Mr Robert Timothy Teasdale

Norfolk Villa Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place over three days, 29 February 2016, 2 March 2016 and 15 March 2016. The first day of the inspection was unannounced.
The service provides care and accommodation for 19 older people, some of whom are living with dementia or who may have physical or mental health needs. On the days of the inspection 17 people were living at the care home.

Accommodation and facilities in Norfolk Villa are situated on two floors, with access to the upper floor via stairs. There are some shared bathrooms, shower facilities and toilets. Communal areas include a lounge, a dining room and an outside patio area.

There was a registered provider; the service did not require a registered manager in post. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the last inspection on 12 and 17 September 2015, we asked the provider to take action to make improvements as we found care was not always safe, personalised and consistent. We found people's consent was not always obtained prior to care being given; risk assessments did not always reflect people's needs; there was no proper and safe management of medicines; staff did not always have the knowledge, experience and skills to support people; and the systems in place to monitor the quality of the service were ineffective. The provider sent us a plan detailing the improvements which would be made to meet the legal requirements in relation to the breaches. The provider told us they would make all improvements by the 28 February 2016.

At this inspection we found some improvements had been made, but we continued to have concerns in several areas.

People's medicines were not always managed, administered and stored safely. We found essential checks were not routinely completed to ensure the right people received the medicine they were prescribed. We found that there were gaps in the medicine records which meant we could not be sure people had received their prescribed medicine.

People's care records were not always reflective of people's needs and did not always show whether people were involved in writing them. The records of people's care were not always complete and lacked essential details to ensure care given was appropriate and as desired by the person. People's end of life needs were not always planned with them and their end of life care planning was inconsistent. However, we saw these were being improved during the inspection.

People's individual risk assessments were not reviewed regularly to ensure they reflected people's current risk in relation to their health needs. People were not involved in planning how to mitigate the risks they

faced while living at the service. People's care plans and records did not reflect risks which had been identified by the service.

Not all staff had been trained in the MCA and the associated Deprivation of Liberty Safeguards (DoLS). When people did not have the mental capacity to make decisions about their care and treatment, assessments were not always evident and there was a lack of guidance in place for staff about how to support people to make decisions. However, we observed staff asking for people's consent before providing personal care.

Good leadership and governance was not always evident. The provider had developed new audits but not all of these were effective and had not identified the issues raised during the inspection. However, the provider was working in collaboration with external services to improve the quality of care and during the inspection process, presented a plan to CQC to help ensure all aspects of people's care was of a high quality.

There were activities which occurred at the home which people liked participating in and enjoyed. However, activities were not always personalised to people's specific needs or interests and were infrequent.

Staff were recruited safely. Staff were receiving training and updates to meet people's needs. Staff had received safeguarding training and understood how to identify abuse and keep people safe from harm. Staff had also worked hard to update care plans but we found they lacked the knowledge to develop care plans which reflected people's risks and care needs, for example how to manage people's diabetes, skin care and continence needs. The matron told us during the inspection further training in these areas had been booked.

People's health needs were sometimes met. People could access their GP and other health professionals as required and staff sought advice however we found advice was not always followed or recorded by staff. People received a healthy diet although some people told us choice and involvement in menu planning was limited.

There was a complaints policy in place. People's concerns were dealt with when they arose. People felt comfortable speaking to the registered provider or matron if they had any concerns.

The service was clean and infection control procedures were being implemented and followed by staff. There were systems in place to maintain the equipment and utilities at the service.

The service was working collaboratively with external agencies to improve the quality of care people received.

We found a number of breaches of the regulations. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People were not always protected from the risks associated with their care and health conditions.

People's medicines were not always managed safely.

People told us they felt safe and staff had received safeguarding training.

There were enough staff to meet people's needs.

Safe recruitment practices were in place.

The service was clean and staff followed safe infection control policies.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not always cared for by staff who had received training to meet their needs, however a programme of staff training was planned and in progress.

The Mental Capacity Act 2005 was not well understood by staff but training was being arranged. People told us staff always asked for people's consent and respected their response.

Staff did not always have the knowledge, skills and training to meet people's needs but further training in managing more complex health needs was planned.

People's nutritional and hydration needs were sometimes met. People received a good diet but where people required monitoring for health reasons, this was not always evident.

People sometimes had their health needs met. People told us if they were unwell they saw their doctor. However we found advice given by health professionals was not always followed by staff.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always seek people's advance choices and plan their end of life with them. This meant people's decisions about their end of life care may not be known by staff and they may not receive the care they wanted.

People told us they were looked after by staff that treated them with respect and kindness. Most people spoke well of staff. Staff spoke about the people they were looking after with fondness.

People felt in control of their care and most people told us staff listened to them.

Most people said staff protected their dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always have care plans which were personalised and reflected their current needs, however these were being improved. Care plans did not always give sufficient guidance and direction to staff about how to meet people's care needs. Staff did not always know people's current care and when care and treatment plans had changed.

There were some activities in place which people could engage with.

People felt able to talk to the matron about any concerns.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Systems in place to monitor the quality of care had not identified all the issues raised during the inspection. Although some audits had been developed, these were not robust and monitored to ensure action was taken promptly when issues were identified.

People and staff said the registered provider and matron were approachable and visible.

There were systems in place to ensure the equipment and building were maintained.

