County Care Homes Limited

Norwood House

Inspection report

Littlemoor Road
Middleton Moor
Saxmundham
Suffolk
IP17 3JZ

Tel: 01728668600
Website: www.countycarehomes.co.uk

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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 well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Norwood House is a residential care home providing accommodation and personal care up to 71 people aged 65 and over in one adapted building. Norwood House provides care to older people living with dementia and at the time of the inspection there were 35 people using the service. The service was situated in a rural area of Middleton Moor on the periphery of the village of Saxmundham in Suffolk.

People's experience of using this service and what we found

The leadership and governance of the service did not ensure that a good quality service was delivered. The service has not been rated Good overall since its first rating in 2016. Repeated action plans had not delivered improvement.

Staff training was not always up to date. This put people at risk if staff were not equipped to recognise and report abuse appropriately. Staff did not receive regular supervision of their practice. They also told us that their training was outdated and they would like to receive more practical training to enable them to provide people with effective support.

Risks to people from receiving care and support were assessed however, care plans did not reflect that actions to mitigate the risk were taking place.

Documentation to keep people safe was not always up to date, for example the master record for evacuating people in the case of an emergency was not correct. Risk assessments for the building had not always identified risks that we found.

The mealtime experience for people was poorly managed. We observed staff supporting several people at the same time with their meal. Recording of people's food and fluid intake was poor.

Although the provider had made improvements to some areas of the environment since our last inspection, areas of the environment were not safe.

Some staff expressed concerns regarding the staffing levels. The provider told us they used a dependency tool to assess the required amount of staff. Staff were recruited safely with relevant checks on their history carried out.

Relatives were not always clear about the visiting arrangements in place. People said that making an appointment to visit was difficult.

Medicines were recorded and administered safely.

The mealtime experience for people was poorly managed. We observed staff supporting several people at the same time with their meal. Recording of people's food and fluid intake was poor.

Although the provider had made improvements to some areas of the environment since our last inspection, areas of the environment were not safe.

The manager was clear about their responsibilities under the duty of candour. Visiting professionals said that the service worked well with them.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was requires improvement (published October 2021).

At the last inspection we recommended that advice be obtained from an appropriate source on developing observational audits to further develop the quality and safety of the service people received. The provider had put observational audits in place, but these had not resulted in improvements and had not identified the shortfalls we found at this inspection.

Why we inspected
This inspection was prompted by a review of the information we held about this service and to follow up on the previous inspection findings.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

You can see what action we have asked the provider to take at the end of this full report.

We have found evidence that the provider needs to make improvements. Please see the safe, effective and well-led sections of this full report. You can see what action we have asked the provider to take at the end of this full report. The provider has told us that they have taken action to mitigate the risk identified.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Norwood House on our website at www.cqc.org.uk

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to how the service identified and monitored risk and the overall management of the service.
Full information about CQC's regulatory response to the more serious concerns found during inspections is

added to reports after any representations and appeals have been concluded.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe.	**Requires Improvement**
Is the service effective? The service was not always effective.	**Requires Improvement**
Is the service well-led? The service was not well-led.	**Inadequate**

Norwood House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors and a specialist professional advisor in dementia care.

Service and service type
Norwood House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Norwood House is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. A new manager had been in post for three weeks and had submitted an application to register. We are currently assessing this application.

Notice of inspection
This first day of the inspection was unannounced. We made an appointment to attend on the second day so

that we could meet with the provider.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
Not everyone living at Norwood House was able to tell us their views of the service. We spent time observing the interactions between people and staff in communal areas, in order to help us understand people's experiences.

During the inspection visits we spent time observing care to help us understand the experience of people who could not talk with us. We reviewed five peoples care plans. We also looked at medication records and three staff files in relation to recruitment. We reviewed accident, incident and safeguarding processes and a variety of records relating to the management of the service. This included provider improvement/action plans.

During the inspection visits we spoke with five people, one relative, five staff, a visiting healthcare professional and an advocate. After the inspection visit, we received electronic feedback from six relatives and nine staff. We also spoke with one relative by telephone

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

● Risk to people from receiving care and support were assessed and this was recorded in their care plan. However, the actions recorded in the care plan to keep people safe were not always taking place. For example, for one person assessed as at high risk of developing pressure ulcers and with a history of slow healing, repositioning was not taking place in line with the care plan.

