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Alexandra House Nursing and Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

On 7 and 8 September 2016 the service was rated good overall. At this inspection in July 2018 we identified widespread failings which put people at the potential risk of harm. The service was found to be in breach of Regulations 9, 10, 11, 12, 13, 14, 15, 17, 18 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service is now rated inadequate overall.

The service had a registered manager in place. 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.

Prior to this inspection, the ill health one of the business partners meant they had been unable to be involved in the day to day running of the service as they had in the past. This meant that the other business partner and the registered manager had sole responsibility for the day to day running of the service.

Alexandra House Nursing and Residential Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Alexandra House Nursing and Residential Home is registered to provide a service to 25 older people, some of whom may be living with dementia. At the time of inspection there were 19 people using the service.

Following this inspection we were so concerned that we informed Norfolk County Council and the Clinical Commissioning Group (CCG) of our findings. We also took urgent action to prevent the service taking on new admissions.

The service was not safe. Risks in the premises had not been identified and action had not been taken to protect people from harm. Equipment had not been serviced by competent persons to ensure it was safe for use. Appropriate checks had not been carried out on the water systems and fire safety systems to ensure peoples health, safety and welfare.

Risks to people were not being planned for or appropriate actions taken to minimise these. This included risks associated with dehydration, malnutrition and pressure ulcers. People who were at risk of choking were not being supported and supervised appropriately to reduce this risk. Systems were not in place to protect people from the risks of abuse. Staff had not received safeguarding training.

The service was not consistently clean and the registered manager had failed to address concerns about cleanliness which were observed by the CCG in June 2018.

There were not enough staff to consistently meet the needs of people using the service, to include their

social and emotional needs. The service did not practice safe recruitment procedures to ensure that staff were of good character and were safe to work with people living within the service.

Medicines were not managed or administered safely. Some people had not received their medicines in line with the instructions of the prescriber and the service had taken no action regarding this.

The service was not complying with the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). People's capacity was not assessed appropriately and the service did not encourage and enable people to make decisions.

Staff did not receive appropriate training in subjects relevant to the people they cared for. This included training in using equipment such as hoists. Staff did not have the opportunity to have supervision or one to one sessions with their manager. The registered manager did not carry out clinical supervision of nurses. There was a poor culture in the service with staff including the registered manager not identifying the poor practice of themselves and others.

People were not involved in the planning of their care and their views were not reflected in their care records. Staff did not always uphold people's dignity and respect. People were not encouraged and enabled to be independent.

People received generic care which was not personalised to them as an individual. Not all staff knew people as individuals and care records did not provide information to them about the people they were caring for.

There were no end of life care plans in place for people. This meant that the service could not ensure people's preferences were met at the end of their life. People did not have access to meaningful activity and engagement. People we spoke with told us they were bored.

There was no quality assurance system in place at the service and the registered manager failed to identify the shortfalls we found. This meant that people continued to receive poor quality care which did not meet their needs. The provider had not implemented a system to ensure that an appropriately qualified person was overseeing the quality of the service and performance of the registered manager on their behalf.

The registered manager did not have a knowledge of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 or the framework by which we inspect care homes.

The overall rating for this service is 'Inadequate' and the service therefore is 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 were not planned for or managed effectively. The service had not identified all the risks to people.

Robust systems were not in place to protect people from the risk of abuse.

There were inadequate procedures in place to ensure the safety of the premises and equipment within it.

Some area's of the service required further cleaning and infection control procedures were poor.

Medicines were not managed safely.

The staffing level was not consistently appropriate according to the needs of the people using the service.

Is the service effective?

Inadequate

The service was not effective.

The service was not meeting the principles of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

Staff were not provided with reputable training to ensure they had the skills and knowledge to provide safe and effective care to people.

People did not always receive the support they required to eat and drink sufficient amounts.

People had access to GP services. However, it was unclear how people were supported to have contact with other specialists.

Is the service caring?

Inadequate

The service was not caring.

People were not always treated with dignity, kindness and respect by staff.

Staff and the registered manager had not identified the poor practice of themselves and others which impacted on the quality of care people received.

People were not supported to remain as independent as possible.

The views of people and their relatives had not been sought and were not reflected in care planning.

Is the service responsive?

Inadequate

The service was not responsive.

People's care records were not personalised and did not reflect people's individual hobbies and interests.

There were no end of life care plans in place for people.

There was no provision for meaningful activity to engage people. People told us they were bored.

Is the service well-led?

Inadequate

The service was not well-led.

There were no adequate quality assurance systems in place to monitor the quality of the service.

The manager and provider had not identified shortfalls in the service which put people at risk of harm and taken action to protect people.

