Norse Care (Services) Limited

Robert Kett Court

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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

The inspection took place on the 23 and 25 November 2016. We gave 48 hours' notice in line with our methodology for domiciliary care services. This is to give people notice that we wish to visit them in their own home. The service was last inspected on the 8 January 2014 and the service was meeting all the required standards. Since then there has been a recent change in the management of the service and a new manager and deputy manager have come into post.

The service provides Housing with care. People have their own tenancies with Broadland Housing and Norse care provides care according to people's individual needs. There is a dedicated extra care unit for people living with dementia and a separate unit for older people.

The manager is registered with the Care Quality Commission.

'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.'

During our inspection we received mostly positive feedback from people using the service. The service supports and enables people to live independently and have their own tenancies whilst also providing variable support around their individually assessed needs.

Staffing levels were based on the assessed level of support people required with higher staffing ratios on the Extra Care Unit. Some people using the service and a number of staff told us that at times the levels of staffing were not sufficient to meet people's needs. They gave us examples of when people's needs had rapidly declined and they had needed additional support. Staff said the service was sometimes stretched really thinly. However within the staffing structure the team leaders, deputy manager and manager were not directly rostered on shift to provide care which meant they were able to help staff at busier times. Reassessments of people's needs meant gaps in provision and funding could be identified and decisions made if this was the right service to continue to meet a person's needs or if additional funding could be made available to continue to support the person.

We have made a recommendation about staffing.

Risks to people's safety were managed as far as possible and risk assessments identified what actions staff should take to mitigate risk. Joint meetings between care and housing providers meant environmental and risks associated with care were discussed and addressed by the right service, (housing or care) with clear lines of accountability and responsibility.

People received support as required with their medicines by staff who were trained to administer medicines.

Audits were in place to ensure people got their medicines as required and mistakes could be quickly rectified.

We have made a recommendation about medicines.

Staff received sufficient training to help them support people with their care needs and to assess risks to people's health and safety. Additional training in specific health care conditions could be accessed as required and more training would benefit some of the less experienced staff.

Staff spoken with knew how to safeguard people in their care and felt comfortable in raising concerns through their internal procedures or through external agencies when this might be necessary. Staff had received training in protecting adults from abuse and said they had policies they could follow.

Robust staff recruitment processes helped to ensure that only suitable staff were employed. Once staff were employed they were supported through an adequate, induction and training programme to ensure they had the necessary skills and competencies. Supervisions had recently taken place and there were direct observations of practice linked to staff supervision and annual appraisal of staff performance.

People were supported to remain healthy. Staff monitored people's health and reported any changes to family and relevant health care professionals. Staff supported people in staying active and provided activities to keep people stimulated. People were supported around meal times if required and if people were not eating enough for their needs staff would monitor their food and fluid intake and refer appropriately to the GP

Staff were familiar with people's needs and had care plans to refer to which told them what support people needed. These plans were kept under review to ensure the support provided remained appropriate to need.

Staff supported people lawfully and took into account people's wishes and where they lacked capacity engaged other professionals and family to ensure decisions reached were in the persons best interest. The MCA ensures that, where people have been assessed as lacking capacity to make decisions for themselves, decisions are made in their best interests according to a structured process. DoLS ensure that people are not unlawfully deprived of their liberty and where restrictions are required to protect people and keep them safe, this is done in line with legislation. People were supported to make decisions and any restriction on people with carried out lawfully.

The service was well managed and ran in consultation with people that used it. There were systems in place to assess and monitor the quality of the service so improvements could be identified as and when required. The service learnt from incidents, safeguarding concerns and adverse events.

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.

Risks to people's safety were managed effectively and staff knew how to safeguard people in their care. However record keeping did not always demonstrate robust actions.

There were systems in place to audit people's medicines and medicines were administered by staff who were trained to do so. More information about what medicines staff were administering would be helpful.

There were sufficient staff but the allocation of staff to ensure people's needs were fully met needs reviewing.

The service was not always safe.

Risks to people's safety were managed effectively and staff knew how to safeguard people in their care. However record keeping did not always demonstrate robust actions.

