Mr & Mrs M Jingree

Norfolk House

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

We carried out this unannounced comprehensive inspection on 25 January 2017. This inspection was undertaken to ensure improvements that were required to meet legal requirements had been implemented by the service following our last inspection on 29 July 2015.

At the previous inspection the home was found to be meeting regulations, however the service was given an overall rating of Requires Improvement because further improvements were required to ensure newly recruited staff accessed safeguarding training; chemicals needed to be stored securely and more improvements were required to the general environment to ensure it was suitable for people living with a dementia. At this comprehensive inspection on 25 January 2017 we found improvements had been made to meet the relevant requirements previously identified at the inspection on 29 July 2015.

Norfolk House is a privately owned care home that offers personal care and support for up to 18 older people. The house is a large converted property situated in the Springfield area of Wigan close to local amenities. At the time of the inspection there were 14 people using the service.

There was a registered manager at the home. 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.

People who used the service and their relatives told us they felt the service was safe. There were appropriate risk assessments in place with guidance on how to minimise risk. We observed good interactions between staff and people who used the service during the day. People felt staff were kind and considerate.

Recruitment of staff was robust and there were sufficient staff to attend to people's needs.

Medication policies were appropriate, comprehensive and medicines were administered, stored, ordered and disposed of safely. Safeguarding policies were in place and staff had an understanding of the issues and procedures.

People's nutrition and hydration needs were met appropriately and they were given choices with regard to food and drinks. Staff responded and supported people with dementia care needs appropriately. Care plans included appropriate personal and health information and were up to date. We saw evidence within the records of appropriate assessments being carried out.

People's health needs were responded to promptly and professionals contacted appropriately. Records included information about people's likes and dislikes and we observed that people had choices, for example, about when to get up, what to do and when and where to eat.

There was an appropriate complaints procedure and complaints were followed up appropriately.

People who used the service and their relatives spoke positively about how the service was managed.

Staff told us the registered manager was always available and approachable. Staff told us they attended regular meetings with the manager and we saw evidence of recent staff meetings.

Meetings with residents and relatives were conducted approximately every three months and relatives we spoke with confirmed they were aware of these meetings and received notification in advance.

Annual questionnaires were sent to people's relatives. Resident's questionnaires were also completed and we saw an evaluation of the two most recent questionnaires done in 2016.

Staff supervisions were undertaken regularly and we saw that these were used to discuss issues on a one to one basis.

The manager carried out a comprehensive range of audits and we saw historical audit records were in place.

Throughout the course of the inspection we saw the registered manager walking around and observing and supporting staff.

The service worked alongside other professionals and agencies in order to meet people's care requirements as needed.

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.

People who used the service, their relatives and professionals told us they felt the service was safe.

There were appropriate risk assessments in place with guidance on how to minimise risk. Safeguarding policies were in place and staff had an understanding of the issues and procedures.

Recruitment of staff was robust and there were sufficient staff to attend to people's needs.

Is the service effective?

Good

The service was effective.

People's nutrition and hydration needs were met appropriately and they were given a choice of food at meal times.

Care plans included appropriate personal and health information and were up to date.

The home worked within the legal requirements of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS).

Is the service caring?

Good

The service was caring.

People who used the service and their relatives told us the staff were caring and kind.

Staff interacted with people in a kind and considerate manner, ensuring people's dignity and privacy was respected.

Is the service responsive?

Good

The service was responsive.

People's care plans were person centred and contained

information about their preferences and wishes, likes and dislikes..

There was an appropriate complaints procedure and complaints were followed up appropriately. People knew how to make a complaint.

Is the service well-led?

Good

The service was well-led.

There was a registered manager at the service.

People told us the management were approachable and supportive. Staff supervisions and appraisals were undertaken regularly.

A number of audits were carried out where issues were identified and action was taken.

Norfolk House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 25 January 2017 and was unannounced. The inspection team consisted of one adult social care inspector from the Care Quality Commission (CQC).

