Short Ground Limited

Norcott 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 inspected Norcott House on 12 and 13 February 2018. The first day of the inspection was unannounced which meant the home did not know we were coming.

Norcott House is registered to provide accommodation and personal care for up to 11 people with learning disabilities. The home comprises of two separate buildings, each containing two living units, which provide gender specific accommodation. Each unit contains shared kitchens and bathrooms. Depending on their assessed needs, some people shared lounge areas and some people had their own lounge areas.

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

The home had a 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.

Medicines management and administration at Norcott House was safe. We identified some issues with medicines recording which the registered manager took immediate steps to address.

Norcott House was clean and odour-free. Support workers were responsible for cleaning and we saw they encouraged people to get involved in order to promote their independence.

Sufficient staff were deployed to meet people's needs. Recruitment records showed procedures in place for vetting prospective new staff were robust.

A range of person-centred risk assessments were in place for each person according to their assessed needs. People were supported to take risks if the benefits outweighed them.

A range of feedback measures were in place to ensure the service learned lessons when things went wrong.

Support workers had access to training and supervision to help them provide people with effective care and treatment. They told us they felt supported by managers at the home.

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.

Most feedback from people and their relatives about the food at Norcott House was positive. Action was being taken to adapt meal choices to better meet one person's preferences.

Staff at the home worked well together as a team.

People were supported to access a range of healthcare professionals in order to meet their wider health needs.

People and their relatives told us staff were kind and caring and that they promoted people's privacy and dignity. We saw people were supported to be independent.

People and their relatives told us, and records showed, people were involved in planning and reviewing their care.

The service ensured people's expressed cultural and diversity needs were met. Those people who needed support with decision-making had access to advocacy services.

People's care plans contained information about their communication needs in line with the Accessible Information Standard. The registered manager planned to review the guidance and implement any further requirements.

People and their relatives told us they felt able to complain about the service if they needed to. One complaint had been made and resolved since the last inspection.

People's care plans were detailed and person-centred. Staff were responsive to incidents where people experienced behaviours which may challenge others and any such incidents were analysed to ensure care plans contained up to date information.

People had access to a range of meaningful activities and had opportunities to go on holiday. Records showed they were regularly consulted about their activities preferences and supported to stay in touch with their relatives.

People, their relatives and staff gave us positive feedback about the registered manager and deputy manager at Norcott House.

A comprehensive system of audit was in place which involved various levels of the organisation and encouraged the sharing of good practice.

People, their relatives and staff were encouraged to feed back about the service at regular meetings, and people and relatives received questionnaires.

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.

Medicines were managed and administered in a safe way.

Staffing levels were sufficient to meet people's needs. Recruitment procedures in place were robust.

People felt safe. Staff could describe how to recognise the signs of abuse and said they would report any concerns appropriately.

Is the service effective?

Good

The service was effective.

Support workers received the training and supervision they needed to provide people with effective care.

The service was compliant with the Mental Capacity Act (2005).

Most feedback about food at the home was positive. People had access to healthcare professionals to maintain their holistic health.

Is the service caring?

Good

The service was caring.

People told us staff were caring and respectful of their privacy and dignity.

People told us, and records showed, people and their relatives were involved in planning and reviewing their care.

Staff promoted people's independence. People who needed help to make decisions had access to advocacy services.

Is the service responsive?

Good

The service was responsive.

People's care plans contained person-centred detail and were

up to date.

People and their relatives told us any concerns they had were resolved quickly and they felt able to make complaints if they needed to.

People had access to a range of person-centred activities.

Is the service well-led?

Good

The service was well-led.

We received positive feedback about the registered manager and deputy manager from people, their relatives and other staff.

A system of audit and monitoring was in place to ensure safety and quality at the service. The registered provider had oversight of audit outcomes and incidents.

People, their relatives and staff were regularly provided with opportunities to feed back concerns and ideas in relation to the service.

