County Care Homes Limited

Norwood House

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?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Norwood House provides accommodation and personal care for up to 71 people, the majority living with dementia.

There were 54 people living in the service when we inspected on 11 April 2016. This was an unannounced inspection.

The registered manager had recently left the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Improvements were needed to ensure that people were provided with their medicines when they were prescribed.

Staff were trained in the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). However, people's care plans did not sufficiently identify which areas of their care they could consent to and which areas they needed assistance with. DoLS referrals had not been kept under review to ensure any restrictions met people's current needs.

Improvements were needed in people's care records to identify people's specific conditions and how they impacted on their daily living. Some care records had not been kept up to date and were contradictory in parts. Improvements were needed in how people's anxiety and incidents were used to plan and provide people's care.

A complaints procedure was in place. Records of complaints were not all complete.

The service's quality assurance system was not robust enough to independently identify shortfalls and address them. The service was not up to date with their responsibilities under the Duty of Candour.

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

There were systems in place to safeguard people from abuse.

Staff were trained and supported to meet the needs of the people who used the service. Improvements were ongoing to ensure staff were provided with regular supervision meetings. Staff were available when people needed assistance, care and support. The recruitment of staff was safely completed to make sure that they were suitable to work in the service.

People's nutritional needs were assessed and met. People were supported to see, when needed, health and social care professionals to make sure they received appropriate care and treatment.

Staff had good relationships with people who used the service and were attentive to their needs. Staff respected people's privacy and dignity and interacted with people in a caring, respectful and professional manner. People were provided with the opportunity to participate in activities which interested and stimulated them.

Prior to our inspection, the service had notified us of an incident that had occurred in the service. During our inspection visit we looked at the actions taken to reduce the risks of similar happening again and the action the provider had taken as a result of this. We are in the process of considering our regulatory responsibilities and action. If we do take further action we will report on this.

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.

There were systems in place to safeguard people from abuse.

Improvements were needed in how people were provided with their medicines as prescribed.

Staff were available to provide assistance to people when needed. Recruitment checks were completed to make sure that people were safe.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were trained to meet the needs of the people who used the service. Improvements were ongoing in the provision of staff supervision meetings.

People's records did not hold sufficient information about people's capacity to make decisions and the assistance they needed if they lacked capacity.

People's nutritional needs were assessed and professional advice and support was obtained for people when needed.

People were supported to maintain good health and had access to appropriate services which ensured they received ongoing healthcare support.

Is the service caring?

Good

The service was caring.

People were treated with respect and their privacy, independence and dignity was promoted and respected.

People and their relatives were involved in making decisions about their care and these were respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care records were contradictory in parts and lacked detailed information about specific conditions. Records of people's behaviours were not sufficiently used to ensure that their individual care was planned and delivered in a way which reduced their anxiety.

People were provided with the opportunity to participate in meaningful group and individual activities.

Records of concerns and complaints were not complete and did not show that all were addressed and used to improve the quality of the service.

Is the service well-led?

Inadequate

The service was not always well-led.

The service's quality assurance system was not robust enough to independently identify shortfalls in the service provided to people.

The provider was not up to date with their responsibilities regarding the Duty of Candour.

Norwood House

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.

This inspection took place on 11 April 2016, was unannounced and undertaken by two inspectors and an Expert by Experience. An Expert by Experience is a person who has experience of using or caring for someone who uses this type of service. The Expert by Experience had experience of older people and people living with dementia.

We looked at information we held about the service including notifications they had made to us about important events. We also reviewed all other information sent to us from other stakeholders for example the local authority and members of the public.

We spoke with ten people about their experiences of using the service and five people's relatives. We used the Short Observational Framework for Inspections (SOFI). This is a specific way of observing care to help us understand the experiences of people. We also observed the care and support provided to people and the interaction between staff and people.

We looked at records in relation to six people's care. We spoke with the two acting managers and six members of care staff. We also spoke with two visiting health professionals. We looked at records relating to the management of the service, staff recruitment and training, and systems for monitoring the quality of the service. We received positive feedback about the service from the local authority. They told us that they had undertaken an adult social care outcome toolkit visit the month before our inspection. This had been a positive visit with good outcomes for safety, social participation and dignity.

Requires Improvement

Is the service safe?