The registered provider and matron were receptive to inspection feedback and working collaboratively with external agencies to improve people's care.	

Norfolk Villa Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place over three days, 29 February 2016, 2 March 2016 and 15 March 2016. The first day of the inspection was unannounced and undertaken by two inspectors for adult social care. The second day of the inspection, 2 March 2016, was announced and was undertaken by three inspectors for adult social care. The third day of the inspection, 15 March 2016, was announced and undertaken by one inspector for adult social care. Following the inspection we met with the provider on 20 April 2016 to discuss our findings.

Prior to the inspection we reviewed the information held by us about the service. This included previous inspection reports and notifications we had recieved. Notifications are reports on specific events registered people are required to tell us about by law.

Before the inspection we also sought feedback from professionals involved with the service. This included health and social care professionals.

During the inspection we spoke with 6 people who lived at the service. We asked them their view of the service and their care. We looked at the care of three people in detail to check they were receiving their care as planned. We spoke with them where this was possible. We looked at people's medicine management. We observed how staff looked after people in the lounge room and in the dining room at meal times.

We spoke with the registered provider, the matron and three care staff. We spoke with the matron about improvements made since the previous inspection. We reviewed the records kept on monitoring the quality of the service, audits and maintenance records.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in September 2015 we found risk assessments were not reflective of people's identified needs. The registered provider sent us an action plan advising us risk assessments would be updated and in place by the 30 November 2015.

During this inspection we found risk assessments were not sufficiently detailed to support people to live safely at the service. Risk assessments were not in all cases up to date and did not always reflect people's needs and risks in relation to their skin care, falls or nutrition. In addition, identified risks were not clearly linked to people's care plans. For example one person who had a history of skin damage had a skin care assessment which identified them as high risk. There was no date on this assessment, no review noted and the score on the assessment had not been added up correctly.

Where risk had been identified, the care and action required to minimise the risk and protect the person had not in all cases been followed as agreed. For example, one person had lost weight; a nutritional assessment completed in April 2014 had identified them as at high risk of malnutrition. A further, undated nutritional assessment said the person weighed 80.6kgs and their weight on 17 February 2016 was recorded as 73.6kgs. A referral to a dietician was made in January 2016. The dietician advised the introduction of food and fluid charts as well as weekly monitoring of the person's weight. Weekly weights were not recorded when we checked on 2 March 2016. Staff advised the person was no longer on a food or fluid chart as they were eating well, however they did not know whether the person's weight was now stable or not. This person had also been identified in their assessment as a likely continence risk. There was no further information in the care records regarding what the risks were or how to support the person with their continence needs. The person and staff told us they had a catheter in place.

Another person at Norfolk Villa was noted to be "a high risk of verbal aggression and extremely likely to have behaviours that could harm others". There was no further information for staff about how manage the person's behaviour or reduce the risks to others. Another person had a moving and handling assessment in place. This was undated but reviewed in January 2016 and identified the person to be at high risk of falls. There was no further information about how to support the person with their mobility and reduce the likelihood of falls. Staff told us they had a mobility aid and observed them closely.

People with a diagnosis of diabetes did not have appropriate risk assessments in place to manage their condition and ensure staff could support them safely. The care records of two people we looked at stated they had diabetes. From the records we reviewed we saw one person had fluctuating blood sugar levels. Their care plans did not guide staff on the signs and symptoms they should look for to indicate the person might have very high or very low blood sugars, nor the action staff should then take. Both people's diabetic information said they should still be having blood sugar monitoring but the matron advised this was no longer the case. However, the care staff we spoke with thought they still required blood sugar testing. The absence of clear, up to date and accurate information in people's care records could place them at risk of not receiving the care they required.

During the inspection period the registered provider and matron were working closely with the local authority to improve the assessment of people's risks and care plans.

We found body maps were now being used. This meant injuries, sores and bruises would be noted as they occurred. These helped staff assess and monitor people's skin condition to ensure healing was taking place and to monitor any further deterioration.

At the previous inspection we found people did not always receive their medicines safely. We asked the provider to send us an action plan to describe how they would address these issues and by when. The provider's action plan said staff were completing further medicines training. We were told weekly medicine audits and a daily checklist would be developed for people at risk of missed medicine doses and protocols would be developed for people who were prescribed Warfarin. The action plan was undated for this area.

We were told by the matron that changes and improvements were being made to the way medicines were managed. We were told some staff had received training and medicine checks had been developed. However at the time of this inspection people's medicines were not always managed safely. TO HERE

Medicines were not always administered safely and in line with current guidance. We observed one medicine round. Staff did not check that they were administering the medicines to the right person or that person's medicines had not changed before administering. Staff did not check the person's photo or the Medication Administration Records (MARs) for the first person to be administered to at the lunchtime medicine round. They collected the person's blister pack and then went to administer. We raised this as an immediate concern and after that the member of staff checked each person's identity. We were told by both the staff member and the provider that this was because they knew people well and knew what medicines people were prescribed. One person told us they were on prescribed bath emollient and not all staff would follow the prescribed amount to be put in their daily bath for their leg ulcers. They told us they had to inform staff of the amount and tell them it was not like "bubble bath."