Norcott 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 12 and 13 February 2018; the first day was unannounced. The inspection team consisted of one adult social care inspector and one 'expert by experience' on the first day of inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the second day the team comprised of one adult social care inspector.

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.

To prepare for the inspection we reviewed the information we held about the service and requested feedback from other stakeholders. These included Healthwatch Kirklees, the local authority safeguarding team, the local authority infection prevention and control team, and the Clinical Commissioning Group. After the inspection we received feedback from five healthcare professionals involved with people using the service.

During this inspection we spoke with five people who lived at the home and four of their relatives to obtain their views of the support provided. We spoke with nine members of staff which included five support workers, the registered manager, the deputy manager, the regional manager, and the nominated individual for the registered provider.

We spent time observing people receiving support from staff in communal areas in all four units in order to help us understand the experience of people using the service.

We reviewed a range of records which included three people's care files. We also inspected three staff members' recruitment and supervision documents, staff training records, six people's medicines

administration records, accident and incident records, and various other documentation related to the running of the service.

Good

Is the service safe?

Our findings

People living at Norcott House told us they felt safe. One person said, "I feel safe", and a second person told us, "I like it here." People's relatives told us their family members were safe at Norcott House. Comments included, "[My relative] is safe", and, "[My relative] is absolutely safe."

As part of this inspection we observed a medicines round and reviewed people's medicines records. We found a safe system was in place for the ordering, receipt and return of medicines. Medicines were stored appropriately and within the correct temperature range. We observed the staff member administering medicines followed the registered provider's policy for medicines recording and provided people with their medicines in a caring and person-centred way.

We checked the stock of various medicines not supplied in pre-packed dosette boxes. This included controlled drugs. Controlled drugs are those covered by misuse of medicines legislation, and include strong painkillers. We found medicine stock reconciled with recorded amounts.

Some people were prescribed medicines on a 'when required' basis, which meant they only took them when they needed them. We saw each person with 'when required' medicines had person-centred care plans in place to guide staff as to when and how to administer each medicine. The service had a robust system in place for the administration of 'when required' medicines to help calm people who were experiencing behaviours which may challenge others. This involved obtaining authorisation from a manager and ensuring records were kept to describe the de-escalation and re-direction techniques tried before resorting to medication. This meant medication was administered to people experiencing behaviours that challenged as a last resort.

Most people's medicines administration records (MARs) evidenced they had received their medicines as prescribed. However, we identified some issues with the recording of medicines administration in one of the two buildings which comprised the home. We found the application of some people's topical creams had not been recorded on their MARs. After investigation, the registered manager found support staff had created separate forms to record some of these creams which he was not aware of. In addition, some MARs had been amended by staff to clarify instructions or change regular painkillers to 'when required' because people did not experience pain on a daily basis. MARs should only be changed by a healthcare professional qualified to prescribe medicines. However, there was no evidence people had been supported in an unsafe way.

When we fed back our findings to the registered manager at the inspection he arranged a meeting with a representative from the pharmacy which supplied medicines to the home the following day. This was to discuss good practice in medicines recording. The registered manager also arranged a meeting with support staff to discuss the findings of this inspection and highlight the improvements to record keeping required. This meant most aspects of medicines administration and management were safe and the registered manager took prompt action to address the issues with medicines recording we identified.

Throughout this inspection we found the home to be clean, tidy and odour-free. Personal protective equipment, such as gloves and aprons, were available to staff. Support workers led on cleaning tasks and we saw they encouraged people living at the home to get involved by cleaning their rooms or doing their own laundry. This meant support staff used the completion of domestic tasks at Norcott House as an opportunity to promote people's independence.

People told us sufficient staff were deployed to meet their needs. One person said, "There are enough staff", and a second person told us, "There are lots of staff. They are all nice." People's relatives agreed. One relative said, "I think there are enough staff." Staff at Norcott House we spoke with also told us they thought staffing levels at the home were appropriate. A healthcare professional involved with the service commented, "The service appears to retain the staff longer than other providers. This is good for the relationship between clients and staff."

