Care Quality Commission

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

Overall summary

We inspected the service on the 12 and 17 September 2015. The inspection was unannounced.

We last inspected the service on the 14 April 2014 and found no concerns.

Norfolk Villa Residential Home provides residential care without nursing for up to 19 older people. People living at the service may be living with mild dementia. There were 18 people living at the service when we visited.

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.

Not all people had care plans in place. Care plans that were in place did not detail people's individual care needs sufficiently to ensure staff knew what care to

Summary of findings

deliver, and these were not regularly reviewed to help ensure they reflected people's needs. People were not always involved in planning their care and enabled to make choices about how they wanted their care to be delivered. The matron, registered provider and staff were knowledgeable about people and their needs.

Not all people had risk assessments. Where there were risk assessments, these had not been regularly reviewed and were not always clearly linked to people's care plans. Risks associated with people's individual needs were not formally recorded to help ensure people were protected and staff had the full information to meet people's needs.

People's medicines were not always administered safely, records did not always demonstrate medicines had been given. Some staff were recording people had taken their medicines when they had not.

Not all staff followed safe infection control practices. Protective clothing was not always worn and we found some bedrooms and bathrooms were not clean. Equipment such as commodes were not clean and hygienic.

Most people who lived at Norfolk Villa had mental capacity to make their own decisions about their care but staff's understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) was limited. Where people did not have capacity we did not see evidence of assessments having occurred and there was no clear guidance for staff about how to support people to make decisions.

There were sufficient staff to meet people's needs safely. There was a training programme in place but some staff had not completed the provider's essential training. Some training such as moving and handling was out of date. Staff were recruited safely. Staff understood how to keep people safe from harm and felt any concerns would be taken seriously.

People received a good diet but their nutritional needs had not always been assessed and their likes and dislikes were not always known by the staff. The kitchen staff did not have information about dietary needs such as those who required a low phosphate diet or had diabetes. Allergies were not consistently communicated to the cook. People were not involved in developing the menu and there was a lack of choice available on the menu.

People could see their GP and other health professionals as required. Any concerns about people's health were addressed quickly by the staff and referrals made to external services when required.

Staff conversation and engagement with people was minimal during the inspection. Activities were limited but very much enjoyed when they occurred. Care records did not always detail what people enjoyed doing or their past histories so staff did not know what activities might interest them. People had their faith needs met.

People and those who mattered to them had their complaints and concerns responded to appropriately when they had raised issues.

There was a management structure in place and during the inspection process, roles and responsibilities of management were being reviewed. Staff told us they did not always feel listened too, supported and valued. The team were not working cohesively to provide high quality care.

There were not robust systems with regards quality monitoring processes in place. There were no audits in place to identify the concerns we found during this inspection. The registered manager had not submitted the legal required notifications to CQC to inform us of incidents or deaths relating to people living at Norfolk Villa.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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. The administration of medicine was not always safe. The recording of people's medicine administration was not always accurate.

Some people had risk assessments, some did not. Risk assessments were not always clearly linked to people's care plans. Some risks were not formally recorded to help ensure people were protected.

Infection control procedures were not in line with current guidance. People may have been at risk of cross contamination.

There were sufficient staff that were recruited safely to meet people's needs.

Is the service effective?

Requires Improvement

The service was not always effective. Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were not understood by all staff. People's assessments in line with the MCA were not always recorded.

People were cared for by staff that were not always appropriately trained or sufficiently supervised to help ensure they were able to offer competent, good care.

People's food and nutritional needs were not always met. People were not involved in planning and deciding what to eat. Allergies were not always known and people's choices, likes and dislikes were not communicated within the staff team.

People's health needs were met. People could see their GP and other health professionals as required.

Is the service caring?

Requires Improvement

The service was not always caring. People did not always have choice, control and involvement in their care and treatment.

People were looked after by staff that mostly treated them with kindness, respect and dignity however some people felt this was not always the case.

Visitors were always welcomed and family felt they were fully involved in their loved ones care.

End of life care was compassionate, but people's end of life needs were not always planned or known.

Summary of findings

Is the service responsive?

Requires Improvement 

The service was not always responsive. People's care plans were not personalised, some people did not have assessments and care plans in place. However, staff knew most people's needs well and described how their care was delivered.