● Care plans detailed actions and outcomes, but the information was not always consistent. One care plan detailed a person was at high risk of falls and they required supervision when mobilising. The next section reported they were fully independent on stairs and when walking about the service. When we visited, the person was not receiving any supervision when walking about close to a staircase with unrestricted access. Staff would have been unaware had they fallen as this person is living with dementia and unable to call for help.

● Some stair wells in the service had restricted access. However, access to one stairwell to a first floor where people had bedrooms was not restricted. People in the service had been assessed as being at a high risk of falls. However, there was not a risk assessment in place for all people regarding the access to the stairs which could increase people's risk of falling and cause harm.

● The upstairs corridor has unused curtain hooks screwed into the wall. These could act as ligature points. One person living with dementia regularly walked the corridor, running their hands along the walls and rails, the hooks presented a risk as they could catch and hurt their fingers.

● Each person had a personal evacuation plan. However, the master document to be used if the service was evacuated was not up to date. Some people were not on the list and there were people on the list who no longer lived in the service. This could cause confusion and avoidable delays in event case of an emergency.

● One member of staff who administered medicines had made repeated medicines errors. They had received a supervision from the registered manager in place at the time after each incident. However, nothing had been put in place to help them improve their practice.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Reports were completed when people had a fall. These were regularly reviewed, and referrals made to the appropriate agency when required.

Staffing and recruitment

● The provider told us that they used an assessment tool to determine the number of staff needed to meet

people's needs. They said staffing levels were regularly reviewed and staff numbers increased if people's needs increased.
● The majority of staff contacted expressed concerns regarding staffing levels and the impact this was having on the care provided. The rota demonstrated that on the majority of days the service had met its assessed staffing levels. The provider told us that they were actively recruiting more staff and had had a good response to recent advertisements.
● All required checks had been completed before staff began working at the service. These included Disclosure and Barring Service (DBS) checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions

Using medicines safely
● Medicines were stored safely, including those that required refrigeration. Numbers of controlled drugs in stock agreed with the records. The medication room was clean, and well ordered.
● Staff confirmed they had received training to administer medicines.
● Medication administration records (MAR), included information about people's allergies and medicines to be administered as required (PRN). Staff were observed to safely administer medication and offer PRN pain relief.
●The member of staff observed administering medicines told us the service did not use a standardised pain assessment tool as most people were able to tell them when they wanted pain medication. However, care plans reviewed recorded that people were not always able to express their feelings. One person's care plan specifically recorded that a pain assessment tool should be used.
● We found for one person a discrepancy between the topical cream administration chart and the care plan. The care plan recorded that barrier creams should be applied at every continence pad change. However, the topical MAR chart stated barrier creams should be administered PRN.
● One person was prescribed medication at 9am and 9pm. They were often asleep for the 9am dose. Staff gave this later in the day and adjusted the time of the evening dose accordingly. However, the MAR did not reflect the actual times given and there was no information of when a missed dose should be withheld to prevent two doses being administered too close together.
● Body maps were used to record the application of topical medications such as creams and patches. This ensured medications were administered in the correct places and patch sites were rotated to avoid breakdown of the person's skin.

Systems and processes to safeguard people from the risk of abuse
● There were systems and process in place to monitor and record safeguarding incidents. Staff spoken with told us they would report any concerns to the team leader.
● Staff spoken with said they had completed e-learning training that included safeguarding adults. However, records demonstrated that only 20 of 42 staff were up to date with this training. Out of date training meant that safeguarding incidents may not be recognised and reported by staff.
● People told us they felt safe living in the service. They said staff were attentive and they were supported to use aids and equipment safely.
Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was supporting people living at the service to minimise the spread of infection.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was responding effectively to risks and signs of infection.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes

● Relatives spoken with were unclear about visiting procedures. One relative said, "We can book to see [person] when we want but are still limited to seeing [person] in the reception area, which is understandable, but does limit our view of the care as a whole." Another relative said, "There is never anybody on reception now. You have to do your own COVID test and temperature and record yourself. Visiting is still restricted. You have to make an appointment for an hour. You are kept in the lounge by the door. It takes days to get through on the telephone to make an appointment."

●Government guidance on visiting in care homes is clear. It states, 'Contact with relatives and friends is fundamental to care home residents' health and wellbeing and visiting should be encouraged. There should not normally be any restrictions to visits into or out of the care home.'