We found there was no system in place to ensure the timing between medicine administrations was in line with the prescriber or manufactures guidance. Staff had their own routine for who to administer medicines too and in what order. For example, we were told the medicine round should start at 12.30pm however, by 12.50pm this had not started. We were told by the provider medicine timings were flexible but there was no time recorded when the last medicine was administered to ensure the next one was not given too late or too early. This meant if people were on medicine which required a time gap in between dosages or medicine before or after food, the prescriber's guidance was not always followed.

Medicine Administration Records (MARs) were in use. The most recent records started on the 29 February 2016 so we requested to see the previous month's records. On reviewing the previous MARs it showed that not all tablets had been administered as prescribed. There were gaps in some records with no supporting documentation that this was then reviewed or the person received their medicines at another time.

The recording of when people refused medicines and the administration of when required (PRN) medicines was not in all cases consistent. Not all staff were recording medicine refusals and medicine to be taken as required (PRN) in the same way which could lead to potential risk. Also, there was a concern staff administering medicines did not understand the difference between prescribed and PRN medicines. For example, one person was administered two paracetamol five times on the 15 February 2016. They were prescribed a course of paracetamol to be taken at 8.30am, 12.30pm, 5pm and 9pm. The MAR recorded two paracetamol were given on each of these occasions, but an unsigned note on the foot of the MAR stated the person had also been given two paracetamol at 5am. There was no reason recorded as to why the person

required further pain relief. The staff member had not understood medical advice was required on this occasion and the paracetamol could not be given as PRN because the person had already received the maximum amount. This error had not been identified in any audit and therefore not investigated or showed medical advice had been sought.

The matron stated they reviewed the MARs each time they ordered the medicines. We were told before ordering the medicines for the next cycle the matron reviewed staff were completing the MARs correctly. However, they said this was not recorded anywhere. Along with the issues identified above, the MARs from the previous month's cycle had unsigned changes on them, did not always have the total of stock carried forward from the start of the cycle on them and there were new handwritten MARs started part way through the cycle. The hand written ones did not contain the signatures of the staff who completed them and also did not have a second signature to ensure they were accurate. This made it very difficult to evidence any audit had taken place or enable a stock check on the day of the inspection. We checked the stock of people's eye drops against the MARs and found four people had eye drops in the fridge to be given as prescribed however, these had not been carried forward on to the MARs for this cycle. This meant they had not been given since the 29 February 2016. We inspected medicines on 2 March 2016. This error had not been noted by the manager when booking the medicines in until we pointed it out. No action was taken immediately but we were assured by the provider in feedback that this would be looked into to ensure people received their prescribed medicines.

Medicines were not always managed safely. Staff were handling people's medicines. Staff were observed popping people's tablets into their hand before giving them to people. Gloves were initially used however the same gloves were used to handle more than one person's medicines without being changed or cleaned. We asked staff how they could ensure people and they were protected if they were not washing their hands. There was no facility on the trolley for staff to disinfect their hands. When we asked if they had dispensing pots which were available to dispense medicines into, the staff member located four pots which had the original use of urine samples and cough medicines pots. One was also cracked. None of the pots could be guaranteed as clean and each one was then used more than once. One person had put one of the pots to their mouth and despite being advised this could not be used again (along with the other pots) the same pots continued to be used. We were told by staff there were no dedicated pots for the safe, hygienic administration of medicines. This meant people were exposed to cross contamination and residue from other people's medicines. On the third day of the inspection new pots had been ordered to safely dispense medicine.

Medicines were not always stored safely. A robust system was not in place to ensure people or unauthorised staff could not access medicines. The keys were kept in the medicine folder, in an open office. We raised concerns with the matron about the keys being easily accessible and no action was taken immediately. It took several attempts before we were assured that the staff on shift with responsibility for medicines kept the keys on their person. Medicines to be returned had been stored in an area that could be easily accessed and therefore put people at risk of consuming them.

People's medicines in the dedicated medicine trolley were not stored in line with current guidance. Some people had individual trays with their prescribed medicines in, others did not. Some people's medicines were placed in trays labelled "MISC" which staff stated stood for "miscellaneous". These contained several people's medicines and were for people on respite or short stay. The trays were not secure in the cabinet and one fell out on the floor after the trolley was moved and opened again. Staff also had difficulty locating some medicines as the trays had been placed in a different place than expected. In discussion with staff we found that different staff used the trolley in line with their own unique preferences. This again made auditing medicines difficult as there was no sense of order or system in place.

Medicines were not being returned regularly. There was a large quantity of medicines to be returned. The last time people's tablets had been returned was in November 2015. Some of what the manager called "bulky products" like creams had been returned on the 1 March 2016. This still left a significant amount of medicines requiring disposal.

People's records did not in all cases include information about their currently prescribed medicines. Where we found information about people's medicines had been documented, the information was not in all cases accurate or up to date. People's medicines were not clearly linked to people's care plans or risk assessments. For example, people prescribed Warfarin (a blood thinning medicine) were receiving their medicines as prescribed and had regular reviews. However, there was no linked care plan or risk assessment to ensure staff understood the risks associated with this medicine. Also care records did not record which foods people on such medicines should avoid to prevent it affecting the effectiveness of the medicine. However, we saw these had been added to people's dietary information sheets in the kitchen.

Systems were not in place to consistently document people's allergies. None of the MARs contained a record of people's allergies. We were told by staff that the information would be in the pre-admission paperwork however we found 10 out of the current 19 people living at the service had not been asked if they had any allergies on starting to live at the service. One person had an allergy noted for a certain type of eye drops but this had not been recorded with the MARs to ensure staff were aware of this.

