Short Ground Limited

Norcott House

Inspection report

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Date of inspection visit:
25 February 2022
06 April 2022
25 April 2022

Date of publication:
22 July 2022

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Norcott House is a residential care service which can accommodate up to 11 people with learning disabilities or autistic people. 10 people were using the service at the time of the inspection. People who used the service lived in ground floor accommodation with four separate kitchens on each unit, lounges, bedrooms and bathrooms.

People's experience of using this service and what we found
We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

The service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture.

Right support
People were not always kept safe from the risk of infection and the provider took action to put things right following the first day of our inspection. Accidents and incidents were recorded, although it was not always clear what had been done to mitigate risks and reduce incidents.

We have made a recommendation the provider ensures debriefs are detailed after each incident, to help identify possible triggers and prevent a reoccurrence.

Staff were recruited safely to care for people and there were enough staff to meet people's needs. Medicines were managed safely overall.

People had some involvement in planning their care and future goals, and staff used activity checklists to include in each person's support plan. Activity planners did not always fully reflect people's choices, although staff supported people with independent living skills and people chose their own activities daily. Staff were kind and patient and said they supported people in the least restrictive way possible and in their best interests. People had their own living areas and they were supported to engage in the community and maintain family relationships.

Right Care
Care promoted people's dignity, privacy and human rights. People were supported when they wanted to eat and helped to make some choices in their day. Staff spoke with people in a respectful and caring way. Care plans and risk assessments were person centred, although some staff told us they did not always have time to read these. However, the provider showed us a signed list to show staff had stated they read and

understood people's care plans. People were mostly well safeguarded from the risk of abuse and staff understood the procedures to follow if they had any concerns. Some people told us they did not always feel safe living in the service. The management team were aware of this and tried to give reassurance. Risk assessments were in place, but not always reflective of people's needs or followed by staff.

Right culture
Quality checks were not always robust enough to maintain and improve the quality and safety of the service. There were missed opportunities to identify lessons learnt when things went wrong. People and staff felt supported by the management team and felt they were approachable, although not all staff felt their views were considered.

We have made a recommendation in relation to ensuring quality checks are more robust.

Staff supported people in ways which were appropriate for their needs. However, the complexities of people's needs, and the dynamic of people living together within the service, meant at times some people did not feel safely supported.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 5 April 2018)

Why we inspected
We undertook a targeted inspection to routinely provide assurance in relation to infection, prevention and control. We inspected and found there was a concern with infection prevention and control, so we widened the scope of the inspection to become a focused inspection which included the key questions of safe, responsive and well-led. We undertook this inspection to assess that the service is applying the principles of right support right care right culture.

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well led.

Details are in our well led findings below.

Norcott House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors, a medicines inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Norcott House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Norcott House is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was announced on the first day, and unannounced on the two further visits.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority who work with the service. We used the information the provider sent us in the

provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with four people who used the service about their experience of the care provided. We spoke with five members of staff including the registered manager and support workers. We carried out observations of care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included three people's care records and various medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality audit records. We spoke with five staff on the telephone and with seven people's relatives and advocates about their experience of the care provided.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Good. At this inspection this key question has changed to Requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk people could be harmed.

Preventing and controlling infection

- Risks associated with infection prevention and control (IPC) were not always effectively managed. The provider has a detailed IPC policy and procedure, but this was not being followed in practice. However, action taken during the inspection process provided sufficient assurance. We noted the handwash basins available to people may be too high for some people to reach easily. However, this did not apply to people who used the service at the time of the inspection. The provider told us they would consider specific adaptations prior to a person's admission. The management team said they would give this some consideration as part of the wider refurbishment plans.
- We were not initially assured that the provider was promoting safety through the layout and hygiene practices of the premises. On the first day we visited, there were concerns about the cleaning regimes, and the cleanliness of the premises and some equipment. We decided to return to see if action taken during the inspection process provided sufficient assurance. Action had been taken to make sure the home was clean, although there were some areas awaiting refurbishment.
- We were not initially assured that the provider was using PPE effectively and safely. For example, face masks were not always worn correctly. Action taken during the inspection process provided sufficient assurance and staff had been reminded about the safe use of PPE.

Visiting in care homes

- Visiting arrangements were in place and people were receiving visitors in line with current guidelines.