The registered manager told us, and rosters confirmed, 13 staff were deployed between 8am and 3pm, and 12 staff were deployed between 3pm and 10pm. A supernumerary team leader supervised each shift, and all other staff were allocated to support one or two people who used the service. At night, three support workers were on duty; they could access an on-call manager by telephone if they needed advice or support.

Due to people's assessed needs, some people needed one-to-one or two-to-one support during the day within Norcott House. For some people this was higher when they accessed the community, according to their risk. The registered manager told us each person's funding body determined the level of support they received, however, at times the home increased support levels for community access for people deemed to be at higher risk, to ensure the safety of the person and support staff.

The registered manager and deputy manager were not included in the staff numbers, and during this inspection we saw the deputy manager covered for support workers who called in sick. One support worker said of the registered manager and deputy manager, "If ever we need owt (anything) they will help out. They're always on call if we need them." Feedback from people, their relatives and staff concurred with the observations we made throughout this inspection that sufficient numbers of staff were deployed to meet people's needs.

We sampled the recruitment records of support workers and found robust procedures were in place for the vetting of prospective staff. A range of checks were in place which complied with the regulations, and included a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions. In addition, we saw examples whereby the disciplinary policy had been used to address issues with staff performance and conduct.

Records showed a range of checks were in place to ensure the safety of the home's equipment, facilities and utilities. This included the supply of gas, electricity and water. People had personal emergency evacuation plans which could be used by emergency personnel in the event of a fire or other emergency to help people evacuate. The home's fire safety equipment was checked regularly and people took part in evacuation drills. This meant the risk to people posed by the building and utilities had been assessed and managed.

Support workers we spoke with could describe the ways people at Norcott House might be vulnerable to abuse and said they would report any concerns appropriately. Records showed safeguarding and whistleblowing procedures were discussed in staff supervision sessions and in team meetings on a regular basis. In addition, any safeguarding concerns which had arisen had been investigated and reported according to the registered provider's policy. This meant systems were in place to help safeguard people from abuse.

People's care files contained a range of person-centred risk assessments whose aim was to minimise the risk of specific events or outcomes relating to people's needs, activities or choices. For example, one person had risk assessments for their fluid intake, their interaction with other people using the service, and for their support at night. A second person had risk assessments for choking, their mobility, and their mental health. People's risk assessments showed how they were supported to take risks, and evidenced risks were managed such that people with more complex needs could still access the community and take part in activities.

One person's independence had been promoted by their undertaking unsupervised domestic tasks within the home's premises; a risk assessment was in place to facilitate this. Other people had been supported to go on holiday by staff. Risks posed by this had been assessed and managed and they had enjoyed holidays. This meant risks to people were assessed and managed in a person-centred way.

The service learned from mistakes when things went wrong. The registered manager described how changes to practice and records had been made in response to a medicines error. Meeting minutes showed lessons learned had been added to the staff meetings agenda. At the December 2017 staff meeting staff had discussed an incident which had occurred at another service run by the same registered provider; it was used to emphasise the importance of following people's care plans when out in the community.

Records showed a daily analysis was undertaken of incidents of people experiencing behaviours which may challenge others. Weekly figures were displayed on a board in the registered manager's office so it could be clearly seen which people, if any, had been unsettled or involved in incidents that week. Incidents were also reported weekly to the registered provider, and a new electronic system was about to be implemented whereby the registered provider could access information on accidents and incidents in real time.

The registered manager told us accidents and incidents were analysed for each person on an individual basis, but there was no overall trend analysis for the service as a whole. We discussed this with the nominated individual, who was the operations director covering a range of the registered provider's services including Norcott House. They told us they would consider adding a service-wide analysis of accidents and incidents to their existing safety monitoring system. This meant various systems were in place so that lessons could be learned from mistakes and incidents.