Not all people who self-administered their own medicines had risk assessments in place. Where risk assessments were in place, some of the information and guidelines for staff were unclear and potentially confusing. It was unclear when staff were administering the medicines or the person was administering part of their medicines themselves. For example, one person's records stated "The staff do all my medication" in their "This is me" document. However, they then had a self-assessment and risk assessment in place for administering their inhaler. It was not then recorded if they had used their inhaler on the MARs. The MARs only stated "self-administered", but there was no staff signature that recorded whether the inhaler had been required. It would not be possible to ensure this medicine was required, being effective to meet their need, or if they were managing self-administration.

Systems were not in place to ensure prescribed skin medicines were admistered appropriately. We looked at the records of two people who had prescribed creams due to skin damage. The documentation used to record when creams were administered had gaps which meant it was not clear whether they had their skin creams applied as prescribed. In January 2016 one person was noted to have a sore, red sacrum; their care records advised regular skin cream and they were prescribed this. This area of skin had broken down in February 2016. This person's skin cream chart had gaps during this period. For example, there was nothing recorded between 10/1/16 and 15/1/16; 15/1/16 and 19/1/16; 19/1/16 and 28/1/16. This meant we could not tell whether they had received their medicine as needed which may have reduced the likelihood of skin damage.

Not all staff who administered medicines had up to date training. Competencies were being checked by the matron and deputy matron. However, neither of these had been signed off as competent to do this. The matron's training was also not up to date having last been updated in January 2014. Also, the service used agency staff at night however; there was no record to ensure their training was up to date. From the discussion we had with the registered provider we could not guarantee a staff member was always on duty...who had the skills and training to be able to administer medicines safely. When we raised this with the registered provider, we were told a member of staff would stay on to administer the night time medicines if required. We advised that a member of staff who is trained and competent needed to be on duty 24 hours a day as people might require PRN medicines to be administered.

We found care and treatment was not always provided in a safe way for people. Aspects of the management of medicines were not safe. People's risks were not always assessed to ensure they received the care they needed and potential risks were minimised. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager stated they had dedicated time to order medicines each month. They also stated they had reviewed staff medicine training recently and this was ongoing to ensure all staff were up to date.

Personal emergency evacuation plans (PEEPs) were in place and the provider had a contingency plan to ensure people were kept safe in the event of a fire or other emergency, however we found the fire list did not reflect room changes which had occurred. This meant if there were a fire, the fire brigade would be looking for people in the wrong room. We told the registered provider who updated the fire list immediately.

People were looked after by staff who understood how to identify abuse and what action to take if they had any concerns. Staff said they would listen to people or notice if people's physical presentation or emotions changed and that this might indicate something was wrong. Staff would pass on concerns to the senior member of care staff on duty or the registered provider. All staff felt action would be taken in respect of their concerns. Staff said they would take their concerns to external agencies, such as CQC, if they felt concerns were not being addressed. External professionals told us they were concerned the learning which might be recommended following safeguarding allegations was not always implemented and embedded. For example we were advised if a safeguarding alert had been unsubstantiated but there were improvements which could be made, the registered provider did not realise the need to heed this advice to minimise the risk of a repeated event occurring. During the inspection process concerns were raised about the lack of robust systems in place to manage people's finances. We spoke with the registered provider and were informed clear processes and systems would be developed.

At the last inspection on 12 and 15 September, we found areas of the home were not clean. The provider sent us an action plan advising staff training in infection control would be undertaken, an audit undertaken and procedures updated. We were told this would be in place by the 31 January 2016. We found the service had made some improvements in this area.

We found however, where people had health conditions which placed them at risk of infection, these people did not have care plans in place to guide staff how to minimise the risk of infection. For example people with continence needs or skin ulcers. We spoke to the matron about incorporating these people's needs into care plans as they continued to develop.

The home was clean, an audit had been undertaken and systems improved to reduce the risk of cross infection. Hand washing facilities and protective clothing such as gloves and aprons were available for staff around the service. New dustbins were in place to differentiate between general rubbish, recycling and clinical waste. Pedal bins were being ordered for bedrooms to reduce the risk of infection. Colour coded laundry hampers were now in place. Staff explained the importance of good infection control practices and how they applied this in their work. Staff were aware of how to mitigate the risks of infection if a person had an illness such as diarrhoea and vomiting or a skin infection and had updated their knowledge in this area. We spoke to the registered provider about staff with particular health needs which meant they were unable to use the protective clothing required to reduce infection. On the third day of the inspection staff had the equipment they required to carry out their roles safely.

People confirmed they felt safe living at Norfolk Villa. People felt comfortable speaking with staff and told us staff would address any concerns they had about their safety.

There were sufficient staff to meet people's needs safely during the inspection. The registered provider had systems which were flexible to ensure staffing levels were maintained at a safe level in line with people's needs. We were concerned the reduced hours worked by the matron meant it had been difficult to fully implement the action plan. The registered provider told us they were recruiting to an additional post to work alongside the matron to provide clinical leadership within the service. A new deputy matron had been appointed on the last day of the inspection.

Staff told us there were enough staff for them to meet people's needs safely although they had little time to spend with people and they told us this was discouraged and the registered provider would often find them jobs to do. We fed this back to the registered provider who agreed to consider these comments when assessing how many staff were needed to meet people's needs and make care less task focused and more person-centred.