Our findings

The management of medicines was not consistently safe. People were prescribed medicines that were to be administered when required (PRN), such as pain relief and medicines to support them at times of anxiety. Protocols and care plans were not detailed enough to show when PRN medicines should be considered, for example one protocol stated the medicines should be administered when the person showed, "Signs of anxiety." Each person shows anxiety in different ways and the specific indicators for each person should be identified to provide effective and safe guidance for staff. One person had their medicines changed and there was no PRN protocol in place for the new medicine and the previous one was still on file. Another person was prescribed with PRN medicines and there was no protocol in place. Although staff said that they knew people well, the lack of information did not ensure that staff would all recognise and provide the care needed consistently.

We found some gaps in the medicines administration records (MAR) and asked a staff member how these were checked. They said that team leaders checked the MAR after handover and left a note to the team leader on duty when the gaps occurred to make sure they were investigated and addressed. However, in the cases we found, there were no notes and the gaps had not been explored. This is important to demonstrate if medicines had been administered or not. Records of the administration of prescribed creams were not completed appropriately and in line with their prescription. An acting manager told us that they would address this to ensure that people received these where required.

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

Despite concerns about the oversight and records for medicines, people told us that they were satisfied with the way that they were supported with their medicines. One person said, "I always get my tablets when I need them." Another person told us, "They always make sure I take my medicine on time." One person's relative said, "They always make sure [person] gets [person's] tablets when [person] needs them." Another person's relative commented, "[Person] certainly gets [person's] medication on time and there has never been a problem."

We observed part of the lunchtime medicines round and found that people were provided with their medicines safely.

A staff member showed us the systems in place to dispose of medicines safely, which was confirmed by records. Regular temperature checks were undertaken to make sure that medicines were stored safely. Where people were prescribed with medicines with variable doses, such as, one or two tablets, the amount administered was recorded. Records also showed that medicines in the form of patches were put on alternating parts of the body to ensure effectiveness. Controlled medicines were appropriately stored and recorded. We checked the amount of controlled medicines stored against the records and found that they were correct.

Care records included risk assessments which provided staff with guidance on how the risks to people were minimised. This included risk associated with mobility, pressure ulcer prevention and behaviours that may pose a risk to themselves and others. Where people were at risk of developing pressure ulcers records showed that there were systems in place to reduce these risks, including ensuring they were supported with their continence and used pressure relieving equipment. One of the acting managers told us that there were no people living in the service who had pressure ulcers.

One acting manager told us that people's bedroom doors were locked when they were not present to ensure that their personal belongings were safe. They also told us about how they ensured that people were kept safe in the service. For example, guidance given to staff not to move one person's furniture in their bedroom to allow them to mobilise safely.

Electrical equipment and hoists had been serviced and checked so they were fit for purpose and safe to use. Information was available for staff in each person's care records on how they were to be supported to evacuate the service safely in case of an emergency.

People told us that they felt safe living in the service. One person said, "I do feel safe here. They really do look after me well." Another person told us, "I do feel safe in the home and have no worries at all." One person's relative said, "[Person] thinks it is like [person's] home. [Person] feels very safe here." Another person's relative commented, "I have no worries about my [relative's] safety [person] is really well looked after and [person] is very content here."

Staff told us that they felt that the people who used the service were safe. One said, "If I would not put my family in here, I would not work here."

Staff had received training in safeguarding adults from abuse. They understood the policies and procedures relating to safeguarding and their responsibilities to ensure that people were protected from abuse. They knew how concerns were to be reported to the local authority who were responsible for investigating concerns of abuse.

People told us that there were enough staff to meet their needs. One person's relative said, "[Person] never has to wait for anything. [Person] can get it when [person] wants it." One health professional commented, "They [staff] are very busy and they work very hard. There is no evidence of anyone suffering because they are busy. They go the extra mile for their patients."

Staff said that there were enough staff to make sure that people's needs were met and they were safe. One said, "We could always do with a couple more, but we do our best for the residents, we work hard and help each other." Another staff member commented, "Residents are happy and well looked after." Another said that sometimes they were short, due to short notice absence of colleagues. They told us that when this happened other staff were approached to cover and trade days off, which worked.