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 improvements they plan to make. Prior to the inspection we reviewed information we held about the home in the form of notifications received from the service such as accidents and incidents. We also contacted Wigan Local Authority Quality Assurance Team, who regularly monitor the service.

We spoke with three people who used the service, four visiting relatives and five members of staff including care staff the registered manager and proprietor. We also looked at records held by the service, including four care files and four staff files. We undertook pathway tracking of care records, which involves cross referencing care records via the home's documentation. We observed care within the home throughout the day.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

A relative of a person who used the service said, "I have no concerns about this home, staff give [my relative] a lot of 1-1 time and pay a lot of attention to his needs and I feel lucky that he is here." A second relative told us, "I'm really satisfied with the care and attitude of staff caring for [my relative.] The bedroom is always spotless every time I've visited; communication is great and I get informed if they have any concerns about [my relative.]" A third relative commented, "I'm very satisfied with the care provided. If there are any issues they call me up immediately and we can also call the home anytime which we like." A person who used the service said, "I've always felt safe living here, the staff and manager talk to me a lot. There's no bad staff here and they always speak to me with respect." A second person commented, "This is a safe place to live."

At the previous inspection on 29 July 2015 staff training records showed that only a quarter of care staff had undertaken safeguarding training. At this inspection we found 80 percent of staff had now attended this training.

There was a safeguarding policy in place, which referenced legislation and local protocols. This was last reviewed in January 2014 and was in need of reviewing to ensure the latest guidance was followed. The policy included details of the local authority safeguarding process, including contact numbers and also contact details for CQC. We spoke with care staff who demonstrated an awareness of safeguarding and were able to describe how they would make a safeguarding referral. One staff member told us, "Abuse may be physical, neglect, financial or sexual. I have done training in safeguarding and would go to the manager in the first place if I was concerned." A second staff member said, "Abuse could be bruising or a change in mood or behaviour but I haven't come across this in the past, and you also need to think about abuse from families as well. I've done safeguarding training and have the contact numbers for the local authority and CQC if need be."

The home had a whistleblowing policy in place. We looked at the whistleblowing policy and this told staff what action to take of they had any concerns or if they had concerns about the manager and this included contact details for the local authority and the Care Quality Commission. Staff we spoke with had a good understanding of the actions to take if they had any concerns and told us they would contact the proprietor, the local authority or CQC.

We saw people had risk assessments in their care plans in relation to areas including falls, nutrition, moving and handling, pressure sores, continence. We looked at how the service managed accidents and incidents. There was an appropriate up to date accident/incident policy in place. Accident / incident forms were completed correctly and included the action taken to resolve the issue and the corresponding statutory notification form required to be sent to the Care Quality Commission.

There was appropriate information regarding the maintenance of the premises. We looked at a health and safety file, which included information about the maintenance and testing of the lift, hoisting equipment and fire equipment. All the records were complete and up to date. There was a fire risk assessment and a fire policy and procedure in place. Care files included an initial assessment and a bedroom assessment to help

ensure people's safety.

Staffing levels were sufficient on the day of the inspection to meet the needs of the people who used the service. We looked at the staff rotas for January 2017 and these consistently demonstrated that there were sufficient care staff on duty to meet the needs of people using the service. When determining the level of staff required to meet people's needs the service took into account people's needs and their dependency level, using a formal dependency level tool which identified if people were independent, if they needed prompting, if they required moderate or full staff assistance.

There were two care staff on waking night duty and a minimum of two care staff on duty during the day. The staff rotas identified that some care staff shifts overlapped which resulted in three care staff being on duty for part or all of the day on some days. We saw that at least one senior care assistant was always on duty during the day and the night time.

We looked at four staff personnel files and there was evidence of robust recruitment procedures. The files included written application forms, an equal opportunities form, a medical history questionnaire, proof of identity and at least two references. There were Disclosure and Barring Service (DBS) checks undertaken for staff in the files we looked at. A DBS check helps a service to ensure the applicant's suitability to work with vulnerable people. This showed us staff were recruited safely.

