Speciality Care (Rest Homes) Limited

Norwood

Inspection report

30 Norwood Avenue
Southport
Merseyside
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Tel: 01704534433

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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 this service on 23 August 2018.

This was the first inspection of this service since the registered provider had registered with the Care Quality Commission (CQC) in July 2017.
Norwood is a care home. The service is a semi-detached house in Southport, situated close to the town centre and its amenities. 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.

Norwood has links to Arden College which provides specialist further education for young people aged 16-25 years of age with learning disabilities. Norwood currently provides accommodation for four young adults aged over 18 who have completed their education at Arden College. This was referred to as an 'After College Provision.' The support is provided 24 hours a day. The house was split into three self-contained flats and shared communal areas.

The home has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

A registered manager was in post.

A registered manager is a person who has registered with CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the time of our inspection four people were living at the home.

There was a process for analysing incidents, accidents and near misses to determine what could be improved within the home. We saw that when incidents and accidents had occurred, staff were fully debriefed and relevant professionals were updated as and when required.

There was personal protective equipment (PPE) available within the home, such as gloves, aprons and hand sanitiser. These were available for staff to use when they supported people with their personal care or helped people complete cleaning tasks in their flats.

Medication was well managed and only administered by staff who had the correct training. We saw that one person chose to self-medicate and they were supported to do this by staff. This process was reviewed every

few months by staff. Medication was stored securely within the home.

There were enough staff to help people with their day to day support needs, such as accessing the community or support with their personal care. There was some agency use, however the same staff were often requested. Staff told us they never felt short staffed and family members did not raise any concerns regarding staffing.

Staff records we saw demonstrated the registered manager had robust systems in place to ensure staff recruited were suitable for working with vulnerable people.

There were systems and processes in place to ensure that people who lived at the home were safeguarded from abuse. This included training for staff which highlighted the different types of abuse and how to raise concerns within the infrastructure of the organisation. Each person had specific instructions in place for staff to follow with regards to keeping them staff.

Risk assessments were detailed and specific, and contained a good descriptive account for staff to follow to enable them to minimise the risk of harm occurring to people who lived at the home. Detailed protocols were in place in relation to people's challenging behaviour. These protocols were reviewed regularly by the person's keyworker and the registered manager.

The service was operating in accordance with the principles of the Mental Capacity Act (MCA) and consent was sought in line with people's best interests. People's mental health needs were assessed appropriately, and they were treated with equality and diversity which was evidenced in the outcomes of their support. Appropriate referrals were made when people were required to be deprived of their liberty. There was information recorded in people's support plans which outlined any best interest decisions and who was involved in them. Consent was also sought and clearly documented in line with legislation and guidance.

Staff had the correct training to enable them to support people safely. Staff also completed additional training to support people who may present additional behaviours. This training was sourced separately.

Staff engaged in regular supervision with their line managers, and had annual appraisals.

Menus were varied, people told us they had input into the menus and often cooked their own meals and this was something they were encouraged and supported with. People were supported by staff to make good choices in accordance with dietary needs and eating plans.

People had access to other medical professionals who often visited the home Regular meetings with external healthcare professionals took place when needed.

People were treated as individuals, and their choices and preferences were respected by staff. This was evident throughout our observations around the home, and the information recorded in people's support plans. Staff also described how the ensured they protected people's dignity and choices when providing personal care.

Staff spoke with people and about them with warmth and sensitivity and there was clearly pride in what people had achieved since being at Norwood.

There were examples of accessible information for people who used the service. This was presented in various formats to support people's understanding and we saw that in most cases, people had been

provided with an adapted version of their support plan to help them understand the content.

People's support plans were person centred and contained a high level of detail about the person, their likes, dislikes, how they wanted to be supported and what successful support looked like for them. This information was reviewed every month and changes were documented within support plans.

We reviewed the complaints policy during the inspection. There were no on-going complaints and there had been no complaints since the service had been registered.

Staff undertook training to enable them to respectfully care for someone who was at the end of their life, however most people who lived at Norwood were younger adults. The registered manager informed us that if someone's health declined their wishes would be respected and provisions would be made to support them.

