The Norfolk And Norwich Association For The Blind

Thomas Tawell House

Inspection report

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Date of inspection visit:
13 November 2017
14 November 2017
15 November 2017

Date of publication:
25 January 2018

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 13 November 2017 and was unannounced. We also returned on the 14 and 15 November 2017. The registered manager and chief executive officer [CEO] was given notice of the other dates, as we needed to spend specific time with them to discuss aspects of the inspection and to gather further information.

At our last inspection on 20 and 21 September 2016, we found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found there were not sufficient systems in place for assessing, monitoring and improving the quality of the service provided. Improvements were needed to develop risk assessments in relation to people's welfare. Records relating to people's care were not detailed.

At this inspection, we found the service had further deteriorated. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection for the key question, 'is the service responsive?' we found the service was not always responsive to people's individual needs and preferences. The staff interactions were limited to focus on tasks rather than conversational and individual. There was a survey in place for people to give feedback on the service. We found that where people requested something to be altered, this was not always considered. The care records were not always detailed and individualised. We saw in some people's care records that they had variable continence. There was no further information, risk assessment or guidance about how best to support them. Where some people had a catheter in situ, there were no risk assessments in place concerning potential problems with them. Visiting agency staff or new staff did not always have clear, concise guidance to follow about people's care within the records.

At this inspection, we found the service had deteriorated resulting in six breaches of Regulation.

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

Thomas Tawell House accommodates 37 people in one adapted building. There were 29 people living in the home on the day of our inspection. The home supported people who were over 65 years of age, some of whom were living with sensory impairment.

There was a registered manager in post. 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 of the Health and Social Care Act 2008 and associated regulations. The CEO visited the service on the second day and third day of our visit at the request of the inspector.

Although the provider had systems in place to protect people from harm, we found these were not always effective. The majority of staff were trained in safeguarding adults yet the training was not always implemented in practice whilst supporting people. Staff told us they were aware of their responsibility to keep people safe however, they failed to identify some of the practices within the home which were abusive and breached people's rights to receive safe, respectful and dignified care. At the time of our visit, we requested the registered manager to complete a safeguarding referral to Norfolk local authority safeguarding team reporting our findings. The registered manager told us she did not know how to do this and we were given assurances from the CEO this would be done without delay. Evidence of this was seen before the end of our third day.

Risks to people's health and wellbeing were not appropriately assessed and reviewed. Care plans were not sufficiently detailed to provide an accurate description of people's care and support needs. Our concerns also involved the lack of intervention and reporting of visiting medical professionals, we shared these concerns with the primary medical services within the Commission who monitor and inspect General Practitioner [GP] practices. Those concerns have since been shared with Norfolk Clinical Commissioning Group [CCG].

Whilst staff were safely recruited there were insufficient staffing levels to support people's needs and people did not always receive care and support when required.

The registered manager could not demonstrate lessons learned and improvements made when things go wrong. The registered manager although demonstrated understanding of the Duty of Candour they were unable to explain their responsibilities in relation to it. Services are required to comply with the duty of candour regulation. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' in relation to care and treatment. It also sets out some specific requirements that services must follow when things go wrong with care and treatment. We found this had affected one person. However, the CEO who had commenced with Norfolk & Norwich Association for the Blind (NNAB) in August 2017 had identified they needed to respond to the person impacted before we spoke with them. The CEO demonstrated sound knowledge of the duty of candour. The CEO shared with us their lessons learnt and improvement plan from our last visit in September 2016 identifying where improvements were needed. However, this was in its early stages and there had not been enough time since the CEO commenced and our visit for those areas to be explored properly with the registered manager.

The majority of the staff had completed training on the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). However, we identified one person whose rights had not have been protected because the registered manager had not assessed their capacity to consent to receiving care in bed and had not considered whether they had their liberty deprived unlawfully. This had resulted in the person's human rights also being impacted.

We identified gaps in training provided to staff. In spite of staff's best efforts and hard work to provide care in a supportive and friendly way, they lacked experience and training. All people living at the home had a sensory impairment and although staff had received training in regards to this when they first commenced employment, the training was not refreshed or revisited. We found some people lived with epilepsy, diabetes and some people had a catheter in situ, however, some staff had never completed training specific to those needs and others required an updated course. Some staff had received an appraisal of their work performance and most had received regular support and supervision. However, this had not always been effective in identifying inconsistencies in staff knowledge and practice.

Although people were treated in a caring and respectful manner, staff did not always engage with people when given the opportunity. People, who used the service, or their representatives, were not always encouraged to contribute to the planning of their care. We found that people's privacy, dignity and independence were not always respected and promoted.

People did not receive person centred care as the care records did not give adequate information required for individualised care. We received mixed views on activities available. Some people told us that they were not given the opportunity to choose the way that their individual and group activities would be delivered. Other people told us although they were given opportunities to discuss activities their suggestions were not always met. We found there were few opportunities to engage in activities and people were seen sitting in the lounges or their bedroom with no meaningful activity or positive interaction taking place. Although processes were in place to deal with people's complaints and concerns if received, we were not satisfied the registered manager operated an effective accessible system for identifying complaints. There had been no documented complaints since 2013.

There was no shared understanding of the service's vision and values and a culture of task-centred instead of person-centred care was embedded. The management of the service was inconsistent and lacked continuity. Systems in the service that were meant to monitor and identify improvements were not effective and records were not always maintained and completed in full. This lack of effective governance led to all people not receiving safe and consistent care. The care plans for people using the service were incomplete or did not contain up to date and regularly reviewed information. This meant staff was not able to perform their duties efficiently.

Policies and procedures were in place to ensure the safe ordering, administration, storage and disposal of medicines. Medicines were managed, stored, given to people as prescribed and disposed of safely. The home was clean and tidy throughout, routinely maintained and monitored by the provider. There was a varied and nutritious menu where people could make choices. Steps were taken to ensure people had adequate food and drink. People's health care needs were assessed, monitored and recorded. People had regular contact with health care professionals. We looked at documentation related to staff handovers. These recorded how people were supported to live healthier lives. They included appointments with healthcare professionals, feedback from healthcare professionals and action plans for staff to follow. The environment of the home was appropriate for people who were living with sensory impairment. The home was well maintained, decorated and furnished in a style suitable for the people who used the service.

At the time of our visit, the registered manager, CEO and board of trustee's acknowledged and agreed with the shortfalls identified. The CEO and board of trustee's demonstrated a willingness to change practice and drive improvement. The CEO took immediate action to improve people's safety and quality of care delivery. We received further assurances since the inspection and continue to be in regular contact with the provider to ensure standards improve imminently. However, the registered manager told us they did not have the knowledge or skills to improve practice and ensure compliance with the Health and Social Care Act (Regulated Activities) Regulations 2014. Since our visit we have been informed the registered manager has resigned and are no longer employed by NNAB. The CEO has offered assurances that they are in day-to-day management of the service until such time a new manager is appointed.