Alexandra House Nursing and Residential 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 comprehensive inspection was carried out by one inspector on 16 and 18 July 2018 and was unannounced.

Prior to the inspection we reviewed the contents of notifications received by the service. Services have to notify us of certain incidents that occur in the service, these are called notifications.

Some people using the service were unable to communicate their views about the care they received. We therefore carried out observations to assess their experiences throughout our inspection. We spoke with four people using the service, two relatives, three care staff, three nurses, two domestic staff, the registered manager and to both partners in the business.

We reviewed five care records, four staff personnel files and a sample of records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

At the last inspection on 7 and 8 September 2016 the service was rated 'good; in this key question. At this inspection the service is now rated 'inadequate' in this key question.

The service had failed to fully assess and plan for risks that could compromise the health, safety and welfare of people. Some risk assessments had been carried out, for example choking risk assessments or falls risk assessments which identified people at being at risk. However, this did not translate into clear care planning with steps on how staff should support people to reduce the risk to them.

We were told four people were at risk of choking and we reviewed the care records for these people. We found that there were no care plans in place in respect of this risk for these people. Therefore, staff did not have sufficient instruction on how to minimise the risk. The registered manager told us they felt that the risk was mitigated because people were on a liquid diet however, they had not considered the other factors that can influence people's risk of choking. The registered manager told us that these people had been placed on liquid diets following swallowing assessments by the Speech and Language Therapy Team (SALT). However, they could not provide us with the documentation the team would have provided with the instructions on supporting people.

We spoke with care staff and nursing staff who told us they were not aware of any specific instructions on supporting these people whilst eating and drinking. We observed one person who was identified to us as being at the highest risk whilst they were eating lunch. They were situated alone at the back of the dining area eating independently. Two staff towards the front of the dining area had their back to the person and were helping other people to eat. We observed that the person began coughing on two occasions but the staff did not acknowledge this, look at the person or check they were okay. This demonstrated a lack of understanding around the signs of someone choking or aspirating food.

Where people were identified at risk of developing pressure ulcers, there were no care plans in place to provide instructions for staff on reducing the risk. For example, the service provided care to some people who were very frail and whose skin was fragile. There was no information about how the risk of skin breakdown was being reduced such as whether they required repositioning or pressure relieving equipment. Staff were unsure of what skin breakdown would look like and care staff told us that nursing staff did not carry out personal care so may not identify if someone's skin was breaking down.

Some people using the service were at risk of falls but there was no care planning in place to guide staff on reducing this risk. The registered manager told us that people at risk of falls were all accommodated on the top floor of the building so that night staff could monitor them more closely. However, it was unclear how the risk of falls was being managed during the day. We observed that two people at risk of falls continually walked around the service during our visit but staff were not always present in those areas to provide assistance to them if needed. The registered manager told us that they had gained advice from the Falls Prevention Team but could not provide records to evidence this nor tell us about the advice that was provided to them.

People were not protected from the risk of dehydration. During our two inspection visits the outside temperature was consistently above 26 degrees. Despite this, we observed that people did not have drinks offered regularly nor did they have access to drinks in any other capacity. Where people were brought drinks, these were hot drinks such as small cups of tea but we did not see any other cold drinks being offered. During lunch we observed that people did not have drinks with their meal and were not offered these. This included people who had been seated in the sunny garden. There were no care plans in place to provide guidance for staff on how to protect people from the risk of dehydration and what a suitable fluid intake would be. People who were unable to verbally communicate or take action to keep themselves hydrated were not having their fluid intake recorded. This meant no one would know if they had taken enough fluids throughout the day. When we spoke with staff about dehydration, they did not demonstrate a knowledge of the signs of dehydration.

The registered manager did not have a robust system in place to monitor incidents and accidents. Whilst we saw that staff recorded incidents such as falls, the registered manager did not carry out investigations or monitor incidents for trends, such as the times of day people were falling. This meant they could not take action to reduce the risk of repeat incidents.

The lack of clear, accurate and adequate care plans for staff to refer to meant that people were placed at the risk of potential harm. We were intially told that the service had a stable staff team and therefore the staff knew people's needs. However, a review of recruitment files and discussions with staff demonstrated that new staff had been recruited recently. One staff member we spoke with had been working for the service for a week, they told us that they had not read people's care plans and were reliant on hoping other staff knew what care people required.

Staff had not been provided with reputable training in moving and handling. We were told that staff were trained by the registered manager to use the hoists and other mobility equipment. However, the registered manager did not have a qualification which verified they were competent to deliver this training. They told us they felt that their nursing training they completed 20 years ago meant they were qualified to train staff. When we spoke with staff about the training they received, they stated that the manager showed them the hoists and slings but they were provided with no further guidance. During our inspection we witnessed one staff member moving a person in a wheelchair with their feet dragging along the ground because they did not place them on the footplates.