Good

Is the service effective?

Our findings

People and their relatives told us support workers at Norcott House had the training and experience they needed to meet people's needs. One person said, "The staff know me; if I'm in a mood they give me my space." Comments from relatives included, "They know how to deal with [my relative], they understand [them]", "[My relative] is encouraged to be as independent as [they] can be. They (staff) do very well with [my relative]", and, "[My relative] is very complicated but [they] get good care."

Staff told us, and records showed, staff had access to a range of training courses and received regular updates. Courses included safeguarding, food hygiene, fire safety, and health and safety. Support workers also received more specialist courses relating to the needs of people they supported, for example epilepsy, autism, and the safe use of restraint for people experiencing behaviours which may challenge others. Senior support workers who administered medicines received medicines training and were subject to regular competency checks.

Records showed all new staff completed the Care Certificate as part of their induction. The Care Certificate is an introduction to the caring profession and sets out a standard set of skills, knowledge and behaviours that care workers follow in order to provide high quality, compassionate care.

Support workers also received regular supervision sessions with either the registered manager or deputy manager. Feedback about these sessions was positive; one support worker told us, "They're useful – you get to offload and get feedback." All staff we spoke with told us they felt supported by the registered manager and deputy manager. This meant staff at Norcott House received the support and training they needed to meet people's needs.

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

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

People's records contained capacity assessments and best interest decisions for various aspects of their care and treatment. For example, support with medicines, physical intervention by staff to manage behaviours which may challenge others, covert medicine administration, finances, and people's receipt of one-to-one and two-to-one support. Records showed people with capacity for some aspects of their care and treatment had signed consent forms, for example, for photography.

DoLS authorisations were in place for people who had been assessed as needing them, although there had been people who had challenged their restrictions with the support of advocates. This meant people's capacity to consent to their care and treatment had been assessed, and those wishing to challenge decisions made for them were supported to do so.

The service used good practice to inform people's care and support. At a meeting of registered managers shortly before this inspection, the requirement for services to be compliant with the Accessible Information Standard (AIS) had been discussed. The AIS aims to ensure people with disabilities, impairments or sensory loss get information they can understand, plus any communication support they need when receiving healthcare services. In response, the registered manager and deputy manager had visited another service run by the same registered provider where the AIS had been implemented fully in order to learn good practice. At the time of this inspection they were in the process of assimilating their learning in order to make changes at Norcott House.

The registered manager had also identified a learning need for support workers in relation to their understanding of the DoLS process. He felt that because he and the deputy manager made DoLS applications, support workers may not always appreciate fully how the process worked or how decisions were made. In response, the registered manager had sourced additional training for staff. This meant good practice and legislation was used to inform people's care, treatment and support.

Most feedback about the food at Norcott House was positive. Comments from people included, "We get a bit of choice", "I get asked what I'd like", "I like the food", and, "The food is good. We have a takeaway every two weeks." Most relatives were happy with the food people were offered. One relative said, "I'm happy with the food [my relative] gets", and a second relative told us, "They encourage [my relative] to cook meals and be healthy."

A third relative said their family member who used the service was not keen on a lot of the food served at the service, and food was taken to the home by the family for the person to eat. The registered manager acknowledged this issue, and said improvement measures had been put in place. This had involved asking the family for recipes, and staff had sought recipes online to try. Support workers told us they had started cooking meals in accordance with the person's preferences, and hoped to better meet their dietary needs in future.

Records showed people were regularly consulted on the content of menus in residents' meetings. Support workers either made meals for people and encouraged them to help, or supervised people to make their own meals. One person said, "I cook my dinner if I want, and cook for others." Support workers told us people could have something else if they did not like the menu choice for that day, and they tried to encourage people to make healthier choices. People also went out for meals regularly, and during the inspection we observed support workers providing one person with options for where they would like to go out and eat. The person chose the local pub. This meant people were supported by staff to meet their nutritional needs and could make choices about the foods they ate.