Fire call points were tested regularly and we saw there were monthly emergency lighting and fire door tests and weekly fire alarm tests. Fire drills were undertaken on a four monthly basis and any issues identified at the drills were noted and addressed. There were personal emergency evacuation plans (PEEPS) for each person who used the service which identified their level of dependency and what assistance was required in the event of an evacuation of the building. Staff were also formally observed by the manager to ensure their competency in emergency evacuation situations. This would help ensure people received the required level of assistance in the event of any emergency.

We observed the morning medicines round. The staff member wore gloves and a medication tabard and we saw they checked each person's medicine administration chart (MAR) before administering each medicine to ensure they were administering it correctly. The medicines round was not rushed or interrupted and when the medicine had been administered the staff member completed the MAR chart as required before moving on to the next medicine. We saw that staff had been given instruction to ensure the administration of medicines was not interrupted.

There was a medicines policy in place that included a range of guidance on self-medication; ordering, storing and disposing of medicines; PRN medication (which is medication taken as and when required); homely remedies; controlled drugs (CD); guidance on transfer and discharge; medication errors; safe disposal of medication; and arrangements for when people were going out of the home; covert medicines. A covert medicine is medication given without the person's knowledge when they are unable to make an informed decision and the medication is given in their best interests.

The systems for medicines were robust and only trained staff were allowed to administer medication. Staff competency assessments in the administration of medicines had been undertaken which included a direct observation of practice. Medicines were stored safely, in a locked trolley and a locked room. There was a lockable cupboard for controlled drugs, but the service was not administering any controlled drugs at the time of the visit.

Body maps were in place for the administration of creams, which identified the areas of the body that

required application of creams. At the time of the inspection no medicines were required to be stored in the fridge. A new fridge was being ordered and shortly after the date of the inspection the service informed us that the new medicines fridge was in place.

MAR charts had a photograph of the person attached to them which would help to ensure medicines were given to the right person. 'As required' (PRN) medicines were recorded separately with times of administration on each person's individual MAR. There was a policy on the administration of PRN medications. There was guidance for staff regarding people who were unable to communicate, on how to recognise indicators of pain. This helped ensure people were given their medicines when they required them and in a safe and timely manner. Regular checks were made of staff competence with regard to medicines administration to ensure they continued to be able to administer medicines safely.

There was a daily and monthly cleaning schedule which was signed and dated and this identified tasks to be carried out in various areas of the home. There as a four week cleaning schedule in place which ensured that all bedrooms received a deep clean at least once each month and this would assist with reducing the potential for the spread of infections. Bathrooms and toilets were cleaned daily and a night cleaning schedule was also followed. Records regarding cleaning were completed and up to date.

Liquid soap and paper towels were provided in each of the toilets/bathrooms. There was instruction on appropriate hand washing techniques which helped to minimise the risk of cross infection within the home. The premises were clean and tidy and there were no malodours in any areas.

Equipment, such as pressure mats which alert staff when someone has got out of bed, were in place to help keep people safe and these were identified in people's care plans.

A refurbishment programme was on-going and some improvements to the décor were in evidence since our last inspection. A wet room had been added on the ground floor and this was now in use. Some areas had been repainted and there was dementia friendly signage throughout the building for example in the dining room, lift, lounge area, toilets and bathrooms. Handrails had also been repainted so that people could see them more clearly which would assist people living with a dementia to better orientate around the building.

Good

Is the service effective?

Our findings

The relative of a person who used the service told us, "Staff don't step outside of professional boundaries, so doctors are always called when needed and [my relative] has had chest x-rays done. [My relative] feels at home here and is happy with his routine." A second relative told us, "Communication is great. The home lets us know about any changes and regularly contact us even if there are no particular concerns. [My relative] is happy with the food and always tells me she is warm, never hungry and always comfortable and I'd know if she wasn't, she would tell me."