Prior to our inspection we had received a concern via our website which stated that the staffing levels were low at weekends, including management cover. Minutes of a staff meeting on 15 March 2016 stated that staff were concerned because of the lower numbers of staff at weekends. Staff felt that they could not train/guide new staff properly because there were not enough staff on shift. The acting managers said that they had addressed a recent shortfall in staff and were now fully recruited. They told us that they had also planned an open day for recruitment and they were trying to establish links in the community with the local college and sixth form to recruit staff. Following our inspection visit the provider sent us the dependency levels tool which was used to calculate the numbers of staff needed against people's needs.

Records showed that checks were made on new staff before they were allowed to work alone in the service. These checks included if prospective staff members were of good character and suitable to work with the people who used the service. Staff confirmed that they were not allowed to start working in the service until their references and checks had been received. One staff member told us that new staff had recently been recruited and they were waiting for their checks to come back before they could start work.

Requires Improvement

Is the service effective?

Our findings

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

People can only be deprived of their liberty 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). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. An acting manager told us that they were waiting for approval of DoLS referrals from the local authority. They understood when applications should be made and the requirements relating to MCA and DoLS. Staff were provided with training in MCA and DoLS and understood how the principles of these and how they were important when caring for people using the service.

One person's records showed that a referral had been authorised and was due to renewal in 2017. However, the other care records we reviewed showed that DoLS referrals had been made in 2014, there was no follow up information to show where they had been reviewed or further referrals had been made in line with people's changing capacity. The care plans we looked at during our inspection did not clearly identify people's capacity, how this impacted on their daily living and the arrangements in place to assist people with their decisions. The records were contradictory in parts, for example one person's records stated on their immediate legal information sheet that there was no DoLS in place, but on the DoLS form it stated a DoLS referral had been sent October 2014. No further information was in place to show if this had been authorised or not or if it was kept under review. Another person's records showed that there had been a DoLS referral sent in 2014, again no further information was in place. Following our inspection the provider wrote to us and said that their records relating to DoLS would be reviewed.

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

People described how staff always spoke with them before starting their care and made sure that they were happy with what they were doing. One person commented, "They [staff] are all very polite and always ask me if it is alright when they help me." Another told us, "I can tell them to go away if I don't want to do anything and they listen." Another person commented, "They always speak to me when they are doing things for me and make sure I am happy with it." One person's relative said that the staff, "Always ask if it is okay to do things for [person]."

We saw that staff sought people's consent before they provided any support or care, such as if they wanted to participate in activities, what they wanted to do and where they wanted to spend their time. However, care records did not identify how people or their relatives, where appropriate, had consented to the care

provided and the contents of the care plans. This would evidence that people had formally been asked for their consent about the care that was planned and provided.

We received varied comments about the skills of staff. One person told us, "They certainly know what they are doing and ask if that is alright for me." Another person said, "I think the staff generally know what they are doing." Another said, "I think they are well trained." One person's relative commented, "The [staff] certainly know how to look after my [person]." Another said, "The skill quality of the staff is a bit variable. The more experienced staff are very good but some are less experienced and it shows by the way they care for [person]." Another commented, "Some staff need to be trained to understand how to communicate with residents. They need to understand what make them tick and what their interests are."

The provider had systems in place to ensure that staff received training and achieved qualifications in care to improve their practice. An acting manager said that all staff were provided with training, which meant that they could support people's assessed needs whenever needed. This was confirmed by staff. One told us that they sometimes worked as care staff and other times as a dining room assistant. This provided staff with the knowledge and skills to understand and meet the needs of the people living in the service. Staff understood their work role, people's individual needs and how they were met. We saw that the staff training in supporting people with their anxiety was effective because they had identified when the risks of people's behaviours that may challenge others and took swift action to divert them. However, one staff member told us that they would like more training in this subject. We spoke with the acting managers who told us they had recognised training specific to the people they supported was needed and were working on providing it. A local authority staff member told us that the manager had requested that they provide support to the staff team in moving and handling which was planned for the week of our inspection.

An acting manager told us that staff had started working on the new Care Certificate as part of their induction. This showed that they had kept up to date with changes to training requirements in the care sector. One staff member told us that they felt that their induction prepared them well for their role. This included training and shadowing more experienced staff until they could work alone.