The home had safe recruitment processes in place. Required checks had been conducted prior to staff starting work at the home. For example, disclosure and barring service checks had been made to help ensure staff were safe to work with vulnerable adults.

Requires Improvement

Is the service effective?

Our findings

At the last inspection we found people's mental capacity was not always being assessed which meant care may not be given in line with people's wishes. The provider's action plan advised training would be accessed, there would be clearer recording of people's capacity to consent to their care and advice would be sought from professionals in relation to Deprivation of Liberty (DoL) applications. We were told this would be in place by 9 November 2015. During this inspection we checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) and whether any conditions on authorisations to deprive a person of their liberty were being met. We found improvements were ongoing.

The matron advised training in the MCA and DoLS had not yet been undertaken but this was booked during the inspection process. 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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We found staff followed the principles of the Mental Capacity Act in their practice for example by assuming people had capacity to consent to their care. However, people's records gave conflicting information about people's capacity and little guidance to staff on how to involve people in decision making where they did not have capacity. Records did not always demonstrate MCA assessments were taking place as required and the MCA was being followed. For example one person's undated capacity assessment said they had capacity. Their care plan went on to say they had capacity to consent to their care and treatment, were free to leave and were not under constant supervision and control. However, an application had been submitted to the supervisory body to deprive them of their liberty. These applications are only submitted for people who are deemed not to have capacity. Staff told us they felt the person did not have capacity to decide whether it was safe to leave the home and understand the possible risks of doing so.

Staff told us they discussed people's care with a range of professionals and the family where appropriate to ensure any decisions were made in the person's best interest but this was not always recorded. Staff were not given clear guidance in the care plans on when they were acting in people's best interest, and staff did not always know who had the mental capacity to make their own decisions and who did not. For example one person who staff felt did not have capacity frequently wanted to leave the home and had bought an airline ticket to visit another country. Staff described the action they took to protect them, with the person's best interests in mind, but their care plan gave no guidance for staff on how to manage these incidents if they occurred again.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered provider had applied for DoLS on behalf of all people who might require one. The registered provider had submitted two requests which were awaiting review by the local authority designated officer. We were concerned the registered provider had not

considered an urgent authorisation for the person who had wanted to go abroad and bought an airline ticket. We spoke to the matron and advised an early review was requested.

The matron advised us that the new care plans which were in progress would incorporate people's capacity to consent and DoLS information.

People's health needs or conditions were not always clearly recorded; advice sought was not always recorded and care plans were not updated as people's needs changed. This meant all staff did not have the latest information and guidance to maintain their health. For example one person had a sore sacrum (bottom) and redness on their skin which was noted by staff through January 2016. Daily records stated the district nurse team had advised a pressure mattress and gel cushion for the person to sit on. They advised hourly movement to the bathroom, a two hour bed rest in the afternoon, and hourly turns. On 2 March 2016 we observed this person's care between 10am and 4pm. They were assisted by staff to move their position once during the day at 10.45am. This meant staff were not following the guidance given by professionals to ensure this person received the care they required to heal their skin. Another person's care plan did not reflect the updated advice given by their doctor for their diabetes management. This meant not all staff were aware of the change in their treatment plan.

Care records and care given by staff did not always reflect people's dietary needs or specialist guidance. For example, care records did not reflect people's health needs such as diabetes, their allergies were not always recorded and where people had nutritional needs due to weight loss and were on food and fluid monitoring charts care plans did not reflect these needs. One person had a speech and language therapy assessment as they had swallowing difficulties. This advised staff to be on standby and observe the person in the dining room when they ate. We observed the person having their lunch unattended in the lounge area. Staff would have been unaware if they had required assistance. Where people had identified risks such as choking their care plans were not always clear, for example one person's care plan said they would tell staff if they were choking.

Care plans and care and treatment provided did not always reflect people's needs. This is a breach of Regulation 9(1) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems were not in place to regularly monitor people's weight and to identify and respond to any concerning weight loss. The absence of these systems meant plans to address these issues and prevent further weight loss had at times been delayed. We did however see (or were told about) occasions when staff had recognised people had lost weight and had made referrels to the person's GP. We found people's weights recorded inconsistently and not as described in their care records. People's nutritional assessments were sometimes not dated or not reviewed which meant changes might not be identified. Staff advised they had not received training in how to complete these nutritional assessment tools.

Not maintaining accurate, complete and contemporaneous records of people's care is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and staff gave us conflicting information about their involvement in the menu and the choices of food available. The registered provider, who cooked three days a week, told us people were asked in the morning what they would like to eat for lunch and if they did not like a particular option, an alternative meal would be made available to their liking. Two people said there was no choice and the meals were the same each week and on the same day. One staff member told us "It is the same menu week in and week out" another said "People are given a choice in the morning of two dishes and two puddings – stew or steak, banana split or rice pudding." One person told us when they were admitted they were asked their cereal

preference and every day since when they had come down for breakfast there was a bowl of bran flakes waiting for them. They told us this was already in their bowl so they were unable to choose their portion size or if they preferred something different for breakfast that day. Staff told us that night staff did this and "That's the way." This person also told us people's tea, including their own was already poured for them before they arrived at the breakfast table which meant it was sometimes only lukewarm. We asked staff who confirmed this was the case. We spoke to the registered provider about this and they were unaware of this practice and agreed to look into this. The register provider told us they found it difficult to meet people's choices and preferences and maintain routine and structure within the service for example if someone wanted a later lunch as they had breakfast late.

