ADR Care Homes Limited

St Nicholas Care Home

Inspection report

1-3 St Nicholas Place
Sheringham
Norfolk
NR26 8LE

Tel: 01263823764
Website: www.adrcare.co.uk

Date of inspection visit:
20 November 2018

Date of publication:
31 January 2020

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

St Nicholas is a 'care home'. People in care homes receive accommodation and 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. St Nicholas accommodates up to 39 people, some of whom may be living with dementia, in one adapted building. At the time of our comprehensive unannounced inspection on 20 November 2018 there were 17 people living in the home.

A new manager had been appointed in September 2018 and they were in the process of applying to become 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.

We found the provider failed to comply with six of the regulations as required under the HSCA 2008 (Regulated Activities) Regulations 2014. The provider continued to fail to make and sustain improvements within the service. After this inspection we asked the provider what immediate action they would take in response to the concerns we found. They provided us with an action plan which detailed the action they would be taking to ensure the safety of people living in the home.

During this inspection we found that good practice had not been maintained in relation to the safe management of people's medicines. Administration records for people's medicines were not complete and medicines stored within the service were not accurately accounted for.

Risk assessments for people's individual care needs were not accurate and lacked detail. There were no environmental risk assessments for different areas of the home. Personal emergency evacuation plans for people did not accurately reflect the support they required to evacuate the building in the event of a fire. Therefore, there were insufficient measures in place to identify, manage and mitigate risks both to people and within the environment.

Some areas of the home were not clean and staff did not follow guidance to protect people from the risk of infection as they did not always wear the correct personal protective equipment.

Safeguarding incidents had not been identified and reported to the appropriate authorities. Accidents and incidents were not fully documented and follow up of people's health and wellbeing post incident did not take place.

There were not enough staff to be responsive to people's needs and to ensure their safety was maintained. These findings meant that the provider remained in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not involved in day to day decisions about their care and treatment and staff lacked knowledge about the importance and guidance around making a decision in a person's best interest. Where people were deprived of their liberty, records relating to this had been not completed in line with the Mental Capacity Act 2005. Therefore, the provider remained in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff did not support people to maintain a healthy nutritional intake and did not follow health professional's guidance relating to people's food and fluid intake. This meant the provider remained in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider remained in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people were not treated with respect and their dignity was not upheld. Staff did not have enough time to spend with people other than when they were performing care tasks.

People's care plans and associated records did not detail their most current care needs and some documents had not been reviewed. Where records had been reviewed, this process was not thorough and did not identify any changes.

Staff were not adequately deployed to ensure they remained responsive to people's needs. Therefore, the provider remained in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
There was a lack of processes in place to monitor and assess the quality of service being delivered. Systems that were in place were not robust and did not identify shortfalls within the service and drive improvement. This meant that the provider was still in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessment of people's care needs had improved and the manager went to visit people in hospital to assess their needs.

Staff completed an induction when they started work at the service and all staff received supervision with the manager. Staff did not receive training specific to people's individual care needs.

People had access to healthcare professionals when needed.

Staff enjoyed their work and felt supported by the manager in their role.

The overall rating for this service is 'inadequate'. Therefore, the service remains in 'special measures'. We do this when services have been rated as 'Inadequate' in any key question over two consecutive comprehensive inspections.

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.

Individual risks pertaining to people's health and welfare were not identified, managed or mitigated.

Risks within the environment had not been identified and services such as the heating and water safety were not monitored.

Infection control procedures did not ensure that the home was clean and staff did not observe safe infection and control procedures.

People's medicines were not managed in a safe way.

There were not enough staff to maintain people's safety.

Accidents and incidents were not thoroughly recorded and safeguarding incidents had not been identified and reported to other agencies.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not follow the principles of the Mental Capacity Act (2005).

People were not supported to maintain an adequate intake of food and fluids.

Staff training was minimal and staff did not receive training relating to people's individual care needs.

Staff did not always follow guidance given by healthcare professionals.

People were able to access other healthcare professionals where there were concerns about their health or wellbeing.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always speak with people in a caring way.

People were not supported or cared for in a way that maintained their dignity and privacy.

People were not always encouraged to express their views about their care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care records were inaccurate, lacked detail and did not reflect their current needs.

People's needs and preferences were not always respected.

Staff were not adequately deployed to meet people's needs.