Staff provided minimal time for people to remain socially active. People had their faith needs met. When activities and outings occurred, these were enjoyed.

People's complaints and concerns were investigated. The matron ensured people were happy with the outcome.

Is the service well-led?

Requires Improvement 

The service was not always well-led. The registered provider had not ensured CQC was told about incidents that affected people living at the service in line with their legal requirements.

Staff did not always feel motivated, inspired and supported by the management of the service.

There were not robust systems in place to audit and maintain the quality of the service.

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 on the 12 and 17 September 2015 and was unannounced.

The inspection was carried out by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed the information about Norfolk Villa Residential Home held by the Care Quality Commission (CQC) such as previous inspection records and notifications we had received from the registered manager. Notifications are required to be sent by the registered provider and inform CQC of any significant events about the service or people living at the service.

During the inspection we spoke with 14 people and three relatives. We observed how staff interacted with people in the communal areas. We reviewed eight people's care plans in detail to ensure they received their care as planned. Where able we also spoke with them so they could tell us about their life at Norfolk Villa. We also read other associated records about people's care such as their medicine administration records (MARs), weight records and the accident book.

We spoke with the registered provider, the matron and six staff which included the cook and cleaning staff. We were supported during the inspection by the registered provider and matron.

We reviewed the records held by the registered provider and matron that detailed how they helped ensure the service was managed effectively. This included audits, policies and procedures, maintenance records and feedback from people, family and professionals.

During the inspection we spoke with a visiting community nurse who worked closely with staff at the service. We also contacted the local authority quality improvement team and social services after the inspection.

Requires Improvement

Is the service safe?

Our findings

People did not always have their medicines managed safely. Medicine administration records (MARs) were in place but were not always correctly completed. Medicines were given to people as prescribed but some staff had signed that medicines had been administered without having observed people had taken them. For example, we found one person, whose MAR had been signed as administered, had been hoarding their tablets so there was a risk they may take them all at once. We also found gaps in the MARs which meant we were unable to know whether people had received their prescribed medicines or not. For example one person appeared not to have received their warfarin medicine on three separate occasions. This is a medicine to reduce the likelihood of developing a blood clot. The medicine should be taken daily at the same time but there was no recording of this in the person's MARs. This meant people were at risk of receiving medicines incorrectly.

People's controlled drugs were administered as prescribed but not always in line with the directions for use. For example, where people were on patches for pain relief we were unable to see how staff recorded alternating the placement of the patch. Body maps were not in use, and there was no recording on the MARS to inform staff where to place the patch. Patches which are not alternated can cause skin irritation and inflammation. The consequences of not alternating where they are applied can be discomfort for the person receiving the patch which may also lead to them removing the patch or attempting to remove the patch and so not getting the benefit of the pain relief.

People's skin creams were kept in their rooms and people told us staff always applied their creams. Some creams did not always display the date they were opened and we found gaps in the MARs and in the bedroom recording sheets. This meant there was not a clear audit trail to indicate whether people had received their creams as prescribed. We saw this had previously been highlighted with staff by the matron but improvement was not evident at the inspection. During the second day of the inspection the matron had started to check all areas of medicine management to implement improvement.

Medicine audits were in place but had not been completed recently as the matron had been away from work. Where previous audits had identified areas for improvement in recording when tablets were administered these had not been followed up and checked by management to ensure they had been actioned. During the matron's absence their responsibilities for medicine management had not been delegated.

Most of the home was free of odours and looked clean. However, three rooms where people had continence needs smelled strongly. The registered provider informed us there was no carpet cleaner at the home and an external company cleaned the carpets but they were on holiday. There was no contingency plan to ensure these rooms remained hygienic during their absence. Some staff wore aprons and gloves appropriately but this practice was inconsistent increasing the risk of cross infection to people and staff. Staff were not always knowledgeable about how to follow safe infection control techniques. For example, the cleaner cleaned the toilet without wearing any gloves or apron. We found dustbins were broken, some had no lids and others were not closed. General waste bins and the recycling bin had items in them which had been used for personal care. Areas of the home such as parts of the kitchen were not clean. We also found stained sheets and commodes in people's rooms which were not clean. We showed these to the registered provider who agreed this was not acceptable. Norfolk Villa had an infection control lead but we did not see evidence that they had undertaken recent training in this field. By the second day of the inspection cleanliness checks were being developed.