During this inspection, we found the provider was in breach of six regulations of the Health and Social Care Act (Regulated Activities) Regulations 2014, one of which was a continued breach from our previous inspection. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not always safe.

Whilst some people said that they felt safe, we found that the registered manager did not have effective arrangements to ensure risks were assessed, monitored and mitigated. This meant there were risks to people's safety, health and welfare.

Staffing levels were not sufficient and were not effective to maintain people's safety and meet their needs.

Not all accidents and incidents had been properly recorded. The ones, that had been recorded were not analysed to identify any patterns or trends to help prevent them from happening again.

The registered manager and staff did not demonstrate thorough knowledge of safeguarding procedures.

People received their medicines safely. The home was clean and tidy throughout, routinely maintained and monitored by the provider.

Is the service effective?

Requires Improvement

The service was not always effective.

Systems were not in place to ensure there was an appropriate response to a person's changing healthcare needs. There were delays in one person receiving professional advice and treatment.

Staff knowledge of the Mental Capacity Act (2005) was limited, which placed people at risk of not being appropriately supported if they lacked capacity to make their own decisions. People, were being restricted in their choices regardless of having capacity.

Staff had not always received appropriate training and supervision to ensure they could perform their roles and responsibilities effectively.

People had sufficient to eat and drink and were encouraged to eat a healthy diet. People were supported to maintain good

health and had regular contact with health care professionals. People's needs were met by the adaptation, design and decoration of premises.

Is the service caring?

Requires Improvement

The service was not always caring.

People's choices, likes and dislikes were mostly respected however, staff did not engage socially with people when they had the opportunity. Staffing arrangements meant care was task focused and not focused on people.

People's preferences for the way in which they were supported were not suitably met or clearly recorded. Care was centred on people's immediate individual needs, in a re-active and unplanned way.

People were not always involved in making decisions about their care.

People's privacy and dignity was not always supported.

Is the service responsive?

Inadequate

The service was not responsive.

Care and support was not responsive to people's individual needs. It was not evident people had been involved in planning their care.

People were not always supported to undertake social activities within the home and the broader community. Opportunities for people to follow their interests or be involved in social activities were limited.

There was no effective system in place for identifying complaints.

Is the service well-led?

Inadequate

The service was not well-led.

There was a lack of managerial oversight of the service as a whole. There was a reactive rather than proactive approach by the management team, which meant that people did not receive a consistent safe and appropriate service.

There was no shared understanding of the service's vision and values and a culture of task-centred instead of person-centred

care was embedded. The service lacked appropriate governance and risk management frameworks, which resulted in poor outcomes for people who used the service.

Thomas Tawell 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 13 November 2017 and was unannounced. We also returned on the 14 and 15 November 2017. We told the registered manager and chief executive officer (CEO) about the other dates. This was because we needed to spend specific time with them to discuss aspects of the inspection and to gather further information.

On the first day of our inspection visit, the inspection team consisted of one inspector, one specialist nurse advisor 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. Their area of expertise was for sensory impairment. On the second and third days of our inspection visits, there was one inspector.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We reviewed information we held about the service, including safeguarding concerns shared with us from the local authority, previous inspection reports and notifications of significant events the provider sent to us. Notifications are events that the provider is required by law to inform us of.

Due to the nature of people's complex needs, we were not able to ask everyone direct questions. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us. We spent time observing people in areas throughout the home to see interactions between people and staff. We observed people as they engaged with their day-to-day tasks, the care they experienced, including the breakfast and lunchtime meal, medicines administration and activities.

We spoke with seven people who lived at the service, the CEO, senior executive officer (SEO), registered

manager and deputy manager. We spoke with eight care staff, two senior carers, the health and safety officer, the cook, kitchen assistant and craft instructor. We also spoke with a visiting district nurse and two GPs.

We looked at the care plans and associated records for 10 people. We looked at four people's medication records. We reviewed other records, including the provider's internal checks and audits, staff training records, staff rotas, accidents and incidents, menu's, relative questionnaires, and health and safety checks. Records for four staff were reviewed, which included checks on newly appointed staff and staff supervision records.

Inadequate

Is the service safe?

Our findings

Without exception people who were able to, told us they felt Thomas Tawell House provided a safe service. However, our observations did not always support this. We found there were risks to people's safety, health and welfare.

People who lived in the service were not always protected from the risk of potential abuse or neglect. Training records showed some staff had not completed training to help them recognise and respond so possible abuse. This meant we were not confident all staff would know how to respond if they encountered any concerns.

Staff were able to tell us different types of abuse and stated they would raise concerns to their immediate line manager. However they were not aware of how to share their concerns with external agencies such as the local authority safeguarding team, the police or the Care Quality Commission. This meant there might be times when issues regarding people's safety would not be reported and acted upon robustly.

Our observations found staff lacked insight into what constituted abuse and, in particular, a lack of understanding of institutional abuse and neglect by omission of care. A number of safeguarding issues we identified during our visit had not been recognised or reported by staff. Although staff told us they were aware of their responsibility to keep people safe, they failed to identify some of the practices within the home were abusive and breached people's rights to receive safe, respectful and dignified care.

When we asked staff to explain why it was necessary for one person to remain in bed contrary to the persons wishes, staff could not explain why this had been left for over 16 months. A staff member told us, "I don't think any abuse has taken place, it's in her best interest, and it's to keep her safe, from falling and injuring herself."

We observed staff not following moving and handling best practice techniques. We observed and staff told us they, "drag lifted" people, as they did not have time to use people's assessed equipment. A drag lift is when staff assist people to stand up, transfer or move by pulling or dragging them under their armpits. It can be very painful for the person and can result in injury, including for the staff. Without exception staff confirmed, their practice presented a risk to people. However were not able to say and did not recognise this was a neglectful response to supporting people.

We spoke to the CEO at the time of our observations who provided assurances that all staff will be retrained and competency assessed by the end of December 2017. The CEO also provided assurances that staff would be met with at a team meeting to discuss themes and topics including safeguarding reporting, moving and handling best practice, assessed risks and how to keep people safe. We were told these meetings would occur monthly. On the third day of our visit, we observed better moving and handling practice. People were safely supported to move from their chairs to wheelchairs and to sit at the dining table for their meals. We observed staff communicating with people during transfers to check people felt safe and comfortable.

The registered manager did not always take appropriate action in the event of possible safeguarding concerns and this may have placed people using the service at risk of unsafe care. Accident and incident forms we reviewed detailed a number of incidents where the registered manager should have raised a safeguarding alert with the local authority.