Medicines were not administered or managed safely. We identified nine occasions where medicines were signed for on the Medicines Administration Records (MAR) as being given but were still present in the monitored dosage system (MDS). This indicated that they may not have been given as suggested by the records.The reason for these medicines being missed was not recorded on the MARs. For example, we found Risperidone for one person remained in the MDS on five days of the current cycle. Three nurses, including the registered manager, had administered medicines for this person but had not identified that this medicine remained in the MDS. We asked the registered manager if they had identified this and contacted the person's GP's to seek medical advice on whether this could have a detrimental impact on their health. They told us they had not. We were told an audit of medicines should have been carried out monthly. However, this had not been done since May 2018 and therefore had not identified the issues we identified. The nurse responsible for carrying out these audits had administered medicines on the day of our visit but not queried or reported medicines left in the MDS. This did not reassure us that this staff member was competent to carry out robust audits which identify and explore shortfalls.

Protocols were not in place for 'as and when' (PRN) medicines. These should be available to provide information to the person administering medicines about when it may be appropriate for the person to

receive these medicines.

The service had not identified risks in the environment. For example, hot water reached scalding temperatures because there was no thermostatic control on taps. This included in assisted baths where there were also no water temperature thermometers present during our visit. We also observed that pipes below radiators and hot water pipes were not covered, which presented the risk of someone receiving a burn if they fell against one. The service had not risk assessed this and therefore there were no management plans in place to reduce the risk.

There were two windows where window restrictors were not present during our visit. This presented the risk of some people who may lack capacity in relation to their own safety, falling or climbing out of the windows and becoming injured. The service had not identified this risk.

There were multiple steep staircases in the service with no gates at the bottom or top to reduce the risk of people with poor mobility climbing them and falling. Staff told us that sometimes one person climbed the stairs and they stood at the bottom to 'catch them if they fell'. The service had not identified this as a risk, carried out a risk assessment and put into place actions to minimise this risk.

The registered manager and provider told us that they had a maintenance person who carried out annual servicing of hoists in use and PAT testing on electronics at the time of our visit. Health and Safety Regulations state that servicing of hoists must be carried out at least every six months. In addition, stickers on some electronic equipment in the kitchens indicated they had not been tested at all since 2015. Furthermore, both the servicing of hoists and PAT testing must be completed by a suitably qualified person or one whose competency has been assessed by a suitably qualified person. The maintenance person was not suitably qualified to carry out these safety checks. This meant that the service placed people who used the service and staff at risk.

The service had not had a qualified person undertake a service of their water system to check for the presence of legionella or to identify works that were required to reduce the risk of the presence of legionella for a year and a half. Legionella is a bacteria that when present in water systems can cause Legionnaires Disease. The service had not been carrying out flushes of the water system or checks on the water temperatures to reduce the risk of the presence of legionella. This had been picked up prior to our inspection during a visit by the Infection Prevention and Control Team from the Clinical Commissioning Group (CCG) on 28 June 2018.

Following this the service had developed a new template for checking water temperatures and carrying out flushes, as well as a legionella policy. However, despite the risk being identified to them the service did not understand the seriousness of this risk and commence risk management procedures promptly. When we highlighted this risk on 16July 2018 we requested that the service take action to ensure that they sourced a qualified person to undertake a legionella risk assessment at the service. When we returned on 18 July 2018 we found that they still did not have a date by which this would be completed. After a further request, we were told the assessment would be carried out later that week. However, we were later informed it would not be carried out that week but would be carried out the following week. The service did not demonstrate that they fully understood the seriousness of the risk identified to them by us and the CCG.

The service was not carrying out regular checks on the fire alert and safety systems. The service was unable to demonstrate they carried out regular tests of the fire alarms to ensure they were in full working order. However, the registered manager and provider told us that they "…knew they worked because they sometimes went off." Checks were also not carried out at the required frequency on equipment such as fire

doors, safety lighting and extinguishers. The service had completed a fire risk assessment but this had not been carried out by a suitably qualified person and was not adequate in relation to setting out how people would be safeguarded in the event of a fire.

We observed that there were several burn marks on the carpet in an upstairs hallway. Staff were unable to explain how these came to be there. When we spoke with staff about fire safety, two staff were not aware of individual plans which were in place setting out the support people would require to evacuate the building in the event of a fire. They also stated they had not read the service's fire policy or procedure. Following our inspection we raised concerns with the Norfolk Fire Service who sent a representative to the service. They confirmed the shortfalls we identified.