Support workers attended handover meetings at the start of each shift. We attended one such meeting and noted each person was discussed and any incidents or occurrences relating to them, as well as appointments they were to attend or that needed booking, and their day's activities. At this meeting support workers were allocated to named people for that shift. A communication book was also used to share information between members of the staff team. This meant an effective system of communication was in place to facilitate team-working at Norcott House.

We asked people and their relatives if they were supported to see healthcare professionals such as GPs, dentists and practice nurses if they needed to. One person said, "I get to see the doctor when I need to. I go to them", a second person told us, "I usually ring the doctor but the staff will do it for me. They come with me", and a third person said, "[The registered manager] would contact the doctor and staff would come with me." People's relatives also gave positive feedback about their family members' access to healthcare. One relative said, "[My relative] sees a doctor when [they] need to. They respond well to any illnesses. I'm always kept informed", and a second relative told us, "They are brilliant at medical care; they even got [my relative] to the dentist." One healthcare professional involved with the service commented, "Communication between the service and families/other professionals involved is good." During the inspection we observed one person asked the registered manager to arrange a meeting with their social worker. The registered manager checked the person did not have any immediate worries or concerns, and said they would do this for them. This meant people were supported to access healthcare professionals to help meet their wider health needs.

Adaptions had been made at Norcott House to better meet the needs of people living there. We noted people's rooms were decorated in their personal style. Two of the units catered for two people, in which each person had their own lounge which had been designed to meet their needs and preferences. For example, one person's contained sensory equipment. Shortly before this inspection, one of the unit's kitchens had been converted so that only specific cultural foodstuffs or vegetarian food could be cooked there. This had involved purchasing new cooking equipment. The registered manager told us this was to meet the needs of both people using the service and staff. This meant the service had been adapted to better meet people's needs.

Good

Is the service caring?

Our findings

People and their relatives told us support workers at Norcott House were kind and caring. One person said, "The staff treat me well, like an adult. We have a laugh and a joke." A relative told us, "All the staff goes the extra mile for [my relative]." One healthcare professional told us, "I find the placement really positive and staff seem very knowledgeable and caring about the people they support, especially those with complex needs."

People told us, and records showed, they were involved in developing and reviewing their care plans. One person said, "I know what's in my care plan, I get a say in what happens to me", and a second person told us, "Yeah, I get a say in what happens with my care." People's relatives also told us they took part in care planning discussions. Comments included, "They discuss what is happening with me", "There is good communication with staff. I'm involved in decisions when there are changes", and, "We are included in discussions about [my relative's] care plans and [their] needs."

During the inspection we noted staff promoted people's dignity. We also observed numerous interactions whereby staff provided people with kind and supportive care which was person-centred. Staff spoke fondly of people's likes, dislikes and preferences, and clearly knew people well as individuals. We saw daily records, including those detailing incidents when people had experienced behaviours which may challenge others, contained factual and respectful language with no judgement or blame attributed. One support worker said of a person's complex behaviours, "It's just the way [name] shows [their] pain."

People told us staff respected their privacy. One person said, "Staff always knock on my door", a second person told us, "They knock on my door and wait", and a relative commented, "[My relative] gets privacy and dignity." Throughout this inspection we observed staff knocked on people's doors before entering their rooms.

Staff had considered how to maximise each person's involvement in care planning meetings. Records showed some people had requested specific relatives or staff attend, others had asked for certain food and drinks to be served or music to be played. One healthcare professional commented, "I can confirm that [people] residing at Norcott and their families are involved to write up their care planning. During reviews clients and families are involved fully."

People told us they were supported to retain and build their independence. One person said, "I do washing up and laundry", a second person told us, "They help me to be independent; they make me do things for myself. I do a lot of things on my own but I'm lazy so I need to be encouraged", and a third person said, "I read and cook. Staff help me to do things on my own." Relatives echoed this feedback. One relative said, "The staff help [my relative] to be as independent as [they] can. [My relative] can turn to them if [they] can't manage." One healthcare professional told us, "They promote independence on a daily basis through starting small with the intention to take greater steps with this in the future."