For example, care staff had recorded unexplained bruising on a person's arms. Another person had an unexplained skin tear and one person had a burn as a result of staff not delivering one to one support assessed as needed. There was a person who had received care in bed for a long period and despite deterioration in their mobility, the registered manager had not sought appropriate advice from health and social care professionals to ensure staff were meeting this need. In addition, where staff had identified that staffing levels had compromised the care people received, this had not be reported as potential neglect of people's needs. The registered manager and staff had not identified where risk of institutional neglect or self-neglect may have taken place and had not taken action to protect people from this.

The registered manager should have informed the local authority's safeguarding adult's team and the Care Quality Commission (CQC) of these possible safeguarding concerns. The registered manager told us she did not know who or how to make a safeguarding referral. This did not provide assurances that the registered manager would know how to report suspicion of abuse. The safeguarding adult's team would have enabled an independent investigation of the incidents to ensure people using the service were cared for safely. For people with the unexplained injuries, body maps had not been completed detailing the injury and there was no evidence of these injuries being followed up on to ensure they had healed. We identified these to the registered manager who was unable to provide an explanation to these.

At the time of our visit, we requested the CEO to complete a safeguarding referral to the local authority safeguarding team as part of their duty to keep people safe from harm. The CEO said this would be done without delay. Evidence of this was seen before the end of our third day. Following our visit the CEO confirmed the local authority had acknowledged the referral and was going to investigate the concerns raised.

The registered manager failed to establish systems and processes to prevent abuse of people. The provider had failed to ensure appropriate investigation of potential safeguarding issues, which placed people at risk of abuse. This was a breach of Regulation 13 of the Health and Social Care Act 2014.

People who lived at the service were not always protected from risks to their safety. The risks to individuals were not always assessed when they were admitted to the home. In addition, the assessments in place did not give staff enough information on how to manage the risks to keep people safe.

Four people remained in bed. These people had been assessed as being at risk from social isolation and were assessed as at risk of not drinking enough. One person told us, "I am thirsty, I am always thirsty." For this person we asked staff to attend to them and support them with a drink. We found although people had drinks in their room, these were not within reach and for two people they were not able to drink for themselves. We found that all four of these people either could not use their call bell or did not have their call bell within reach. These people's care plans did not include how often they should be checked to ensure their wellbeing and safety. We spoke with the registered manager who told us they would update people's care plans to ensure routine staff checks were introduced and these were to be documented. We will not be able to confirm if sufficient action has been taken until we next inspect the home.

We found three people had diabetes but their records contained no evidence about on-going management or treatment for this condition. Staff were also unable to explain how they monitored and supported people

with diabetes. Although records demonstrated people, had their blood glucose readings taken and recorded, there was no guidance to confirm what was considered normal limits, no indication about what to do if their levels were too high or low and what action staff should take to support them.

One person had epilepsy; they had no risk assessment or care plan for this risk. They did not describe the type of seizure the person could have and what signs to look for. However records described the person as being vacant or unconscious during the day. The deputy manager told us these were signs the person was having a seizure. The deputy manager told us this information was not formally documented or reviewed.

We found some of the same people and an additional two people had catheters in situ. These risk assessments did not identify specific risks and there was a lack of explanation to the measures which were needed to ensure people were safe. For example, where staff needed to position the bag, ensuring they were not dragged risking internal damage, kinks, how to check the flow and additional precautions in hoisting.

Three people had bedrails in place. However, there was no clear rationale within people's care plans to identify why bedrails were required. There were no risk assessments in place for the use of bedrails, which would identify any further risks such as entrapment. There was no additional evidence that the risks associated with these had been fully explored. The documentation for people who had bedrails did not show that the least restrictive options had been considered or discounted before bedrails were put in place.

People were supported with specialist equipment such as pressure relieving mattresses to reduce the risk of pressure areas developing on their skin. We identified three mattresses' that should be set, according to the person's weight. Having the mattress set too firm or too soft could result in pressure damage occurring. Weight records indicated that these people had not been weighed in 2017 due to not being able to weight bear any longer. The registered manager had not considered other ways of weighing people. There was also no guidance in people's care plans as to the correct setting. Staff we spoke with were not aware of the correct settings for the mattress. The registered manager told us, the district nurses checked these settings on their weekly visits. However, the district nurse confirmed they did not visit everyone with a pressure mattress and currently were visiting two people, one of which did not have a pressure relieving mattress. Therefore we could not be assured that all people had their mattresses at the correct setting, which could result in pressure areas developing on people's skin.

The four people in who remained in bed, we were told by staff needed repositioning at regular intervals to relieve the pressure on their skin due to prolonged immobility. There was no guidance in people's care plans as to how frequent these turns should be. Staff were unable to explain how they knew what side a person should be turned to and disclosed times were guessed as they were not recorded.

We fed this back to the registered manager and CEO who told us they would update peoples care plans and risk assessments by 1 December 2017. We will not be able to confirm if sufficient action has been taken until we next inspect the home.

Moving and handling assessments did not give staff clear guidance on how to support people when moving them. We noted suitable equipment such as hoists and wheelchairs were available for staff to use, however staff were guessing what sling size to use for people as they did not have slings for each person's individual use. This could potentially cause injury if a person slipped through the sling, but also if the person was too large for the sling, it could rub and cause a skin injury.

The registered manager had failed to thoroughly assess risks to people's health and safety and had not taken action to mitigate known risks. Individual accidents and incidents that had been recorded had not

been analysed to identify any patterns or trends to help prevent them from happening again. For example, although staff logged incidents, the registered manager did not review or use the information to improve people's safety. The registered manager acknowledged this practice was not safe.

We raised these concerns with the registered manager and CEO at the time of the inspection, who said they would take action to ensure all risk assessments implemented where assessed as needed and contained all of the relevant information needed to make sure people received safe care.

The registered manager had not done all that was reasonably practicable to mitigate the health and safety risks for people to receive safe care and treatment. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

We looked at staffing levels on the first day of our visit. Members of staff told us the home was understaffed and one member of staff said, "There is not enough staff. People are being 'drag lifted.' We just don't have time." Another staff member said, "We do not have enough staff. It's so stressful." The registered manager had held team meetings and these identified that, in some instances, people's care was compromised by staffing levels.

The registered manager told us they had completed an individual dependency assessment for people who lived at the home. However, they stated this was a number of years ago and therefore could not confirm the staffing levels needed to support people safely with their current needs. Staff and the registered manager told us; more than four people required two staff to support with hoisting and transfers. Four people required one to one staff support for eating meals. With the current staffing numbers, this would leave staff struggling to attend to people in a timely way. We observed this left many people waiting for long periods with no support. The number of staff on duty left individuals with mobility needs, dementia needs, and individuals at risk of falls, vulnerable. This is the third inspection the registered manager still had not reassessed staffing levels and make changes in light of concerns that staff were not able to deliver safe care.