People's care and treatment was not always clearly recorded and did not always reflect assessments had been completed and their risks identified. One person was admitted to the home in July 2015. We read the person's hospital discharge summary which identified sensory needs, mobility needs, nutritional needs and cognitive needs. There were no completed assessments, care plans or risk assessments in their file. Daily records indicated concerns regarding the person's skin on 31 July 2015. There was no recording of a plan in place to manage this; the daily records did not mention the person's condition again until three weeks later. On 21 August 2015 records indicated the person's skin had broken down. Records on this date advised daily monitoring and to alert the district nurse if the person's skin deteriorated further. The next entry in their daily records was 2 September 2015 so we were unable to see from the documented evidence advice had been sought or the person's skin had improved. On the 2 September 2015, the records said a large bruise had been

Requires Improvement

Is the service safe?

noted on their back. There was no body map completed to record this, no incident form completed, and no further documentation indicating this was reported. We asked the matron how the person was, they checked the person's skin and we were informed their skin was intact.

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

Another person at the service had been at the home since October 2014. Their hospital discharge information indicated a terminal illness, cognitive problems and a risk of malnutrition. This person had a nutritional assessment completed by staff on their admission identifying risk. This information was not carried through to a care plan and there were no risk assessments in place. The person had fallen in August and bruised their head. There was no falls risk assessment in place or care plan identifying how staff should provide care to reduce the person's risk and help keep them safe. These assessments and care plans when completed, guide staff to provide the care people need to reduce the likelihood of potential risk.

A further person's care file who had been admitted to the home in June 2015, only held information from an assessment carried out by external services prior to their admission. This assessment identified sensory needs, a need to monitor the person's skin integrity, mobility needs and nutritional concerns. The lack of an assessment, care plans or risk assessments meant there was no guidance in place for staff to ensure safe, consistent care was given.

Where assessments had been completed such as skin care assessments or mobility assessments, often these were not dated or reviewed to ensure they reflected people's current care needs. Where risks had been identified we were unable to see what action had been taken by the service to protect people. For example, one person was assessed as high risk of skin damage by staff but there was no special equipment sought such as mattresses or cushions. The district nurse then advised a special mattress was required whilst visiting the person for skin damage.

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.

People told us they felt safe living at Norfolk Villa. All visitors felt their friend or relative was safe. Staff demonstrated they were knowledgeable about how to identify abuse and keep people safe. They told us they would always pass on any concerns to senior staff and the registered provider and these would be taken seriously and acted on. They advised they would blow the whistle if necessary. For example, if they were not happy their concerns were being investigated they would talk to CQC or the local authority.

There were sufficient staff on shift at any one time to help ensure people's needs were met safely. The matron explained if there was sickness "bank" staff were contacted first and then agency staff. To ensure consistency for people the same staff were asked to work they were aware of people's needs.

People were supported by suitable staff. Safe recruitment practices were in place and records showed appropriate checks were undertaken before staff began work. Disclosure and Barring Service checks (DBS) had been requested and were present in all records. Staff confirmed these checks had been applied for and obtained prior to commencing their employment with the service. A new recruitment folder had been developed to ensure thorough checks were undertaken prior to people's employment with the service.

Requires Improvement

Is the service effective?

Our findings

Some of the people who lived at Norfolk Villa lived with dementia. There were no comprehensive plans in place and records did not evidence that staff accurately assessed people's capacity to make decisions or assessed whether deprivation of liberty had been considered for people. Some records also referred to people with capacity requiring best interests meetings. People's care plans did not always contain guidance and directions for staff about how to support people when they did not have the capacity to make decisions for themselves. The registered provider confirmed one person had a DoLS application in progress with the relevant authority. The staff had correctly identified this person lacked capacity and was under constant supervision and control. However, this person had no care plan, risk assessment or any information recorded indicating the rationale for the application. There was no guidance for staff about how to support the person with decision making in any aspect of their care or treatment or how they should provide care in the least restrictive way to keep the person safe.

The Mental Capacity Act provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. The matron and registered provider had received training in the MCA and Deprivation of Liberty Safeguards (DoLS). Most staff however had limited understanding of these laws. Comments included, "Not 100% clear about it"; "Not aware of where the policies and procedures are" and "want to learn more about MCA and DoLS". This meant staff did not always have the knowledge of how to support people to make decisions about their care and treatment to enable them to follow the legal processes in place to protect people.

