Livability

Livability Norwich Road

Inspection report

3 Norwich Road
Long Stratton
Norwich
Norfolk
NR15 2PG

Tel: 01508536059
Website: www.livability.org.uk

Date of inspection visit:
31 July 2018

Date of publication:
20 August 2018

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?	Requires Improvement

Summary of findings

Overall summary

This inspection was announced three working days prior to our visit, as it is a small home and we wanted to ensure that someone would be available to speak with us. This was the first comprehensive inspection carried out of this service which was registered with the Care Quality Commission (CQC) in June 2017 under new care providers.

3 Norwich Road 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 care home accommodates up to 3 people in one adapted building. At the time of our inspection 3 people were living in the home.

3 Norwich Road provided accommodation and care to adults who have a learning difficulty. The home had communal areas such as a kitchen and lounge, and people were accommodated in their own rooms, with communal bathroom and separate toilet.

There was not a registered manager working in the service. 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. A manager had been recruited and had been in the service for just over two weeks, they also managed another of the provider's services in the area. They had commenced the process of registering with CQC. They attended the inspection along with the deputy manager of both homes.

There were quality assurance systems in place for the assessment, monitoring and improvement of the service but these had not been utilised consistently. These areas had been identified by the manager, however they had not yet had time to ensure these were properly implemented. Areas which required some further oversight and improvement were the medicines records, infection control, competency checking and keeping care plans up to date. This included people's records in relation to their capacity to make decisions.

People were supported by a suitable number of staff who understood how to keep them safe, and staff were recruited safely. Risks to people were assessed and mitigated, including those associated with the environment they lived in as well as their own health needs. Staff administered medicines safely, and people received these as prescribed.

People's needs were thoroughly assessed prior to moving into the home. The staff continued to work effectively with other teams to ensure people received consistent care. Staff received training relevant to their roles, including the provider's mandatory training as well as training specific to some people's needs. They also received supervisions from the management team. Staff supported people to drink enough and to

eat a balanced diet, and to access healthcare as needed.

People lived in a homely environment which was adapted to their needs. Staff knew about people's mental capacity and understood how to support people to make decisions, however improvements were needed in respect of records.

There were caring and supportive relationships between staff and people. Staff adapted their communication according to people's needs. Privacy and dignity was promoted at all times, and people and relatives were involved in their care as much as possible.

Care records were in place for people living in the home, and these contained individualised guidance for staff about how to support people. People were able to go out into the local community if they wanted, and participate in activities, as well as do activities in the home with staff.

There was a complaints system in place, and people were encouraged to raise concerns if they had any.

There was good leadership in place and staff felt happy and rewarded in their roles, and were aware of their responsibilities. The manager was also aware of their responsibilities, and they were supported well by the provider's organisation.

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 systems in place to keep people safe and manage risks associated with their care.

There were enough staff to keep people safe and they understood how to keep people safe.

Medicines were administered as they had been prescribed.

Is the service effective?

Good

The service was effective.

Staff were competent and received training relevant to their roles.

People were supported to eat and drink enough to meet their needs.

Staff understood people's mental capacity and supported them to make decisions.

The organisation supported people to access healthcare and worked with professionals to achieve consistent care.

Is the service caring?

Good

The service was caring.

Staff had built positive relationships with people and were kind, caring and compassionate.

Privacy and dignity was respected and staff encouraged people to maintain their independence.

People and their families were involved in their care as much as possible.

Is the service responsive?

Good

The service was responsive.

The service supported people to participate in activities which reflected their interests, both within the home and the local community.

Care plans reflected people's needs and contained guidance for staff on meeting people's needs.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There were systems in place to monitor, assess and improve the service. However, these had not been utilised consistently and as a result there were shortfalls in some areas of the service.

There was good leadership and teamwork in place and the management team were approachable and accessible. The manager was aware of their responsibilities.

Livability Norwich 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 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.

The inspection took place on 24 July 2018 and was announced. We gave the service 3 working days' notice of the inspection because it is small and the registered manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in. The inspection was carried out by one inspector.

Before the inspection, we reviewed the information available to us about the service, such as the notifications that they had sent us. A notification is information about important events which the provider is required to send us by law. Prior to the inspection, the provider also 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. Before the inspection, we also obtained feedback from the local authority.

During the inspection, we spoke with the manager, the deputy manager and one support worker, as well as a healthcare professional who was involved with the service. We looked at two care records, as well as all three Medicines Administration Records (MARs). We also looked at records relating to the management of the service, such as audits and rotas. We were not able to gain verbal feedback from people using the service, due to communication needs and some being unavailable. We observed some interactions between staff and people.

Good

Is the service safe?

Our findings

Staff knew how to protect people from harm and had received relevant training. Staff were able to tell us what different types of abuse there were and who they would report any concerns to should they have any.

People's care records contained individual risk assessments, which included information about people's behaviour, health conditions, eating, drinking and mobility. They contained guidance for staff, who demonstrated good knowledge of risks to people and how these were managed. Risks associated with the environment were managed properly, for example water, electricity and fire. Each person had a PEEP (Personal Evacuation Plan) and the service had completed fire drills regularly to ensure that staff knew what to do in the event of a fire. There were safety mechanisms in place such as window restrictors throughout the communal areas of the home and people's rooms.