We asked the registered manager to calculate staffing levels needed on the first day of our visit. The registered manager had still not started this by the end of the third day of our visit. The staff rota showed there were six care staff on in the mornings 7am to 2pm; four care staff on in the afternoon and early evenings 2pm to 9pm and two night staff overnight 9.15pm to 7.15am. The registered manager told us this was the usual level of care staff. The CEO provided assurances that as a minimum a fifth carer would be allocated from 2pm to 9pm and a third carer would be allocated at night from 9.15pm to 7.15am with immediate effect. During our visit, the CEO placed an advert to increase staffing after discussion with the inspector. The service had a 24 hour on call system in case of unforeseen events and if additional staff were needed. In addition to the care staff, the service had a team of domestic staff, a cook and kitchen assistant. This allowed the care staff to attend to people and their needs.

Throughout the inspection, we noted people were left in the lounge areas unattended for long periods of time. People with needs related to dementia and mobility were unable to get the support they required. We observed a person drop their drink on the floor in front of them, in attempting to pick this up there was a risk of falling and no staff to respond to this. Other people appeared confused and distressed and there were no staff available to provide reassurance or support. Staff could not monitor people living in the home effectively and they were over stretched with the workload. There was no interaction between staff and people living in the home other than during the delivery of care as staff did not have time to spend with people. We observed four people who did not have access to their call bells and had not been checked on to ensure they were comfortable. Staff told us they did not have time to check people who could not call for assistance. Staff stated they are checked on each meal time.

From the second afternoon of our inspection, the overall level of risk to people's safety and well-being was mitigated by the use of additional staff which the registered manager had organised. The provider agreed to keep the additional staff in place until people's needs had been reassessed.

The registered manager and provider had not ensured that there were sufficient numbers of staff to meet people's needs and keep them safe at all times. This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager could not demonstrate lessons learned and improvements made when things go wrong. For example the areas as identified for requiring improvement from our last visit in September 2016 had not been reviewed by the registered manager. Although the registered manager was able to verbally explain part of the Duty of Candour they were unable to explain their responsibilities in relation to it. Registered persons are required to comply with the Duty of Candour regulation. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' in relation to care and treatment. It also sets out some specific requirements that services must follow when things go wrong with care and treatment. We found this had impacted one person. However, the CEO who had commenced with Norfolk & Norwich Association for the Blind (NNAB) in August 2017 had identified they needed to respond to the person impacted before we spoke with them. The CEO demonstrated sound knowledge of the Duty of Candour. The CEO shared with us their lessons learnt and improvement plan from our last visit in September 2016 identifying where improvements were needed. However, this was in its early stages and there had not been enough time since the CEO commenced and our visit for those areas to be explored properly with the registered manager.

The premises were purpose built and the layout was such that it did not present significant difficulties in evacuating people in the event of an emergency. People had individual Personal Emergency Evacuation Plan (PEEP) in place on how they should be supported to evacuate the building in the event of a fire. An environmental risk assessment was in place which identified risks to people, staff and visitors. Daily, weekly and monthly health and safety checks were carried out. Fire drills took place and equipment such as fire, electrical, moving and handling equipment was serviced and fit for purpose.

Recruitment practices were safe. References were obtained from previous employers and checks with the Disclosure and Barring Service (DBS) were made regarding the suitability of individual staff to work with people in a care setting. There were records to show staff were interviewed to check their suitability to work in a care setting.

People's medicines were safely managed. There were policies and procedures for the safe handling of medicines. Medicines were administered by trained staff. Training for staff was provided by the supplying pharmacist. The deputy manager had implemented a system of observing staff competency to handle medicines safely. Staff completed a record each time they administered medicines to people and we observed this practice taking place. Stocks of medicines showed people received their medicines as prescribed. When people had their medicines administered on an 'as required' basis, there was a protocol for this which described the circumstances and symptoms when the person needed this medicine. The temperature of the medicines storage room was monitored as was the temperature of the fridge used to store medicines. These were within the recommended safe limits.

The provider had appointed domestic staff to ensure the home was clean and tidy throughout. One person told us, "They're [staff] excellent generally. The domestics who clean do a great job too." Another person told us, "You can't fault the cleanliness here. The cleaners are very good." A third person told us, "There are very high standards of cleanliness in this home. All the staff know the home must be perfectly fresh and

clean."

Cleaning schedules were in place to ensure the environment remained clean, hygienic and well maintained. We observed the home was clean and tidy throughout, routinely maintained and monitored by the staff. Staff were observed wearing aprons and gloves when giving personal care.
The senior carer was observed washing her hands between each person when administrating medication and wearing gloves when administrating eye drops. The health and safety officer carried out monthly recorded environmental checks. This involved walking around the building and checking all areas of the home including people's bedrooms to ensure there were no offensive odours or any trip hazards.

Requires Improvement

Is the service effective?

Our findings

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) and whether any conditions on authorisations to deprive a person of their liberty were being met. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The registered manager told us there were a number of people who had not had mental capacity assessments completed when people were deemed to lack capacity and a decision needed to be made concerning a person's wellbeing. We found best interest decisions did not always include the appropriate professionals, advocates and relatives.

For example we identified one person who we were told by a GP had fluctuating capacity, had been cared for in bed for a significant period, due to no longer being unable to weight bear. We found that no referral had been made for an occupational therapy assessment to explore what equipment might be offered to enhance the person's quality of life. The person told us, "This place is a zoo, I am a caged animal. I'm in bed because they [staff/registered manager] tell me I can't do much else. No one has given me any other choice. I stay in bed because that's my only choice." The registered manager had not completed a capacity assessment for this person and although they had consulted the family, no best interest meeting had taken place. The person may have been deprived of their liberty as the registered manager had not assessed their ability to consent to care and treatment and ensure decisions were made in their best interest to protect their rights. The registered manager told us they had made the decision for the person to remain in bed in their best interest. We viewed care plans from that point of decision confirming staff had been instructed to keep the person in bed without formal review or external professional input. The registered manager told us, "Yes I can understand from the outside this looks and reads bad." The registered manager demonstrated a lack of understanding regarding the significance of her decision-making and the impact this had on the person who had been restricted to bed.