The service worked in partnership with the local community, as well as other professionals such as the Local Authorities, GPs, the college, and the police. The vision of the organisation was person centred and the staff we spoke with told us they liked working for the company.

Quality assurance systems were robust and sampled a wide range of service provision. Where issues had been identified, an action plan was devised, reviewed regularly and updated with the latest action points.

Further information is in the detailed findings below.

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.

Risk assessments were in place and reviewed as part of people's support needs. These were detailed and gave staff clear instruction of how to manage and minimise assessed risks.

There was enough staff on shift to meet people's needs. The use of agency staff has decreased in the last few weeks.

Medicines were managed safely and stored appropriately. Medication was only given by staff who were trained to do so.

Staff were only offered employment once suitable pre-employment checks had been carried out which included an assessment of their suitability to work with vulnerable people.

Is the service effective?

Good

The service was effective.

The staff had the correct training to reflect their roles, this was evidenced in the training matrix.

Staff received regular supervision and annual appraisals.

People were supported to eat and drink appropriately.

The service was working in accordance with the principles of the Mental Capacity Act and associated legislation.

Is the service caring?

Good

The service was caring.

People spoke positively about the staff and we saw staff treating people with kindness throughout our inspection.

People told us they were involved in the planning of their support. Support plans we looked at confirmed people had been

consulted with.

Records and confidential documentation were stored securely, in a lockable cupboard.

Is the service responsive?

Good

The service was responsive.

People and their relatives were fully involved and included in all aspects of service provision.

Support plans were tailor made to suit the needs of the person; primarily focusing on their needs and how support could be adapted and changed depending on their wishes, preferences and aspirations.

There was a complaints procedure in place, however there had been no complaints.

People were supported sensitively with arrangements for end of life care.

Is the service well-led?

Good

The service was well-led.

There was a process in place to check the quality of the service. Action plans were formulated to address any highlighted concerns.

People spoke positively about the registered manager. The culture of the organisation was person centred, and the manager had a good level of knowledge of each person and their support needs.

Team meetings took place; additionally, people were encouraged to share their views regarding service provision.

Norwood

Detailed findings

Background to this inspection

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

This comprehensive inspection took place on 23 August 2018 and was announced. We gave the service 48 hours' notice that we would be attending as the service. As the service provides special support for young adults who are often at college or out during the day, we wanted to be sure someone would be available to speak to us.

The inspection team consisted of an adult social care inspector.

Before our inspection visit, we reviewed the information we held about Norwood. This included notifications we had received from the provider, about incidents that affect the health, safety and welfare of people who use the service. We viewed the provider information return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We also used this information to populate our planning tool. This helps us plan how the inspection will be carried out.

Due to people's individual communication needs we were not able to establish their thoughts and feelings with regards to living at the home. However, we did speak with one person who lived at the home. Additionally, we spoke with two relatives and three members of staff and the registered manager. We also contacted two health and social care professionals by email to ask for feedback. We received a response from one person. We looked at the support plans for the four people who lived at the home and the recruitment and training files for four staff. We also looked at other documentation associated to the running of the service.

Good

Is the service safe?

Our findings

We spoke with one person who lived at the home and contacted two family members of people who were receiving support. We also contacted and received feedback from one health and social care professional.

The person who lived at the home said that they felt safe, and enjoyed being supported in their own flat. Family members said, "I never worry or doubt that [relative] is well taken care off." Another family member said, "I know if there was any concerns the staff would call me straight away."

Rotas showed that agency staff were utilised most weeks in the home. We spoke to people about staffing, and asked if they received consistent staffing. Also, regular staff confirmed that the agency staff who came to the home were 'block booked'. This meant that the registered manager requested the same staff each time. By doing this, the staff and the people who lived at the home were getting the opportunity to know the agency staff and develop relationships with them.