People's consent to care and treatment had not always been sought. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not always have their nutritional needs met although people felt the food was good "My relative always eats their meals. They have put two stone on. It's been the making of her." People received a varied diet but were not routinely involved in planning the menu and choices were limited. The cook told us they were not always informed of people's dietary needs such as their allergies or if they required a special diet. Staff were not always aware of people's preferences. They said they often found out by accident. One person at the home had allergies and had been given food they should not have eaten. They were monitored by staff following the error and on this occasion there was no ill effect. One person who was served sausages and mash, told staff they should know they didn't like this meal. Those people who required additional dietary support did not always have a care plan in place to reflect this or a risk assessment. For example, some people had been identified as being at risk of malnutrition when they had been admitted to Norfolk Villa. However, there was no evidence of subsequent nutritional assessments, care plans, risk assessments or of their weight having been monitored. Another person told us they disliked coming downstairs for meals and ate most of their meals in their room. Prior to their admission they had been neglecting themselves and not eating well. They had capacity to make this choice but felt not all staff respected this preference. There were no records in place to reflect their preference or any potential risks to guide and inform staff. We spoke with the matron about this person's concerns and this was followed up on the first day of the inspection.

Where nutritional assessments were in place, these were not reviewed regularly and there were significant gaps in people's weight records. Not completing and reviewing these nutritional assessments at frequent intervals could mean people's needs are not identified and action to minimise any health needs were therefore not taken promptly.

We fed back to the registered provider staff's concerns and by the second day of the inspection the matron had started to write a list of the people who had special dietary needs such as those who required a low phosphate diet. A meeting was due to be held with the registered provider and cook to improve the process or system of the food ordering and menu planning.

People's nutritional needs were not always assessed and their preferences, allergies and special dietary needs known. This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service effective?

Most staff received an induction to Norfolk Villa when they joined the service. The registered provider was aware of the new care certificate but this had not been started with new employees at the time of the inspection. The care certificate is an identified set of standards that health and social care workers adhere to in their daily working life to promote consistency amongst staff and high quality care. One member of staff felt disappointed by the induction and that it hadn't prepared them, another told us they had not had an induction. We found some staff undertook poor practice in areas such as infection control where they had been signed off as discussing this in their recent induction. Another new member of staff had not received moving and handling training. This could place people and staff at risk of injury.

People were supported by staff who had received some training. The MARs indicated some staff were managing medicines but had not undertaken training and had not been assessed for their competency. Not all staff had received moving and handling training prior to working with people following their induction and, for other staff, their training was out of date. Some staff had not completed food hygiene training but were responsible on a regular basis for providing meals for people. Staff had also not recently undertaken infection control training. Where people had particular health requirements such as continence needs, diabetes, and mental health needs, staff had not received training to support people's specific needs effectively. The matron confirmed staff were booked to do moving and handling training in September 2015, medicines training in October 2015 and that a care planning workshop had been organised for 19 September 2015. A deputy matron took the lead in organising training and we were informed by the registered provider they had links with organisations to provide guidance on best practice. Staff told us they wanted their training to be updated to enable them to provide the best care for people. Staff told us they could not always attend training which had been planned as they were required to find other staff to cover their own working shifts. This had a negative impact on staffs' willingness to attend training sessions.

Not all staff felt supported to carry out their roles and responsibilities. We informed the registered provider of staff feedback and a staff meeting was planned. Most staff had received appraisals but staff told us they had not had regular supervision. Staff told us they would like the opportunity of formal supervision. Staff were not communicating effectively within the team, and were not clear of their roles. For example, the cleaner did not know whether they or the care staff should be cleaning the commodes out. We spoke to the registered provider about who was responsible for this during the inspection and he intended to clarify staff responsibilities immediately. On the second day of the inspection we were informed the matron would be undertaking staff supervision and clarifying roles and responsibilities within the team.

Staff did not receive appropriate support, training, professional development and supervision. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had their health needs met and staff promptly sought advice where needed. People told us they could see their GP as necessary and were supported to attend hospital appointments as required. People saw an optician, dentist and podiatrist as required.

Requires Improvement

Is the service caring?