There were systems in place to audit people's medicines and medicines were administered by staff who were trained to do so. More information about what medicines staff were administering would be helpful.

There were sufficient staff but the allocation of staff to ensure people's needs were fully met needs reviewing.

Is the service effective?

Good

The service was effective.

Staff had sufficient training for their role but where staff lacked experience they could benefit from additional training.

People were encouraged to eat and drink enough for their needs and staff monitored this to help them take appropriate actions when necessary. Staff liaised with other health care professionals to ensure people's needs were met.

Staff consulted people about their health care needs and

support. Consent was sought and where people lacked capacity staff acted lawfully to ensure decisions were made in their best interest.

Is the service caring?

Good

The service was caring.

Staff were respectful of people's needs and helped them stay as independent as they would like.

The service was inclusive and there was good engagement with the local community.

The service engaged with people and their families to help ensure people had their needs and wishes met

Is the service responsive?

Good

The service is responsive.

People's needs and wishes were known and staff acted accordingly. Care was planned and reviewed to ensure it remained appropriate to their needs.

Social stimulation was promoted through the provision of activity and opportunities to meet collectively.

People had the opportunity to raise suggestions or concerns and these were be responded to as the service took into account people's experiences

Is the service well-led?

Good

The service was well led

The manager was visible and acted upon feedback. There were systems in place to monitor the quality and effectiveness of the service to ensure the service was well received.

The service was inclusive and people reported good outcomes.

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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 over two days: 23 and 25 November 2016 and we gave the provider 48 hours' notice of our intended visit in line with our methodology for domiciliary care providers.

The inspection was carried out by one inspector. Before the inspection we looked at information already known about the service including notifications which are important events which the service are required to tell us about. We also looked at previous inspection report. We did not receive a provider information return which providers are asked to complete giving us some basic information about the service. The provider told us they were not asked for this information. Following our inspection we did ask for some additional information which was received promptly.

During our inspection we spoke with eleven people using the service, we spoke with eight staff including: the manager, deputy manager, two team leaders, three care staff and domestic staff. We spoke with five visitors. We spoke with the GP visiting on the day. We also reviewed staffing records, records relating to the management of the business and three care/support plans.

Requires Improvement

Is the service safe?

Our findings

The service provided differential levels of support according to people's needs over a twenty four hour period.. Some people and their families said they could do with a bit more support, examples given were around help to do laundry and more help with personal care, and more frequent showers. People said staff prioritised their calls according to need and said this at times had compromised their needs. For example one person told us, "Staff are always busy." We observed this on the day of our inspection. Staff forgot to administer a person's medication at the right time because they were busy with someone else. The person got their medication later in the day with no ill effect. We also observed a person asking for support around transferring into a chair, staff did not come back as promised and when they returned later to ask them about any lunch requests they told them they did not have time to transfer them into their chair until after lunch. We noted most people came in to the main dining room for lunch and some were waiting at the table for quite a while after their meal was finished. A relative also told us of an incident when their family member did not get the support they needed close to their preferred time and this had no effect on the person as the family were there but they were concerned about others who might not have family. Another person told us, " lunch time is protected time as staff help out with lunch and team leaders are meant to answer the call bells but this does not always happen. " The manager told us carers were available and domestic staff support people in the main dining room.

Other people were really positive about the support they received, one person said, "Literally nothing to worry about, press the button and they respond, they come quickly unless they are really busy, they let you know. " Several family members told us that staff provided reassurance to their relative and staff and, "Always have time." Another told us staff; meet their family member's needs although they were complex.

Staff told us it could be busy and at times they struggled when the flats were all occupied and dependency levels were high. They said balancing everyone's needs could be stressful and people using the service sometimes had to wait for their support. Staff also said they did not always have sufficient time to sit with people particularly when they were unwell. A visiting professional told us staff were always busy and their walkie talkies went off continuously which they said was distracting. We also felt this was not ideal in terms of supporting people with their personal care whilst responding to other people who were calling for assistance.

However staff told us that staffing levels had improved and they were using less agency staff and were able to work effectively as a team. Agency staff were currently used to manage long term sickness and staff holidays.