Proper processes for assessing whether or not a person has capacity to understand the risks associated with using bed rails had not been followed. We found no evidence of decisions to use bed rails being made in the person's best interests if this was applicable. This meant that the decision for their use might not have been in the individual's best interest and proportionate to the risk of not having them in place. Staff had not recognised the potential impact on people or explored alternative and more suitable options. Failure to gain consent of people where the persons may have lacked capacity, is not acting in accordance with the Mental Capacity Act 2005. This placed people at risk of having unnecessary restrictions placed on them that was not proportionate to the assessed risk.

We could not see that the registered manager had considered their compliance with the Mental Capacity Act 2005, Equality Act 2010 and Human Rights Act 1998 to ensure people's rights were promoted or protected. Consequently, the registered manager had disregarded the needs of people for care and treatment.

The registered manager had committed an act that controlled a person which was not necessary or a proportionate response to risk. This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 13.

Records confirmed that staff had completed training in the MCA. Staff understood the importance of seeking consent to deliver people's day-to-day care. For example staff confirmed that people were enabled to give consent to most decisions concerning their day-to-day support by using communication techniques individual to the person. One senior carer was knowledgeable about the communication needs of the person and gaining consent to administer medicines. They said, "[Person] is partially deaf so I stand close, touch him softly and reassuringly. [Person] then relaxes and holds their hand out and that's their way of telling me they are ready for me to give medicine."

Staff told us and records stated that they had received induction training. The induction training was not based on the Care Certificate. The Care Certificate is a nationally recognised qualification. This Certificate covers 15 standards of health and social care that all care staff should know as a minimum. It is achieved through assessment and training. The registered manager did not know it was best practice for registered managers to use the Care Certificate for induction training of staff who were new to care. The induction training in place did not cover the same breadth of training as the Care Certificate requires. The induction training provided was minimal. It included, managing medicines, fire procedures and Deprivation of Liberty Safeguards (DoLS), with little information about or focus on the individual people using the service and how their personal needs should be met.

The provider maintained a spreadsheet record of training in courses completed by staff, which they considered were mandatory for staff to provide effective care. This allowed the provider to monitor when this training needed to be updated. These courses included fire safety, infection control, moving and handling, health and safety and first aid. Records confirmed all staff that had finished their induction, had received this training. However, there were a number of staff whose training had run out and they not completed any refresher training. We also found that although staff had received moving and handling training, their practice had not been monitored or addressed when staff were no longer doing this safely.

The provider stated on their website that, "There is an excellent staff ratio and all our staff are trained in the care of elderly people with poor sight. They take part in regular updates to ensure that they maintain and improve our existing high standards." Throughout our visit, we found this philosophy had not been applied. There was no evidence that specific training needs were being addressed to reflect some of the conditions experienced by people that staff were expected to manage. This included areas such as dementia awareness, diabetes, pressure care, falls prevention and epilepsy. This was evident in our observation of staff, that they did not understand how to support people living with dementia, people with changing mental capacity and people at risk of specific health conditions. All people living at the home had a sensory impairment and although staff had received training in regards to this when they first commenced employment, the training was not refreshed or revisited. This meant staff knowledge had deteriorated and they were unable to implement best practice. The registered manager told us catheter care training had been arranged and was due in November 2017.

Some staff had received an appraisal of their work performance and most had received regular support and supervision. However, this had not always been effective in identifying inconsistencies in staff knowledge

and practice.

The registered manager had not ensured persons employed received appropriate training and support necessary to carry out their duties effectively and meet people's needs. This was a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People were supported with eating and drinking and staff showed they understood people's needs. A care worker asked a person if they had enough after they had eaten their main course. The person's eyes lit up and they smiled, clearly happy with their meal. The service had a menu plan which showed varied, nutritious and balanced meals. People were offered a choice of food and were asked in advance what they wanted to eat which was recorded for the kitchen staff to follow. Stocks of food included fresh vegetables and fruit and the cook told us dishes were homemade from fresh ingredients.

People's nutritional needs were assessed and care plans recorded where people needed support with eating and drinking. Where people had problems with eating and drinking, referrals were made to the GP, dietician or Speech and Language Therapist (SALT). Copies of SALT reports were included in people's care records so staff knew the type of support people needed. Some people's food and fluid intake was monitored and recorded and showed people had sufficient to eat and drink. People's weight was recorded and reviewed monthly to check if people who were at risk of weight loss were in receipt of the most appropriate care and treatment.

We looked at documentation related to staff handovers. These recorded how people were supported to live healthier lives. They included appointments with healthcare professionals, feedback from healthcare professionals and action plans for staff to follow. People's care records showed their health care needs were monitored by staff and arrangements made for health care checks and treatment. One person told us, "The staff organise the doctor. The chiropodist comes regularly." Another person told us, "The staff will say if you need a doctor. If you need a GP, the staff call the surgery. The chiropodist comes in." We observed a senior carer discussing the needs of one person with a visiting district nurse to plan how to meet the person's needs. Care records also showed people were supported to have eyesight checks and that oral health care needs were assessed.

The environment of the home was appropriate for people who were living with sensory impairment. People had access to large call buttons which were portable which allowed for increased freedom as people were able to use them in the garden. The registered manager told us people also wear a pull cord for additional support and safety. The corridors were wide, fitted with handrails and changing floor surfaces to help those with sight impairments to get around. All bedrooms and bathrooms were wheelchair accessible. The outside patio/garden areas were wheelchair accessible. Where people needed specialised beds, seating and wheelchairs, these were mostly provided. The service was well maintained, decorated and furnished in a style appropriate for the people who used the service.

Requires Improvement

Is the service caring?

Our findings

The majority of the interactions we saw related to tasks being undertaken for people. These interactions were positive with people and staff talking easily to each other. However, we also noted there were occasions when there were opportunities for staff to engage socially with people that were not acted upon. This was not solely due to demands placed on staff or staffing levels. We saw staff standing in the lounge area and dining area not engaging with the people in the room. One person was keen to engage in conversation with staff at breakfast but they were ignored. The person continued to talk aloud to themselves. The person stated they missed the company of people. This showed a lack of person centred care for the people who lived in the home. The mealtime experience lacked the air of sociability for the people in the room and had a negative impact on their dining experience.

Where people were at risk of being socially isolated because they received care in their rooms, there was little interaction or support observed to reduce this risk and treat them with dignity. People who were not able to use their call bells were observed in their rooms for long periods without staff offering support or reassurance.

Records reflected that the registered manager had discussed people's support needs, including their choices and preferences with relatives, at the time of the pre-admission assessment but this collaboration had not continued following people's admission to the home. The records did not show that families or people using the service had been involved in the care planning process since their family member moved into the home.

The people we spoke with told us they were able to express their views and make day-to-day decisions about their care. However, we could not find any further evidence that people or their relatives were involved with planning their care. Although some care plans had been signed by people, they had been completed a number of years ago. As a result, there was no evidence that people or those who knew them best had been involved in planning or reviewing people's care.