Newly recruited staff followed a formal induction programme and were required to undertake a range of basic mandatory training and to read and sign certain policies prior to starting their employment. An induction checklist document was completed for each new staff member and this was carried out over a three day period. One staff member told us, "I had an induction when I first started and this included shadowing other staff until I was assessed as being competent. I read policies and procedures and did training and I felt confident after the induction." Two other staff also confirmed they had been subject to a formal period of induction.

Care staff had completed training in mandatory areas. For example all care staff had completed training in moving and handling, all care staff who administered medicines had completed medication training 90% of care staff had completed training in food hygiene and further training was on-going. One staff member told us, "I've done training in medicines, MCA/DoLS, moving and handling, food hygiene, infection control and safeguarding." A second staff member said, "I've done training in safeguarding, MCA/DoLS, whistleblowing, medicines administration was well as an induction at the beginning when I shadowed other staff and had my practice observed by the manager."

The Care Quality Commission has a duty to monitor activity under the Deprivation of Liberty Safeguards (DoLS). The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act (MCA) 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. Although the registered manager had yet to complete training in this area they demonstrated a good understanding of the principles of the MCA as they had attended meetings on the subject in order to complete the paperwork for people who used the service and were booked onto a training course in October 2015 provided by Wigan Council.

There was appropriate paperwork relating to the people who were currently subject to DoLS. There was a restrictions screening tool in each file and records of restrictive practices if these were in place. Best interest's assessments had been completed by the relevant professional in partnership with the person concerned, their family members and other relevant care staff.

A relative told us, "[My relative] is looked after really well. The family have been involved in all discussions about DoLS. The local authority did the best interest assessment which I think is good."

There were appropriate MCA assessments in place, which were linked to screening tools, restrictive practice

tools and applications for DoLS where the indication was that this was required. These were up to date and reviewed regularly to capture any changes in the person's capacity. We also saw that the conditions relating to DoLS authorisations related to what was recorded within the care plans about people's support. Mental health care plans were reviewed monthly. Appropriate supporting policies and procedures were in place, for example, the service had a policy on physical restraint.

Staff received regular supervision from their line manager in addition to an annual appraisal, and the documentation within staff files confirmed this. There was a supervision planner in place and we saw staff had received supervision in accordance with the supervision policy. One staff member said, "I get supervision at least every other month and I find it useful as I can talk to the manager about anything." A second staff member said, "Supervisions are about every six weeks or so, and these are useful because I feel I can discuss any problems with my manager in confidence."

We looked in the kitchen and saw that it was clean. The fridges, freezers and cupboards were well stocked with food. There were plenty of frozen and tinned provisions as well as dry goods, fresh food and fruit.

People were eating breakfast when we arrived which was cereal, toast and jam/marmalade, and there was now a cooked option available if requested. We saw snacks and drinks were offered throughout the day. There was a food hygiene policy and we saw that staff had completed training in food hygiene. There was a menu which was hand-written and placed on the wall of the dining room in addition to a pictorial version of the menu that was used when people had difficulty understanding written language to help them make a choice about what to eat.

In the morning we saw staff explaining to people what was for lunch and asking what they would like for lunch. At the lunchtime meal there was a relaxed unrushed atmosphere and we saw that staff interacted with people in a respectful and dignified manner, recognising people as individuals' and encouraging their engagement. There was discussion and laughter between people who were dining. Staff provided assistance to people who required it and spoke politely to people confirming with them what they wanted to eat and drink before serving it.

Information on special diets was posted in the kitchen and there was also guidance around high calorie food for those who required extra calories. We saw evidence of diet and fluid charts for people who required monitoring in these areas, which were complete and up to date. New kitchen worktops/work surfaces had been installed since the last inspection.

Care files included appropriate health and personal information and appropriate risk assessments were in place and were up to date. People's health requirements and allergies were recorded and there was a dependency profile to assess the level of assistance required by each person who used the service. This was updated monthly to ensure recording of people's support needs was current. We saw evidence of professional visits and appointments.