People's daily records contained a specific section in which staff recorded how each person had been

supported to retain their independence that day. We saw this involved encouraging people to cook or make drinks, managing laundry and other domestic tasks, speaking to healthcare professionals over the telephone, and ordering and paying for food in a shop. Records also showed equipment had been purchased to enable one person to shower independently. During this inspection we observed staff supporting people in the kitchen and helping them to do their laundry. We also noted people got out of bed at times which suited them. This meant support workers promoted people's independence.

People had care plans and risk assessments around their expressed cultural and diversity needs and preferences. Care plans were in place to inform staff how to best to support people to stay in contact with the family and friends who meant most to them. One person's adherence to their cultural traditions varied; we saw this was documented in their care plans and the person's capacity to make decisions regarding this aspect of their care had been considered. Records also showed staff had supported people to explore ways of meeting others with a view to forming romantic relationships, if people chose. Support workers also helped people to express their sexuality by promoting their dignity and to dress according to their own personal style. We saw people's preferences in terms of their appearance was recorded in their care plans. This meant people were supported meet their diverse needs.

Some people at Norcott House had support from advocacy services when they needed help to make decisions. Others had statutory Independent Mental Capacity Advocates (IMCAs) to represent them in the Deprivation of Liberty Safeguards (DoLS) process. Records showed some people had challenged the restrictions posed by their DoLS with the support of their IMCAs. The registered manager could give relevant examples whereby people may need support from advocacy services and was aware of the referrals process. This meant people had access to independent support with decision-making if they needed it.

Good

Is the service responsive?

Our findings

People told us the service was responsive when they made complaints. One person said, "I've made complaints in the past and they were dealt with. I complained that the washing machine kept breaking and now we have a new one", and a second person told us they had complained about a specific issue which was also in the process of being resolved.

Relatives told us they felt able to complain if they needed to. One relative said, "I'd be confident in taking a complaint up with them", and a second relative told us, "I have raised issues occasionally and they have always been addressed."

We saw the complaints policy was available to people, and people were asked if they had any concerns or complaints in their monthly meetings with keyworkers. Only one formal complaint had been received by the service since the last inspection in 2015. Records showed support workers had assisted a person to make this complaint, which was about another person living at the home at that time. We found there were no records relating to the investigation of the complaint or its outcome. The regional manager, who was the registered manager at the time the person had complained, had spoken with the complainant and the person they had complained about was no longer using the service, so the complaint had been resolved. The current registered manager could describe the complaints procedure and the importance of accurate record-keeping, and said he would ensure any future complaints were documented according to the registered provider's policy.

We reviewed the care plans of three people who used the service and found they were detailed and person-centred. Care plans were individualised, and addressed the risks or preferences relating to each person, for example, nutrition, personal care, and sensory needs and cognition. Records showed people's care plans were discussed at an annual review meeting with each person, their relatives and other relevant healthcare professionals. They were also subject to a six-monthly review and evaluated each month. People also had monthly meetings with their keyworkers, where they could raise any issues relating to their care and treatment needs. This meant people's care plans were up to date and their regular involvement ensured they were person-centred.

One healthcare professional told us, "The care plans are very goal based and the people I see have made big steps forward over the last 12 months. Whenever there have been issues I have always found that these issues have been dealt with correctly, quickly and efficiently."

We saw care plans and risk assessments for people who experienced behaviours which may challenge others contained detail about the triggers for their behaviour and the ways in which staff should respond when incidents occurred. Routine was very important to one person; we saw their care plan contained excellent detail around how best to manage the person's anxiety, and included examples of questions the person might ask and responses staff should give to minimise the person's distress. The person also had a bedtime book which support workers read with them each night to let the person know what was happening the following day; this was another technique used to reduce the person's anxiety.