Our findings

People had not been involved in the planning, creation or review of their care plan to help ensure it reflected how they wanted their health and social care needs to be met, including end of life care, or evidenced their views were listened to. This meant the staff could not know whether they were meeting people's particular needs in terms of their wishes, preferences, disability or beliefs. One person commented "I would like to be more involved in what staff write about me."

Care and treatment was not planned in a person-centred way. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's records were not always kept securely. The door to the office where people's confidential personal information was stored was often left open and unlocked, which meant people's confidential files were accessible to anyone living in or visiting the home. The dining room held personal information about people, which was moved after we brought this to the registered provider's attention.

People's 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.

Staff were kind and caring when they interacted with people. A visitor told us "The staff are a lovely bunch" and a person who lived in the home told us they felt cared for commenting "I feel pretty good. My health has improved and people tell me how well I am looking." However during our observations there were many missed opportunities for interacting and engaging with people. Some staff chose to spend time together in the dining area rather than sit and speak with people. During our afternoon observation fewer than five minutes in three hours was spent talking with the many people who sat in the lounge. The registered provider told us they recognised this was an area for improvement. When staff communicated with people this was in a way which suited their needs. Most staff demonstrated familiarity and knowledge of some people's likes and dislikes. Staff spent time with people who they noticed were upset and were compassionate. Staff called people by their preferred name.

Staff showed concern for people who were not well in a caring way and spoke of people fondly, One person commented "Everybody is very kind here and good". Some people had health needs which challenged staff. However, these people's needs were not always well understood by staff. For example, people with mental health needs, including those who lived with dementia who required greater support. Staff had recognised these people's needs were greater than their own expertise. Local authority reviews had been requested by staff.

The matron told us prior to their period of absence they had visited people each morning and gave them time to express their views and check they were well. They planned to reinstate this imminently. They explained they expressed their caring attitude by trying to ensure the small things people wanted or needed were arranged. The matron said she also often sat with people, listened to them and this allowed them to share anything on their mind.

The registered provider often took people to their hospital appointments and tried to make this into an outing if they wanted that, for example, going for a drive to an area they liked following the person's appointment. Other staff who went shopping asked people if they needed anything bought for them. Special occasions were celebrated within the home such as birthdays and Christmas.

The matron gave examples of how compassionate end of life care had been given and staff understood the importance of ensuring people's wishes were known and respected. Their goal was to provide people's comfort in their last days, which included the involvement of district nurses in people's care. Family had been able to stay at the service to enable them to say their final goodbyes.

Residents' meetings encouraged some involvement with people able to contribute their ideas to the menu, outings and activities. The matron informed us this was people's space and time for discussion. The last residents' meeting had been held in July 2015.

People's dignity was respected and people were encouraged to be as independent as they were able. For example, those able to go out into the local community were supported to do this or transport was organised for them. Relatives were able to visit without restriction and the staff supported people to stay in touch with those who mattered to them and their family.

Requires Improvement

Is the service responsive?

Our findings

Some people had no assessment, care plan or risk assessments in place during the inspection. This meant staff did not have the guidance they needed to provide individualised care. Those people who did have assessments, care plans and risk assessments in place were not reviewed frequently and there was little evidence of involvement of people in these processes. It was not evident that care was appropriate or met people's needs and preferences for how they liked to receive their care.

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

However, the registered provider and staff were able to describe people's needs and how people were to be supported to have them met. All were consistent in how this was achieved and were aware of how people liked to be cared for. Staff told us shift handovers were detailed and other written communication methods supported them to keep up to date with people's needs.

We spoke with the matron and registered provider about the contrast between what staff were telling us and the care plans. They confirmed plans were in place to address the concerns raised and improvements would be made. For example, hospital passport forms were being developed; these would improve the experience people had if they required hospital admission as their needs would be known to the hospital staff. Care plans had started to be updated on the second day of the inspection. A care planning workshop was planned to educate and inform staff what was required and the matron was seeking support from external colleagues to further improve this area. In addition the matron confirmed their role would be changing to be more managerial, providing opportunity to focus on good care planning and enable record keeping to be implemented.

Most people we spoke with were happy about the care received and the staff's role in meeting their needs. We spoke with the registered provider and matron about the people who were not happy with aspects of their care and these were followed up during the inspection. People had choices and felt they could get up and go to bed when the wanted to and have a wash as they desired. Where people had care records completed we saw these did contain personal information about people's backgrounds, history and hobbies. These important aspects of people's lives prior to living in Norfolk Villa helped staff know people better and meet their individual needs.