A complaints procedure was in place and people knew how to raise a complaint.

Is the service well-led?

Inadequate

The service was not well led.

The provider failed to implement and sustain improvement.

There was a lack of robust systems in place to monitor and assess the quality of service being delivered.

Safeguarding incidents had not been correctly identified.

The service did not work collaboratively with other organisations.

Staff enjoyed their work and felt supported by the manager.

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

This unannounced inspection was carried out on 20 November 2018 and was carried out by two inspectors, a medicines inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also looked at all the information we held about the service. This included information about incidents happening within the service and which the provider or registered manager must tell us about by law. In addition, we reviewed information supplied to us from the local authority's quality assurance team.

During our inspection visit, we observed how people were being supported and how staff interacted with them. We met and spoke with eight people living in the home and three relatives. We also spoke with the manager and three members of care and support staff, including two carers and the activities coordinator.

We looked at assessments and plans of care for three people and checked how they were supported. We reviewed records associated with the employment of three staff, minutes of meetings and staff training records. We also looked at the arrangements for storing, administering and auditing medicines and a sample of other records associated with the quality and safety of the service.

Inadequate

Is the service safe?

Our findings

At our last inspection on 5 and 6 February 2018, we rated this key question as 'Requires Improvement'. We had concerns with regards to the identification and management of risks relating to people's individual care and within the environment. These findings constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider sent us an action plan detailing the actions they would take to meet the regulation and said that these actions would be completed by 15 June 2018. We found during this inspection that the required improvements had not been made and we found additional concerns around the management of people's medicines and the way accidents and incidents were reported. Therefore, the provider remains in breach of this regulation and this key question is now rated as 'Inadequate'.

Risk assessments for people's individual health and wellbeing needs were not complete. For example, one person was at risk of developing pressure ulcers. They had lost weight and their Waterlow score had increased from 'at risk' to 'high risk'. The Waterlow score is an assessment to estimate a person's risk of developing a pressure ulcer. When staff had reviewed the person's pressure care risk assessment, we noted that they had just written 'no change' on the review. We also noted from this person's care plan they required repositioning every two hours during the day and every four hours at night. This was not in line with the care plan written by healthcare professionals in the person's care file which stated that the frequency of repositioning should be every two hours. We looked at their repositioning chart and saw that they were not repositioned every two hours. In addition to this, we were unable to find any reference in their care records relating to the repositioning frequency of four hours. The healthcare professional's care plan also stated that the person's heels should not be resting on their chair, during our inspection we saw that the person was sat in their chair with their heels resting on the foot rest. Therefore, we could not be satisfied that every practicable step had been taken to mitigate the risk of this person developing pressure ulcers.

In a second person's care file we looked at, we noted that their moving and handling care plan stated that they used a stand aid. During our inspection we were told that they could no longer use the stand aid and used a full body hoist for all transfers. We looked at the risk assessment relating to moving and handling and noted that this had not been updated to reflect the risks associated with using a hoist. This person also showed behaviours that challenged and their mood could fluctuate. They had previously stated that they wanted to harm themselves. To maintain their safety, and that of others, their care plan stated that their door should be left open at all times unless they were receiving personal care. During our inspection we noted that this person's room was located on the first floor at the end of a corridor and their door remained closed.

As a result of these findings we could not be assured that staff had the correct information to support people in a safe way. This meant people were at risk of harm.

Risks within the environment had not been identified. We asked to look at risks assessments for different areas of the home and the manager was unable to produce these. We looked at records associated with the utilities within the home. There was insufficient monitoring around the risk of Legionella. Maintenance

records we looked at showed that hot water temperatures were being monitored but cold water temperatures were not sampled to ensure that they were below 20 degrees Celsius. The water system in the home had not been inspected by a contractor to carry out Legionella testing since June 2017. This was of concern given that there was insufficient monitoring in place for cold water outlets, most of which were accessible by people who lived in the home.

The boilers had last been serviced in August 2017 and this check should be done annually or when a concern is identified. We noted that the service was cold and the temperature in one of the lounges was 18 degrees Celcius. We noted that some people were sat with blankets over their laps. Some of the people we spoke with commented on the lack of heating. One person told us, "I could do with the heating in the lounge working as it's really cold and it's going to get colder." One person's relative commented, "The heating is not working and [family member] has to sit with a rug [around them]." We raised this with the manager who turned the heating up. However, we noted that the temperature did not increase and a portable heater was taken into one of the lounges. The manager confirmed that the boilers were going to be serviced in December and that there was currently nothing wrong with the heating system. Due to our findings and observations, we could not be assured that the heating system was adequate to keep people warm.