Systems and processes to safeguard people from the risk of abuse

- Systems and policies were in place to protect people from avoidable harm.
- The registered manager was aware of their responsibility to raise safeguarding concerns and liaise with the local authority and CQC. Incidents were reviewed, and systems were in place using the provider's central risk team, to identify if matters needed reporting further.
- Staff were confident to identify and report concerns, and they were clear about whistleblowing procedures.

Assessing risk, safety monitoring and management

- People had individual risk assessments contained in their care and support plans, but these were not always known or followed by staff. For example, risks were documented around the management of one person's behaviour, but their daily notes showed staff took a different approach.
- People did not always feel safely supported, which the management team were aware of and were providing some measures to reassure people and had discussions to review their care needs.

● Where risks had been identified, action was taken to reduce the risk of harm. For example, staffing ratios were increased for some people when their needs determined they needed more support.

Staffing and recruitment

●There were enough staff to support people's care needs. People required a high ratio of support from staff and rotas showed this level was met. However, the deployment of staff was not always effective.

● We saw staff had time to spend with people, but also their time was allocated to ancillary tasks, such as cleaning, because no cleaners were employed at the home. Staff assured us they prioritised the needs of individuals over cleaning duties.The management team confirmed it was part of support staff role to carry out these domestic tasks with people.

● People's relatives and advocates thought there were enough staff. One relative said, "I am happy with the ratio of staff at Norcott House" and another relative said, "There are always enough staff on duty." One person's advocate told us, "It is a safe environment because they have enough staff."

● Safe recruitment practices had been followed. Pre-employment checks included obtaining references and checks with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and help prevent unsuitable people from working in care services. Staff newly appointed told us their interview and checking process had been thorough.

● Safety related training was completed, such as for positive behaviour support, yet some staff reported a lack of confidence when dealing with some behaviour that challenged.

Using medicines safely

● Medicines were safely managed overall. Safe protocols were in place for the receipt, storage, administration and disposal of medicines. Staff who supported people with medicines had been appropriately trained to do so.

● People's relatives and advocates thought medicine support was appropriate. Advocates told us they could look at medicines records for the people they supported.

● Staff completed medicines records accurately and stored and managed all medicines and prescribing documents safely overall. However, one door to the room where medicines were stored was not locked. The service took action to address this risk.

● The room and fridge temperatures were being recorded. However, one storage area temperature was not always within the recommended ranges. The service was aware of this and was taking steps to manage the risk.

● Instructions for medicines that are given when required (PRN) were not always person centred. For example, one person's PRN protocol stated 'look for subtle signs [person] is in pain' but did not explain what these were. This meant that if staff did not know a service user well, they might not know what signs to look for to indicate that they were in pain or feeling anxious and needed some medicine.

Learning lessons when things go wrong

● The registered manager recorded incidents in the service and analysed these to help identify themes and trends. However, incident records lacked detail, such as outcome and debriefs, and so there were missed opportunities for the service to learn and help prevent re-occurrence.

● The management team responded promptly when we raised concerns about IPC on day one of the inspection. They took swift, appropriate action to address the issues of concern and prevent a reoccurrence.

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 MCA 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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Good. At this inspection this key question has changed to Requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

• It was not always clear how people's individual support was managed in a person-centred way or how staff were deployed to meet their needs. Records of people's care and support were written in a person-centred way, although not always reflective of their needs

• People had detailed positive behaviour plans in place which showed proactive strategies for staff to follow to support people, and signs of escalating risk. However, people were not always appropriately supported to manage their behaviour and plans were not always reflective. Records showed PRN medicine was, at times, being used prior to de-escalation techniques. One person on occasion was being 'held' by staff in the community and this was not reflected in their care plan. The person's care plan highlighted there should only be one member of staff to communicate with the person at times of distress, yet care records showed this was not always being followed. Staff were not always familiar with the agreed reassuring words to use, or how to respond to escalating situations of concern.

• We received mixed views from relatives and advocates about people's choice and control to meet their needs and preferences. One relative said, "[Person] has to eat what's on the menu. The home should employ a cook rather than staff doing the cooking." The provider told us separate meals were cooked throughout the home to ensure that meals were person-centred and flexible, depending on the preferences of individuals. A kitchen in each unit allowed for service users to be involved in meal-preparation to support engagement, choice and independence. Another relative said, "Absolutely my relative can make choices and decisions about their care."