People did not have an opportunity to comment on their care planning or whether their needs were accurately reflected. The senior staff and deputy manager evaluated the care plans themselves monthly. There was no evidence of how people were asked to be involved or what steps the registered manager had taken to try different ways of involving people.

None of the people we spoke with were aware of their care plan. One person told us, "There's no involvement that I'm aware of." Another person told us, "We're not listened to really." This meant staff may not have been aware of people's wishes and aspirations. There was no evidence that people or their representatives were enabled to make their care choices known and where preferences were identified these were not consistently carried out in line with this.

The registered manager had not ensured that care was carried out or assessed collaboratively with the relevant person and had not planned people's care to ensure their preferences and choices were

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

People told us their relationship with the staff was good and that staff were caring and respectful. People we spoke with told us the staff were kind to them and willing to assist them when required. One person told us, "The staff are busy so it's difficult for them to find the time to socialise. The staff are very good and caring, and treat us with the utmost kindness." Another person told us, "The staff are so busy but I think they've [staff] summed me up. They do treat me well and are caring and kind. They just haven't always got time." One person told us, "The staff seem kind and caring." One person told us, "I feel I'm respected." Another person told us, "They [staff] are kind, caring and respectful with a sense of humour which helps with a lot of people."

People were comfortable in the presence of staff and were appropriately dressed, clean and well presented. We were told that visitors could visit freely and were welcomed. People responded well to staffs' approach, staff appeared to know people well and enjoyed providing support to people in a comfortable way. There was a relaxed and welcoming atmosphere. Observations demonstrated that people enjoyed the interaction they had with staff, there were lots of smiles, laughter and banter. However, despite this, we found areas of practice that required improvement.

Peoples' diversity, with regards to their preferences on how they spent their time, was mostly respected, for example, some people preferred to spend their time in the communal areas of the home, whereas others preferred to spend time in their own room. Peoples' privacy was respected and maintained. Observations showed that when people required assistance from staff that staff did this in a discreet and sensitive way. For example, staff spoke in a low voice when asking people if they needed assistance to access bathroom facilities and had closed peoples' bedroom doors when supporting them with their personal care needs. People confirmed that they felt that staff respected their privacy and dignity as they knocked on their doors before entering their rooms.

Privacy, with regards to the information held about people, was promoted as records were stored in locked cabinets and offices. Staff maintained confidentiality. Conversations about personal issues or phone calls made with professionals were carried out in the office.

We looked at comments from compliments cards and saw these indicated staff had shown compassion and kindness to people who used the service.

Inadequate

Is the service responsive?

Our findings

At the last inspection in September 2016, we found the service was not always responsive to people's individual needs and preferences. The staff interactions were limited to focus on tasks rather than conversational and individual. There was a survey in place for people to give feedback on the service. We found that where people requested something to be altered, this was not always considered. The care records were not always detailed and individualised. We saw in some people's care records they needed support with going to the toilet. There was no further information, risk assessment or guidance about how best to support them. Where some people had a catheter in situ, there were no risk assessments in place with regards to potential problems with them. Visiting agency staff or new staff did not always have clear, concise guidance to follow about people's care within the records.

Staff told us, due to staffing levels they were unable to provider person centred care. One staff member told us, "I am stressed out and over worked. I am finding it tough. We don't have time to sit and talk to residents. It's all task orientated. Sitting and talking to them would be lovely but that's a luxury we don't have."

At this inspection, we found the registered manager had not made any improvements and that the same concerns remained. For meeting the needs of people with dementia the service offered little in the way of objects or activities to aid reminiscence to help engage people in conversation. Staff were busy and had very little time to spend with people in communal areas. One person told us, "My relationship's okay, they're [staff] kind enough when you ask them to do anything but with so little time, it's difficult to get to know them or for them to get to know me. If I needed emotional support, I'd talk to my [relative]." Another person told us, "I get emotional support from my [relatives]. I just sit in here [room] most of the day. I do listen to books, I enjoy that."

We identified four people being at risk of social isolation. One person told us, "I do get bored and feel isolated, yes. I don't like to be alone." Another person told us, "I am safe. I used to leave my window open but I have been told I must not in case someone gets in. I'd be quite glad if they did, it would give me someone to chat to." Another person told us, "I wish I could take a nice long walk, or at least be supported in a wheelchair for a nice long walk. I do not think there is enough for me to do. I know I just have to put up with it. I would like to return to the lounge and sit with others." Not all of these people had care plans that stated they were at risk of social isolation and should be included in activities. We observed these people were left alone in their room for many hours during all three days of our inspection. We checked these people's daily logs completed by staff and the information was brief and could not evidence that any meaningful interaction had taken place for these people. Therefore, it could not be assured that this need was being met consistently and in line with their care plan, for those that had one.

Files that contained peoples' care records, contained outdated and generic information such as information sheets for staff to provide guidance as to what to do if a person died. Older paperwork, such as risk assessments and care plans remained in the files. This made it difficult for staff to access the most current information that was important to the person. One persons' care plan was more detailed than others, containing information on their likes, dislikes and hobbies. Whereas others did not contain this type of

information and did not demonstrate 'the person' within their care records.

It was apparent that due to the staff team who had been working at the service for a number of years, staff knew peoples' needs well; however this knowledge of peoples' individual needs was not supported by clear guidance to ensure consistent care. There were various generic care plans in place such as personal care and mobility, however, these were not sufficient or detailed enough to provide individual guidance for staff. For example, a person who remained in bed their care plan stated that the person was unable to undertake activities on their own. There were no guidance in place for staff to know when and how often to offer activities. There were no activities listed as what the person enjoyed and disliked. One person told us, "I don't think they [staff] have the vaguest idea about who I am. The staff have no time to get to know people properly. No-one speaks to you. I like a chat and I go into my neighbour's room sometimes."

At the previous inspection, an area identified as in need of improvement related to the reviewing of peoples' care to ensure that it was up-to-date and met their current needs. At this inspection, this still had not occurred. We found that there was a lack of management oversight for staff within the service to ensure that they were following care plans and understood people's changing needs. This meant that there was the potential that peoples' current needs had not been identified or met.

We looked at how people's care was evaluated each month. Staff commented on changes that had occurred but this was not consistent and some evaluations missed reporting on incidents the previous month. Most of the monthly evaluations stated 'no change' even when changes had occurred during the review period. This meant staff had limited information about people's needs and there was a risk that people may receive inappropriate care. The information in evaluations was also not always updated in the care plan so staff would have to read through pages of evaluations to see when changes had been made. Similarly, advice and treatment from professional visitors such as G.P's and speech and language therapists was included in 'professional visitor's logs' or letters following visits, but the information was not always added to the care plans. This meant there was a risk of updated information about care and treatment not being readily available to staff in care plans.