● The provider told us that there were no visiting restrictions in place although they did like relatives to let them know they would be coming. They told us they would review the visiting arrangements and ensure that communication went out to relatives so that they were clear about visiting arrangements.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- Staff had face to face manual handling training and completed a programme of e-learning modules to cover mandatory requirements such as infection control, safeguarding, equality and diversity. However, records demonstrated that staff were not always up to date with training requirements. For example, only 27 of 42 staff were up to date with dementia training. A member of staff told us they were aware they needed to complete their e-learning, but they did not get time to do this whilst on shift
- Staff told us they would like more condition specific training such as dementia care, mental health, epilepsy and seizures and Parkinson's disease as they found it difficult to apply the learning from the basic online courses to real life care.
- Staff also told us the online training was a 'little outdated' and did not help them meet people's care needs . For example, disrespectful terminology was used to describe people such as; 'fully wheelchair bound', and 'suffering from cognitive impairment'.
- Care plans stated the team leader must be informed before 'as required' medicines were given to manage behaviour. The team leader had had no additional training in supporting people with behaviours that may challenge or managing distress in people living with dementia.
- Staff recording in daily notes was brief and did not record a persons' overall wellbeing. Staff had not been trained to fully record their actions.
- Staff did not receive regular one to one or supervision meetings to discuss their practice. The manager told us that this was something they had identified and had plans in place to address.

Supporting people to eat and drink enough to maintain a balanced diet

- People told us, they enjoyed the meals, there was always plenty to eat and it was tasty. One person said the chicken and plum sauce followed by walnut cake and custard was 'exceptional'. They also enjoyed a glass of beer with their meal.
- People who required assistance were supported by staff to eat and drink at lunchtime, but several people had to wait over thirty minutes for their meal to be served.
- Where people were identified as being at risk of malnutrition and dehydration care plans showed they were monitored through being weighed regularly and the use of food and fluid charts used to record intake.
- However, recording on these charts was poor. Fluid charts showed that one resident consistently failed to meet their daily target, but it was not clear what steps care staff took to address this. Food charts did not demonstrate exactly how much food was eaten
- Where a person had been identified as at risk of weight loss the food chart did not demonstrate what if any additional food had been offered.

● Staff were observed to be supporting more than one person with their meal. This made the meals meal disjointed and a less enjoyable experience. Some people were left for an extended amount of time before receiving their meal. It was unclear as to whether this was due to lack of staff or poor deployment of staff.

Adapting service, design, decoration to meet people's needs
● There were dementia specific adaptions within the service. For example, personalised door decorations to help people locate their room. However, newer residents had not had their name plates added to their doors, so it was not always possible to tell which rooms were in use and which were empty.
● Contrasting colour tablecloths were used in the dining room on some tables, which made it easier for people with visual spatial impairments to see their plates and cups
● There were communal areas for people to sit and spend time with friends and family.
●There was a garden and outdoor spaces available for people to use. However very few people had shoes or slippers on, one person went outside in her socks.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● The majority of staff were not up to date with training in the MCA. A good understanding of the MCA is essential to provide effective dementia care.
● There was no evidence of supported decision making. People and their relatives were unable to tell us how they had been involved in creating their care plan
● Care plans for two people recorded that they may refuse personal care. The care plans and best interest records stated, recorded that staff could carry out personal care against the persons wishes when they were refusing and in need of care. There was nothing to elaborate on how staff should provide care against that person's wishes in a safe and dignified manner. Training records did not show that staff had received training on how to intervene in this way.

Where somebody did not consent to care, staff were not supported to understand what action they should take. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● The manager told us that they visited people before they moved into the service to ensure the service could meet their needs and that a care plan was written as soon as possible after they moved into the

service. However, we found for one person who had moved into the service three weeks prior to our inspection visit the service was using the care plan from their previous service. We note that they had had less episodes of anxiety and distress since moving into Norwood House.

● Although the needs of people living with dementia had been assessed and we observed equipment such as twiddle muffs available to engage people these were not used during our inspection. Paper and paint brushes were left on a table in the middle of the lounge but there were no chairs at the table and no paints, colours or pencils, and no one was supported to take part in any activity there.

● Staff told us activities were now all 1:1 at the previous managers direction. They reported they did not have time to provide 1:1 activity themselves and felt people used to benefit from the group sessions such as the exercise group. Staff said people had taken part in activities such as archery and ball games and these had stopped.

