Norfolk Care Limited

The Close

Inspection report

The Close Residential Home
53 Lynn Road, Snettisham
Kings Lynn
Norfolk
PE31 7PT

Tel: 01485540041
Website: www.norfolkcare.com

Date of inspection visit:
01 September 2016

Date of publication:
14 October 2016

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?	Requires Improvement

Summary of findings

Overall summary

The Close provides accommodation and personal care for up to 30 people, some of whom were living with dementia. There are external and internal communal areas for people and their visitors to use.

This unannounced inspection took place on 1 September 2016. There were 26 people receiving care at that time.

The service had a registered manager in place. 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.

Systems were not always followed to ensure people's safety was effectively managed. Staff were aware of the actions to take to report their concerns. However, a matter had not been reported to the local authority as required by local protocols.

There were sufficient staff to ensure people's needs were met safely, but staff were very busy and did not always have time to engage with people. Staff were only employed after satisfactory pre-employment checks had been obtained.

People were supported to manage their prescribed medicines. People's health and nutritional needs were met.

People received care from staff who were trained and well supported. Staff treated people with dignity and respect and in a caring manner.

Where people did not have the mental capacity to make decisions, processes had not have been followed to protect people from unlawful restriction and unlawful decision making. People were involved in every day decisions about their care. There were examples of where people were encouraged to be as independent as possible. However, this was not always the case.

People's care records did not always provide staff with sufficient guidance to ensure consistent care to each person. However, staff were aware of people's needs.

There were organised events for people to take part in. However, there were limited opportunities for people to develop hobbies and interests or take part in activities of daily living.

Records were not always stored securely.

The service did not have an effective quality assurance system. Concerns identified in this inspection had

not been previously identified, compromising the quality and safety of the service.

People and their relatives had opportunities to comment on the service provided and people's comments were listened to and acted on. People had access to information on how to make a complaint and were confident their concerns would be acted on. The registered manager provided strong leadership for staff who felt well supported.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Systems were not always followed to ensure people's safety was effectively managed. Staff were aware of the actions to take to report their concerns.

There were sufficient staff to ensure people's needs were met safely, but staff were very busy and did not always have time to engage with people. Staff were only employed after satisfactory pre-employment checks had been obtained.

People were supported to manage their prescribed medicines safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Where people did not have the mental capacity to make decisions, processes had not have been followed to protect people from unlawful restriction and unlawful decision making.

People's health and nutritional needs were met.

People received care from staff who were trained and well supported.

Is the service caring?

Good

The service was caring.

People received care and support from staff who were caring and respectful.

People and their relatives had opportunities to comment on the service provided. People were involved in every day decisions about their care.

Staff treated people with dignity and respect.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care records did not always provide staff with sufficient guidance to ensure consistent care to each person. However, staff were aware of people's needs.

There were organised events for people to take part in. However, there were limited opportunities for people to develop hobbies and interests or take part in activities of daily living.

People had access to information on how to make a complaint and were confident their concerns would be acted on.

Is the service well-led?

Requires Improvement

The service was not always well led.

Records were not always stored securely.

The service did not have an effective quality assurance system that monitored if people received a good standard of care.

People were encouraged to provide feedback on the service in various ways. People's comments were listened to and acted on.

The registered manager provided strong leadership for staff who felt well supported.

The Close

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 unannounced inspection took place on 1 September 2016. It was undertaken by one inspector. We asked for feedback from the commissioners of people's care, Healthwatch and the local authority infection prevention and control officer.

During our inspection we spoke with four people, four relatives and two visiting healthcare professional. We also spoke with the registered manager, the deputy manager, two senior care workers, three care workers, a cook, and a domestic. Throughout the inspection we observed how the staff interacted with people who lived in the service.

We looked at three people's care records, staff training records and other records relating to the management of the service. These included audits, rotas and meeting minutes.

Following our inspection the registered manager sent us the results of surveys sent to people who use the service and their relatives. We also received information from an officer from Norfolk Fire and Rescue Service.

