Community Integrated Care

Norfolk Road

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This was an unannounced inspection that took place on 8 March 2018.

Norfolk Road is situated in Denton Holme and is near to all the amenities of the city of Carlisle. It is operated by Community Integrated Care who run similar services nationally.

Norfolk Road 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. When we last inspected this service in September 2016 we rated it as 'requires improvement' and we made recommendations.

The home accommodates six people in a large adapted period property. At the time of our visit there were five people living there.

The home had a suitably qualified and experienced registered manager. 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.

The staff team understood how to protect vulnerable adults from harm and abuse. Staff had received suitable training and could talk to us about how they would identify any issues and how they would report them appropriately. Risk assessments and risk management plans supported people well. Arrangements were in place to ensure that new members of staff had been suitably checked before commencing employment. Any accidents or incidents had been reported to the Care Quality Commission and suitable action taken to lessen the risk of further issues.

The registered manager ensured that there were sufficient staff to support people. Our findings corroborated this. Staff were suitably inducted, trained and developed to give the best support possible. We met experienced and confident team members who understood people's needs as well as new staff who were keen to learn.

Medicines were appropriately managed in the service with people having reviews of their medicines on a regular basis. People in the home saw their GP and health specialists whenever necessary.

We saw that good assessment of need was in place and that the staff team analysed the outcomes of care for effectiveness. People appeared happy with the food provided and we saw well prepared healthy meals that staff supported and encouraged people to eat.

The house itself was warm, clean and comfortable on the day we visited. Suitable equipment was in place to support people with their mobility.

The staff team were aware of their responsibilities under the Mental Capacity Act 2005. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

We observed kind, patient and suitable support being provided. Staff knew people and their families very well. They made sure that confidentiality, privacy and dignity were maintained. People were encouraged to be as independent as possible. No one was receiving end of life care when we visited but there were plans in place and training available should the need arise.

Risk assessments and support plans provided detailed and relevant guidance for staff in the home. People in the service were involved in the writing of support plans and were able to influence the content. The management team had ensured the plans reflected the person centred care that was being delivered.

Staff took people out locally and encouraged people to follow their own interests and hobbies. The service was establishing links in the community.

The registered manager demonstrated good vision and values. Staff were able to discuss good practice, issues around equality and diversity and people's rights.

The service had a comprehensive quality monitoring system in place which was used to support future planning.

Complaints and concerns were suitably investigated and dealt with and good records management was in place in the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

There were sufficient staff available to meet people's needs in a timely manner.

Staff, including the registered manager, were knowledgeable about abuse and knew how to keep people safe.

Medicines were managed appropriately.

Is the service effective?

Good

The service was effective.

People's needs were being thoroughly assessed.

The staff were well trained, competent and confident in their approach.

People were not being deprived of their liberty inappropriately.

Is the service caring?

Good

The service was caring.

People were able to, and had, accessed advocacy services.

Staff treated people with dignity and respect.

People lived their lives as independently as possible.

Is the service responsive?

Good

The service was responsive.

People were able to access the community and take part in a wide variety of activities.

People were not at risk of social isolation.

There was a complaints policy and procedure in place.

Is the service well-led?

Good

The service was well led.

There was a culture of learning lessons and improving practice.

The registered manager was present within the home and took an active role in all aspects of the service.

The quality assurance system helped support continuous improvement in the service.

Norfolk Road

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 provide a rating under the Care Act 2014.

This inspection took place on 8 March 2018 and was unannounced.

The inspection was carried out by one adult social care inspector.

Prior to the inspection we gathered and reviewed information we held about the service including statutory notifications we had received. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We observed people's care and support in communal areas. We spoke with two of the people who used the service and six staff including care workers, the registered manager and her deputy. In addition, we consulted two representatives of the local authority, reviewed two care records and various other records relating to the service such as training records and equipment maintenance logs. We walked round the building and its grounds and with permission entered people's rooms.

Good

Is the service safe?

Our findings

People were not easily able to tell us detailed information about their views and opinion of the service. However, when we spoke with people some were able to respond with yes and no answers, others were able to communicate in other ways. We observed that people who used the service appeared happy and content.