Consent forms were kept within people's files, including consent to care and treatment and consent to have photographs taken and used. Within the care files we looked at there was evidence of appropriate and timely referrals to relevant professionals including opticians, chiropodists and doctors. A staff member told us, "I always ask people before I do anything with them. Consent is also written down in people's care plans, but I just ask people each time." A second staff member told us, "Consent is recorded in people's care plans but we ask people each time we do something and explain it first."

We heard staff seeking verbal consent from people for all support provided, for example at lunch time. This

ensured that people were happy with the care being offered before it was provided.

We found there were people living at Norfolk House who were living with dementia. We saw staff responded and supported people with dementia care needs appropriately. We saw most people's bedroom doors had their photo on it which would assist some people to orientate to their room.

People's health needs were recorded in their files and this included evidence of professional involvement such as GPs, podiatrists or opticians where appropriate. Relatives we spoke with told us they were kept informed of all events and incidents and that professionals were called when required. One relative told us, "They call the GP out when they need to. [My relative] was struggling with taking medicines before they came here but they [the service] have addressed it and everything else I have asked for. I was involved in discussions with the GP, [my relative] and the manager about using covert medicines."

Good

Is the service caring?

Our findings

One relative told us, "Before [my relative] came to the home we had a look around and I got a guide to services. Staff treat [my relative] with the utmost respect at all times and go that extra mile. The manager goes into detail with anything we ask for and [my relative's] clothing is always fresh and clean." A second relative said, "Staff here are very caring and I feel [my relative] is well looked after. [My relative] has a personalised room and staff always keep us in the loop and I have no worries." A person who used the service commented, "I have my own key to my room and can come and go as I please. The staff are good carers and my bedroom is peaceful and personal to me."

Throughout the inspection we observed staff members to be kind, patient and caring whilst delivering care. The home had a privacy and dignity policy in addition to a human rights policy, which helped staff to understand how to respond to people's different needs. Staff were aware of these policies and how to follow them. We asked staff how they ensured people's dignity was respected when delivering care, one staff member said, "If I'm providing personal care I would make sure the door is closed and the curtains. I'd cover up any body parts not being washed and encourage the person to be involved as much as they can." A second staff member told us, "It's about closing doors and curtains and covering people up if you're helping them to have a wash. You've got to talk to people when you're doing this and not just do it without asking them first."

The manager told us that prior to any new admission a pre-assessment was carried out with the person and their relative(s) and a trial period of residence was offered. We verified this by looking at care records and speaking with people.

People who used the service who had the ability to contribute and their relatives were involved in care planning and decisions about who was involved in their care. A relative told us, "The manager came out and did an assessment with me before [my relative] came into residence. I know all the staff on first name terms and they are all very caring." A second relative said, "I was involved in a pre-assessment and we decided on a permanent placement at the home. At that time [my relative] had capacity and made the decision them self. Staff have always welcomed us and been very friendly."

Staff were caring and kind with the people they supported. It was clear that staff knew the people they were supporting and had developed good relationships. We saw people smiling and enjoying the interaction that took place. We saw many instances were staff took the time to speak to people and enquire about their welfare or inform them of what was going on, for example a staff member said to one person "Good morning [person's name] how are you today. Later this afternoon we're doing a ball throwing exercise game if you want to join in." In another example a staff member said to another person, "Hi [person's name] are you feeling ready for a cup of tea yet."

Another person asked a staff member to assist them to the lounge. The staff member then assisted the person to rise from their chair, using a safe technique. The staff member then walked alongside the person until they were safely seated in the lounge area. This promoted the person's independence and recognised

what they could do for them self.

We asked staff about how they promoted people's independence. One staff member said, "To promote independence you need to encourage people to do as much for themselves as they can, such as shaving." A second staff member told us, "To maintain independence you have to encourage people to be involved as much as they can or they may lose their independence."

The home had a Service User Guide and this was given to each person who used the service in addition to the Statement of Purpose which is a document that includes a standard required set of information about a service. The guide contained information on how to raise any issues of concern and referenced the local authority and the Care Quality Commission. The guide also identified that the home had an open visiting policy which meant that relatives of people who used the service could visit at any time.