Requires Improvement

Is the service safe?

Our findings

People receiving the service said they felt safe. One person told us this was because, "Staff are here day and night. They're marvellous." Another person told us that a person living in the home used to come into their bedroom. They said that they felt safer now that their bedroom could only be entered using a key code.

Systems were in place to identify and reduce the risks to people who used the service. Risks identified included assisting people to move, people at risk of falls, and people at risk of poor skin integrity. Measures were in place to minimise these risks. For example, regularly repositioning a person to prevent the development of pressure ulcers. However, we saw these systems were not always used. For example, one person had sides fitted to their bed. These sides had gaps wide enough to trap the person's limbs. The bedsides did not have covers on them to prevent entrapment. The senior staff member confirmed the sides were used when the person was in bed. However, they could not find a risk assessment about this person's use of bedsides and they did not know whether the bedsides should have covers on them when they were in use.

We also found that risk assessments were not always followed. For example, the registered manager confirmed that risk assessments stated that two staff members should always assist people when they were being transferred using a hoist. However, a visiting healthcare professional and a relative told us they had on occasions seen people being transferred using a hoist with only one member of staff. In addition, a staff member told us that staff had moved a person using the "standing hoist" on their own. This puts both the person and the staff member at risk of injury.

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

Staff considered ways of planning for emergencies. Each person had an individual evacuation plan. This helped to ensure that appropriate support would be given in the event of an emergency, such as a fire. However, a fire officer visited the home following our inspection, on 12 September 2016 and found there was only one key to unlock the front door. This meant there could be a delay in people being able to leave the building in an emergency. The fire officer requested urgent action be taken to review this procedure. Following the fire officer's visit, the registered manager told us that the provider's procedure was that all staff on duty carry a key to the front door. They said that they have reinforced this with staff and ensured there are enough keys on the premises.

Staff told us they had received training to safeguard people from harm or poor care. They showed they had understood and had knowledge of how to recognise, report and escalate any concerns to protect people from harm. One member of staff said, "There's no poor practice here. It's why I like it." Staff told us they felt confident that the registered manager would act on any concerns they raised.

Staff were aware of the provider's reporting procedures in relation to accidents and incidents. We saw these were recorded, investigated internally and acted upon. For example where a person had had a fall, measures had been put in place to explore possible reasons for the fall and reduce the risk of future falls.

However, we noted that one person had a large unexplained bruise on their arm which had not been reported to safeguarding as required under existing protocols. At our request the registered manage reported this to the local authority under safeguarding protocols retrospectively.

We received mixed views as to whether there were sufficient staff. Some people felt there were sufficient staff. One person told us, "[Staff] always come about the same time. They're, alright. I have a laugh with them." Another person said that staff "come quickly" when they pressed their call bell. However, other people felt this was not the case. One person said, "They're short staffed at the moment. They come at different times depending on other [people's needs]." A relative told us, "Sometimes I think there should be more staff on. They are absolutely rushed off their feet. There are often only three on in the afternoon. I feel there should be [more staff on duty] to give the care [people need]. Sometimes people have to wait. The carers do a grand job but there's not enough of them. The carers don't walk, they run."

A healthcare professional also said they felt there was not always enough staff, especially in the mornings when they saw staff "rushing to get [people] washed." They told us there were "a lot" of people who required two staff to provide their personal care, but that they sometimes saw that one member of staff would attempt this care on their own.

The registered manager told us that they did not use agency staff and that staff leave was covered by the existing staff team. The registered manager told us she did not use a formally recognised tool to assess people's dependency and the number of staff needed to care for them. She told us, that she and the deputy manager provided care and therefore continuously assessed how many staff were required to meet people's needs.