We last inspected this service in September 2016 during which we made a recommendation about staffing levels within the home. At that time staff told us that there was not sufficient staff to keep people safe, especially if there was an incident or emergency. When we spoke with staff during this inspection they told us, "I never feel that we are understaffed, if anything needs covered [on the duty rota] it gets covered." and "We always run on safe levels."

According to the duty rota there were sufficient staff on each shift. For example, during the busy lunch period there were three care workers, the deputy manager and the registered manager available to support the five people who used the service. In addition, a member of staff told us, "People are able to go out all the time and are out for longer." Our observations confirmed this.

Staff records indicated that all staff had undergone background checks before commencing employment including references from previous employers and checks to see if they had a criminal record. Where staff had not attained the best standards of conduct they had been dealt with in line with the providers human resource policy.

We spoke with all the staff on duty and asked them how they safeguarded the people who used their service from abuse. Staff were able to tell us about different kinds of abuse such as physical, financial or emotional. They told us what they would do if they suspected abuse was taking place, "I'd report it to the manager straightaway." This meant staff knew how to identify and report abuse. We spoke with the registered manager and her deputy. They demonstrated their knowledge on how to report and investigate issues relating to abuse and safeguarding. We saw from our records they appropriately raised any concerns with the local safeguarding authority. The policies and procedures relating to safeguarding were all on clear display in the staff office along with guidance on whistleblowing. Having whistleblowing guidance meant that staff were aware of how to confidentially raise concerns about the conduct of colleagues.

Records indicated that the service had responded well to incidents and accidents. At times people who used the service could present with behaviour that challenged. Such incidents were dealt with quickly at the time by staff trained to do so. We looked at one incident and questioned whether staff could have done things differently. The registered manager showed us evidence that she had spoken to each of the staff members involved and then discussed the incident with the team and asked the advice of the local NHS community learning disability team. Staff had discussed the incident and made changes to their practice and to people's care plans which would minimise the risk of the incident happening again in the future. This is known as a 'learning lessons' approach and is in line with best practice. We asked the registered manager to ensure that all documentation was completed around these incidents as they happened to help embed a learning lessons culture into the service.

We looked at people's care records and saw that they each had individualised risk assessments covering a variety of areas, for example mobility and accessing the local community. In addition, the registered manager carried out generic risk assessments on the building including fire risk and health and safety risks. The risk assessments undertaken identified ways to minimise risk to people who used the service and helped keep them safe from harm. For example all of the five people required staff to escort them in the community. We saw equipment, such as hoists, were well maintained and regularly serviced as were domestic appliances such as the boiler.

The safe administration of medicines was outlined in policies and procedures at the service. Medicines were administered by staff trained to do so whose competencies were regularly scrutinised by senior staff. All medicines were stored safely in people's rooms along with the appropriate records. There was a fridge for medicines that required cool storage. There were no controlled drugs in use at the time of our inspection though we noted the service were able to safely secure and manage them if required. The ordering and disposal of medicines was carried out in conjunction with a local pharmacy.

We saw the home was clean and well maintained. Staff had access to personal protective equipment and had the training and knowledge to carry out safe infection control practices.

Good

Is the service effective?

Our findings

People were not easily able to tell us detailed information about their views and opinion of the service. However, when we spoke with people some were able to respond with yes and no answers, others were able to communicate in other ways. We observed that people who used the service were being cared for by staff with the appropriate skills and training.

The service had a system of assessment in place called 'The golden thread'. The golden thread focused on people who used the service and their wishes. They contained information about people's lives so far, their aspirations and details about what they thought was a good day for them. These assessments were detailed and written in the first person. Staff told us that people were as involved as they possibly could be in the assessment process.

Assistive technology was available within the home. There were pressure sensors placed around beds to alert staff that people had risen during the night and may require support. An electronic tablet was available to one person to help them communicate their choices to staff.

We spoke with staff and asked them if they felt confident and competent whilst carrying out their role. Staff told us, "We do loads and loads of training" and, "Training and the trainers are really good.....we keep learning."

Records confirmed that staff had completed mandatory training. This included positive behaviour support, infection control and safeguarding vulnerable adults. New staff were provided with induction training which included a period of probation. During this period their competencies were regularly checked by senior staff. Staff were able to access more formal vocational training, to help support them with further education the provider offered maths and English courses.