The Infection Prevention and Control Team from the CCG visited the service on 28 June 2018. They identified multiple concerns about the cleanliness of the service. This included equipment such as toilet risers being contaminated with faeces, dirty equipment such as hoist slings, inappropriate disposal of clinical waste and poor infection control procedures. During our visit, we identified that area's of the service still required thorough cleaning and staff still did not fully understand how to limit the spread of infection. For example, we observed dirty soiled laundry on the floor in one communal bathroom. There were used incontinence pads in a bag next to a sink. We found that some equipment, such as hoists and baths, had rusted area's where the enamel was broken so they could not be effectively sanitised.

This was a breach of Regulation 12: Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service did not practice safe recruitment procedures. We reviewed the records of five staff members who had been recently recruited. We found that Discolosure and Barring Service Checks to check whether staff had criminal convictions (DBS) were not carried out for domestic staff who would have contact with people using the service. For one domestic staff member whose records we reviewed, the service had also not obtained any photo identification or proof of address, so their identify had not been verified. Other staff members had been employed on the basis of old DBS checks which had been completed some years earlier and the registered manager had not considered whether it was appropriate to repeat these. Some of these were not enhanced enough for this role because they had not included a check of the barred list.

The registered manager had not obtained suitable references for prospective staff. References had been accepted from friends even where the staff member had previous employers who could have been contacted. For another applicant, they had specified two colleagues of the same level as them at a previous employer. The registered manager had not questioned this and requested a reference from someone more senior.

This was a breach of Regulation 19: Fit and proper persons employed of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not protected from the risk of avoidable harm or abuse. We observed several people during our inspection who had bruises or cuts and staff were not sure how these had occurred. The registered manager told us that all unexplained bruises and injuries were recorded on an incident form which was reviewed by them. However, when we reviewed incident records for the past six months there were no records of any bruises or unexplained injuries being reported.

We spoke with care and nursing staff about the process they took when people had unexplained brusising or injury. They stated they would record this on a body map but did not say they would record this on an

incident form or report to the registered manager. Staff had not received training in safeguarding and displayed a poor knowledge of the subject, not knowing who it would be appropriate to report safeguarding concerns to outside of the service. The registered manager could not provide any records to demonstrate they had carried out any investigations into unexplained bruising or injuries. When we discussed this with them, they did not understand why this was necessary in safeguarding terms. This meant we were not reassured that there were robust procedures in place to protect people from the risk of abuse.

This was a breach of Regulation 13: Safeguarding service users from abuse and improper treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they sometimes had to wait for support from staff. One person said, "They are rushed, you do have to wait. Lots of us need two staff to get us up and seen to so if someone else is up then you are left for a while." Another person commented, "They don't have as many as I am used to [at another care home]. They are not there for you when you need them sometimes. They do try their best though."

We observed that staff were not always present in or near communal areas where people were seated. People had no way to call for staff assistance during these times and due to the layout of the building so we were concerned that staff would not be able to assist people when required to keep them safe. People were all seated downstairs in the lounges and staff told us that this was so everyone was in one place and they could keep an eye on them. The staffing level did not allow for people to make choices about where they would like to spend their time. We observed that some people became frustrated by other people vocalising and they may have benefitted from the option to have quiet time in their bedroom. There were no staff around to diffuse the situation which could have posed a risk to people's safety.

We were told that during the day there were four carers available to support people. We observed that one person was having one to one from a carer who walked around the service with them. This meant that there were only three carers left to support the other 18 people using the service, most of whom required the support of two staff to mobilise and undertake tasks such as visiting the toilet.

The registered manager had not considered people's social and emotional needs when deciding upon the staffing level. People were disengaged throughout our two visits and left alone with no social interaction for extended periods of time. This meant people were at risk of becoming socially isolated.

This was a breach of Regulation 18: Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite our findings, people who could verbally communicate with us told us they felt safe. One said, "I do feel safe. I don't have to be scared." Another person told us, "I have no concern over safety. I have always felt safe." A relative said, "I think [person] is safe here, I wouldn't have [person] here if I did not feel that way."

Inadequate

Is the service effective?

Our findings

At the last inspection on 7 and 8 September 2016 the service was rated 'good; in this key question. At this inspection the service is now rated 'inadequate' in this key question.

People were not consistently protected from the risk of not eating enough. Whilst the service assessed people's risk of malnutrition using the Malnutrition Universal Screening Tool (MUST), where they identified a risk this did not transfer into clear care planning.