They told us that there were usually four care staff on duty from 8am to 2pm and one care staff from 8am to 12 noon. However, on the day of our inspection there were only four staff on duty between 8am and 12pm. Two staff had started their shift an hour earlier, at 7am, in order to help people to get up. Some staff told us they felt this did not have an impact on people. One staff member said, "We do the same job and spend the same time with people." Another staff member said, "[Staffing in all care homes is] a struggle. Everyone here gets personal care and we make time to chat to people." However, another staff member said, "We cope, but the fifth [staff member] can make a big difference. We have more time with residents, for example when they are bathing."

Overall we found people's needs were met, but staff were very busy. There was little interaction between staff and people unless staff were performing tasks such as personal care or serving food or refreshments.

The staff we spoke with told us that the required checks were carried out before they started working with people. These included two written references, proof of a recent photographic identity as well as their employment history and a criminal records check. This showed that there were systems in place to make sure that staff were only employed once the provider was satisfied they were safe and suitable to work with people who used the service.

People were satisfied with the way staff supported them to take their prescribed medicines and said they received these in a timely manner. One person said, "Oh yes, I always get my medicines. [Staff] give them to me every morning and every night. They're very good."

We saw that people were safely supported with the administration of their medicines. Staff reminded people what their medicines were for. There were appropriate systems in place to ensure people received their medicines safely. Staff told us that their competency for administering medicines was checked regularly. We

found that medicines were stored securely. Medicines were administered in line with the prescriber's instructions. Appropriate arrangements were in place for the recording of medicines received and administered. Clear guidance was in place where medicines were to be administered 'when required'. Checks of medicines and the associated records were made to help identify and resolve any discrepancies promptly.

An audit carried out by an infection prevention and control (IPaC) officer from Norfolk County Council on 27 January 2016 found numerous areas for improvement within the service. At their follow up visit on 24 May 2016 the IPaC officer found the registered manager had not received their action plan and guidance. Despite this, actions noted by the senior care worker at the initial visit had been actioned. During our inspection we saw that good progress was being made with the action plan they received they had received from the IPaC officer on 24 May 2016. For example, various areas of the home had been redecorated and hand towel dispensers were now wall mounted.

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.

The registered manager had made applications to the local authority for DoLS where appropriate. For example, some people had been assessed as requiring support from staff if they went out into the community and they were not free to leave the service alone. The registered manager told us the local authority had acknowledged these applications.

Staff told us they had been trained in the MCA and DoLS. However, this knowledge had not been embedded. Staff were not clear about which people living at the service could be legally deprived of their liberty. We asked a senior staff member whether a person had a DoL authorisation in place. The staff member told us, "I don't know, [The registered manager] does that part. I think most of them have. When we had to lock the door to keep people safe, we had to get DoLS. No-one is safe to leave the building on own but we can always arrange for staff or family to go with them." However, another member of staff told us that two people were able to make the decision to leave the building unaccompanied.

A staff member told us that a person who had expressed particular dietary preferences throughout their life and this was recorded in their care plan. Staff told us the person was now living with dementia and were choosing to eat a food they would not have eaten previously. The registered manager described consulting the person and their relatives about this change. However, no mental capacity assessment or best interest decision had been carried out in relation to this significant change in the person's wishes.

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

People said they received enough food and fluids and staff knew what they liked. We received mixed comments about the food. Most people said they liked the food. One person said, "I can't complain about the food at all. They give me what I like every dinner time… I love it. They know what I like." Another person said they "Can't fault one scrap." Another person shook their head when we asked them about the food. They said, "Some is good, like the roasts… but the food is on and off." A relative told us, "[The staff] know what [my family member] likes." They went on to tell us that staff always made sure their family member

had food they liked. However, another relative commented that their family member found the food monotonous with sandwiches for tea several times each week and a lack of fresh seafood and vegetables on the menu. They said that their family member felt frozen food "just doesn't taste the same." One relative commented that their family member had referred to the "plastic ham" that was served and we noted in the provider's survey that one person had commented that their family member would like "more fresh fruit and good cheese and ham."