On the day of our inspection the service had the number of staff it said it needed for the number of people using the service. The service has 40 flats two were suitable for double occupancy. In addition to thirty flats for people with a housing and care need there were a further ten flats for people living with dementia who required more support. Staff were always based on this wing with two staff during the day a ratio of 1-5 and in the other wings accommodating up to 32 people three staff, this reduced by one in the afternoon and at night there were three staff in total one on the dementia suite and two in the other part of the home. Two

people were receiving end of life care and five people needed the assistance of two staff for their manual handling needs. Staff were regularly checking people throughout the day and night to ascertain their well-being, safety and to deliver care.

We discussed the feedback we had received with the manager. They told us they were able to respond to people's needs appropriately and in addition to care staff they had domestic staff who assisted people at lunch time in the dining room. They said the manager, deputy manager and team leaders were not directly rostered on to provide care but could be called upon when needed to assist and support the care staff. They said there were night care coordinators who could respond to a situation, either by offering advice or practical support to night staff in any given situation. They did night audits to ensure current staffing levels were adequate to need. They were also able to look at the handsets to see how many calls had come in to see if staffing levels were sufficient to respond to these. Call bell response times were expected to be within five minutes and this was communicated to staff. In response to our concerns the manager said call bells were diverted to the team leaders if care staff were unable to answer them and they were looking at staff allocation which was currently based on number of flats rather than people's dependency levels. The manager said they would allocate staff according to people's needs with a mixture of people who needed more support and those that needed less so. Hence the work would be evenly allocated and all care staff would have an even spread.

We recommend that the service revisits the dependency tool they have in place and review and update this more regularly along with more frequent reviews of people's support needs which could change gradually over the year..

One relative told us it would be good idea to have a picture board on arriving at the service which had photographs of all the staff and their positions, showing who was working and who was leading the shift so they knew who they could contact. The manager said this was a good idea and said they were going to adopt it.

There were systems in place to help ensure people received their medicines as intended. We asked several people about their medicines. One person had been able to take all their medicines independently but a change in their need resulted in a series of reviews to establish, if they were safe to continue to do so. People could take their own medicines if they were able to but realistically staff administered most medicines. One person told us, "I have help with my medication, some people take theirs independently. The staff kept daily records and do monthly audits." We spoke with another person whose family member ordered their medicines and they were able to take theirs independently but had support from the district nurses around maintaining their health.

Staff administering medication told us there was an annual assessment of their competence unless errors had been made in which case retraining and competency assessments would automatically be done. Staff said in terms of competencies they would be observed at least twice and then be signed off. Staff said they use a bio-dose system where medications were pre-dispensed by the pharmacist into individually labelled pots and then checked in by two staff to help minimise errors. Some people and, or their families ordered their own medications. There were monthly medication audits of stock medicines which would highlight any concerns. There was also a three monthly audit of each person's medication. Team leaders were responsible for a number of named people and had the responsibility to review their needs and audit their medications and were the named point of contact. In addition the medication recording sheets were checked at the end of each shift. This meant that missed signatures could be identified quickly and if medication had been missed could be rectified. Medication records showed what actions were taken. So for example of the morning of our inspection medication was missed for one person which was identified at

changeover. The GP was contacted and confirmed it was alright to still administer with no expected side effects. The organisation had a medication compliance officer who helped ensure safe practice and where there were concerns about whether people could continue to take their medicines safely they would be involved in assessments/discussions with the person. They were also a source of reference for staff.

One person asked staff what the tablet they were taking was for and staff told them they did not know. We raised this with the manager.

We recommend that information leaflets in people's records would help staff know what they were administering, its uses and any potential side effects.

Where people had creams or pain patches body maps showed the site and patches were rotated showing the site they were applied to help reduce skin irritation. People had medication profiles including a list of medication, any special requirements, and any known allergies.

Staff did not administer insulin but did assist people requiring insulin to ensure they took it appropriately and the syringes drawn up by District nurses in advance of when people needed them were accurate. We saw the service had a policy of the management of diabetes and people administering their own insulin had risk assessments in place. Some staff had received general diabetes training. Following our inspection the manager confirmed they had made an application for selected staff to undertake Level 2 Certificate in Management of Diabetes.