People's personal emergency evacuation plans (PEEPs) did not reflect people's most current support needs and therefore did not provide the detail required by staff or emergency service when supporting people to safely evacuate the building. One person's PEEP listed the incorrect moving and handling equipment. A second person's stated that they were able to move quickly in the event of a fire but during the inspection we found that they required the use of a full body hoist.

We found areas of the home that were not clean. There was a malodour in some areas of the home and a toilet had what appeared to be unflushed urine in it, around the seat and on the floor. We checked this several hours later and noted that it remained in the same state. When we looked in the laundry cupboards, we noted that there was a bin with used gloves in one of them. The gloves were in contact with clean bedlinen.

Staff did not wear the correct personal protective equipment to prevent cross infection. We observed one member of staff carrying what appeared to be wet or soiled laundry without wearing an apron or gloves.

A member of the CQC medicines team looked at how the service managed people's medicines and how information in medication records and care notes supported the safe handling of their medicines.

Oral medicines were stored safely and at correct temperatures. However, we found that medicines prescribed for external application such as creams and ointments were not secured and could be accessed by people living at the service with the potential of causing themselves accidental harm. The service had not considered the risks around this.

We looked at people's medication records and found there were gaps and discrepancies for both oral medicines and medicines prescribed for external use. This meant records did not confirm people received their medicines as prescribed. We also noted that there were discrepancies with some controlled drugs (medicines that require extra records and special storage arrangements because of their potential for misuse).

Audits were in place to enable staff to monitor medicine administration and their records. However, we found the audits were ineffective at promptly identifying and resolving medicine issues that we had identified during our inspection. In addition, there was a lack of an effective system for reporting medicine

errors and incidents to enable staff to take action to resolve them, learn from them and help prevent them from happening again.

Supporting information was available for staff to refer to when handling and giving people their medicines. There was personal identification to help staff give people their medicines safely. For people prescribed medicines for external use, there were body charts in use to show staff where on the person's body they should be applied. For people prescribed skin patches there were additional charts to show they were applied to people's bodies in varying positions to reduce skin effects and to confirm they were later removed before the next patch was applied to ensure safety. However, these records were not always completed by staff. For a person who had regular blood tests to check the effectiveness of a cardiovascular medicine, the result sheet alongside their medicine chart was out of date and showed a former dose schedule for the medicine. This could have led to an error and potential harm to the person.

When people were prescribed medicines on a when-required basis, there was written information available for staff to refer to for most but not all medicines prescribed in this way. When medicines were prescribed for when-required use to assist with people's psychological agitation we noted the written information was not sufficiently detailed to show staff how and when to give them to people to ensure they were given consistently and appropriately.

Accidents and incidents were not always reported to other authorities when required. We looked at records of safety incidents and saw that one person had become trapped between their bedside table and their bed rails. Unexplained bruising was found on a second person over the course of two days. A third person was found to be severely dehydrated and attended hospital. These incidents were not reported to the local authority safeguarding team or the Care Quality Commission. By law, the provider has to notify us of any safeguarding incidents or when an accident has resulted in harm to a person.

Records of accidents and incidents lacked detail and did not evidence that any monitoring took place of people after they had been involved in a safety incident. For example, we saw from records that one person had tripped over their crash mat and that a cold compress had been applied to their head. There was no further information regarding the injury and if staff would be monitoring the person to ensure that they had not suffered any ill effects as a result of hitting their head. We saw that a second person had sustained a red mark and a graze sustained from a fall. No body map had been completed to show where these injuries were.

We had concerns that there were not enough staff to support people safely. Some of the people we spoke with told us that there were not enough staff to support them safely. One person told us, "Sometimes [the staff] are very quick if I press the buzzer, but there are times where they can take a while. That is because they are often short of staff." A second person explained, "[The staffs'] response to my buzzer depends on who is on duty during the day. There appears to be the minimum number of staff on duty most days. A lot of staff have left." One person's relative explained, "I have a concern for my [family member] because of the staffing levels, I don't think they are high enough."