There were enough staff to keep people safe and ensure there was time to spend meaningfully with people. Staff confirmed that there were enough staff, and this was reflected by the staff rota which we looked at. The registered manager explained that the service used their own staff to cover shifts in the event of staff absence, and they were registered with an agency as part of a contingency plan, but these were not used regularly.

There were systems in place to ensure that only people deemed suitable, in line with the provider's guidance were working in the home. The recruitment policies and induction processes contributed to promoting people's safety. This included relevant checks, such as a DBS (Disclosure and Barring Services) had been completed. This allows organisations to see whether potential staff have any criminal record, and contributes to the safe recruitment of suitable staff.

The people living in the home received support to take their medicines. We checked the medicines administration records (MAR), and further records relating to people's medicines. We saw that staff signed the record when medicines had been administered, and that people received their medicines as prescribed. There were not protocols in place for PRN (as required) medicines which guide staff on how and when to administer these. The management team had identified this on their recent action plan and assured us that these would be put in place. The staff member we spoke with explained how and when they administered PRN pain killers to people, and demonstrated that they knew how to do this. Staff had also received recent training in medicines administration. The deputy manager explained what action they had taken when a medicines error had occurred, and we were assured that this was appropriate.

Medicines were stored securely, and the temperature was checked regularly. This had gone above recommended temperatures recently and staff took action by placing frozen bottles of water inside the medicines cabinet. The manager had identified this problem on their recent audit. We saw medicines were dated when opened so staff could monitor whether they were safe for use. We discussed the option of adding a column to the audit so that an outstanding task could be ticked off to show as completed to ensure this happened in a timely manner.

There were systems and equipment such as gloves, available and in place to prevent the spread of infection as much as possible. However, there were some areas of the home that were not clean, for example the plug area in the sink in a communal toilet. We noted that a recent infection control audit, which was in place, had not been carried out.

Where there had been any safety related incidents recently, the home had worked closely with others. For example, with a psychiatrist and the police when there was a risk associated with people's behaviours.

Good

Is the service effective?

Our findings

Prior to living in the service, people's needs had been fully assessed so that the service could ensure they were prepared and fully able to meet a person's needs. This included gathering details of the persons needs including support with personal care, health conditions and emotional and mental health needs.

We observed that staff supported people effectively. There were no new staff working in the home. However, they were currently recruiting new staff to work in the home. The manager told us about how new staff would receive inductions which would be individualised according to their confidence and experience. The induction would also include shadowing a more experienced member of staff for two weeks in each of the providers' homes, for a total of six weeks.

Staff we spoke with told us they felt the training was effective, and they received enough. Some training they received was carried out in-house in a classroom session, and some was via the computer. The training which the provider had deemed mandatory included manual handling, equality and diversity, practical first aid and medicines management. Staff also received specialist training according to people's needs, such as epilepsy. The staff had not received recent competency checks, however these were planned as part of the service's actions for improvement. Staff were supported by the provider to undertake further qualifications such as the care certificate to develop their skills for their roles. This is a qualification in health and social care which covers a range of relevant topics. Staff also received supervisions and support where they had an opportunity to discuss their role with a member of the management team.

Staff supported people to eat a varied, balanced and healthy diet according to their needs. Staff also supported some people to participate in making their own meals in the kitchen, and people could choose what to have. People were also supported to drink enough.

The staff worked closely with other organisations and professionals, for example people's social workers, GPs and consultants to ensure people received proper treatment and that their quality of life was enhanced. The healthcare professional we spoke with said that staff were able to share information appropriately and work together with them to ensure the person received consistent care. This included following any recommendations and ensuring appropriate referrals were made for people. Staff supported people to attend appointments when they needed, and access healthcare as necessary.

The environment was homely, however required some repair work which the providers were planning to undertake, and some repairs had been completed already, for example to a fire door and a toilet. Where possible people had chosen how they wanted to have their rooms arranged. However, there were stairs in the home which were becoming more difficult for one person living in the home. The staff had requested a review from a relevant healthcare professional to ensure they received any equipment they required.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to

take particular decisions, any made on their behalf must be in their best interest and as least restrictive as possible.

We saw that there were no decision-specific mental capacity assessments carried out where people's capacity was impaired, for example to ascertain people's ability to make decisions around finances, or healthcare. We discussed these with the manager who told us they would ensure these were carried out. This would ensure that the person is being supported to uphold their rights. We saw that the staff had worked closely with other healthcare professionals in relation to managing people's capacity, and had a good understanding of individual's mental capacity. Where people had variable or limited capacity, the staff supported people by making decisions in their best interests, and involving family and healthcare professionals where appropriate.

People can only be deprived of their liberty to receive care and treatment when this is in their best interest and legally authorised under the MCA. The application procedures for this in care homes are called Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The previous registered manager had applied for DoLS for some people living in the home, however the appropriate mental capacity assessments were not in place to demonstrate how this decision was arrived at. The staff member we spoke with told us how they supported people to make day to day decisions.