Staff told us that they were supported in their role. One staff member said that the provision of supervision meetings had improved recently because they were not always getting them regularly previously. Records confirmed what we had been told. An acting manager acknowledged that this had been identified as needing improvement and staff had not had as many supervision meetings as they should have had. Supervision meetings provide staff with a forum to discuss the ways that they worked, receive feedback on their work practice and used to identify ways to improve the service provided to people. We saw notes of meetings where performance issues had been addressed.

People were supported to eat and drink sufficient amounts and maintain a balanced diet. People told us that they were provided with choices of food and drink. One person said, "I get a wide variety of choice of food which I like. I can have a drink whenever I want by just asking." Another commented, "The food is alright and I am happy with it and I can choose what I want. They always give me a pot of coffee after lunch which I really enjoy." Another person said, "The food is really nice and I have a special diet as I am diabetic." One person's relative commented, "The food is really good here and [person] can get what [person] wants for [person's] meals." Another told us, "The food is very good and they understand my [relative's] food allergies."

During lunch we saw that a choice of two meals were offered, with the option to choose something else if people did not want what was on the menu. This included salads, omelettes or sandwiches. People were offered choices of hot and cold drinks throughout our visit, including during meals. People were assisted

with their meals, at their own pace, by staff where needed.

People's records showed that people's dietary needs were assessed and met. Records were kept of what people had to eat and drink each day. Where issues had been identified, such as weight loss and difficulty swallowing, guidance and support had been sought from health professionals. This included a dietician and/or speech and language therapist, and their advice was acted upon. For example, providing people with food and drinks to supplement their calorie intake.

People's health needs were met and where they required the support of healthcare professionals, this was provided. One person said, "I can get to see the doctor whenever I need one. So far I am pretty healthy." Another commented, "I do see the doctor who is keeping a check on me." One person's relative told us, "If [person] needs a doctor or the district nurse that can be arranged." During our inspection we saw that health professionals visited people as arranged. One health professional told us, "They are very good at contacting us if they see anything of concern. We work well together. It is a year since I have been coming here and I have no concerns."

An acting manager told us that the doctor from a local surgery visited every Monday and Friday. There was good support from the surgery and they had their own dementia clinic so they had a lot of knowledge about people's diverse needs. The acting manager also said that they liaised with the Parkinson's disease specialist when needed.

Records showed that people were supported to maintain good health, have access to healthcare services and receive ongoing healthcare support. Records showed that people were provided with treatment from health professionals including a chiropodist, doctor and community nurse where required. Where concerns about people's wellbeing were identified, guidance and support from health professionals were sought promptly.

Good

Is the service caring?

Our findings

People told us that the staff were caring and treated them with respect. One person said, "They [staff] are really thoughtful." Another commented, "The [staff] who look after me generally know what they are doing and are always polite and use my first name which I like." Another person said, "They do care for me and they do speak nicely to me." Another told us, "The staff are brilliant and very caring. Nothing is too much trouble. They are always respectful and polite to me." One person's relative said, "They treat [person] so well and are very respectful." Another person's relative commented, "They generally are polite but some speak to [person] a little too much familiarity calling [person] 'lovey'." This was confirmed in our observations. We spoke with the acting managers about the use of terms of endearment and they told us that they would ask people if they were happy with this.

We saw that people's choices, independence, privacy and dignity was promoted and respected. For example, staff asked for people's permission to open a window. Staff knocked on bedroom doors before entering. People were able to make choices throughout the day. One person chose to watch television for most of the day. A few people chose to reside in their bedrooms whilst the majority chose to spend most of the day in the main lounge involving themselves in the planned activities. Staff encouraged people's independence and respected their abilities. One person said, "They help to keep moving and make sure I can do as much for myself as possible." A local authority staff member told us that a recent visit showed that the service had scored highly in ensuring people's dignity.

We saw that the staff treated people in a caring and respectful manner. People were clearly comfortable with the staff, they responded to staff interaction by smiling, laughing and chatting to them. When communicating with people, staff were patient allowing people time to express their views, positioned themselves at eye level and checked with people their understanding of what they had been told. We did note an interaction which was not professional and we spoke with the acting managers about what we had seen. They assured us that this would be addressed.