People were offered a choice of what they would like to eat and drink. The menu showed the meal and tea on offer, and included an alternative for those who required a diabetic menu. However, although one person living at the home preferred a vegetarian diet, this option was not included on the menu. People told us that the cook or chef visited everyone who was able to make a choice, each day to ask if they were happy with the meals on offer or if they would prefer an alternative. One person said, "Cook comes round every day and taps on the door and says 'How are you today? Anything you want special?'"

People were supported to have enough to eat and drink. People were offered a choice of fluids at regular intervals throughout the day. Relatives and a visiting healthcare professional said this was always the case. Staff offered people assistance with their meals and drinks, if they needed this. We saw that staff gave each person the time they needed and did not try to rush them.

Appropriate diets were provided to people who required them and people were referred to a dietician when needed. For example, we saw that some people's meals were pureed where they were at risk of choking on more solid food.

Staff told us that lunch was served at 12 noon. Many people were sitting at the dining tables before this time. However, there was a delay in the main meal being served at lunchtime resulting in some people sitting at the table in excess of 25 minutes before they received their meal. Staff waited for everyone to finish their main course before desert was served. There was a further 10 minutes delay where people were left waiting for their desert. There was limited interaction from staff who only spoke with people when serving their food, or medicines or responding to a request. Some staff cleared tables without speaking to the people sitting at them.

People had access to health care professionals and were supported to manage and maintain their health. One person told us, "If I'm poorly [the staff] call the doctor." A relative commented that staff had supported their family member to access an optician who assessed them for new spectacles, which staff had supported them to wear. They also told us that staff had reacted promptly when they suspected the person had a medical issue.

We saw that staff made appropriate referrals to healthcare professionals. Records confirmed that people were supported to access the services of a range of healthcare professionals, such as the community nurses, the GP, an optician and chiropodist. This meant that people were supported to maintain good health and well-being.

People told us they liked the staff who worked at the service and that their care needs were met. Relatives said that staff were trained. One relative told us, "[The staff] were being trained yesterday. Periodically they get instruction in how to use the hoists etc." Another relative said, "[The staff] all seem to know [my family member]. Staff are really good to [the people living at The Close]. The [staff] are lovely." A healthcare professional said the staff were all trained to meet the needs of people and had a basic knowledge in areas such as the prevention of pressure ulcers. They told us the staff were very keen to gain knowledge.

Staff told us they enjoyed their work. One staff member said, "I love it here. We can have a laugh with the residents. They'll have a laugh with us. It's calm. It's a lovely atmosphere."

Staff were supported to develop and maintain their skills and knowledge. Staff told us that they felt that they had sufficient training to meet the needs of the people living at the service. New staff told us they 'shadowed' a more experienced care worker until they were deemed competent and were confident providing care. One staff member said, "I couldn't touch a hoist until I'd been shown and trained. I didn't get thrown in the deep end here." They told us an important part of their induction was "learning [people's routines] and getting to know the residents."

Staff told us they received regular refresher training in key areas such as assisting people to move, food hygiene, infection control and safeguarding. They told us the registered manager was well organised at reminding them when their refresher training was due. One member of staff told us they had received dementia awareness training. They said, "I think it's quite helpful for getting new updates. It refreshes your mind. It's very good for new staff."

Staff were supported to achieve nationally recognised qualifications. Records showed that 10 of the 14 care staff had achieved a nationally recognised qualifications of level two or above in health and social care.

The registered manager told us they aimed to formally supervise staff three times per year, one of which would be an observation of them providing care. In addition staff received an annual appraisal of their work. Staff told us that in addition to this formal supervision, the registered manager sometimes provided personal care and worked alongside them, providing informal support. Staff told us the registered manager was supportive and that they could approach her outside of the formal supervision to discuss any issues or concerns.

Good

Is the service caring?

Our findings

People and their relatives were complimentary about the staff. One person said, "[The staff are] alright. I have a laugh with them. All the staff are very good to me." Another person said, "Staff are marvellous." This person said staff understood and met their care needs. One relative said the staff were, "Generally quite good. They seem to care for [my family member]. The staff treat [people] very well." Another relative said the staff were, "Fine. I think they spoil [my family member] bit." A healthcare professional told us, "All the staff do care, absolutely." Another healthcare professional said, "The staff are very friendly and helpful. They're nice staff."