We looked at supervision and appraisal records for staff. Supervision sessions gave staff and the registered manager the opportunity to discuss training required or requested and their performance within their roles. Staff were able to discuss all elements of their role during supervision sessions. When we spoke with staff they told us that they found these sessions helpful in terms of their development and performance.

People's nutritional needs were being met. We saw everyone had support plans relating to food and fluid. We noted that staff were making meals from scratch using healthy options and alternatives. For example, the shepherd's pie they made on the day of our visit was made using low fat beef mince. This helped to support people to achieve a healthy balanced diet in line with their support plans. Where people needed specialist support the opinions of dietitians and speech and language therapists had been asked for and provided.

The home had recently accepted a transfer of a person from another service. We saw that the staff had carefully planned this and managed it appropriately. They had ensured the person had kept in touch with people who they wanted to keep in touch with from their previous service.

Support plans were in place to ensure people's health and wellbeing were monitored. We saw that people regularly attended the GP or the dentist or were seen at home by visiting professionals. Support plans contained information about how people would communicate feelings of discomfort, illness or pain. This might be verbally or non verbally dependant on how people preferred to communicate.

The home had undergone some redecoration since our previous visit. Communal areas, corridors and bedrooms were clean and in a good state of repair though the exterior did require some minor attention. There were separate areas for people to watch television and relax, a dining area and each person had their own bedroom which was personalised to how they wanted it. The grounds of the home were extensive, secure and well kept.

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 make 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 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. We found that all of the people who used the service were either appropriately subject to a DoLS or were awaiting authorisation for one.

Good

Is the service caring?

Our findings

People were not easily able to tell us detailed information about their views and opinion of the service. However, when we spoke with people some were able to respond with yes and no answers, others were able to communicate in other ways. We observed that people responded well to the kindness of the staff. When we asked one person if they felt they were being looked after properly they replied, "Yes."

The registered manager had details of advocacy services that could be contacted if people needed independent support to express their views or wishes about their lives. Advocates are people who are independent of the service and who can support people to make or express decisions about their lives and care. The registered manager knew how to ensure that individuals wishes were met when this was expressed either through advocacy, by the person themselves or through feedback from relatives. The registered manager was able to give examples of this. We looked at people's written records of care and saw support plans were devised with the person who used the service with support from their relatives or advocates. This meant where possible, people were actively involved in making decisions about their care treatment and support.

When we spoke with staff they appeared to know people well. They were able to tell us about people's preferences and what kind of support they required. This information was accurately recorded in people's support plans. The sufficient staffing levels allowed staff to spend time sitting and talking with people. This meant staff were equipped with the correct information and had the time to build caring relationships with the people they supported.

We observed staff treating people in a respectful manner. During our inspection people's privacy or dignity was compromised. Staff had received training on how to ensure all of the people who lived at the service were treated with kindness and respect. I addition they had been trained to treat people equally and account for people's diversity.

Staff were able to explain to us how important it was to maintain confidentiality when delivering care and support. The staff members we spoke with were clear about when confidential information might need to be shared with other staff or other agencies in order to keep the person safe.

Support plans clearly stated what people were able to manage independently and what support staff would be required to provide. Where people were unable to manage tasks independently, staff told us they made sure people were given choices to enable them to retain as much independence as possible. We saw that some people were able to move freely around the home alone, whereas other required staff support. All of the people who used the service were encouraged to be as independent as they wanted and were able to be.

The home had a welcoming atmosphere, we saw that family relationships were positively promoted as part of day to day life within the service.

Good

Is the service responsive?

Our findings

People were not easily able to tell us detailed information about their views and opinion of the service. However, when we spoke with people some were able to respond with yes and no answers, others were able to communicate in other ways. We observed that people left the home to go on outings throughout the day of our inspection. When we asked one person if they enjoyed being able to access the community they replied, "Yes."

People's support plans were written in the first person and with the involvement of people who used the service, their relatives or advocates and staff. People's strengths and areas where they required support were included. For example, some people required help getting dressed but had made sure their preference for style of dress had been documented.

People had clear ideas how they wished to spend their day, for example we looked at one person's morning routine. In it they stated the time they preferred to get up, when they liked to have breakfast and when they wanted to access the local community. We were able to observe this person and saw staff had ensured that the persons wishes had been followed to the exact detail.