Staff talked about people in a caring and respectful way both when speaking with us and each other, such as in the handover meeting. The handover meeting was used for the staff at the end of their shift to tell the oncoming staff what had happened and about people's wellbeing. They were knowledgeable about people's individual needs, conditions and preferences. This was confirmed by people and relatives. One person said, "They clearly know what I like and they always make sure I get it." Another person commented, "They make sure you get what you like which makes a difference." One person's relative said, "They do understand my [person's] likes and dislikes even when [person] tells them [person] is a vegetarian, when in fact [person] is not."

People's views were listened to and they were taken into account when their care was planned and reviewed. One person said, "The staff are very caring and are very polite and allow me do what I want to do. I enjoy reading the newspapers." Another commented, "They do care well for me. They always make sure I get what I want when I need it. They always speak nicely to me." People's relatives told us that they were involved in organising and planning their relative's care. One said, "We organised the care for [person]

together, so [person] was directly involved in the choice." Relatives told us about informal discussions with the previous registered manager to evaluate their views of the care. A number of staff were observed speaking with relatives about their relative's progress and wellbeing.

People's bedrooms were personalised and reflected their choice and individuality. People had the opportunity to include personal items of decoration and furnishing to personalise their space. Each person's bedroom door had a box that contained items to describe them and their past. Most contained photographs of the individual together with memory items.

Requires Improvement

Is the service responsive?

Our findings

Some information in care plans was person centred and reflected the care and support that each person required and preferred to meet their assessed needs. These records provided staff with guidance on how people's needs were met. Improvements were needed because there was limited information about how these affected their daily living. For example, Parkinson's disease and stages and types of dementia. Some care plans and risk assessments had been reviewed monthly. However, some had not been reviewed since November 2015.

There were also inconsistencies in people's care records, which could be confusing to staff when providing care. For example, one person's records stated that there was no advanced care plan, relating to their end of life wishes, in place, but there was. Another person's care records associated with nutrition stated, "Does not have specific nutritional needs at this time," but on the same sheet it said, "Diabetes diet controlled."

An acting manager had told us about the specific details about one person's needs but, when we checked this in their care plans there was no reference to what we had been told. Without this information in the care records we could not be assured that all staff were made aware of how the person's history reflected on their current care needs.

People's care plans included information of causes of their anxiety and distress and how staff should support them to reduce their anxiety. However, behaviour charts, used to identify when incidents had occurred and actions staff had taken, were in different places in the office. For example, they were stored in people's personal records and in two places on an office wall, some of these were from October 2015 to the present date. We asked a staff member how these behaviour charts were monitored and used to identify triggers and methods of supporting people. They told us that the team leaders included them in their monthly reports. There was no record to show which behaviour charts had been checked and if any changes in people's care plans were needed. In addition, one person's records stated that they became distressed when being assisted with personal care, this person was living with dementia. The documents said that two staff were required to assist the person with their personal care. There was no further information about how they were to be supported to reduce their anxiety, for example, to change staff or return later. A behaviour chart from April 2016 showed that two staff were, "Struggling" with assisting the person with personal care. A third staff member then went to assist them which resulted in the person, "Digging [person's] nails, spitting and fighting with us." This suggested this was not the approach that should be used. Another person's records showed that they had assaulted staff. Guidance for staff about how to protect themselves and the person was not included in the care plans. This meant the service could not demonstrate that there were effective and consistent approaches to the care they provided. Without monitoring and development of these matters people and staff were at put at risk.

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

Despite the shortfalls we had identified, one person said, "The staff understand what I like." One person's

relative said, "The care my [person] gets is fantastic and [person] gets anything [person] needs and they have gone to a lot of trouble to find out what [person] likes and what [person] does not like." Another relative said, "When they [staff] are caring for [person] I can tell which of the different carers who have done the work by the way [person] looks." One health professional told us, "It is a very good care home. It has a great vibe and people are entertained well." Another commented, "I am amazed at how good it is…They do allow someone to be themselves. They truly meet their personal and individual needs, true essence of holistic care."

We saw that staff responded to people's needs. For example, a member of staff spoke with a person who was confused. They put them at ease and offered a range of possible options from which the person selected one and the staff member assisted them to go where they wanted. Another person attempted to pull the table cloth off the table during the meal, a staff member spoke with the person calmly and distracted them from this. An acting manager told us how they had responded to people's preferences and needs. For example, they supported on person to move from one bedroom to another because they were not getting along with their neighbour. They also told us that the night staff wore pyjamas, which assisted people living with dementia to recognise that it was night time.