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

• People's communication needs were assessed, and the service ensured steps were taken to communicate effectively with people. Easy read and pictorial information supported people to make decisions, such as with the COVID-19 vaccination.

• Staff skilfully communicated with people when people had limited verbal abilities, using gestures, signs and visual choices. For example, one person was supported with their choice of meal because staff showed them the options available.

• Relatives told us staff had devised appropriate communication skills, such as pictorial, easy-read or picking up on non-verbal cues.

Improving care quality in response to complaints or concerns
• When people were unhappy with the service, their views were not always recorded or shown to be acted upon. For example, one person complained about another's behaviour, but there were no recorded complaints from people who used the service.
• There was a lack of recorded evidence debriefs were being completed after incidents, particularly with the individual people affected. This meant there were missed opportunities to identify possible triggers and help to plan for more personalised behaviour support.

We recommended the provider record in more detail the debriefs which take place after each incident and take steps to identify potential triggers for behaviour that challenges.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
• Staff developed good relationships with people, knew their likes and dislikes and interaction was consistently positive and attentive.
• A range of meaningful activities was considered for each person, including activities in the community, with due regard for people's religious and cultural needs. People's independence was promoted in activities such as shopping. One person told us, "I love shopping, it's great." On occasion, people's preferences did not always appear to be followed. For example, one person's care and support plan stated they did not like crowded places, yet we saw they had been on a trip to a busy seaside location.
• People said they enjoyed activities such as cinema and bowling. However, staff told us activities were at times restricted due to staffing availability or worked around people's medication needs.
• Families and advocates said the service met the needs of the people living there and gave us positive feedback. People mostly said were happy living at Norcott House.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Good. At this inspection this key question has changed to Requires improvement. This meant the service management and leadership was not always consistent to support the delivery of high quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- On the first day of the inspection, there needed to be clearer delegation for staff to ensure lines of accountability and responsibilities were understood with regard to managing the risk of infection. This was actioned during the inspection.
- The provider and registered manager carried out regular quality audits in all areas, although these did not always highlight or address areas in need of improvement, such as those found at this inspection.
- Quality checks needed to be developed to help ensure the culture in the service was person-centred and not task orientated. The key values and vision of the service were not always known by staff or fully embedded in the service.
- The management team was established and consistent, and there was continuous provider support. Teamwork was evident and staff gave praise for the support they gained from one another. One member of staff said, "Teamwork is fantastic" and another member of staff said, "They are a great team to work with."
- Staff reported high morale and enjoyed their role in supporting people. Positive feedback was given about the management team and how they were supportive. Staff felt the service was open and transparent. Staff meetings had clear agendas, feedback and praise for staff.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- Staff gave positive feedback about the service and the care provided. Staff felt included through staff meetings and supervision, which had clear agendas, feedback and praise for staff. Staff completed surveys and had access to support for their wellbeing through workplace initiatives. The majority of staff were confident to speak out with any concerns, although not all staff felt enough action was taken when they raised issues.
- People's relatives said they felt involved in care plan reviews. One relative said, "I am involved with care plan reviews, they also document everything that happens." Another relative said, "I receive questionnaires and I do respond to them.
- People's advocates felt the service promoted partnership working. One advocate told us, "I am always invited to a multi-disciplinary team meeting concerning my client."
- Since COVID-19 restrictions had eased, various holidays had been booked with individual people in order to meet their needs and improve their quality of lives.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Continuous learning and improving care

● The provider and registered manager were aware of their responsibility with regard to duty of candour. The management team welcomed feedback about the service and care provided.

● Processes were in place to ensure lessons learnt meetings were scheduled with the provider's quality team. Incidents were discussed during staff meetings. However, there needed to be clearer and more robust quality assurance systems within the home and oversight of risk. For example, there was not always thorough investigation, outcomes, debriefs and continued reviews of staff concerns, safeguarding, accidents and incidents. Outcomes of incidents were duplicated throughout different incident reports. Rationale for safeguarding concerns was not always documented.

We recommended the provider considers further ways in which audits can be carried out to more objectively assess the quality of the service and drive improvement.