We looked at the staff rotas covering the previous four weeks and saw that there were four staff on during the day with the exception of one day and one afternoon and two staff worked at night. The manager showed us how staffing numbers were calculated and this was based on people's dependency. We were not confident that the dependency tool used accurately reflected people's care needs. There were seven people living in the service who required two staff to support them with their moving and handling needs. The service was also big and people were living across two floors. In addition to this, there were only two staff on at night. We could not be assured that there were enough staff to safely support people or respond quickly

in the event of an emergency.

As a result of these findings, the provider remained in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People we spoke with told us that they felt safe living in the home. One person told us, "Yes, I do feel safe here. I have no concerns about any of the staff or the other residents." A second person commented, "I do feel safe here, they look after me well." Staff understood what constituted abuse and described to us how they would report any concerns. However, we noted from the accident and incident records that concerns were not always shared with the appropriate agencies.

Recruitment practices could be more robust to ensure that a detailed employment history of any newly recruited staff is obtained before an offer of employment is made. We looked at three personnel files and noted that these were not complete. We saw a gap in employment in one person's file that did not have an explanation and no full employment history for a second member of staff. We also saw that there was no reference from a member of staff's most recent employer.

Requires Improvement

Is the service effective?

Our findings

We found during our last inspection, that the provider was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This regulation is called 'need for consent'. This was because where people lacked the mental capacity to make a specific decision, the provider had not acted in accordance with the requirements of the Mental Capacity Act 2005 (MCA). The provider sent us an action plan after our last inspection to tell us what actions they had taken to meet the regulations. The provider stated in the action plan that they had completed the actions to meet this regulation. We found during this inspection, that sufficient improvements had not been made and the provider was still in breach of this regulation.

The 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

We saw one person sitting in a reclined chair in their room, they also did not have the ability to mobilise without the assistance from staff. We noted that the door was open but there was not always a staff presence along that corridor. We saw from the person's mental capacity assessment that they did not have the capacity to make decisions for themselves and we were concerned that they would not be able to summon assistance if needed. We looked at this person's DoLS. This only made reference to the locks on the external doors as a restriction on their liberty. There was no mention of any other restrictions placed on their movements such as the call mat placed in their room. We concluded that there were not the appropriate authorisations in place for all restrictions on the person.

We also looked at the person's mental capacity assessment in detail. We noted that the person was unable to make decisions about most areas of their care and treatment and all of these areas had been covered in one assessment rather than each area being explored in detail to maximise the person's ability to make a decision for themselves. For example, considering if the person is more lucid at a certain time of the day and different ways of communicating with the person. Where people lack capacity to make choices about their care and treatment a decision can be made in their best interests. We saw that there was a best interest assessment in place for this person but this was handwritten and it was not clear who was present at the meeting. We were not assured that every step had been taken to fully assess the person's capacity to make specific decisions as required by the MCA.

A second person's mental capacity assessment stated that they did not have the capacity to make choices. However, when we spoke with the person it was clear that they were able to make day to day decisions such as when they would like their care to be delivered, what they would like to eat and how they liked their room to be set up.

Not all of the staff we spoke with had a good understanding of the MCA. One member of staff we spoke with thought that the MCA meant, "Always being nice to people."

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

At our previous inspection in February 2018 we found that the provider was in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people's nutritional needs were not being met. In the action plan sent to us after the inspection, the provider told us that actions had been taken to meet the regulations and these had been completed. At this inspection in November 2018 we found that sufficient improvements had not been made and the provider was still in breach of this regulation.

People were not always supported to maintain a healthy nutritional intake. We saw from one person's care plan that they were at risk of choking. Advice from the Speech and Language Therapy (SALT) team stated that they should be sat upright and supervised whilst eating. Staff should still be able to see them for 20 minutes after consuming any food and drink. During our inspection we observed that staff did not follow this advice and no staff were in the vicinity of the person's room while they were eating their lunch. We also noted that the person was not sat upright.

Another person required their food to be pureed. We saw from the person's care plan they preferred the different components of their meal to be pureed separately. On the day of our inspection we saw that the different parts of the meal had been pureed together to form a soup. We noted that they had not eaten much of this.