Risk assessments were in place for people who lived at the home. Risk assessments were in place for areas such as touching, verbal aggression, physical aggression, spending personal time with partners, road safety, wandering, stranger danger, allergies and smoking. Each risk assessment was divided up into red and amber sections. The red meant mandatory action to be taken, and the amber meant advisory action to be taken. For example, we saw a risk assessment for the amount of alcohol one person had agreed to drink while they were being supported by staff in the pub. Also, how staff must advise them to return home from the pub when the person had consumed their agreed amount of alcohol to continue drinking at home if they wished. The risk assessment contained words and phrases that the staff must use to enable the person to engage with them rather than escalate or trigger behaviours which could put the person at risk.

We also saw numerous risk assessments around cyber bullying and safe internet usage. These risk assessments were in place both in the home to help people remain safe whilst using the computer equipment. There was a detailed process for the staff to follow to help keep people safe with regards to internet usage.

We checked how the service was using information to make improvements within service provision and people's support. We saw that an analysis of incidents and accidents had shown that one person experienced an increase in incidents at certain times or during a particular television programme. We saw how the staff had worked together to find alternative solutions for this person, so they were less likely to become agitated and as such the person's incidents had reduced. This meant the service responded promptly to their analysis of risk to mitigate risk.

Staff explained the course of action that they would take if they felt someone was being harmed or abused, this was reflected in the registered providers safeguarding policy. Staff we spoke with also said they would whistle blow to external organisations such as CQC, the local safeguarding teams or the police, depending on the nature of the concern.

Staff records we saw demonstrated the registered manager had robust systems in place to ensure staff recruited were suitable for working with vulnerable people. The registered manager retained comprehensive records relating to each staff member. Full pre-employment checks were carried out prior to a member of staff commencing work. This included keeping a record of the interview process for each person and ensuring each person had two references on file. The registered manager also requested a Disclosure and Barring Service (DBS) certificate for each member of staff prior to them commencing work. A valid DBS check is a check to ensure that staff who are employed can provide care and support to people within health and social care settings. This enables the manager to assess their suitability for working with vulnerable adults. This shows there were safe procedures in place to recruit new members of staff.

Medication was well managed. Medication was only administered by senior staff who had undergone specific training which included annual assessments of their competency. We viewed some of the MAR (Medication Administration Records) charts and saw that they were filled out correctly. We checked the procedure for controlled drugs, (CD's). These are medications with additional safeguards placed on them. We saw the procedure for administering controlled drugs was in line with the provider's policy and national guidance. One person was being supported to self-administer their own medication. This was regularly assessed between the person and their key worker, to ensure the person had the right support with regards to this. We spoke to this person who said they were happy to be able to do this for themselves and they felt the staff were very supportive. They said, "What I like the most is that the staff will always try and encourage me to do things like this for myself."

We saw that all firefighting equipment had been checked, and new equipment was in place in various parts of the home to help people evacuate safely. Personal Emergency Evacuation Plans (PEEP's) explained each person's level of dependency and what support they required to ensure they were evacuated safely. We spot checked some of the other certificates for portable appliance testing (PAT), electric, gas, and legionella. These were all in date. Procedures were in place to ensure the safe removal of hazardous waste, and bins and toilets were regularly cleaned and checked. Personal protective equipment (PPE)was available for all staff, such as gloves and aprons. There were hand sanitizers fitted to the walls in various areas of the home to help support infection prevention control.

Good

Is the service effective?

Our findings

We spoke to one person who lived at the home who told us that staff were skilled and helped them to maintain their independence. Family members we spoke with made the following comments, "I always feel the staff have the right skills to support [relative]." Another family member said, "Yes, the staff are really good," in response to us asking if they felt staff were knowledgeable with regards to their relative.

Staff confirmed they were required to attend regular training. We viewed the training matrix and checked that the dates recorded matched the dates we saw on staff certificates. The training matrix showed that all staff had attended training in subjects such as first aid, safeguarding, medication, autism, and conflict. Other specific training included TEAM TEACH, which trains staff with regards to guidelines which have to be used if the person required physical interventions.