Good

Is the service caring?

Our findings

We observed that staff and people living in the home had built a good rapport. People appeared comfortable and relaxed around staff, who adapted their communication to meet their needs. This supported people to communicate as much as possible about their preferences. The staff also understood how people behaved and what this meant for them, for example how they were feeling. The healthcare professional we spoke with confirmed that staff communicated effectively with people, and knew them very well.

We observed that the staff had a patient and caring approach towards people, which was reflected by the healthcare professional we spoke with. One staff member explained how they supported people to maintain their dignity by encouraging people to be supported with personal care when appropriate. They also explained how they carried this out always behind closed doors and prompted people to maintain their privacy. Staff also said they found working with the people in the home rewarding. They knew people well, and we observed they used humour with certain people because they knew they enjoyed this and engaged well.

Care plans and other information was presented to people in a way that they were better able to understand than text, for example, with pictures to depict certain choices or emotions. This supported people to be involved in their care as much as possible and maintain as much control over their lives as possible.

Staff explained to us how they prompted and encouraged people to do as much as they could for themselves, and supported them only when needed, whether physically or through supporting people to make a decision. People were empowered to go out into the community if they were able and wished to. Staff also supported people to go out, prepare meals and clean their own rooms as far as possible in order to learn and maintain their independence.

Good

Is the service responsive?

Our findings

People received care that was responsive to their own individual needs. Staff gave us examples of how people maintained choice and control, for example choosing when they wanted to have a shower or bath. Where people's communication was impaired, staff knew their body language and behaviours well. This meant that staff were able to meet their needs as much as possible, by ascertaining whether they were comfortable. Care plans were in place to guide staff on how to meet people's needs, for example, with regards to their eating and drinking, emotional wellbeing and supporting people with activities and personal care. Care records were not always updated when people's needs changed to reflect these, in a timely fashion, however staff communicated well within the team and knew people's changing needs.

People were supported to participate in various activities both in the home and going out into the community to engage with sports and activities. On the day of our inspection all of the people had gone to a local day centre and returned in the afternoon. There was a pool car available for the home which meant that people were able to go out regularly. Where people wanted to plan an activity or had an aspiration to do something specific, staff supported them with this.

There was a key worker for each person, and the registered manager told us that the main part of their role was to engage with people to ensure they were receiving appropriate care. They held regular discussions with people. This role was to act as a key worker to all of the people living in the provider's homes, and the registered manager told us this worked well.

All the staff were approachable. The healthcare professional we spoke with said they would feel comfortable to raise any concerns they had with staff, but they had not needed to so far. The deputy manager explained to us how they supported people to raise concerns if they had any. They had not received any recent complaints, however the provider had a complaints system in place.

People's care records contained information which would be used to ensure people had their preferences met towards the end of their lives, however there was not a need for palliative care in the home at the time of our inspection visit. Some staff had received training in end of life care, and the manager ensured that appropriate professionals, including GPs, were also involved with people's care throughout their time living in the home. There were care plans for staff to complete with people in respect of end of life care, which would be completed if appropriate.

Requires Improvement

Is the service well-led?

Our findings

There had not been a registered manager in post since April 2018, and we found that some improvements were needed in respect of the management and oversight of the service. The current manager had been in post for two weeks at the time we inspected, and had commenced the process to begin registering with CQC. The deputy manager had been overseeing the service in the time when there had been no registered manager. They had been supported by the area manager. Both the manager and the deputy manager told us they felt well-supported by the provider's organisation.

We found that although there were systems in place for quality assurance, these had not all been used recently and effectively to monitor and improve the service. The audits in place had not regularly been carried out, for example, for the oversight of care plans, medicines, competency checking, records around people's capacity, and infection control. The manager had identified some areas for improvement, and subsequently developed an action plan for the service and but had not yet had time to implement these improvements. The deputy manager and the manager explained that the home was going to be managed in conjunction with one of the provider's other local services. They told us that they would therefore bring across the quality assurance systems from the other home and ensure they were properly implemented in this service.

There were questionnaires to gain feedback from people living in the home, with support from staff to fill them in, and the deputy manager told us that these had been completed in 2018. We looked at these and saw that people were positive about living in the home.

There was a positive culture amongst the staff working in the home, and the staff told us they were happy working for the provider, and enjoyed their work and worked well as a team. Without exception, the staff we spoke with said that they felt well-supported by the management team and the provider's organisation. The registered manager or the deputy manager was available to support staff if needed and someone was always on call in the case of an emergency or extra support needed. The healthcare professional who we spoke with said they had found the management and the staff, contactable and responsive.

The manager was aware of their responsibilities to report certain incidents or information to CQC and other authorities when required. We found that when we reviewed the PIR, this reflected what we found during our visit.

The staff team worked closely with other organisations, such as a local day centre which people went to regularly. They also communicated with organisations within the local community to support people to engage safely in the local community.