Some people were on food and fluid charts to monitor their nutritional intake. The food and fluid charts we looked at were not detailed and did not give exact amounts of what people were consuming, only documenting the type of food they were served. The charts also did not specify how much fluid people should be encouraged to drink. We observed a member of staff offering hot drinks to people and noted that one person did not have a drink. We were advised that they had been given a drink earlier. This had not been noted on their food and fluid chart and this person should have had a member of staff present with them whilst having a drink. We could not be sure that this person had a drink or that a member of staff was present to ensure their safety while they were having a drink.

We also saw from this person's food and fluid chart that they had been offered nuts as a snack, this is a potential choking risk as the person did not have enough teeth to chew the nuts. Staff did not always follow the advice given by SALT which stated that staff should observe the person while eating or drinking to minimise the risk of choking.

These findings meant that the provider remained in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received mixed reviews from people when we asked them if they enjoyed the food. One person told us, "The food is very basic but it is good." A second person commented, "The food isn't too bad, a bit more

variety would be nice." A third person told us, "The food varies a bit, some of it is good and some of it bad." One person's relative told us, "[Relative] has a pureed diet and we have had some issues, particularly when the meal is not pureed properly. They also give [relative] a chocolate yogurt everyday which gets a bit boring. They did try [relative] on strawberry yoghurts but it had bits in it. Also, [relative] does not like fish which they do keep giving [relative]."

Assessments of people's needs had improved. Before people moved into the home, the manager would visit them first to assess their needs. We saw that these assessments were detailed and took into account people's physical and emotional needs.

Assistive technology and equipment was used to help promote effective care. Some people had pressure mats in place to alert staff when they were mobilising. Some people also had pressure-relieving mattresses in place which helped to minimise the risk of developing a pressure ulcer.

There was an induction in place for new staff. We saw from training records that staff would be observed carrying out certain tasks by a more senior member of staff before they worked without supervision. In addition to this, new staff were supernumerary on the rota while they were completing their induction and shadowing other members of staff.

Staff completed training set by the provider and the training matrix we looked at confirmed that all staff were up to date with their training. However, we noted that staff did not receive any training relating to people's individual care needs such as pressure care, end of life care, nutrition and hydration or challenging behaviour. We noted that on one person's pre-admission records that it stated that staff should receive training in behaviour that challenged to effectively meet the person's needs. This training had not been undertaken by staff at the time of our inspection. Due to our observations on the day, we were not assured that staff demonstrated the competencies required to meet people's needs in order to promote their health and wellbeing.

Staff received regular supervision with the manager. Supervision is a confidential meeting between staff and their manager to discuss any training needs and support they need with their role. Staff we spoke with and records we looked at confirmed that staff attended their supervision meetings as well as an annual appraisal.

There were measures in place for healthcare professionals to communicate with staff about people's care needs. We saw there was a communications book in the staff office where district nurses would document when they had seen a person and what treatment had been given. On the day of our inspection the paramedics were called for one person. We saw that staff were liaising with them and handing over any information asked for.

People we spoke with told us that they were able to see healthcare professionals when needed. One person told us, "If I feel that I need a doctor then I just ask the manager." A second person commented, "I can see the doctor whenever I need to." People's care records showed that referrals were made to relevant healthcare professionals where needed. For example, we saw that one person had lost weight and a referral was made to the GP to source input from a dietician.

The decor of the home was tired and required updating. On the day of our inspection we observed that some decoration was taking place. A communal area of the home was being used to store furniture and hoists. The conservatory that was in use was cold and this area was used for activities. There was a second lounge which had been recently updated but this area was also cold. The home was draughty and there was

a window on one of the landings which would not close fully.

Requires Improvement

Is the service caring?

Our findings

At our previous inspection in February 2018 we found that the provider was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.This was because people were not treated in a respectful way that upheld their privacy and dignity. After our last inspection, the provider sent us an action plan which stated that they would be compliant with the regulation by 11 June 2018. At this inspection in November 2018 we found that sufficient improvements had not been made and the provider remains in breach of this regulation.

Throughout our inspection we noted that staff did not have enough time to spend interacting with people outside of delivering their care. Staff also missed opportunities to engage people in meaningful conversation of activity. For example, we saw one member of staff rushing past a person in the corridor, they briefly enquired about their wellbeing before walking around them. Due to the number of people spending most of the day in their rooms along with the low numbers of staff we were concerned that people were isolated as the home was large and the doors to some people's rooms were not open. One person's relative had concerns about their family member being isolated and told us, "…Because [relative] is at the far end of the home, [relative] feels [relative] is forgotten about."