We were told one person was struggling to maintain their weight and had a low weight because they were very active throughout the day. Staff told us that the person was not eating much at present. There was no care planning around how staff should support this person to eat sufficient amounts. Whilst a nurse we spoke with told us about this person being offered two meals, care staff did not reflect this same knowledge. The nurse also told us that this measure was not effective as the person rarely stopped to eat both meals, but no other measures had been considered such as finger foods or snacks that could be more easily eaten whilst mobilising. The registered manager told us that the dietician had been to see this person however, they could provide no records of the advice given and could not recall the outcome of this assessment. Any advice that may have been provided was not transferred into care planning and staff were not aware of any specific instructions to boost the person's intake.

We were told another person was at risk of malnutrition and had a low weight. They were very active during the day and this may have been a contributing factor. Their care plan did not reflect any risk or any measures in place to reduce the risk. Care staff were not aware of any specific instructions to support this person to reduce the risk of malnutrition. The registered manager told us that this person was offered two separate meals in the afternoon rather than one to boost their intake. However, it was unclear how this was consistently implemented as we did not observe this taking place during our two visits.

We spoke with the cook who did not demonstrate an understanding of how to fortify meals to increase their calorie content for people with a low weight. They had received no training or guidance in this area. Foods such as cream or whole milk is often added to meals for people at risk of malnutrition. However, neither of these were present in the kitchen during our visit and the cook said they did not add these to people's meals.

The support people required to eat and drink was not documented. As the service had recently employed new care staff, there was a risk that they would not know which people required support. One member of new care staff was unsure of which people required support to eat or drink but said they hoped other staff would know. We observed lunch and saw that staff did not offer people occasional support where they were not eating. Staff removed meals without encouraging people to eat more or offering them an alternative meal. People's food intake was not recorded which meant the registered manager was unable to monitor this and quickly identify where people's intake was reducing. This meant we were not assured that people were offered appropriate support to eat sufficient amounts.

We observed that people's requests for foods were not always met by staff. We observed two people ask for food during our visits. One person's requests were not met by staff at all, with staff telling them they had eaten breakfast and that lunch would be served an hour later. Another persons requests were not met for over an hour and they were continually told they had already eaten. Staff did not demonstrate why it was important to meet people's requests for snacks in between meals and missed opportunities to boost people's nutritional intake.

People told us they were not offered a choice of meals. One person said, "You don't know what it is until it arrives." Another person told us, "You get what you are given." One other person commented, "There is no choice. I don't know what it is until staff bring me it." Three people also told us that on occasions they were brought food they did not like. One person said, "I don't like banana's but they've sent me things with banana's in before'." Another person told us, "Fish Pie. I detest fish pie. I was given it and it was disgusting. I had to say I couldn't eat it and I had to have toast instead."

During our visits we asked care and nursing staff what was for lunch and they were unsure. The cook told us they prepared one meal per day but if people didn't like it they could have toast instead. They said one person refused most meals so they were provided with a jacket potato every day. They were not aware of any particular likes and dislikes people had. This meant that the meals they made were not based on the preferences of people using the service. People's food preferences were not included in care planning.

This was a breach of Regulation 14: Meeting nutritional and hydration needs of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The service was not complying with the principles of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). DoLS applications had not been made for all people using the service where this would have been appropriate. Inappropriate restrictions were placed upon people which deprived them of their liberty. For example, we saw one staff member trying to stop a person rising from their chair and mobilising, despite them being independently mobile. We saw another person was seated in a chair which tipped back and staff told us this was to 'stop the person getting out'. Other people had equipment such as pressure mats to alert staff when they mobilised or bed rails. The service had not followed an appropriate best interests process in line with the MCA to determine whether this was in their best interests. A formal best interests process should involve, where appropriate, any relatives the person may have as well as any healthcare professionals involved in their care. This helps to ensure that decisions made on the behalf of a person who may lack capacity is reasonable and lawful.

The service had not assessed the capacity of people using the service under the MCA. Staff demonstrated no understanding of the MCA and of supporting people to make decisions. They told us they had not had any training in this subject. We observed staff making decisions on people's behalves or carrying out care without their consent. For example, we saw a staff member move one person in their wheelchair without

asking them. The person shouted "where are we going" repeatedly and was distressed.

Where people had relatives or power of attorneys in place, information about these people and how they should be consulted about decisions were not reflected in care records. A bed rails assessment for one person stated that they had agreed with the decision but we were told this person had no verbal communication and no capacity to make this specific decision. There were no records to show that the person's relatives had been consulted about the decision and the registered manager told us they didn't think they had been.

People received generic care which was not based on their individual preferences and did not support and encourage independent decision making according to their ability. For example, we were told everyone had a bath each morning and was supported to go to bed at the same time each night. The service had not considered people's choice in this matter and made attempts to ascertain their routines prior to them developing dementia. Most people using the service had advanced dementia and were unable to communicate their views and preferences.