On the provider's website, it states, "A lively social programme is pursued and activities include crafts, games and musical entertainment as well as occasional outings for general enjoyment in our own minibus. Whilst we strive to ensure a full programme of activities, there are of course our large delightful gardens with mature trees, landscaped flower beds and in the summer months our scented roses, to be enjoyed on lazy, restful afternoons." Throughout our visit, we found this portrayal as incorrect. During the day, people were observed sleeping or just sitting in a lounge with little stimulation. The registered manager told us they did not employ an activities coordinator but an employed craft instructor visited every Wednesday to offer activities. On the third day of our visit, we met with the craft instructor and sat in on their activity session. Five people joined in and were making Christmas wreaths. However, the people that joined in were mobile and independent. Thursday afternoons a volunteer visited the service and sang for people. Alternative Fridays there was a quiz available for people to attend. People told us they made their own entertainment but it was said repeatedly that the staff had little time to spend with residents and one person who was blind became emotional when talking about limited human interaction causing them to feel bored and isolated. The person told us, "The days are so long."

One person told us, "I do word puzzles and wander around during the day at my own pace. I do not get bored, I just go to sleep. I do go to the quiz every couple of weeks but the carers do not always bring people along. There were only two of us last week, others did arrive later, but as many residents need help to move around, it is difficult to get people together if staff are not able to help. I go and sit in the lounge but no one speaks to you. The staff don't spend time on hobbies or anything."

The registered manager told us, "For a long time I have wanted an activity co-ordinator, we need someone to do that so that the care staff can do their job, which they are incredible at. The activities are lacking." We viewed minutes of board meetings and reports that offered conflicting views on activities being offered. Some minutes reflected people's needs were being individually met, and others indicated this was an area requiring improvement. The minutes did not offer a solution and there was no outcome documented on how activities were going to be reviewed.

The registered manager had not ensured that people received care and treatment to meet their assessed needs or which reflected their preferences and wishes. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

In the providers Provider Information Return (PIR), they told us, "Resident's meetings are held on a regular basis and a copy of the minutes are displayed in the corridor and filed in the manager's office. These meetings give our residents an opportunity to bring concerns or complaints to the manager." However, we found these meetings did not occur regularly. There have been two meetings which took place in February and then September of 2017. The minutes did not reflect people had been given the opportunity to raise a concern or a complaint.

We looked at how the registered manager managed complaints. There was a policy in place for dealing with complaints and a procedure setting out how to make a complaint. However, this was not in a format that would be accessible to people living in the service.

People that we spoke to about this did not know how to access the policy or who to speak to if they had a complaint. There was no evidence that people were spoken to about how they could make a complaint and multiple people confirmed that this was not discussed at residents meetings or on a one to one basis. Four people indicated they would speak to their relative if unhappy. The registered manager told us the complaint procedure was available to people in accessible formats for example Braille (Braille is a tactile writing system used by people who are visually impaired) or on audio, however could not show us who had been offered this. The last documented complaint was made in October 2013.

The CEO offered assurance that she would personally meet with each person living at Thomas Tawell House to go through the complaints procedure and offer each person an accessible format of that procedure. The CEO stated she would also offer each person the opportunity to express how they feel about living at Thomas Tawell House and from that, establish if there is anything else the provider needs to respond to.

The registered manager had failed to ensure they had an effective and accessible system for identifying and responding to complaints. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

For people who required less support and who were more physically able, they told us they could entertain themselves and were happy to do this. One person told us, "No I never feel bored or isolated. After breakfast and lunch, I like to just sit in the lounge. I have no sight in this eye and only some in this one, so I am limited. The lounge is often quiet and isn't used as much as I'd like." Another person told us, "I do listen to audio books but mainly I just sit in my room. I cannot wander about on my own. I do sit in on the craft session on Wednesdays but cannot do anything of course. I enjoy the quiz every other Friday." Another person told us, "What's on offer is amazing; I actually went to my first Halloween party with people dressed up. I try not to get bored. I do like to knit, I enjoyed a writing class and go to the fortnightly quiz. The craft session is held when I have my bath so I go along afterwards. I also like to join in with the singalong." Another person told us, "I don't get bored. I listen to talking books, join in with the craft and the quiz and am making woolly balls

at the moment."

Inadequate

Is the service well-led?

Our findings

At the inspection in September 2016, the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found the provider had continued to fail in ensuring that there are systems and processes in place to continually review and improve the service. At this inspection, the provider was still in breach of the regulation.

At this inspection we found the provider had not ensured that they operated effective systems and processes to make sure they assessed and monitored their service against the regulations. Since our last visit, we found the provider lacked complete oversight and responsibility for Thomas Tawell House, resulting in a systematic failure in meeting the regulations. Despite the concerns raised at our previous visit there had been an absence of formal support and development to the registered manager. Consequently, we found inadequate monitoring of the quality and safety of the service provided.

The registered manager was line managed by the senior executive officer SEO and demonstrated she had limited oversight. We found that this had an impact on the service, in terms of governance and ensuring quality was sustained. Throughout our visit, we found that records were not available or did not exist. This meant that the provider could not provide evidence that they had appropriate governance and oversight procedures in place and could not fully assess the quality and effectiveness of the service. The breaches of regulation we identified should have been prevented through the operation of robust systems to monitor quality and compliance.

We identified inconsistencies in the quality of care with documentation and care delivery of variable quality dependent on the area of the home. For example we identified some issues with risk management, MCA compliance not being adhered to, care documentation and a lack of assessment of people's needs, as well as observing some good areas of practice in these same areas. Therefore, the quality and outcomes for people were inconsistent.

We viewed monthly records from January to November 2017, which showed structured processes in place for regularly auditing staff training, staff personal files, infection control, and general cleanliness of the home and all aspects of the medication administration records. However, there was no auditing system for reviewing care plans and risk assessments. The registered manager's audits did not reflect all of our findings and therefore were not effective in addressing areas for improvement.

Identified and assessed risks to people's wellbeing and safety had not always been effectively mitigated. People who had been identified as at risk of skin breakdown had equipment such as pressure relieving mattresses. Having the mattress set too firm or too soft could result in pressure damage occurring. We found that people who used a pressure relieving mattress did not have a checking system in place, linking weight to pressure relieving mattress settings as described in the guidance for the different manufacturers. There was also no record of the mattresses being routinely checked to ensure they were in good working order or on the correct setting. Records relating to the care and treatment of people were not always complete or accurate. We found a number of issues relating to health needs, including epilepsy and diabetes where

information lacked detail regarding the risks associated with these needs and the guidance for staff to follow.