Staff did not always treat people with respect. We heard one member of staff speaking in a curt way to one person. We heard them saying, "Stop that…don't do that." One person's relative told us that staff shouted at their family member once.

People's dignity was not consistently upheld. On the day of our inspection the emergency lighting was being tested. This meant that some areas of the home were not well lit. One of the inspection team noticed that one person was having to use the toilet with the door open as there was not enough light in the toilet. We also noted that one person in a lounge was sat on a continence pad. We saw a notice on the en suite door in one person's room which read, 'Please make sure you are using [person's name] creams over her body. Thank you'. This addition to the person's room did not create a homely environment which was respectful of the person staying in the room.

People were not supported to maintain their personal care. One person's relative told us, "I have a list of things that have concerned me…[family member] has only had one bath or shower in the eight weeks they [family member] has been here." They went on to say that there were no towels in their family member's bathroom and their bedding had not been changed for the first four weeks of their stay. A second relative we spoke with described how one member of staff didn't know that their family member wore dentures or that they had to clean them. We noted that some people's hair looked unkempt and one person had dirty fingernails. This was of concern because they preferred to eat finger food at mealtimes. People's rooms were not kept clean and we saw that a district nurse had written a note for staff in a communication book asking that they clean around a person's bed and described it as 'filthy'.

When we looked in the laundry cupboards we noted that the bedlinen was faded and old and people did not have their own sets of bedsheets. Towels were also threadbare and had rips in them. In the downstairs

laundry cupboard, we saw a drawer which was labelled 'communal net knickers'.

People were not always encouraged to express their views about their care. Staff had bi-monthly meetings with the people they were the main carer for. We saw in one person's care records that there was a sticker stating, '[Person's name] is unable to answer key work sessions'. This did not demonstrate that alternative methods of communication were used to try and engage the person in reviewing their care.

As a result of these findings the provider remained in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some of the people we spoke with were complimentary about the care they received. One person told us, "I think the care I get is all right, I am able to make my own choices and have my room the way I like it. [The staff] do what I need." A second person commented, "I find the younger [staff] are caring, but the older [staff] less so."

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection in February 2018 we found that people's care records were not written in a person-centred way and the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider sent us an action plan after the last inspection and stated that they would be compliant with this regulation by 6 June 2018. At this inspection in November 2018 we found that sufficient improvements had not been made and the provider remained in breach of this regulation.

People's care records were not always updated to reflect their most current needs. We saw that one person's care plan for mental capacity stated that they did not have the capacity to make any decisions about their care and treatment and then went on to read they should continue to make decisions for themselves. One person had a hospital passport. This is an overview of people's care needs which is handed over to hospital staff when a person is admitted to hospital. This was out of date and did not contain information reflective of the care the person required.

Care plans and risk assessments also lacked sufficient detail. One person's risk assessment around using their walking frame did not account for how their limited vision and hearing impacted on their risk of mobilising safely or how any medicines they were on could affect their mobility.

The reviewing process of people's care records was not robust and did not identify any changes to people's care needs. For example, one person's medicines care plan stated that their medicines had been changed from liquid form to tablet form as they found the liquids difficult to take. The monthly reviews for the accompanying medicines risk assessment stated that there had been no change in their medicines. The monthly reviews for a second person's pressure area risk assessment stated, 'no change' but their Waterlow scores indicated that their risks of developing a pressure ulcer had increased.

People's needs and preferences were not always respected, one person's relative explained, "It's the simple things like bringing a cherry pie for lunch when [family member] does not like cherries, also, they did not bring a spoon." We saw from one person's care records that they liked to get up at 4.30 am. A member of staff told us that the two night staff on shift were unable to meet this request as it would mean that neither staff would not be able to attend to other people during that time. However, we saw from another person's daily notes that they were routinely assisted by both night staff to get up before day staff arrived. We saw from one person's care records that they had religious and spiritual beliefs that were important to them and these played an important part in their daily routine. We saw nothing in the person's care records about how they were supported with their expressing and practising their religious or cultural beliefs.

Staff were not responsive to people's needs. During our inspection we saw that two staff had gone out for a cigarette together. This meant that only two care staff were left in the home to support 17 people. We then noted over the lunchtime that one member of staff was talking to a personal visitor of theirs while there was a person who required staff support with lunch sat alone in their room.