People had their faith needs met. People were able to attend church services as they wished and the local vicar visited people at the service. Activities were occasionally provided on both a group and individual basis. Some people commented that they watched TV all day and would like more to do and one person said "I stay in my room as downstairs is dead and flat." The matron informed us they wanted to restructure the day so staff had more time to spend with people partaking in activities they enjoyed. The registered provider had purchased some quiz activities which people had thoroughly enjoyed. People were able to have their nails and hair done which made them feel good about themselves. Those who were able to go out by themselves enjoyed doing this, one person sometimes met their brother in the pub and another liked to go shopping. People told us they had thoroughly enjoyed the singers and animal visits when these had been arranged. The matron told us there were links with the school and previously children had come in to sing for people which had been appreciated. Halloween was also enjoyed with children visiting for sweets. People had enjoyed seeing the children's costumes.

The matron had systems in place to ensure people's concerns and complaints were investigated. The complaints policy was visible and there were comment cards by the entrance door if people or visitors wished to complete one. People told us they would speak to the matron in most instances. People were aware of how to make a complaint and most felt they would. A visitor commented "I would go the matron or the owner." The registered provider and matron told us they would look into any issues people raised. They would then feedback to the person or relative to ensure they were happy before the investigation was completed. One person raised a complaint with us. This was promptly investigated by the matron and was resolved to the complainant's satisfaction.

Requires Improvement

Is the service well-led?

Our findings

Norfolk Villa is owned by Mr Timothy Teasdale and he is the registered provider. Norfolk Villa is his sole service. Mr Teasdale visits the home most days and cooks the lunch three days a week. He had regular contact with the matron and deputy matrons who ran the service on a day to day basis. The matron had just returned from a period of extended leave prior to the inspection.

The registered provider and staff were unfamiliar with the recent changes in legislation (the Care Act 2014) and the new inspection methodology. We explained this to them at the start of the inspection and shared the Guidance for Providers which detailed the new regulations and expected standards. We were concerned the registered provider was not aware of their legal responsibilities.

Previous inspections in 2013 had resulted in improvement to the systems in place to monitor the quality of service provision but these had not been sustained. We identified failings in a number of areas. These included record keeping, medicine management and infection control. Environmental audits and staff daily checks which occurred within the home were not robust.

There was no evidence of recent quality monitoring of the care records to ensure they reflected people's current needs and treatment. Some people had no assessments or care plans, some care plans lacked detail and some did not have sufficient guidance for staff to follow. We found poor documentation and record keeping made it difficult to evidence care being delivered. These issues could have been identified through a formal auditing system to assess and monitor the quality of care records. The lack of robust auditing impacted on the staff's ability to be proactive in identifying risks and areas for improvement.

Where there were records of audits taking place such as medicine management audits and falls audits these were not clearly analysed and actions promptly recorded to demonstrate learning and changes had occurred. Although there were policies in place, these were out of date and did not always reflect current guidance and standards. Shortly after the inspection the matron was proactive in seeking advice from other local services to see how these areas could be developed and best practice shared.

The lack of effective systems to assess, monitor and improve the quality of the service is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Our records showed the registered provider had not returned any of the required notifications from 2011-2015. This meant CQC had not been informed of any of the incidences affecting people living at the service as required by law. Records showed people had previously had accidents which had resulted in injury and required treatment and incidents involving the police had not been submitted to CQC.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

CQC had also never received any death notifications for the same period. We had not been informed of the passing of any person whilst resident at Norfolk Villa.

This is a breach of Regulation 16 of the Care Quality Commission (Registration) Regulations 2009.

The registered provider advised they had tried to submit notifications by email and they had been returned. They were not aware they could be completed on the CQC website.

Throughout the inspection the registered provider and matron were available, helpful and facilitated the inspection. People and staff had mixed opinions on how the service was run. Staff expressed frustration by how the service was managed and did not always feel their views were always listened to, respected and acted upon. One staff member said, “I bring things to their attention and they do not listen to me.” Other staff commented they had spoken to the management of the challenges of providing care, laundry, cleaning and cooking duties but felt these had not been properly considered stating, “Things won’t change.” People and staff felt the matron was approachable and they could talk to her. We fed back the views of the staff team to the registered provider who was aware of their views and addressing these through staff meetings.