In addition, they had not recognised that people were not always involved in their care, that they were not always afforded choice within their lives, nor their independence promoted and that there was a lack of person-centred planning, implementation and review. Other shortfalls in peoples' care related to peoples' lack of access to stimulation, meaningful occupation and activities. The provider had not reviewed staffing levels in response to peoples' changing needs to ensure that these were sufficient.

Accidents and incidents were recorded, including falls. There was no evidence of audit or review of incidents and accidents to identify patterns to inform care planning or flag up concerns. The evidence above shows that the provider had failed to maintain an accurate, complete and contemporaneous record in respect to each person's care and treatment.

We found serious concerns with care and support delivery at the home that necessitated a referral to the local authority safeguarding team to ensure people's safety. These shortfalls had not been identified by the current management team.

Although people's views had been sought these had not been used to improve the quality of care. There had been two resident meetings held in 2017 for people the last one being in September 2017. At these meetings, the menus and activities available were discussed, however suggestions made by people were not reflected on the current menus or activity schedule.

There remained inadequate processes for assessing and monitoring the quality and safety of the service provided for the purposes of continuing development. This is a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In the providers PIR, they told us, "Thomas Tawell House promotes a positive culture by ensuring the home has policies and procedures encompassing privacy, dignity, respect, equality, diversity and choice for all." However, we found that the culture of staff and registered manager meant that people were living in an institutionalised environment. Mostly resulting in people's functional needs being met. For example, care was task orientated and entirely lacked personalisation.

The culture of the home was largely task focussed, was not person centred and did not empower people to live fulfilled lives. The home had policies and procedures in place to offer the framework for how staff should conduct themselves but it was not followed through or embedded in their practice. The registered manager told us, "There is a cultural issue and the staff are used to things the way they are."

People told us they found the management and staff at the home to be approachable and helpful. However, we found the staff lacked effective leadership and management support and their morale was low. Our findings from this inspection demonstrated that the registered manager and provider had failed to provide good quality and safe care to people and had not acted upon known risks and shortfalls.

We discussed our concerns with the registered manager and CEO, who acknowledged improvements in the monitoring of safety and quality were required. The CEO told us she had identified the need for improvement shortly after being appointed in August 2017. At that point the CEO told us they had put together an action list that was taken from our previous two inspection reports. Between September 2017 and our inspection the CEO provided sufficient evidence that two attempts had been made with the registered manager to identify what areas still needed improvement and what support did the registered

manager need.

During this time, the registered manager was also offered support from Norfolk County Council (NCC) who were supporting providers who had been inspected and rated as 'Requires Improvement' by the Commission. The offer of training from NCC was declined by the registered manager. This demonstrated the registered manager's lack of willingness to improve her own practice to ensure she could lead and role model to staff. The board of trustees provided support to the registered manager by visiting on four occasions in 2017 and giving their feedback about the service. However, the feedback was hand written and not entirely legible. There was no action plan or follow up by the board of trustees with the feedback provided.

The CEO explained that the SEO line managed the registered manager and agreed there had been a complete failure in ensuring formal support and supervision was being conducted to support their registered manager in making the positive and needed changes to improve practice and protect people's safety.

The CEO agreed that better quality monitoring should have taken place since our last inspection to check if changes were being made. We found the board of trustees and SEO had adopted a culture of asking the registered manager if she was ok/needed support and requesting information around occupancy, staffing levels and activities but had not checked/asked for evidence and instead relied on what they were being told. The CEO and board of trustees confirmed this was a failure on their behalf and that they needed to be more vigilant in their monitoring of the service and support being offered to the registered manager.

The registered manager told us they did not have the knowledge or skills to improve practice and ensure compliance with the Health and Social Care Act (Regulated Activities) Regulations 2014. The registered manager also told us, "I don't think my best is good enough." Since our visit we have been informed the registered manager has resigned and are no longer employed by NNAB. The CEO has offered assurances that they are in day-to-day management of the service until such time a new manager is appointed.

Each time we informed the CEO of our findings, she immediately responded by ensuring shortfalls were addressed. This included informing the safeguarding team of concerns, notifying staff that all, increasing staffing levels with immediate effect, arranging monthly staff meetings to offer additional support and guidance and updating the services audit tool to ensure the areas we identified would be included. Following the inspection the CEO offered assurances they would also audit the service on a weekly basis offering the deputy manager and staff support to ensure all safety and quality monitoring aspects of the service improves. At our next inspection, we will assess how changes to their quality assurances processes have been embedded to ensure improvements are made and sustained.

The CEO also provided sufficient evidence that all training needs were booked and planned for to ensure staff had the knowledge and skills to meet people's needs. The CEO told us, "On the balance of what is right for our service, it is not in our interest to put any more people in the house until hand on heart we know staff are trained to work with people. The board of trustees are in support of this."

The CEO has contacted us since the inspection to inform us she has contacted managers from similar care homes, rated as 'Good' and 'Outstanding' to visit. The CEO explained she wanted to see what good practice and innovative ways other services had of working with people with similar needs. We received further assurances since the inspection and continue to be in regular contact with the provider to ensure standards improve imminently.

People and their families were asked to complete a short satisfaction questionnaire. Questionnaires were last completed in June 2017; however, there was no action plans in place to address the suggestions for improvement. Overall feedback was positive.

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 9 HSCA RA Regulations 2014 Person-centred care The registered manager did not ensure that service user's care and treatment was appropriate, met their needs and reflected their preferences. Care was not always designed to ensure service users' needs or preferences were met or that they understood the care and treatment choices available. (1) (a) (b) (c) (3) (a) (b) (d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way. Risks to people's safety who were living in the service had not always been assessed. Where they had been, actions had not always been taken to mitigate these risks. (1) (2) (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered manager did not have systems and processes that effectively operated to investigate and report allegations of abuse. Care and treatment was provided in a way that included acts intended to control and restrain a

service user. Service users were not protected from being deprived of their liberty.

(1) (2) (3) (4) (a) (b) (c) (d) (5) (6) (b) (d) (7) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered manager had not established and operated an effective accessible system for identifying and responding to complaints. (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered manager and provider had not established effective governance systems to assess monitor and mitigate the risks relating to the health, safety and welfare of service users. The registered manager had not maintained securely an accurate, complete and contemporaneous record in respect of each service user. (1) (2) (a) (b) (c) (d) (e) (f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered manager and provider had failed to make sure there were sufficient numbers of suitably qualified, competent and skilled staff. The registered manager failed to ensure staff received appropriate training to enable them to carry out the duties they are required to perform. (1) (2) (a)