We saw that individual care plans were used to ensure people's wishes and needs were recorded regarding their wishes for the end of life. These were available to staff caring for them. At the time of the inspection no person was in receipt of end of life care. An audit of end of life care had been carried out in 2016 and this recorded the person's name, their wishes regarding end of life care, where they had died, the date of death and the outcome (for example, where they passed away and if this was in keeping with their wishes,) the wishes of the family and if a formal end of life care package was in place.

The home had received a high number of compliments. Comments included, "We would like to thank you all for your care and kindness shown to [my relative] during her stay at your home," and "Thanks to all staff for the loving care you gave to [my relative] during his stay with you. Also your thoughtfulness and kindness towards me."

Good

Is the service responsive?

Our findings

A person who used the service told us, "When I first came in I was quite poorly but I'm feeling much better now and I'm looking for a more independent placement now somewhere else. I get the money I need to buy things I want and I'm happy with the way this is dealt with. When the weather is nice I go fishing and I have all my fishing gear here. My clothes are washed quickly and I usually get them back the same day. My daughter is getting married soon and I'll be going to the wedding." A relative told us, "I have absolutely no complaints at all. [My relative] needed to be on a food and fluid chart and they're now eating and drinking well." A second relative said, "I have no worries at all. I've been given information on how to make a complaint and I would feel confident in speaking to the manager if I had any. This service is definitely meeting [my relative's] needs."

Some people were still in bed when we arrived at the home and we saw that they got up at a time of their choice. We saw that people's choices about times of getting up and going to bed were recorded within their care files. All the people living at Norfolk House were dressed well and well-presented.

We looked at a sample of four care plans. Each care plan we looked at contained evidence that initial assessments had been completed prior to people's care commencing. This enabled staff to gain an understanding of people's care needs and how they could best meet people's requirements. Initial assessments covered areas such as people's current health, medication and mobility. We saw that information in care plans was stored in the correct section and up to date.

People who used the service had a care plan that was personal to them. This provided staff with guidance around how to meet their needs and what kinds of tasks they needed to perform when providing care. We found care plans included detail of whether people required support in making decisions, cognitive capacity, and whether a DoLS was in place. We saw that people's wishes were adhered to, for example, where they wished to take their meals and times of rising and retiring to or from bed.

There was a four weekly activities programme in place which included bingo, 1-1 chats, newspapers, dominoes board games, walks, reminiscence , floor skittles, chair football , quizzes, pass the parcel , card games, manicures/hand massage, colouring and crafts , ball catch and throw, film afternoon music/sing-a-long.

There was a noticeboard in the entrance area of the home with details of activities people could undertake. An activities notice was also displayed in the dining room which identified different activities including board games, quiz, arts and crafts and hairdressing. In the afternoon we saw group activities taking place in the form of a ball catch and throw exercise. Photographs of activities previously undertaken were pinned on the notice board in the hallway. Additional activities were also provided and included visiting singers and entertainers, baking days, gardening, barbeques, raffles, tombola, trips, outings, themed days, celebrations and birthdays.

Residents and relatives meetings were undertaken approximately every three months. We looked at the

minutes of the previous three meetings and saw that discussions included activities, food, care staff, the environment and cleanliness. There was a schedule of meetings for the whole year, which meant that people and their relatives had opportunities to discuss the running of the service and provide their own opinions and suggestions on making improvements.

We looked at care files for four people and saw that care plans were reviewed on a monthly basis using a formal review document. Each file contained a form signed by relatives to indicate the level of involvement they wished to have in the care planning process. Some relatives had opted to have monthly involvement, some three monthly, six monthly, yearly or no involvement at all.

We saw records within people's care files that evidenced that people had been offered a key to their room if they required one. This would afford them privacy when they wanted it, giving them an element of choice.