New starters completed an induction over the first 12 weeks of their role which was aligned with the principles of the Care Certificate. The Care Certificate is a set of standards health and social care workers should adhere to as part of their role. Staff we spoke with said their training and induction was thorough, and they felt well-equiped once they had completed this. One staff member said, "The training is good, I prefer the classroom based learning rather than the e-learning."

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The DoLS provide a legal framework to protect people who need to be deprived of their liberty in their own best interests. We saw that there was relevant paperwork in place for one person who was subject to a 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. All the staff team had received training in the principles associated with the MCA and DoLS. We saw that the process for 'best interests' and decision making was included in people's support plans. Best interest decisions were well documented, and there was an explanation of why the considered decision was in the persons best interests, signed by all involved, such as relatives and social workers. This demonstrated that the organisation understood the principles associated with the MCA, and was supporting people to make more complex decisions themselves with support from any required communication aids. For example, one person regularly chose what they wanted to do, or if they wanted to go out alone. Their capacity assessment determined that sometimes this person would need additional support depending on risk or where the person wanted to go. The support this person required to make this decisions was well documented.

People were supported to access medical care when they required it. Each person had a health record in their support plans detailing their last appointments with GP's, district nurses, opticians and chiropodists.

People had access to food and drink whenever they wanted it. People chose when they wanted food and were supported to make healthy lifestyle choices. We saw that people's likes and dislikes were documented and menus were chosen taking this into account. People at Norwood lived in their own self-contained flats, so completed their own food shop. One person told us they were often supported to cook more complicated meals by staff, and they enjoyed doing this. They said, "I really like cooking, the staff will help me, but I will mostly do it on my own". We saw that one person was supported to follow a healthy eating programme, and they had been involved in choosing foods which were lower in fat.

Records showed, and staff confirmed that they had received regular supervisions from their line manager. Staff who had worked at the service longer than 12 months also had an appraisal.

The home and each person's flat was decorated to a high standard. One person said they liked living in their flat and would not want to live anywhere else. The said, "I like the fact that this is my personal space."

Good

Is the service caring?

Our findings

We received positive comments about the staff. One person said, "They are great". One family member said, "Excellent" and "Really good."

Staff were passionate when they spoke to us about the people they supported. They used respectful language and phrases such, 'promote dignity', 'empower', 'choice',' respect' and everyone is 'different.' One staff member told us "Everyone is different, and it is rewarding getting to know people and supporting them to achieve their goals." This showed that staff were aware of people's diverse needs and choices.

Staff had a common approach and shared culture which was to achieve positive outcomes for people. They provided consistency which had a positive impact on people's wellbeing. For example, we saw staff showing good and familiar interactions with one person, reminding them of their achievements so they could relay this information to us.

People were provided with a choice of a male or female support worker to help them. This was also clearly documented in people's support plans.

We received feedback from one health and social care professional who confirmed that staff offered good support and they had no concerns regarding Norwood.

People were consulted and involved in decisions about their support. Each person had a key worker who coordinated reviews about their care and support. Support plans had been signed by family members who were legally allowed to do so or via a best interest process when people could not consent themselves.

Key workers regularly reviewed and updated each person's support plans . People were supported to express their views about their care and support during these meetings.

The registered manager told us if someone did not have access to family or friends who could support them, they would arrange for an advocacy service to offer independent advice, support and guidance to people. There was advocacy information displayed for people who required this type of support.

People had information presented to them in a way which they understood. For example, some of the documentation, regarding the Mental Capacity Act, had been re-formatted into an easy to read document, using pictures and symbols that people living at the home were familiar with. Each person's support plan was also presented in a way which was meaningful for them. The manager discussed that this was so people could become more involved with their support plans.

People's confidential and personal information was either stored in a locked room or a password protected laptop. There was no confidential information left in any of the communal areas. Some people chose to have information displayed in their flats.

Good

Is the service responsive?

Our findings

People told us they received support which was person centred. Person centred means support which is coordinated and delivered around the needs of the individuals and not the organisation. One person told us, "I feel like I have a say in my support, which is important to me." A family member told us that their relative's support was well structured and consistent, which was important to them.