The service had not considered how people could imply consent in ways other than verbally. For example, they had not considered whether body language or gestures could indicate they did or did not consent. Staff told us one person was not always 'compliant' with personal care. When we asked how they managed this they stated they would carry on regardless because the person required the care. They had not considered whether this person's reluctance implied they did not consent and whether it would be more appropriate to try again later.

This was a breach of Regulation 11: Need for consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had not carried out a thorough assessment of people's needs prior to them being admitted to the service or shortly after their admission. This meant there was limited information for staff about their needs. In addition, the service had not referred to publicly available best practice guidance such as National Institute for Health and Care Excellence (NICE) when writing people's care plans or considering the ongoing support they may need.

This was a breach of Regulation 9: Person centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had not received reputable training which provided them with an adequate knowledge of subjects relevant to providing care to people using the service. We were told two staff were enrolled on the Care Certificate at their request. This is an industry recognised qualification within care. However, the registered manager told us training for all other staff was handled 'in house' and that the service did not arrange training from external providers for staff. The registered manager and other staff who we were told delivered training did not have the qualifications or knowledge to deliver suitable training to the care staff. The registered manager could not produce records to evidence what training they had delivered to which staff. Following the inspection we gave the registered manager two days to provide this. We were provided with the details of ten care staff who we were told were given training booklets for self directed learning. However, they did not know how far the staff had progressed through the booklets and were unsure of what the training covered.

There were 24 care staff employed by the service at the time of our visit and we were not provided with any other records to evidence they had appropriate training. The registered manager had not been carrying out

competency assessments for staff so it was unclear how they could identify whether their staff team had the appropriate skills and knowledge for the role.

Staff we spoke with did not demonstrate an understanding of subjects relevant to the people they provided care to. For example, staff we spoke with did not know the meaning of the Mental Capacity Act or Deprivation of Liberty Safeguards and how this applied to people they cared for. They were unsure of all the ways they could recognise and report abuse. They did not know the signs of people becoming dehydrated and demonstrated a poor knowledge of supporting people with dementia and with behaviour they found challenging.

Staff were not provided with an adequate induction when they joined the service. The registered manager told us the induction consisted of showing the staff around the building, introducing them to people and showing them the mobility equipment. This was confirmed by staff we spoke with. The registered manager told us that staff completed a minimum of two shadow shifts where they were supernumery and were just there to observe the care provided. However, two staff said that due to staff shortages they had been required to deliver care whilst they were supposed to be on shadow shifts. They also said they had not been asked to read the service's policies and procedures, nor were they asked to sign a contract which stated the service's expectations of employee's. Additionally, staff said that reading people's care records did not form part of the induction and they were not given time to do this.

Whilst staff told us they felt supported by the registered manager, they received no formal supervision or one to one with the manager to discuss their performance and training needs. Staff did not receive an annual appraisal to identify goals and objectives for the coming year and drive improvements in the knowledge of staff. The competency of care staff and nursing staff was not assessed, therefore, the registered manager would not be able to identify shortfalls in staff practice. Staff meetings were not held so staff did not have opportunities to feed back their views and discuss issues.

This was a breach of Regulation 18: Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements were required to how the service was decorated in order to ensure it provided stimulation and orientation to people living with dementia. For example, the décor in some area's of the service was plain and did not provide stimulation or orientation for people. There was no signage to direct people to key area's such as lounges, the dining room or bathrooms. We recommend the service refers to best practice guidance around providing an environment which is suitable for people living with dementia.

People told us the food was of variable quality. One said, "Some days it is okay but some meals aren't great." Another person told us, "It varies. Some days great, some days really not good." We observed that the meals for people on a pureed or softer diet did not look appetising and did not promote their dignity. The cook told us they had not received any training in how to provide these meals in an appetising format which would encourage people to eat them. Some foods on the plate were pureed together and the cook did not understand why this compromised people's dignity and respect.

Inadequate

Is the service caring?

Our findings

At the last inspection on 7 and 8 September 2016 the service was rated 'good; in this key question. At this inspection the service is now rated 'inadequate' in this key question.

We identified widespread failings in the service provided to people which meant that people did not always receive the care and support they required to uphold their health, dignity, safety and welfare.

The management team had failed to independently identify these failings and take action to improve the quality of the care people received. This meant that the management team did not promote a culture focused around good practice. Staff were failing to identify and address the poor practice of themselves and other staff members. This meant people were put at risk of harm and received care that did not always meet their needs.

Care and nursing Staff did not always uphold people's dignity and respect. A nurse showed us around the service when we first arrived. Whilst we moved around the home they described people in these communal areas by their needs, without understanding their right to confidentiality and why this may compromise their dignity.