The culture at the service was not inclusive and empowering for people or staff. There was a lack of shared understanding of the challenges and concerns amongst the team. Staff said they did not always feel valued or motivated. The staff team were not working well together

Requires Improvement

Is the service well-led?

and there was a lack of clarity amongst them regarding their roles and responsibilities. For example, the day and night staff had varying views of each other's roles and responsibilities. However, despite the negative feedback by staff, many of the staff team had worked at the service a number of years.

During the week of the inspection a staff meeting was held, staff were able to contribute their agenda items and openly shared their views on areas where they felt change was required. Staff told us the meeting was helpful and they hoped improvements and actions following the discussions would be implemented. Issues we had identified following the first day of the inspection were discussed at this meeting. We were able to see these had been listened to and plans put in place to start improving areas. For example, new cleanliness checks and a list of people's dietary needs for the kitchen. Care records had also started to be audited and updated. In addition the matron advised they would now be office based to enable them time to carry out the managerial work required to maintain a good standard of care. We were informed a new management structure was to be implemented with the registered provider, matron and deputy matrons having clear responsibilities and a better understanding of their roles. The matron's vision was "To get it up to scratch, get the offices sorted out and everything in place, staff doing what they should be doing and ensuring the residents are okay – restructuring things so the girls have more time to spend with residents." The matron felt supported by the registered provider, was confident they would get the support they needed and they felt able to ask for help. They advised the registered provider was going to share more to enable them to stay abreast of changes.

The local authority had visited to undertake a quality review three months prior to our inspection. Suggested improvements had been listened to and the matron had started to gather the information and suggested templates and forms to improve the way the quality of service provision was monitored. They told us it was a challenge to stay abreast of changes with no IT in their office. We were informed they were due to get a computer as a result of staff suggestions following the recent meeting. This would help with accessing evidence based practice, information which is available for providers on websites such as Skills for Care and newsletters from health and social care organisations, and support the organisation of the service.

The service worked in partnership with safeguarding teams, the local authority and social care provision when they needed to although feedback from professionals indicated the service was isolated which affected their ability to remain abreast of changes and evidence based practice. The registered provider was considering the recommendations made by the local authority quality team. We saw help was sought when needed. For example, when the staff felt people were inappropriately placed and they were unable to meet their needs, they worked in partnership with external agencies.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 16 CQC (Registration) Regulations 2009 Notification of death of a person who uses services Notification of death of service user Regulation 16(1)(a) of the Care Quality Commission (Registration) Regulations 2009 The registered provider had not notified the Commission of any death of a person while residing at Norfolk Villa.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents Notification of other incidents Regulation 18(1)(2)(a)(b)(f) of the Care Quality Commission (Registration) Regulations 2009 The registered provider had not notified the Commission of any serious injury, or incidents involving the police.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Need for consent Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People's consent to care and treatment had not always been sought. The legal framework of the Mental Capacity Act had not always been followed.

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Safe care and treatment Regulation 12(1)(2)(a)(b)(g)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Risk assessments were not always in place as necessary, updated, and reviewed. Risk assessments were not always reflective of people's individual needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs Meeting nutritional and hydration needs Regulation 14(1)(2)(4)(a)(c) People's nutritional needs were not always assessed and known by the staff. Food was not always provided to meet people's specific dietary requirements such as their allergies.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Person-centred care Regulation 9(1)(3)(a)(b) People had not been involved in assessing their needs and preferences for care and treatment. Care and treatment had not been designed in a way to ensure this was appropriate, met people's needs and reflected their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Action we have told the provider to take

Staffing

Regulation 18(1)(2)(a)

Staff did not receive appropriate support, training, professional development and supervision to enable them to carry out the duties they were employed to perform.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements 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 HSCA (RA) Regulations 2014 Good Governance The systems were not in place to monitor the quality of service and safety of the service to ensure the care people received was effective. We found people's risks had not always been assessed and monitored. Regulations 17(1) (2) (a), (b), (c), (d) and (f).

The enforcement action we took:
We issued a warning notice.
We have told the provider they are required to become compliant with the Regulation by 24 November 2015.