During the last inspection in September 2015 we spoke to the registered provider about the dining room being used as a staff room with staff notices and staffs' personal belongings in people's dining room. Although staff information had been removed from the dining room, staffs' handbags and personal effects were still there and staff continued to use this room for their breaks. We spoke to the matron and registered provider during feedback and alternative space for staffs' belongings was going to be considered.

Staff we spoke with did know people's food preferences and foods they were unable to eat. There were new forms in the kitchen to inform catering staff of people's preferences and food people were unable to eat.

People's special dietary foods were catered for, for example those who required a special diet for health reasons or those on a soft diet due to swallowing difficulties.

Most people spoke positively about the food which was mostly home cooked and nutritious.

During our inspection in September 2015 we found staff did not always receive appropriate training, professional development and supervision to enable them to carry out the duties they were required to perform. The provider sent us an action plan advising there would be a new induction system and essential training would be identified and completed by staff. We were told this would be in place by 15 October 2015. We found some improvements had been made and a training programme was in place.

Staff did not always have the knowledge and skills to care for people effectively. For example, assessments and care for people with particular health needs such as diabetes, continence needs or skin damage were not always completed correctly and staff were not always sure they were providing care which was correct. For example when we asked staff about how they would manage one person's fluctuating blood sugar levels they said "If they are clammy I would do their blood sugars but I get confused about what is high or low, I'd ring the GP. Diabetes training would be really helpful." Another staff member when asked if they had received training in managing one person's catheter told us "No, I hope I do it right." The person had told us it had leaked because staff did not always do it correctly. We spoke to the matron about this and training for staff to meet people's more complex health needs was booked by the third day of the inspection.

The registered provider and matron had reviewed staff training to ensure staff were having the training they needed for their role. Staff told us they had received some training since the previous inspection and more was planned. This would support staff to deliver effective care. The registered provider and matron had organised training in the forthcoming months in areas deemed essential to support staff to meet the needs of people living at Norfolk Villa. These included training in skin care, the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS); nutrition and hydration, epilepsy, diabetes and continence care. The staff we spoke with felt people's needs had changed over the course of time and this training would benefit them. Staff were positive about the training which had occurred since the previous inspection.

People mostly told us they felt staff had the skills to care for them or their relatives well.

Staff told us they felt supported by the matron and some staff had received supervision and appraisals. Additional informal support and supervision was offered for any staff.

New staff underwent an induction when they started to work at the service. New staff shadowed other experienced staff. The registered provider had introduced the Care Certificate to train all staff new and existing staff to nationally agreed levels.

People told us their healthcare needs were met. The registered provider often escorted people to their hospital appointments and people who had regular hospital treatment for their health needs were supported to attend these appointments. When staff had identified people's needs had changed for example their mobility, weight or skin GP and district nurse advice was sought.

Requires Improvement

Is the service caring?

Our findings

At the previous inspection we found people's end of life care wishes were not always planned with them. The action plan submitted by the provider did not address this area. During this inspection we found on-going concerns in relation to people's end of life planning and care.

Details about people's end of life care and wishes were not always known by staff or well recorded. For example, one person had an incomplete treatment escalation plan (TEP) following discharge from hospital. These are forms that are completed by medical personnel regarding whether or not a person is to be resuscitated and detail end of life treatment to be given or not given. Staff told us they would resuscitate the person but they had an end of life care plan in place which stated it was their wish not to be resuscitated. This meant their end of life wishes and individual needs may not be respected. We raised this with the matron and the person's care plan and TEP was reviewed and updated by the third day of the inspection.

The matron told us people's end of life wishes were to be incorporated into the new care plans being developed. The matron told us they were going to look into an end of life course and share this information with the staff team to improve care in this area.

Part of the service's improvement plan was to enable people to be more involved in their care and treatment decisions. We found care records did not always detail people's involvement and care plans were not always signed. One person told us "There are some lovely staff but people aren't involved or encouraged, there is indifference, I'm treated as if I'm here for their convenience, not mine."

Where people did not have capacity or someone had legal authority to make decisions about their care and treatment, it was not always evident advocates had been involved in decision making or people had been given information about these services.

We found that there was a lack of recorded evidence which demonstrated people were supported with choices regarding their care and treatment, for example most people had designated bath days. However staff told us people could shower / bathe when they wished but this was not evident. One person told us part of their treatment was having a daily bath but one staff member had suggested they bath every other day "They wanted me to conform to their bath schedule." The person concerned had informed staff of the necessity for daily baths. The registered provider told us they found it difficult to balance people's choices with having a structure and routine in the service.

People's private information was not always held securely and conversations about people's care were not always held where they could not be overheard by other people living at Norfolk Villa. For example people's care records were kept in an unlocked filing cabinet, in an unlocked office which was often not staffed. This meant people's private information could be accessed by others living in the home. We also found one person's dietary assessment with their private details on the dining room wall. Health care professionals and staff fedback to us conversations about people's private affairs which were held in public areas. We raised this with the registered provider who immediately removed this information from the communal area and

advised us all staff working at the home would be reminded about maintaining confidentiality.