People's care and the way they were treated by care and nursing staff was not individualised. For example, we observed staff members made decisions about where people spent their time. We were told that people were split between three lounges dependent on their needs. However, people did not have choice in this or have the option to spend time in their bedroom during the day. People were not supported to go to bed at different times and instead were supported to bed at the same time, leaving no opportunity for choice or preference.

We were told that everyone was called by their surname in the service. When we asked if this was people's preference, we were told that most people could not make a choice about this. We were introduced to people by a nurse, who asked one person's name. The person responded with their first name and the nurse said, "No. Your surname." It was clear that this person identified themselves by their first name but this had not been taken into account. We spoke with four people during our visit and asked their names, all four people referred to themselves by their first name. All four told us they preferred to be called their first name, with one commenting "I like my [first] name."

The language sometimes used to describe people's behaviours and the support they needed did not uphold people's dignity. Some people were described as 'uncompliant' in their care records or described in terms which could be deemed as derogatory by modern standards. In one bathroom there was a sign on the door reminding staff to close it when 'toileting people'.

Staff told us the relative of one person had died but that they did not remember this due to their dementia. Whilst we were told this person did not ask after their relative, staff said they kept reminding the person that their relative had died because they didn't remember. This demonstrated a poor understanding of dementia

and compromised this persons dignity and respect.

Parts of the service were dirty and in need of significant redecoration to ensure people lived in an environment that upheld their dignity. One person's bedroom smelt strongly of urine but no action had been taken to address the reasons for this. We observed drips of fluids on the edges of their bed which had not been cleaned.

Care staff and nursing staff displayed a lack of understanding of people living with dementia and how to manage behaviours they found challenging. We observed that one person continually asked staff for something to eat, becoming distressed because this was not provided. We raised this with staff who told us the person always asks for something to eat because they forgot they had already eaten. We observed that staff became frustrated and ignored the person's requests. Eventually after some time a nurse offered to bring the person something to eat. We saw that this eased the persons anxiety and whilst they didn't eat much of the food, whilst they had it with them they were calm and contented. There was no information about this persons behaviours and how staff should repond in their care records.

This was a breach of Regulation 10: Dignity and Respect of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives told us they had not been involved in writing their care plans and records did not evidence people's involvement. One person said, "I wasn't involved, I don't know about that." A relative said, "I haven't been asked but I'll let them deal with all that." People's views and preferences on their care were not reflected in their care plans.

Where people displayed behaviour that care and nursing staff found challenging, there were no care plans in place to provide information about these behaviours. For example, we were told one person sometimes became distressed and would throw objects or on occasions had pushed other people over. There was no information in their care records for staff about the possible triggers for this person becoming distressed and how they could support the person to reduce distress. Staff were unsure of what they would do if the person became distressed and told us they didn't know if there were any triggers for this person.

Despite our findings, people told us they felt the staff were kind people. One person said, "They are very nice. Friendly." Another person commented, "They are nice to me. They are likeable people."

Inadequate

Is the service responsive?

Our findings

At the last inspection on 7 and 8 September 2016 the service was rated 'good; in this key question. At this inspection the service is now rated 'inadequate' in this key question.

People did not receive personalised care according to their individual needs and preferences. Care records did not reflect people's preferences, views, likes and dislikes. Many people using the service had advanced dementia and limited communication. This meant they were unable to tell staff their preferences on a day to day basis. We were concerned that new or less experienced staff would not know enough about people to provide them with care that met their preferences.

For people living with dementia there was limited or no information about their life history and background. This information can help staff to better understand people living with dementia and the behaviours they may display. Knowing or having access to this information would mean staff could provide people with more personalised care.

Many people using the service could not verbally communicate their needs to staff. There was no information available in their records about the other ways they may communicate needs. For example, how body language, noises or facial expressions could indicate they were uncomfortable or in pain. This lack of information meant it was unclear how staff could understand what people may be trying to communicate. This could result in people not receiving support they required to relieve their distress.

The service did not have sufficient end of life care plans in place. The service had not referred to publically available best practice guidance such as the Gold Standards Framework and National Institute for Health and Care Excellence (NICE) guidance when planning people's care. For example, care plans didn't reflect where the person would like to end their life to reduce the risk of unnecessary hospital admissions. This meant that the service was not ensuring that people's wishes in coming to the end of their life were planned for and that there were plans in place around how people should be supported to be dignified, comfortable and pain free.