Support plans were comprehensive and contained information around all aspects of people's health and wellbeing. Staff had taken time to build a 'picture' of each person using a variety of sources including the person themselves, relatives and health and social care professionals. Together the staff and people who used the service had used the information to develop aspirational support plans that took into account people's current needs and abilities and encouraged people to fulfil their potential. For example, one person had started swimming after not being able to for a period of time, another person was planning overnight stays at hotels and holidays.

People regularly accessed the community if they chose to do so. A member of staff told us, "People are getting out and for longer." We observed the majority of the people who used the staff going out of the home, many were going for a walk some had gone to the local shops. Records indicated some people had their own social networks which the staff were supporting them with on a day to day basis. On special occasions staff ensured that people who were important to individuals who used the service were invited into the home.

The service employed a number of strategies to help people communicate their wishes. Some people used technology such as electronic tablets whereas others used picture boards and non verbal communication. The service published easy read documents for people. A variety of communication strategies and procedures were outlined in the providers policies.

The service had a formal complaints policy and procedure. The procedure outlined what a person should expect if they made a complaint. There were clear guidelines as to how long it should take the service to respond to and resolve a complaint. The policy mentioned the use of advocates to help support people who found the process of making a complaint difficult. There was also a procedure to follow if the complainant

was not satisfied with the outcome. There were no recent complaints. The registered manager explained that wherever possible they would attempt to resolve complaints informally.

At the time of our inspection no one was receiving end of life care. There were policies and procedures in place and the registered manager explained there was training available if required. The registered manager told us care at the end of life would be supported by a multi disciplinary team approach which would include the GP, hospice at home and other health and social care professionals.

Good

Is the service well-led?

Our findings

People were not easily able to tell us detailed information about their views and opinion of the service. However, when we spoke with people some were able to respond with yes and no answers, others were able to communicate in other ways. We observed that people who used the service appeared very comfortable in the presence of the registered manager.

We last inspected this service in September 2016 during which we made a recommendation about management arrangements within the home. At that time staff told us they were unsure of what management arrangements were in place and did not see the registered manager often. When we spoke with staff during this inspection they told us, "We are well supported by the [registered] manager."

We noted that the registered manager was involved in all aspects of the service, she was liked and respected by both people who used the service and her staff. She modelled professional behaviour to her team and was clearly knowledgeable about good practice, learning disabilities and autism.

During our inspection we discussed the future of the service with the registered manager and her deputy. The provider was considering making some changes to the services registration. However, the registered manager was clear that any changes made would be of benefit to the people who used the service. She was keen to build on the improvements made since the last inspection and move the service forward and this included continuing community integration. The deputy manager was keen to understand what would be required to make the service 'outstanding'.

We reviewed incidents that had taken place within the service. One incident had occurred recently and had involved a number of staff. The registered manager had debriefed the staff within supervision and analysed the information gathered. She had then discussed this with the staff and they had agreed how they would do things a little differently in the future. We spoke with staff about the incident and they told us what they thought went well and what they thought could have been done better. Staff told us, "We learned so much from the incident, there was a massive debrief and we felt well supported." The registered manager provided us with a report that outlined lessons learned and subsequent changes in practice. This approach of continuous learning helped ensure better quality outcomes for people who used the service.

The registered manager carried out checks on how the service was provided in areas such as support planning, medication administration and health and safety. She was keen to identify areas where the service could be further improved. This included monitoring staff while they carried out their duties to check they were providing care safely and as detailed in people's care plans. This helped the registered manager to monitor the quality of the service provided. All audits and checks were shared with the registered provider to help them monitor the performance of the service. During the inspection, the registered manager and her team were keen to work with us in an open and transparent way. All documentation we requested was produced for us promptly and was stored according to data protection guidelines.

The registered manager was aware of their duty to inform us of different incidents and we saw evidence that

this had been done in line with the regulations. Records were kept of incidents, issues and complaints and these were all regularly reviewed by the registered manager in order to identify trends and specific issues.

There were regular staff meetings held so that important issues could be discussed and any updates could be shared. These were clearly recorded so that members of staff who were not able to attend could read them afterwards. We observed a culture where staff were able to discuss their own ideas for how the service could be improved. There was also evidence within records that people and, where possible, families were consulted about the care and support the service provided.