The registered manager told us incidents of behaviours which challenge others were analysed monthly and used to inform the healthcare professionals involved with people and update people's care plans. At the time of this inspection, one person was unwell which caused them to be unsettled and experience more frequent behaviours. The support workers allocated to the person used the call buzzer system to alert other staff when they needed assistance and we saw support workers from other units were quick to respond. One healthcare professional told us, "Norcott appear to have a good understanding of the complex clients they support and work well with the MDT (multi-disciplinary team) to develop care plans that are least restrictive and minimise risk." This meant people with complex behaviours received person-centred care and support which met their needs.

As discussed earlier in this report, the registered manager and deputy manager were in the process of implementing good practice in relation to the Accessible Information Standard (AIS), to ensure the service was compliant with all the requirements. The AIS came into force in 2016 with the aim of ensuring people with disabilities, impairments or sensory loss get information they can understand, plus any communication support they need when receiving healthcare services. We saw people's care plans already contained detailed information regarding their communication needs, including how people communicated verbally and non-verbally. How best to involve people in discussions around their care and support had also been considered and recorded. We will check the service meets all other aspects contained within the AIS at the next inspection.

People had access to a range of meaningful activities within Norcott House and in the community. One person told us, "I go out for a walk, or on the bus or in the car", and a second person said, "I go shopping, play football and go to the gym." One relative said of the activities support provided to their family member, "[My relative] doesn't do much but that is down to [them], not because they haven't tried." A healthcare professional told us, "They're keen to get [name] into the community and keep [them] in touch with [their] family."

Each person had an activities planner and their activities preferences were recorded in their care plans. Most people completed their activities planners with staff and one person was encouraged to do this on their own. We saw activities were varied and included shopping, trips to theme parks, walks, meals in pubs and restaurants, drives in the car, and arts and crafts. Some people had been supported to access college courses and work experience placements. People could choose what they wanted to do and were asked in their monthly keyworker meetings and in monthly residents' meetings if they were happy with their activities or had ideas for new activities. During this inspection people came and went from the home with support staff to take part in activities in the community, and we saw people watching TV, cooking, and listening to music. One healthcare professional told us, "There's lots on offer at Norcott House, if they (people) want to tap into it." This meant people had access to a range of person-centred activities which they could choose.

People told us they were supported by the service to maintain links with their family and friends. Some people had also been on holiday with support staff. One person said, "I'm going on holiday to [place name]. My family live there", and two other people said they saw their families every Sunday. Another person also saw their family weekly and made overnight stays. Records showed staff were in the process of arranging a holiday for a fifth person. This meant people had opportunities to go on holiday and stay in touch with their relatives.

Good

Is the service well-led?

Our findings

People and their relatives told us the registered manager and deputy manager at Norcott House were approachable. One person said, "The manager is [name] and the deputy is [name]. I'm happy to talk to them", and a second person told us, "[Name] is the manager, I can talk to him." Comments from relatives included, "The manager is [name]. I could talk to him if there was a problem", "[Name] is the manager. He is approachable", and, "[Name] is the manager. He's the best one they've had."

Staff also gave us positive feedback about the registered manager and deputy manager. One support worker said, "They're really supportive. You could go to them if you had something on your mind. They're really open", and a second support worker told us, "I've got really good support with the managers here."

One healthcare professional we contacted told us, "During my involvement I have found Norcott management to be open and honest, communicating well with all involved to ensure we are kept up to date on the individual", and a second commented, "When I've spoken to management they have also come forward and raised concerns about clients and are pro-active when aspects of an individual's care needs looking at." A third healthcare professional said, "I've always felt reassured [the registered manager] will do what he says he'll do."

People and relatives had opportunities to feed back about the service at regular meetings and via surveys. One person told us, "We have monthly residents' meetings. When I raise things they are addressed." Minutes for residents' meetings showed people had discussed staffing, activities, food, health and safety, and the décor at the home. People had also been asked if they had any complaints or concerns. One healthcare professional told us, "They (people) are able to have a voice. They're (the service) very good that way."