People told us that there were social events that they could participate in, both individual and group activities. An acting manager said that one person who was on bed rest spent daily time with the activities coordinator to reduce the risks of them becoming isolated or bored. A local authority staff member told us that the service had scored highly in social participation in a recent visit to assess the quality of care provided to people.

People participated in a range of activities throughout our visit, including reading their newspaper, talking with each other and staff, watching television and listening to music. There was a lively ball game in one of the lounges, a staff member threw a soft ball to people and called out their name. People were clearly enjoying this game, laughing, smiling and having their hands ready to catch the ball if it came to them next. One person laughed and told us, "People are quite rowdy in here, I think they are quite young." Later a quiz and word game was being played by people, again we could see that people were enjoying this and calling out their answers.

There were a number of planned activities during the week. Each morning activity started with a Wake and Shake session. There was an additional activity each morning such as; ballgames, zootastic (the chance for people to see and touch animals), puzzles and jigsaws and coffee mornings. The afternoon sessions included word games, a book club, arts and crafts, karaoke and Sunday sing along. People were provided with the opportunity to participate in both group and individual activities which were meaningful and interested them. An acting manager told us about the activities that involved the local community, including a dog show was held last year, a band visited two or three times a year and a local school visited to sing Christmas carols.

The garden was well maintained and provided seating for people to use in the good weather. There was also an enclosed courtyard set to resemble a beach scene with a nautical theme, this included sensory items, which was positive for people living with dementia. People could handle items which stimulated their senses and memories. Displays of art completed by a person who used the service were on the walls. There was a small lounge which could be converted into a cinema. An acting manager told us that people were given tickets to be collected on entry to the room and people were served popcorn. There was a sensory room which had different textiles and sea themes. There was a table tennis table and we were told by an acting manager that tournaments were held. There was a world map and residents were tracking where they had been with stickers. Around the service were items of memorabilia, including a pram, and sensory

items, which people could use/touch as they wished to stimulate their senses.

People could have visitors when they wanted them. This meant that people were supported to maintain relationships with the people who were important to them and to minimise isolation. Relatives also told us that they could bring in their pets, one said, "They let me bring in our dogs which makes a difference to my [person]." We saw that this made the person happy, "I am very happy here and they let my dog in to come and see me," and other people smiled when they saw the animals.

There was a complaints procedure in the service, which advised people and visitors how they could make a complaint and how this would be managed. People told us that they did not feel the need to raise a formal complaint. However, relatives said that when they had raised concerns these had been addressed. For example one person's relative told us about a concern they had regarding the person's dietary needs and this had been addressed. They said, "Now [person] is having mixed fruit which has cured the problem."

The complaints records were disorganised and two complaints highlighted on the management audits were not logged in the complaints folder. Therefore we could not be assured that these were addressed in a timely manner and used to improve the service.

Inadequate

Is the service well-led?

Our findings

Prior to our inspection the service had notified us of an incident that had occurred in the service. During our inspection visit we received further information about the treatment the person had received as a result of the incident. We looked at the actions taken to reduce the risks of similar happening again and the action the provider had taken as a result of this. We gathered information about this incident and found that there were no investigation records completed by either the previous registered manager or the provider. There were records in place which showed that relatives had been notified of the incident but no further information about how the provider had provided an apology and explanation of the incident. We spoke with one of the person's relatives who told us that another relative had received a verbal apology from the staff member who had been supporting the person. Following our visit we asked the provider to send us any investigation records, they responded by telling us what they had done, including speaking with staff and checking the environment and records. We also asked for a copy of the provider's policy on the Duty of Candour. The director sent us a document which was called, "When to contact a relative's next of kin." This document identified that people's representatives should be contacted if incidents occurred, including falls and accidents. There was no reference to the Duty of Candour. This document did not reflect the requirements of the Regulation and the information provided did not demonstrate the Regulation was being adhered to.

This is a breach of Regulation 20: Duty of candour of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Quality assurance systems in place were not robust enough to independently identify shortfalls. In addition prompt action had not been taken to improve. For example, an audit identified people's weights were not recorded in February 2016 and the action was for the weights to be completed over the next two days, which was not actioned. The audits also identified gaps in bathing and shower charts for two months running so it was not clear that the required improvements were being made as a result of these audits. The acting managers acknowledged that improvements were required in the auditing of the service.