Records were not always kept securely. This is a breach of Regulation 17 of the Health and social care Act 2008 (Regulated Activities) Regulations 2014.

Most people told us staff protected their dignity at all times and they were happy at the home "I'm happy here, they help me wash and dress, staff are kind"; another person said "I watch staff and feel they care for people well." People told us staff were polite and respectful when delivering personal care, staff knocked on people's doors before entering and curtains were always drawn and doors shut. The staff we observed were gentle and engaged with people well, they gave clear instructions and encouragement when supporting people to move with their mobility aids. One person however said they had spoken to staff after they shouted up the stairs for them at mealtimes and some staff they felt had spoken to them in a way which was not dignified "Come on, it's time you were up." We fed this person's complaints back to the matron at the time of the inspection; we were told they were unhappy as they wanted to be in their own home.

Staff knew people who had lived at the home for some time very well and were able to talk easily about their backgrounds and preferences. This enabled positive relationships to be built with people.

We observed that people were relaxed and comfortable in the presence of staff, watching television, talking amongst themselves, and asking questions of staff and each other. There were good humoured interactions between staff and the people they were supporting. Staff spoke appropriately and respectfully to people, most staff had known people for many years and spoke affectionately about them and they showed that they understood people's individual characters and needs. Staff showed that they understood people's individual styles of communication well enough to know their preferences and wishes.

People were made to feel they mattered. For example birthdays and special occasions were celebrated. One person was from a different country and the service had made an effort to celebrate a day which was of significance to their cultural background.

Staff told us the registered provider was kind and people never went without. Those who had been short of clothes or money had been provided for whilst alternative arrangements were made to sort their finances or belongings out. Those who were unable to go out by themselves were supported by the registered provider to go out for a drive or go to the bank.

Residents' meetings were held to encourage involvement but the registered provider said these were not popular with people. Resident's meeting notes were taken and displayed so those people who had been unable to attend could review the discussions held.

Relatives and family were encouraged to visit without restriction.

Requires Improvement

Is the service responsive?

Our findings

At the previous inspection, we found some people did not have a care plan in place and the recording of people's care was not always personalised or consistent across all records. We found some improvement in this area since the last inspection. People now had assessments and care plans. However, people's assessed needs were not always incorporated into their care plans; people were not familiar with their care plans and it was not always evident people or those supporting their care had been involved in developing or reviewing people's care plans.

People's care records continued to lack sufficient detail to enable staff to be responsive to their needs. For example, care records lacked guidance for staff on how to care for people's needs in relation to their skin, diet and weight, mobility and health related conditions such as diabetes. Care records also gave conflicting information and did not always reflect people's current needs. Hospital care passports and "This is me" documents were in place but these did not always have the latest information about people's needs for example their current medication or nutritional needs. One person's hospital passport stated they were "independent with eating and drinking". There was no record that this person had diabetes or had been losing weight and there was no mention they had a catheter fitted in their continence care section.

The matron advised new care plans were being developed and preferences were being incorporated and people were now allocated a keyworker to assess their needs and update their personal information. Staff were able to tell us how people preferred their care delivered and how people liked to be washed and dressed, what their interests were and what food they liked and didn't like. A "choices" sheet had been developed to reflect people's preferences. Some of these had been completed. We spoke with the matron and registered provider about incorporating these choices into people's care plans so they were integral to their daily care and how people liked their needs to be met.

Care plans and people's records were disjointed. People's assessments and identified risks were not always incorporated into care plans to give staff guidance to meet people's needs. Where people's interests had been noted, it was not always possible to see how people were encouraged to maintain their interests and hobbies. As people's needs changed, care records were not reviewed in a timely way so some care plans did not reflect people's current care needs.

There were not accurate, complete and contemporaneous records in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they participated in handovers and there was written information for staff which they told us kept them updated. However, we found some staff were not aware of changes to people's care which meant care may not be responsive to people's needs.

People were provided with limited opportunities to remain cognitively, physically and socially stimulated.

People spent large periods of the day watching television. The activities board was not up to date which could be confusing for people with cognitive deficits. An external entertainer came in to sing every fortnight but people told us it was always the same people and same songs.
People were able to use their personal computers which they enjoyed using and enabled them to remain in contact with friends and family. However, we were told by one person that there were often problems with the internet connection which they found frustrating as it was their only contact with the people outside of Norfolk Villa. We spoke to the registered provider about this and they helped the person resolve the internet problems during the inspection.

Although on the first day of the inspection we were told there were no planned activities, on the second day of the inspection, the registered provider organised a quiz which people enjoyed. People who were able to and enjoyed the newspaper were reading, others enjoyed their crossword puzzles. Staff told us that when people had hospital appointments the registered provider would take them out for a drive too or to visit a place of local interest.

Most people told us they were not quite sure how to raise a complaint but told us they felt comfortable speaking to the registered manager and other staff. The service had a complaints policy in place. This was made available to people and relatives as requested and there was a notice at the entrance to the home detailing how to make a complaint however, people did not know it was there. The matron and registered provider were available and talked to people about their care frequently enabling concerns to be picked up and resolved promptly. We found a record of concerns was not kept which meant there was no system in place to look at themes or learning from informal complaints raised. We were told there had not been any formal complaints made.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection we found the provider did not have adequate systems and processes in place to ensure the quality of the service. At this inspection we continued to have concerns about the effectiveness of quality monitoring of the service.