We observed that people did not have access to adequate activity and stimulation in the service. This was confirmed by three people who told us they were often bored. One person said, "I get very bored, all the time. I used to live at [another care home] before and there was so much to do. Games, trips out. There is nothing here." Another person commented, "It is boring. We don't get to do much. My daughter takes me out but that's about it." Another person told us, "There is no activities, nothing going on." When we asked how the person spent their day, they said, "Sit here watching TV." We asked how people would choose to spend their time. One person said, "Games would be nice. Bingo. Maybe some musical entertainment." Another person told us, "Playing cards. It would be nice if staff played cards with me."

We observed that throughout our two visits people were disengaged with their surroundings. People were split between three lounges, and in each one the television was on the same channel with no one watching it. Staff did not spend time with people engaging them in conversation or any activity. The registered

manager had not ensured that the staffing level took into account people's needs for social interaction and engagement. This meant that people were not protected from the risk of loneliness and boredom.

There were no activities available for people to access independently, such as books, puzzles or craft materials. There was no provision for people to be taken out of the service for trips where this was possible.

Staff were not implementing the Mental Capacity Act (MCA) effectively, and this meant that they were not promoting independent decision making. Improvements were required to ensure that care records reflected the tasks people could complete independently. For example, the parts of their personal care routine they could complete themselves and the parts they required staff to support them with. This information could reduce the risk of staff over supporting people and limiting their independence.

The care provided by staff was task focused and not individualised. Observations concluded that staff did not have an understanding of meeting the complete needs of people, including physical, mental, social and emotional needs. Staff focus was on physical needs such as supporting people to receive personal care at scheduled times.

This was a breach of Regulation 9: Person Centred Care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had not received any complaints at the time of our visit. However, the service did have a complaints policy and procedure in place. Relatives told us they would tell the manager if they had any complaints.

Inadequate

Is the service well-led?

Our findings

At the last inspection 7 and 8 September 2016 the service was rated 'good' in all domains. Following that inspection, the ill health of one of the business partners meant they were unable to oversee the day to day running of the service for a year prior to this inspection. The registered manager and the other business partner were left in charge of the day to day management of the service.

At this inspection, we identified widespread failings which seriously compromised people's health, safety and welfare. The service is now rated inadequate in all key domains and inadequate overall. The service was found to be in breach of regulations 9, 10, 11, 12, 13, 14, 17, 18 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a culture of poor practice within the service, with the registered manager and senior staff such as nurses not leading by example and demonstrating poor practice themselves. For example, the registered manager and all nurses administering medicines had failed to act in accordance with the instructions of the prescriber and in line with the Nursing and Midwifery Council (NMC) Code of Conduct. They failed to identify and address the poor practice of care staff. For example, one nurse was in the room when a staff member was pushing someone in a wheelchair with no footplates but did not identify this.

When we asked one nurse about why they had not raised the issue of medicines having not been given, they said it was not their job and we should talk to someone else about it. This demonstrated a lack of understanding about the duty of care they had to the frail and vulnerable people they provided care to.

The registered manager did not carry out clinical supervision of nurses employed by the service, in accordance with the NMC Code of Conduct. This meant that shortfalls in the practice of these nurses was not identified so reflective practice could take place.

Senior staff in the service demonstrated a lack of knowledge and understanding of people living with dementia, despite working in a service which provided almost exclusively dementia care. This meant that care staff behaved in the same manner and did not identify why this could compromise people's dignity and respect.

Staff told us the registered manager was visible in the service and participated in tasks such as administering medicines, so it was unclear why they had not identified the shortfalls we found and acted upon these.

The registered manager had no quality assurance system in place to monitor the quality of the service provided to people. They had failed to ensure people were protected as far as possible from harm by ensuring staff had appropriate training, knew how to care for people and ensuring that equipment and the premises was fit for use. They had not independently identified shortfalls in these areas and therefore had taken no action to safeguard people from harm. The partners did not have a system in place to monitor the service and the performance of the manager, which meant that shortfalls had not been identified so prompt

action could be taken.

The registered manager was not aware of the regulations under the Health and Social Care Act 2008 (Regualted Activities) Regulations 2014 with which they are obligated to comply. They were also not aware of the Key Lines of Enquiry (KLOE's) which set out the standards services are inspected on by the Commission. This and other useful information and guidance about meeting the regulations has always been available on our public website.

The service did not maintain any links with the community or other care services to share best practice. This meant that they were isolated and did not keep up to date with changes in best practice.

This was a breach of Regulation 17: Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were so concerned about our findings immediately following the inspection we contacted the Clinical Commissioning Group (CCG) and Norfolk County Council to make them aware of our concerns. They put into place measures to protect people from harm. In addition, we urgently took action to place a restriction on the service to prevent them from taking new admissions. We also placed conditions on their registration requiring them to provide us with certain information to assure us they were making the urgent improvements required.