● The system for reviewing care plans did not demonstrate how people had been involved in the review of their records. Handwritten updates were added to care plans when people's health or needs changed but not all areas of the care plan were updated leading to conflicting information, for example about the risk of falls. The home is currently migrating to electronic records.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● People were referred to external services such as speech and language therapist when required.

● One healthcare professional told us that staff were helpful when they visited but they did not always understand their responsibility for responding to people's healthcare needs. They gave an example of a person with a pressure ulcer who required a low-profile bed, but staff did not realize that they should take action to provide this.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The provider had failed to ensure robust systems and processes were in place to monitor people's health, safety, welfare and the quality of care.
- The service was registered with the CQC in December 2010. It has been inspected eight times since registration. Despite successive action plans the provider has failed to achieve a rating of good
- The provider told us that they undertook regular visits and audits of the service. However, they were unaware of changes made by the previous registered manager for example cancelling group activities and the manner of labelling people's clothing.
- There had been three registered managers of the service in the past two years. This high level of turnover meant systems and process had not become embedded leading to improvement in the service.
- Staff were committed to achieving good-quality care but were limited by a lack of oversight and effective response to the management of the service by the provider. Staff felt supported by the head of care, but they were unsure of people's roles and responsibilities within the service. For example, regarding writing and updating care plans, and ordering equipment.
- The service did not maintain up to date and complete records in respect of people's care.
- Staff had not received regular supervision and feedback regarding their performance. Where poor performance had been identified there had not been a proportionate response. The new manager had begun to implement regular supervision meetings for staff.
- The provider told us that they had recently visited other care homes in the area to view the dementia care provided there. The manager told us they used various sources to keep their knowledge up to date including online courses and intranet alerts. However, we did not see this had been translated into practice in the service.
- Relatives told us that they did not feel the service was well-led. When asked about the management of the service a relative said, "Management, there is none." Another relative fed back, "At present I do not know who the manager is. This position seems to be a problem with a turnover of managers and assistant managers over the past six months. Quite often on visiting there is no manager or assistant manager. It says a great deal for the caring staff that the place still functions."

Systems had not been established to effectively manage and improve the service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good

outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Staff were caring on an individual level but the leadership in the service had not developed this into a positive culture person centred culture. For example, some people had their bedroom number written in pen and clearly visible on their socks. We also observed people left in clothes protectors for an extended amount of time after their lunch.

● In addition, we observed people complained several times of the same thing before staff acted. One person was brought to the lounge, they said they required personal care twice on the way, the staff member proceeded to help them transfer from the wheelchair when it became apparent their clothes and the seat cushion were soaked through. They said, 'I've been telling you I [needed personal care], I've been [needing it] for hours. The staff member then took them back to their room and helped them to change before returning to the lounge. Observation of this by inspectors suggested it was a part of the culture.

● People's equality and human rights were not always respected. Language used in care plans was not always person centred and did not value people. The risk assessment for locking people's rooms when they leave them stated, "Residents who live with dementia can become agitated when they enter a room that is not familiar and can become destructive." This suggested the person's response to distress was wrong rather than highlighting how the person could be made to feel safe.

● Deployment of staff within the service was poor. For example, there were quiet lounges but there was no clear plan of delegation to ensure people received appropriate supervision when using these spaces. People were often alone in the lounge for an extended period, especially during lunch time. One resident sat alone in the main lounge for 45 mins while others were being served lunch.

● The registered manager had left the service shortly before our inspection. The provider had employed a new manager who was enthusiastic and told us about improvements they planned to make.

● The new manager had applied to register with the CQC. They would be the tenth registered manager since the service first registered December 2010 and the fourth registered manager in the past four years.

Working in partnership with others

● We received feedback from a professional who stated they were happy with their relationship with the home, that they felt the staff knew people well and they always appeared to be well cared for.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● Relatives told us they were informed promptly if there was an incident involving their family member. One relative told us that the appropriate action had been taken.

● The manager had a clear understanding about their responsibilities under the duty of candour and knew how to act if things go wrong.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Where somebody did not consent to care, staff were not supported to understand what action they should take.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service This placed people at risk of harm.

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 Systems had not been established to effectively manage and improve the service.

The enforcement action we took:

Warning notice