We saw support plans specifically written with people's diverse needs at the forefront of the support. Support plans provided detailed information about people's health, behaviours, communication and the way in which they wanted their support delivered. This information was personalised and an individual personal profile was available which contained information around people's life history, likes, dislikes and personal preferences. For example, for one person, we saw information recorded which stated that they preferred to be addressed and communicated with in a way which they identified with. We saw another person had specific information recorded with regards to their behaviours, and how they showed that they required support. People who required additional documentation to support them with their diet and cooking skills had this in place. We saw that all information contained within support plans was presented in alternative formats to aid people's understanding.

Information was personalised and accessible for people. There was information around how to de-escalate a situation if one person become agitated. The information explained what the staff must do, for example, 'wait five minutes and encourage me to calm down again. Staff to use a calm non-confrontational tone.' Additionally, the support plan stated. 'I sometimes need re-focusing on what I am doing. There was detailed information with regards to people's routines and when they preferred certain tasks to take place. For example, showering and when to shower, and also whether the person was independent with regards to these choices or if they required support.

Support plans were reviewed every month. People and their family members were involved in reviews about their support.

Each person had their own activities board on display in their flats, and they planned their week with their key worker. One person showed us their activity planner and what they enjoyed doing.

There was a complaints process in place for people to express their concerns. One family member told us, "I have only ever raised a little niggle, and they have been dealt with. I would understand how to make a complaint if needed to."

Staff were trained in end of life care. As the home supported young people, it was unlikely staff would have to utilise this information, however, staff were aware of the end of life care.

Good

Is the service well-led?

Our findings

There was a registered manager in post. They had been registered at Norwood since the service became operation last year.

One family member we spoke with stated that they felt the home was well ran. The staff were complimentary in general about the registered manager, deputy manager and said they liked working for the company. One staff member said, "We all work really well together, there is no atmospheres, and we are all here for the services users, which makes a difference."

The culture of the home was relaxed and friendly. Staff supported people respectfully, and there was a clear system of delegation amongst the staff. The staff were motivated and understood the mission and vision of the service which was visible throughout the home using various promotional materials, such as newsletters from 'Specialty Care Rest Homes'. Our observations showed that staff and the management clearly knew each well, and worked well together. Staff confirmed that the management were approachable and open.

There were regular audits being completed by the registered manager. We saw that outstanding actions, for example a support plan that was past its review date, was actioned planned and assigned to the key worker for completion. The areas these audits focused on were medication, support plans, risk assessments, staff supervision, and accidents and incidents.

Team meetings took place. We viewed a sample of minutes. In addition, handover meetings also took place every day to discuss any events of significance that had occurred during each shift.

There was a process completed annually where staff had the opportunity to voice their opinions about the service. Feedback was also gathered routinely from people who used the service and this was presented in a format which they understood. We saw that out of the few forms completed by people no issues had been raised for us to follow up.

We saw that surveys had been sent to families to ask for feedback, and we also saw that feedback was gathered weekly by the staff who phoned families and updated them. Weekly meetings were also held with the people who lived at the home. These methods were appropriate for the size of the service. All feedback was documented and was positive.

The home had policies and guidance for staff to follow. For example, safeguarding, whistle blowing, compassion, dignity, independence, respect, equality and safety. Staff were aware of these policies and their roles within them.

The registered manager understood their regulatory responsibility and had sent all of the necessary statutory notifications that were required to be submitted in relation to incidents or changes that affected the service or people being supported.

There was partnership working within the home which involved other professional people who worked alongside the registered manager and the staff team. There was a collective aim of providing the best possible support to people.

From April 2015 it became a legal requirement for providers to display their CQC rating. The ratings are designed to improve transparency by providing people who use services, and the public, with a clear statement about the quality and safety of care provided. The ratings tell the public whether a service is outstanding, good, requires improvement or inadequate. This was the registered providers first inspection at this location, following the publication of the final report, the registered provider will be expected to display their ratings accordingly.