Audits and checks which had been developed since the previous inspection were occurring, identifying where there were problems, but the action arising to remedy the issues was not evident. For example an audit of care plans had occurred and in people's files there was a list of actions which needed completing. We found some of these audits had been done at the start of January 2016 and at the end of February 2016 no progress had been made to complete the required changes. The audit failed to consider the quality of care plans and whether they reflected people's assessed needs. We spoke to the matron about having a clearer audit tool with the required actions noted, who was responsible, and a timescale for when the actions should be completed by. This would enable progress to be monitored.

We reviewed the January 2016 medicine audit. This had identified gaps in the medicine administration records (MARs) and gaps in medicine recording but had been stopped at the end of January as recording improved. We did not see the actions which had been identified from this audit had been completed and the audit did not identify the issues found at this inspection with medicine management. The audit which had been developed did not assess the service's compliance with best practice guidance.

The systems in place to monitor the quality of service people received were not effective. This is a breach of Regulation 17 of the Health and Social Care Act (2008) Regulations 2014.

The leadership structure at Norfolk Villa was being reviewed but at the time of the inspection it was unclear who was responsible for the delivery of the action plan submitted after the last inspection. The matron worked 15 hours a week and had found it difficult to make progress in all the areas required.

The registered provider and matron had received guidance and support from the local authority but lacked the knowledge and leadership skills required to embed the changes and develop the audits needed to help monitor the delivery of high quality care.

We received mixed feedback from people and staff about the culture at the home. Improvement was required to develop the culture within the service so it was person-centred, inclusive and empowering for those who lived at Norfolk Villa. The culture did not always reflect that people came first. There was a lack of community involvement and links with the local community particularly for those people who required support to go out.

There were minimal processes in place to ask for people's views or for health professionals and relatives to give feedback. Feedback forms were by the entrance of the service but there was no evidence these had been completed by anyone, feedback collated, or reviewed to drive service improvement. People and staff spoke positively about the matron and felt comfortable approaching her. Most people felt any issues would

be heard and acted on.
There were policies and procedures in place but these were not always reflective of current guidance and best practice and had not been reviewed or updated for many years, for example the medicine and infection control policies. Where there was information for people available such as the complaints process this was not available for people in different formats, for example easy read or large print.

There was a lack of a shared understanding amongst the staff team on what the aims and the philosophy of the service were and how they were demonstrating the values they strived for. Staff told us they did not always feel they worked cohesively as a team and some staff did not feel their roles and contribution were valued by the registered provider.

On the last day of the inspection we looked at infection control and the audit in place to monitor the cleanliness within the home. The audit had recently been completed and action was being taken to improve this area.

At the last inspection we found not all significant events had been notified to the Care Quality Commission (CQC). The registered manager knew how to notify the Care Quality Commission (CQC) of any significant events which occurred in line with their legal obligations and we had received a notification about an injury which had occurred.

The registered provider had systems in place to ensure the building and equipment was safely maintained. The utilities were checked regularly to ensure they were safe. Health and safety checks such as that for fire safety equipment took place regularly.

Staff confirmed they were able to raise concerns and said these were dealt with properly by the matron. Staff had a good understanding of their roles and responsibilities and said they were supported by the matron. Staff told us the matron worked alongside them. Staff said there was good communication within the staff team and they were working better together.

The registered provider promoted the ethos of honesty, learned from mistakes and admitted when things had gone wrong. This reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment. We found the registered provider and matron responsive to inspection feedback and keen to improve the quality of the service and care provided.

There was a whistleblowing policy in place to protect support staff and staff felt confident reporting concerns to the matron.

The local authority were working closely with the service at the time of the inspection and staff and the registered manager had found the advice and support helpful in starting to implement the required changes needed.

The registered provider took an active role within the running of the home and had good knowledge of the people and the staff. The lines of responsibility and accountability within the management structure were developing. The matron told us they were going to take a more administrative lead dealing with recruitment and care, and another clinical leadership role had been agreed to support her as they were only working part time. We were told the registered provider managed the business side of the service, repairs, contractors, cooked three days a week and escorted people to their hospital appointments.

Following the inspection we met with the registered provider expressing our concerns the service continued to be in breach of The Health and Social Care Act Regulations at this inspection. We asked the registered provider how he planned to address the concerns raised during our feedback to ensure the service was safe, care was of high quality and there was good leadership in place. The registered provider gave CQC a robust plan which included; gaining the advice and support of a consultancy agency, appointment of a manager to lead the service, and implementation of service wide changes to address the areas identified in this and previous inspections. The registered provider said that weekly reports detailing progress would be submitted to CQC to monitor progress made.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Regulation 9(1)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person centred care Care and treatment did not always meet people's needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12(1) (2) (a) (b) (c) (g) Health and Social Care Act 2008 (Regulated Activities) Regulations 2104 Safe Care and Treatment Care and treatment was not provided in a safe way for people including assessing the risks to the health and safety of people; doing all that was reasonably possible to mitigate risks; ensuring all staff providing treatment were competent and ensuring the proper and safe administration of medicines.

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 17 HSCA RA Regulations 2014 Good governance Regulation 17(1) (2) (a) (c) and Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance Systems and process were not always established to assess, monitor and improve the quality and safety of the service. Records of people's care were not always accurate, complete and contemporaneous.

The enforcement action we took:

Warning notice