The service had received written compliments that also showed the caring nature of staff. These included, "Although [my family member] was only with you for [a short time] she was very happy and content. Your staff are so caring and kind and I can't thank you all enough for your kindness. I do miss coming to The Close as I always found it so friendly and homely."

Our observations showed the staff were caring and respectful to the people they were supporting. Staff called people by their preferred name and spoke in a calm and reassuring way. One person described how a staff member had been very caring when they required an emergency hospital admission. They said, "When I went to hospital a carer came with me. [The carer was] marvellous. It made a lot of difference to me." Another person's relative also praised staff for staying with their family at the hospital when they had been unable to get there.

Staff knew people well and told us about people's history, health, personal care needs, religious and cultural values and preferences. This information had been incorporated into people's care plans.

Staff provided people with clear information about what they were going to do and what was expected of them. For example, after establishing that a person needed assistance to rise from their chair, we heard a staff member say to the person, "Here's your frame. Ready? One, two, three." From the person's reaction we could see this was clearly a routine the person was used to.

Staff consulted people and or their relatives about their care. Throughout the inspection we heard staff consulting people about their care and preferences. For example, we heard care staff ask if people were ready to go to bed and if they preferred their door open or closed. One person said, "I can get up and go to bed when like. I get up between 6.30am and 8am. If I fancied a lie in I'd just tell them." However, people also told us this flexibility depended on how many staff were on duty and how busy they were. Two relatives told us they had been involved in writing and reviewing their family member's care plan. One relative said, "I did see his care plan once. There were a few things [I raised] and they did address them."

People who required advocacy were supported in a way which best met their needs. For example, relatives and people who knew the person well were consulted about people's care and involved in best interest decisions. Information was available should people require an external advocate. Advocates are people who are independent of the service and who support people to decide what they want and communicate their

wishes.

Relatives told us that staff respected people's privacy and dignity when supporting them. Our observations throughout our inspection showed us that staff knocked on people's doors and waited for a response before entering. People told us this was always the case. This meant that staff respected and promoted people's privacy.

People told us they were encouraged to bring in personal belongings to help them feel "at home." One person showed us their room that contained lots of photographs of their relatives. They told us they like to spend time in their room. They said, "I'd rather stay in my own little home as I call it." A relative said that staff had encouraged them to bring in familiar items for their family member. This included artwork that the person had completed. These things helped people to orientate and feel more comfortable at the service.

Staff encouraged people to maintain relationships by making their visitors welcome to the service. People and relatives all told us that the registered manager and staff made visitors welcome. One relative said, "I feel we're very lucky in the village. I can visit whenever we want. We are always offered coffee and we could have lunch. We feel so lucky." Another relative agreed with this view. They said they were "definitely" welcomed. "I'm always offered a cup of tea and a biscuit."

Requires Improvement

Is the service responsive?

Our findings

People and relatives felt that staff understood and responded to people's needs. One person said, "[The staff] always come and get me up properly. They make my bed and bring me breakfast." Another person told us, "[The staff] look after us alright."
A relative commented that their family member's hair and nails were "always clean" and said how important that was to the person.

People's care needs were assessed prior to them moving to the service. This helped to ensure staff could meet people's needs. One relative told us that their family member's social worker had carried out the initial assessment. They said this information had been shared with the registered manager who had then met them and their family member and asked for further information. We saw that people's care records included information on people's life history, preferences, allergies, friends and their hobbies and interests. This assessment was then used to form the basis of people's care plans.

We found the registered manager and staff were aware of people's needs and how to meet them. However, people's care plans were brief and some of the language used did not give sufficient detail for staff to be able to ensure consistent care. For example, one person's care plan stated "staff to assist with toilet management…will require assistance to freshen up after pad change." Other care plans used words that were open to each member of staff's own interpretation, such as 'temperamental' and 'aggressive'.