We looked at how complaints were managed. There was a complaints policy and procedure in place which had contact numbers for CQC and the local authority and a copy was available in the entrance lobby to the home. People told us they had never had reason to make a complaint but would feel confident in doing so. We saw evidence within the complaints log that complaints had been followed up appropriately and in a timely manner. People who used the service and their relatives told us that they knew what to do if they had a complaint.

People were able to personalise their own room and were encouraged to bring personal family photographs and items relevant to the individual. People could use their own bedding if requested. We saw that rooms were personalised and all were clean and fresh.

Good

Is the service well-led?

Our findings

People who used the service and their relatives spoke positively about how the service was managed. One relative said, "The manager's door is always open and the owners are also about the premises a lot as well and the home is definitely meeting [my relative's] needs." A second relative commented, "People are never rushed here and staff know what they are doing. I've attended meetings with other relatives as well." A third relative told us, "Nothing is covered up here, day to day issues are reported, there are no surprises and I have good dialogue with the manager."

There was a registered manager at the home. 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.

We asked staff members about their views of management. They told us the registered manager was always available and approachable. One staff member told us, "The manager is fair and approachable and gives us support and praise when we do good things." A second staff member said, "If there are any problems we can always discuss them with the manager in confidence. I think the manager does a good job, the door is always open and the manager is always there." A visiting local authority professional commented, "The manager makes regular contact with me and asks the right questions about service delivery and development." A visiting relative told us, "Communication from the manager is great and I get regular calls from them." A second relative said, "I have seen some positive changes in the past 12 months with more activities and better decoration and [my relative] feels at home here."

Staff told us they attended regular meetings with the manager and we saw evidence of recent staff meetings where discussions included medicines, care file notes, infection prevention and control, training, people's well-being and activities. At each meeting a policy of the month was discussed which would help to ensure staff understood the contents. Meetings were held at different times of the day to ensure staff who worked different shift patterns could attend a meeting and some meetings were held at the time of a shift handover, for example night to day. One staff member said, "We get regular meetings which I find useful because we can input into the service development and I've always felt listened to."

Meetings with residents and relatives were conducted approximately every three months and relatives we spoke with confirmed they were aware of these meetings and received notification in advance. One relative told us, "I've been invited many times to meetings by the manager but sometimes not many people attend. I'd say that staff are never rushed here and they know what they are doing." A person who used the service commented, "I get invited to meetings but I'm not really interested."

Annual questionnaires were sent to people's relatives. We looked at comments from the most recent questionnaires completed in October 2016 and found that comments were consistently positive. One returned questionnaire stated, '[My relative] decides for herself within her capabilities what she can best do herself and I know staff are always watching and listening.' A second questionnaire stated, 'We are satisfied

with [my relative's] care and think that she is safely cared for at Norfolk House.'

Resident's questionnaires were also completed and we saw an evaluation of the two most recent questionnaires done in 2016. The evaluation identified that all respondents had rated the service as good.

Staff supervisions were undertaken regularly and we saw that these were used to discuss issues on a one to one basis. Staff appraisals were carried out annually and were used to look at progress made, training needs and goals for the future.

There was a business continuity plan in place that identified actions to be taken in the event of an unforeseen event such as the loss of utilities supplies, catering disruption, flood and lift breakdown.

The manager carried out a comprehensive range of audits and we saw historical audit records were in place, including care plan audits, infection control audits, medicines audits, hand washing assessments, building maintenance, housekeeping, health and safety, fire safety and walk rounds or spot checks. These were appropriately recorded and records identified actions required, the person responsible for actions and completion dates.

The service worked alongside other professionals and agencies in order to meet people's care requirements where required. Involvement with these services was recorded in care plans and included Opticians, Chiropodists and Doctors. The service also worked with the 'living faith church' who visited the home regularly to accommodate people's spiritual needs.

Throughout the course of the inspection we saw the registered manager walking around and observing and supporting staff. This meant that they were immediately aware of updates to people's circumstances. We saw that the registered manager was very visible within the home and actively involved in the provision of care and support to people living at Norfolk House.