one relative described a staff member as shrugging their shoulders when they tried to raise an issue. A second family member described raising an issue and the staff member they spoke with as, "…off hand..." and, "…insolent." A third expressed a lack of confidence that they had received proper and consistent explanations when they raised an issue.

Information about how to complain was posted on a noticeboard in the hallway. However, the copy posted in the medication room for staff reference, was out of date and referred to contact details for the regulator of care services that had not been in use for approximately seven years. As at our inspection in August 2015, there was the potential for confusion about how people could raise a complaint and who to contact regarding concerns about the service.

Inadequate

Is the service well-led?

Our findings

At our last full inspection of this service in August 2015, we identified that the registered manager was not complying with their responsibilities and registration conditions. They had failed to notify us about deaths taking place in the service and about allegations of abuse. The registered manager told us that they had taken action to ensure that they were aware of their obligations. They undertook to make these notifications to the Care Quality Commission (CQC) and to do so promptly in the future.

At this inspection, and during the course of reviewing our information, two relatives told us about two separate serious injuries taking place within the home since our last inspection. The registered manager had not told us about either of these in accordance with regulations. Registered persons are required to tell CQC, without delay, about serious injuries, and other specified events taking place in the home. The registered manager reported one of these during the time we were drafting this report, but the injury occurred 11 days before the inspection visit itself. The registered manager did not make the notification until CQC made them aware that we were seeking additional information in relation to the injury. Another person's family member made us aware of an injury occurring around February 2016. We understand there was a delay in diagnosing the person's fracture but we have received no statutory notification of this at all.

This was a further breach of Regulation 18 of the CQC (Registration) Regulations 2009.

After our last full inspection of this service in August 2015, we took enforcement action due to our concerns about leadership within the service. There was a lack of suitable systems for assessing and monitoring the quality and safety of the service and managing risks. The registered persons did not take into account the views expressed by interested parties to evaluate and improve their practice.

We inspected the service again on 1 December 2015 and found that the provider had taken appropriate action to comply with the warning notice. The registered manager had improved the way that they consulted with people for their ideas and opinions. There were increased checks to monitor and review the quality and safety of the service.

However, at this inspection we again found that, although there were some improvements that had continued, systems were still not operating effectively. Risks to the quality and safety of the service people received were not robustly assessed, recognised and mitigated. We identified ongoing risks to people's safety and welfare that the registered manager had not addressed.

We noted that the registered manager was meeting more regularly with staff. However, it was clear from the minutes of a meeting on 27 April 2016 that there were mixed views about the standard of care and that staff were not working as a team. The registered manager told us that the provider's accountant chaired the last meeting and minutes were not yet available. We were not therefore able to see how this was followed up, and what action had been taken to improve in response to the concerns.

The registered manager had not identified in health and safety checks that the service was not complying

with their own fire risk assessment. They had not proactively identified some concerns we found for the integrity of fire doors. They had taken action to repair one specific door we reported to Norfolk's fire service in August 2015. However, they had not identified and repaired others that had holes through them. The use of a wedge to hold open a bedroom door designed to be fire retardant was directly contrary to the provider's fire risk assessment stating that fire doors were not to be wedged.

The equipment for detecting and extinguishing fires was maintained and serviced regularly. However, in house audits were not completed with the frequency stated on the records to ensure people's safety. For example, we found that the record of weekly fire extinguisher checks had not been completed within the fire safety log since 20 May 2016.

The registered manager was completing monthly medication audits. However, these were not as robust as they should be. One completed audit from 17 March 2016 commented that medicines no longer needed were returned to the pharmacy regularly each month. It did not identify that there was an accumulation of medicines awaiting disposal filling the tin used for storage. The audit in April 2016 made no reference to disposal arrangements.

The risks associated with the removal of latches to restrict window openings had not been properly assessed and managed. The audits had not identified the risk of potential injury to one person associated with a loose and dangling cable still containing cable clips and fixing pins.

Infection control audits completed monthly since January 2016 did not identify the concerns highlighted by the local authority's infection prevention and control team in May 2016. We found that shortfalls continued. We accepted that addressing some of them was part of a long-term plan for developing the service. However, for some issues the registered manager should have acted immediately or within a period of up to four weeks and had not done so.

Audit systems did not identify inconsistencies and inaccuracies within care plans about the assessment and management of risk to people specifically around developing pressure ulcers. This meant that people were at risk of not receiving the appropriate care.

The registered manager agreed that quality assurance systems needed further improvement. They recognised that they needed to make improvements to act upon the findings of the audits that they had completed.

The provider information return (PIR) submitted to us said that the service was kept up to date by attending training workshops and, "…focusing on best practice using NICE guidelines." NICE is the National Institute for Health and Care Excellence. This organisation publishes guidance about best practice for health and care services. We asked the registered manager which pieces of guidance they were using. They told us that they did not know and their consultant had filled in the PIR for them. We were concerned that the registered manager was not taking responsibility for identifying best practice and making improvements to the quality and safety of care people received.

This was a renewed breach of Regulation 17 of the HSCA 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered persons had failed to tell us about serious injuries occurring within the home. Regulation 18(1), (2)(a)(iii)

The enforcement action we took:

We took action to cancel the registrations of both the provider and manager of this service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered persons failed to ensure that risks to people's safety and welfare were properly assessed and action taken to mitigate risks. This included risks associated with people's health, in the environment, from lack of measures to control infection and in the way that medicines were managed. Regulation 12(1), (2)(a), (b), (d), (g) and (h).

The enforcement action we took:

We took action to cancel the registrations of both the provider and manager of this service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a lack of effective and suitable systems for assessing and monitoring the quality and safety of the service and for identifying and managing risks. Regulation 17(1), (2)(a) and (b)

The enforcement action we took:

We took action to cancel the registrations of both the provider and manager of this service.