Staff and relatives told us people's care plans were reviewed and issues raised were addressed. For example, one relative said their family member was bathing sufficiently. They told us that the person was now assisted to shower every night before they went to bed. They said this time suited the person as it helped them to sleep. However, we found care plans were not always updated to reflect people's current needs. For example, staff and the registered manager told us that one person's dietary preferences had changed, but this had not been reflected in their care plan.

Some efforts were made to maximise each person's independence. For example, staff made sure people had appropriate equipment to assist them during mealtimes, such as plate guards. Staff told us that where possible they encouraged people to hold 'finger foods' such as sandwiches. One person had an entry code written on a tag on their handbag to help them to access a room on their own. However, we saw several missed opportunities to maximise people's independence. For example, people did not have the opportunity to help themselves to gravy and cream as this had already been added to the plates when people received their meals. Some tables had salt cellars, and other tables had pepper pots, but no tables had both. Staff did provide staff with a salt cellar from another table when they requested it.

There were organised activities, including visits to nearby attractions, which people were supported to attend. A poster advertising the trips planned for the year showed these were a visit to lavender fields in July, and trips to Hunstanton and Sandringham in August. People told us they had enjoyed these trips out very much. Relatives also told us that their family members, who were not able to speak with us due to their complex care needs, had also enjoyed these trips out. Two relatives commented that their family members

had always spent a lot of their time "outside" and had particularly enjoyed these trips. Both relatives told us they didn't feel their family members went outside often enough. Although on occasions people enjoyed short trips into the village and sitting in the garden.

Staff told us that various external professionals visited the service several times each week and provided entertainment and sessions for people to join in with. People told us they particularly enjoyed the music sessions. During our inspection an external facilitator took a session of music and movement. Approximately 10 people attended this session. Their laughter, singing and feedback showed they clearly enjoyed this activity and interaction.

For the rest of our inspection there was little staff engagement with people except in relation to task-orientated activities such as meals, medicines and personal care. People were not supported to pursue their interests or be involved in activities of daily living. Of the five staff we spoke with about how people spent their time, only one staff member talked positively about encouraging people to occupy their time meaningfully. Other staff lacked the knowledge of how to engage people who had more complex needs. One senior staff member told us they "chatted" with people when providing personal care or during their break. They said there was "not really" opportunity to talk with people at other times. We asked them if they thought people were bored. They told us they thought people were, "Quite happy to sleep." Another member of staff said that, "If people look bored we find something to do. Most of the time they are just happy watching television." A third staff member told us that they encouraged people to, "Watch DVD's, play bingo and do colouring." We asked if people did do these things. They said, "Not so much, because most people have dementia." We asked another member of staff if people were encouraged to join in activities of daily living. They told us "The majority of people are in wheelchairs so can't [do these things]. We've tried in the past but they don't really want to do it."

We asked people how they spent their days and if they had enough to do. One person told us they spent their days "watching the TV." Another person said they preferred to stay in their room "watching telly and reading." A third person said they had joined in the music and movement earlier in the day but other than that they would do, "Nothing. Every day is just another day." A fourth person told us what their life was like when they were younger and about when their spouse had died. We asked them if they were able to talk about these things with staff. They said they did, "Occasionally, but [staff] don't really have the time."

Relatives had mixed views about whether people were supported to be occupied. One relative told us their family member did puzzles and read magazines. They said their family had a, "Much better quality of life since [they've] been here." However, another relative said, "[my family member] is not really encouraged to do anything."

People and their relatives said that staff listened to them and that they knew who to speak to if they had any concerns. Everyone we spoke with was confident the registered manager or another member of staff would listen to them and address any issues they raised. One person commented, "My [family member] would see about that. [The staff] know me." A relative said there had been "A few issues" when their family member first moved to the service, but that they had spoken directly with the registered manager and most of these had been resolved. The registered manager agreed to liaise with the relative regarding one issue that the relative felt had not been resolved satisfactorily.