People received questionnaires about their care and support in an easy to read format. Support workers helped people to complete them, if they needed it. We saw people were asked if they thought the staff were polite and respectful, if they liked the food, and if they felt comfortable and safe. We saw most responses to the last survey were positive, although two were not. The registered manager planned to arrange meetings with both people to discuss their concerns.

Relatives also received questionnaires although only one was returned for the last annual survey. This also contained some negative feedback, which we saw the registered manager had already taken steps to address. The registered manager was in the process of arranging a meeting with this relative to provide reassurances about the action the service was taking to make improvements. This meant people and relatives were asked for their opinions about the service and these were used to make improvements.

Support workers told us they found staff meetings useful. One support worker said, "We all get to speak about our concerns." A second support worker told us they received updates about people and their needs, and also shared their ideas for improvement at the home. The registered manager told us the idea to convert one of the kitchens to one dedicated to specific cultural and vegetarian foods had come from staff. After he had approved the idea, staff had then sourced all the new equipment and put up signage. This

meant staff also had opportunities to share concerns and ideas on a regular basis with the home's management and good ideas were used to make improvements.

A range of audits were in place to monitor the safety and quality of the service. These included health and safety, medicines, care plans, infection control, and safeguarding. We saw examples whereby issues had been highlighted and addressed as a result of audit. Audits were reported electronically to the registered provider on a monthly basis. The nominated individual for the registered provider told us these audits were collated for her so she could analyse any trends or highlight risk which would need to be managed. Any incidents were also discussed at a corporate lessons learned group and a quarterly governance meeting, to identify any learning which could be shared across the organisation.

In addition to audits carried out by the home's management team, registered managers from other homes run by the same registered provider undertook care audits at the home on a quarterly basis. Norcott House's registered manager did this for other services. This was a way of ensuring audit was more independent and promoted the sharing of good practice. The regional manager also carried out regular audits and visited the home on a weekly basis. This meant a comprehensive system of audit and monitoring was in place at Norcott House.

We asked the registered manager about the vision and values of the service. He told us, "I want service users to enjoy living here and feel fulfilled, rather for it to be just a place where they are", he continued, "There needs to be a sense of them (staff) enjoying their jobs. That's what we strive for." In order to recognise and reward staff the registered manager had implemented an employee of the month award. Staff voted for their peers and gave reasons for their choice. We saw posters showing the employee of the month with the feedback from the other staff. Records showed staff who did not win still received feedback from any nominations for the award in their supervision sessions. One support worker told us, "It's quite nice to hear you're doing well."

Staff we spoke with said of working at the home, "It feels like a really big home and the staff are a family. We all care so much about these guys (the people), we have that culture", "It's really rewarding – seeing how happy people are and able to do things", and, "I'm working with people who don't get seen by society. I get to make a change and make people happy." Feedback from people and their relatives, and our observations, showed the staff worked in accordance with the registered manager's vision and values.

The service worked well in partnership with other organisations. For example, some people were more likely to become distressed and experience behaviours if they visited the GP surgery. For this reason, the service had worked in partnership with people's GPs to identify if measures could be put in place to reduce people's anxiety or if it was better for people to be seen by GPs at the home. As a result, a decision was made that two people would always be seen by their GP at Norcott House, whereas other people could go to the surgery. This meant the service worked in partnership with others for the benefit of the people it supported.

Under the regulations registered providers are required to report specific incidents to the Care Quality Commission (CQC); notifiable incidents include police call-outs, suspected or actual abuse, and serious injuries. We found all notifications had been made as required. Under the regulations, registered providers also have a legal duty to display the ratings of CQC inspections prominently in their care home and on their website, if they have one. At this inspection we saw the ratings from the last inspection were displayed in the home and on the provider's website in accordance with regulation.