The management actions on incident forms were not always completed as to what was being done to reduce the risk of any re-occurrence. This was seen for the forms in February and March 2016. Monthly falls reports were being completed but this was not consistent. The required action following a fall was not always documented. The GP was updated each month of people who had falls so they could assess if any fall could be medication related. There was no clear action documented as to what, if anything else, was done with the falls information. One noted referral to falls team but this was not clear. Monitoring falls is important to identify any trends to help avoid reoccurrences.

There were only two medicines audits on file for 2015 and actions noted from one audit to another did not include evidence to show that the previous actions had been completed. We were shown two further medicines audits which were difficult to understand because they were on hand over sheets and did not clearly identify any issues found. We received information from the provider following our visit which told us that they were investigating why the medicines audits had not been completed appropriately. They told us

that the medicines audits had been completed previously. However staff on the day of our inspection were unaware and were completing the handover stock takes instead. By the 13 April 2016 a medicines audit had been completed, identifying improvements required, and sent to us. A further medicines audit was completed 18 April 2016. This meant that the risks to people using the service were reduced. However, the improvements were only made after we had identified the shortfall.

People, relatives and others lacked opportunities to formally be consulted and feedback about the quality of the service. There were no satisfaction surveys available from staff, people, stakeholders or families. Residents meetings had not been held frequently with only one meeting held in 2015. There was no evidence of any suggestions made at that meeting being actioned to show that people's views were valued and use to improve the service.

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

The registered manager had recently left the service and there were acting managers who had been undertaking the managerial duties for two and half months. Both acting managers were working towards a relevant management qualification. They were getting used to the record keeping in the service and trying to find the records we asked for promptly. The acting managers were responsive to the inspection process, understood their role and responsibilities and were committed to providing good quality care for the people who used the service. The managers were aware of some of the improvements that were needed but had not formulated this into any plan of action. This was discussed with them and by the end of the inspection they told us that they had begun to put this in place. One of the acting managers said that they continuously looked at areas for improvement.

Following our inspection visit the provider wrote to us and included information that could not be found during our inspection, also advised us of investigations that were being undertaken, and actions they were taking as a result of the shortfalls we had found.

People and relatives told us that they felt happy with the care and the service provided. Relatives felt that the new manager and staff were able to answer their questions and gave them confidence that their relatives were in safe hands. They also told us that the service was well managed.

Compliments records received by the service included, "A huge thank you for the exceptional support and wonderful food provided for the occasion," and, "Thank you all at Norwood house for all the care/ understanding given to [person] during [person's] time with you."

Staff told us that they felt supported and listened to. They told us that they felt supported in their role. One staff member described the acting managers as, "Brilliant." Another said that they felt supported by the management team, including the team leaders. Staff understood their roles and responsibilities in providing good quality and safe care to people. They understood whistleblowing and said they would not hesitate to report concerns. Team meetings had been held within different departments. Minutes of staff meetings showed that they were kept updated with changes in the service and people's needs. They were provided with the opportunity to express their views about the service and suggest improvements.

There were three meetings with the directors on file, these showed that they were kept updated with any changes in the service and, for example, new flooring that was being laid in a person's bedroom, the purchase of a sling for a person, and how the staff rota was managed.

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
Diagnostic and screening procedures	People's care records did not sufficiently provide up to date information about people's specific care needs. Regulation 9 (1) (a) (b) (3) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Diagnostic and screening procedures	People's capacity to consent was not clearly identified in their care records. There was no information to show that people had consented to their care. Where people did not have the capacity to make their own decisions, up to date information was no in place which showed how the provider worked in accordance with the Mental Capacity Act 2005. Regulation 11 (1) (2) (3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Diagnostic and screening procedures	People were not always provided with their medicines as prescribed. Regulation 12 (1) (2) (a) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance

Diagnostic and screening procedures	The provider's quality assurance systems were not robust enough to independently identify shortfalls. Regulation 17 (1) (2) (a) (b) (e) (f)

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 20 HSCA RA Regulations 2014 Duty of candour
Diagnostic and screening procedures	The provider is not up to date with their responsibilities set out in the Duty of Candour. Regulation 20 (1)(3) (b) (c) (d) (e) (4) (a) (b) (c) (d) (6) (7) (9)

The enforcement action we took:

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