Information about how people could complain, make suggestions or raise concerns was available near the visitors signing in book. Staff had a good working understanding of how to refer complaints to senior managers for them to address. We found that complaints were investigated and dealt with appropriately and thoroughly, within the timescales stated in the complaints procedure.

Requires Improvement

Is the service well-led?

Our findings

We saw that most records and confidential information was stored securely. However, this was not consistently the case. We found some information about people's prescribed medicines was stored on the front of a cupboard in the dining room. In addition, information about people's health and medical and physical conditions was displayed on the notice board above the visitor's signing in book.

The registered manager told us they monitored the quality of the service. This included regular recorded meetings between the provider's representative and the registered manager. These included actions and identified who was responsible for these. However, we found the monitoring did not always identify shortfalls and was not therefore always effective. An infection prevention and control (IPaC) officer from Norfolk County Council found numerous areas in need of improvement within the service during their visit on 27 January 2016. These issues had not been identified prior to their visit. During our inspection we also found shortfalls in the service that had not been previously identified. For example, although systems were in place to identify and reduce the risks to people who used the service, we found these were not always followed. In addition, there were shortfalls in staff knowledge and application of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Further care plans were brief and had not been updated to reflect people's current needs. This shows that the current systems for monitoring the quality of the service were not effective.

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

We received positive comments about the management of the service from the people, visitors and staff. People using the service and their relatives all knew the registered manager and said they felt she was approachable. One person said the registered manager, "Pops in" to their bedroom to see them regularly. A healthcare professional told us, "[The registered manager] runs a tight ship."
A relative wrote to the service, "As a retired nursing sister I am delighted to write to you about [the registered manager] and her staff at The Close. Whoever is in charge sets the standard and I cannot praise highly enough the care and attention given to [my family member]…. [The registered manager] is an excellent example to her staff and was professional and also very kind throughout all my communications with her. [The registered manager] and her staff treated [my family member with dignity, respect and compassion and the highest professional standards of nursing care. They went over and above the call of duty….They are quite exceptional."

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

The registered manager had an understanding of their role and responsibilities. They were aware that they were legally obliged to notify the CQC of incidents that occurred while a service was being provided. Records we looked at showed that notifications had been submitted to the CQC in a timely manner.

The registered manager provided strong leadership for staff. They were supported by a staff team that included a deputy manager, senior care workers, care workers and ancillary staff. Staff were clear about the reporting structure in the service. From discussion and observations we found the registered manager had a good knowledge and understanding of the care needs and preferences of the people receiving this service.

The registered manager was approachable and staff felt well supported. Staff regularly attended staff meetings where a range of issues were discussed, including the registered manager cascading a variety of information. For example we saw that they had cascaded information about health and safety issues. Staff told us that they had regular supervision, support and training according to their role. A staff member said, "[The registered manager] sorts out problems as soon as they appear. I'm impressed that all staff talk to each other. If something is needed to be done, it's done just like that." Another staff member said, "[The registered manager] is a very fair manager. She's one of the best managers I've ever had. She's very supportive."

The registered manager sought feedback from people in various ways. This included regular, informal contact with each person and their relatives. In addition formal surveys were sent to people and their relatives each year. We saw responses to the survey sent in June 2016. Responses were received from 18 people and nine relatives. Responses were very positive and we saw that where people had made suggestions, these had been taken on board and actioned. For example, one relative had commented, "I would like Christian names via badges on uniforms." We noted during our inspection that all staff were wearing badges that included their name and role.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Where people did not have the mental capacity to make decisions, processes may not have been followed to protect people from unlawful restriction and unlawful decision making. Regulation 11.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Staff did not always follow systems to identify and reduce the risks to people who used the service. Regulation 12 (1) (2) (a) (b) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Records were not always stored securely and with restricted access. Regulation 17 (2) (c) The current systems for monitoring the quality of the service were not effective. Regulation 17 (1) (2) (a) and (b)