Some of the people and their relatives we spoke with told us they had not been involved in the planning and ongoing review of their care. One person told us, "I can't remember anyone asking what I think of my care. You are the first to ask." One person's relative commented, "Nobody has asked what we think of everything. I have a list that I am going to share with the manager."

As a result of these findings we concluded that the provider remained in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received some positive comments from people about how staff understood their preferences in relation to how they liked their care and treatment to be delivered. One person told us, "[The staff] do know what I like and I do tend to get it. They understand how I like things done." A second person commented, "I think [the staff] are on the ball with what I like and try to make sure that is what I get."

There was an activities coordinator who organised activities in one of the lounges. On the day of our inspection some people were making Christmas cards and listening to music. The activities coordinator told us that they had organised some trips out and we saw photos of these on a display board. They added that some people preferred to stay in their room but they would go and sit with them and do crosswords and other activities with them.

People we spoke with knew how to raise a complaint and two people told us that the manager had been to see them to ask them if they were happy with the service. The manager told us that they had not received any formal complaints since the last inspection. We saw that there was a complaints procedure in place which detailed what action the manager needed to take to address any complaints.

People's end of life wishes were documented in their care records. This included information about any funeral arrangements and if they wished to be resuscitated in the event of a medical emergency.

Inadequate

Is the service well-led?

Our findings

We continue to have concerns about how the service is led and the provider's ability to make and sustain any improvements. An inspection on 17, 18 and 20 November 2014 rated all key questions as 'inadequate'. A crisis manager was employed to drive improvement in the home. On 18 December 2014, the crisis manager raised some concerns with us about the suitability of three nursing staff. A focussed inspection took place on 19, 21 and 29 December 2014 in response to these concerns.

On 19 December 2014, serious concerns were found relating to the safety of people who were living in the home. This was due to insufficient levels of competent nursing staff. The provider's staff worked with the local authority and North Norfolk clinical commissioning group to ensure that nursing cover would be provided over the coming days.

A further inspection on 21 December 2014 found that sufficient nursing cover was available but this was being secured on a day to day basis. This was not safe nor sustainable. A decision was made by the commissioners to relocate people who required nursing care to other homes that could maintain people's safety. This action took place over 23 and 24 December 2014. CQC carried out urgent enforcement action under Section 31 of the Health and Social Care Act 2008 on Tuesday 23 December 2014. This meant that the providers were not allowed to provide nursing care at the service with immediate effect.

A further focussed inspection was carried out on 29 December 2014. This was to check that there were sufficient numbers of staff to safely meet people's needs. We concluded that there were adequate numbers of staff to maintain people's safety and meet their needs.

An inspection on 3 February 2015 found that the provider had made improvements under the key questions of 'safe, 'effective, 'caring' and 'responsive'. The key question of 'well led' was rated as 'inadequate'. We issued the provider with a warning notice for Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This set out what improvements the provider was required to make.

The service was rated 'good' in all key questions following an inspection on 25 May 2015. This was because significant improvements had been made and the provider was no longer in breach of any of the regulations.

An inspection carried out on 30 January 2017 and 1 February 2017 found that the provider had failed to sustain any of the improvements previously made and the service was rated as 'inadequate'. The provider was found to be in breach of multiple regulations and the service was placed in special measures.

A further inspection on 19 June 2017 found that the service was not well led and the provider remained in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and remained in special measures. This was because the provider had not implemented robust processes to monitor and assess the quality of service being delivered.

At our previous inspection on 5 and 6 February 2018, we found that the provider was still in breach of this regulation as they had not made the necessary improvements to ensure that the service was well led. The provider was also in breach of five other regulations. After this inspection, we received an action plan from the provider which stated they had already completed the actions needed to comply with this regulation.

There have been seven changes of manager since the service was registered with the CQC in 2010. We could not be confident that the provider could maintain consistent and stable leadership within the service.

At this inspection on 20 November 2018 we found that the provider was in breach of multiple regulations. These included continued breaches to Regulations 9,10,11,12,14 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This demonstrated that the provider has consistently failed to make and sustain any improvements where non-compliance with the Regulations had been identified in previous inspections. After our inspection, we wrote to the provider to raise the concerns we had found during the inspection and asked them to provide details about how they would address any immediate concerns. The provider sent us an action plan which detailed what action they would be taking in relation to the most serious concerns we raised.

At this inspection in November 2018 we found that there was a lack of robust processes in place to monitor and assess the quality and safety of service being delivered. The audits that were in place failed to identify shortfalls within the service. For example, the medicines audit did not identify the concerns we found in relation to controlled medicines and gaps in some Medicines Administration Records (MAR) charts. The health and safety audits also did not highlight that the cold water temperatures were not being recorded and that the annual check for the heating systems was overdue.

There was no overview of people's care records and the daily records associated with their ongoing care and treatment. Some of the information in people's care plans and risk assessments was inaccurate and did not reflect people's most current care needs. There was inadequate information about people's nutritional intake as records relating to this did not contain sufficient detail.

The assessments of staff competency were not effective as the manager did not ensure that staff demonstrated the skills and attributes required to provide safe care and treatment that met people's individual care needs. There was also a lack of management oversight to ensure that staff were deployed adequately throughout the service. For example, ensuring that staff did not take their breaks at the same times and that all staff were present to support people during busy times such as mealtimes.

Audits carried out by the provider were not comprehensive and did not check that medicines were being managed safely and did not review people's care records. The provider's audit also failed to check that the audits undertaken by the manager had been completed to the acceptable standard and were effective in identifying areas for improvement.

The manager failed to appropriately identify safeguarding incidents and report these to the local safeguarding team or notify us of these incidents. We could therefore not be satisfied that the manager was aware of their requirement to identify and report any safeguarding concerns. Failure to identify such incidents meant that staff in the service did not work in a transparent way with other agencies to provide good quality and safe care to people.

The provider and manager did not demonstrate that they worked with the local authority to drive improvement. We looked at the findings of a report compiled by the local authority after their visit to the service in October 2018. We noted that no steps had been taken to address the concerns raised as a result of

the local authority visit.

As a result of these findings, the provider remained in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was no registered manager in post at the time of our inspection. The previous manager left in September 2018 and a manager who had previously managed the service returned to manage the service again. They told us that they were in the process of becoming registered with the CQC.

There were meetings for people who lived in the home. One person we spoke with confirmed that these meetings took place. However, a second person told us that these did not happen as regularly as they used to. These meetings gave people the opportunity to make any suggestions about how the service is run. Staff also met once a month. Meeting minutes we looked at showed that changes in people's care needs were discussed as well as any staffing issues.

Staff we spoke with told us that they enjoyed their work. One member of staff told us, "I love everything about it." A second member of staff told us that the morale within the staff team was good. Staff also spoke positively about the manager. One member of staff told us, "[Manager] knows how to lead a team." Another member of staff explained, "[Manager] has been helpful to me, they have helped me with my training."

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 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure that the care people received was appropriate, met their needs and reflected their preferences. Regulation 9 (1), (3) (a) (c) (d)

The enforcement action we took:

Notice of Decision to vary a condition on the provider's registration to remove the location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had failed to ensure that people were treated with respect and have their dignity and privacy upheld. Regulation 10 (1) (2) (a) (b) (c)

The enforcement action we took:

Notice of Decision to vary a condition on the provider's registration to remove the location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Where people lacked the mental capacity to make a specific decision the provider had not acted in accordance with the requirements of the Mental Capacity Act 2005. Regulation 11 (1) (2) (3)

The enforcement action we took:

Notice of Decision to vary a condition on the provider's registration to remove the location

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 12 HSCA RA Regulations 2014 Safe care

personal care	and treatment The provider had failed to ensure accurate and effective assessments of risks to the health and safety of people using the service. The provider had also failed to do all that is reasonably practicable to mitigate any such risks. The provider had failed to mitigate the risk of the spread of infection and ensure effective infection prevention and control. Regulation 12 (1) (2) (a) (b) (d) (g) (h)

The enforcement action we took:

Notice of Decision to vary a condition on the provider's registration to remove the location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider had failed to ensure the nutritional and hydration needs of people were consistently met. Regulation 14 (1) (2) (a) (b) (4) (a) (c) (d)

The enforcement action we took:

Notice of Decision to vary a condition on the provider's registration to remove the location

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to implement systems and processes that effectively assess, monitor and determine risks to people or maintain accurate, complete up to date records. Complete records were not kept relating to staff employed by the service. Regulation 17 (1) (2) (a) (b) (c) (d)(i)

The enforcement action we took:

Notice of Decision to vary a condition on the provider's registration to remove the location