Risks to people's health and safety were documented to ensure staff knew what actions they should take to meet people's needs and reduce risk as far as reasonably possible. One person told us that they had fallen a lot but then said they had been seen by the GP and the falls team and their risk of falls reviewed. We saw another person who had fallen and they had also been referred and regular checks were in place.

Where people needed assistance with their manual handling there was a clear plan, stating what support they needed and what equipment was to be used. This included type and size of sling and pictures of equipment. We noted there was a person who had only an approximation of their weight in their care plan and guidance for staff for manual handling equipment.

We recommend that this is updated if the persons weight changes to ensure information is accurate and staff are continuing to use the right size of slings.

Additional monitoring records were in place for some people such as turn charts and food and fluid charts. However if these are necessary it is important for them to be filled in accurately. Care plans stated how often people should be turned to help promote good skin integrity. Records did not include this information and the frequency of recorded turns varied. With the exception of one person people's skin was intact but we were concerned about the quality of these records. In addition fluid records viewed had not been totalled up and it was not clear how much people should be drinking or what was normal for them. Individually agreed fluid targets would help staff recognise when they should be contacting the GP if there was evidence the person was not drinking enough and showing signs of dehydration.

The manager was aware of and had used different technologies to aid people's safety such as door and wrist sensors and tracking devises to enable people freedom of movement but also to alert staff and to the persons movement and where about's.

Staff had a good understanding of what actions they should take if they suspected a person to be at risk of

harm or actual abuse. Staff were aware of safeguarding policies and procedures and who to contact including internal and external agencies. Staff were familiar with the whistleblowing policy. Staff felt the practices at the service were good and people received safe care. People using the service had information about safeguarding and how and who to report concerns too.

We reviewed a recent safeguarding concern in which the service had worked with other agencies to establish what the risks were and to put steps in place to try and ensure the persons safety in the least restrictive way possible without curtailing the person's independence. We found incidents, accidents and concerns were responded to appropriately with the provider investigating or cooperating with an investigation as required. Action plans and lessons learnt were in place.

People could have support with their laundry if required and there was daily domestic support for people. We saw a due regard for infection control with staff having access and using the right personal protective equipment. One relative told us how their family member needed barrier nursing for a long time and this was completed correctly and respectfully by staff.

We look at recruitment of new staff and saw there were robust procedures in place to ensure only suitable staff were employed. This including a checkable work history, proof of address, personal identification, references including a character reference and employment reference. A disclosure and barring check was carried out to ensure the person did not have convictions which would make them unsuitable to work with older people. Interviews questions helped interviewers to judge a person's fitness and character to work with the people using the service.

Good

Is the service effective?

Our findings

Staff had the appropriate experience and training to meet the needs of people using the service. However there were areas of health care in which the staff would benefit from more knowledge. For example diabetes. People spoken with were fond of staff and were overall satisfied with the service they received. Some people said they would be more reassured if staff were medically trained. One gave an example of a person who became temporarily unwell and said staff did not know how to respond. Another person told us about the impact their condition had on their day to day well-being and abilities. They felt staff did not really understand this and gave us examples to illustrate this. Another person told us, "staff are well trained I would give them 11 out of 10."

We spoke with staff specifically about a number of conditions people using the service had and staff had not received any recent training about these conditions and some people had expressed concern about some staffs knowledge. In contrast staff did receive all the essential training they needed to work in care including managing people's nutritional needs, manual handling needs, medication and others. All staff had completed training in dementia care and some were doing more advanced training and they had identified a member of staff to take a lead role. More dementia training was being rolled out to all staff over a number of days giving staff both a 'virtual experience of dementia' and a more theoretical course. A number of staff had not received refresher training within the required timescales which meant their practices were not being kept up to date. Staff had been reminded of the fact and dates set by which time they were to refresh their training. Some staff had specific training around end of life care and this was going to be provided to additional staff.

The manager, deputy manager and team leader we met had vast amounts of experience and were able to effectively lead the shift and support more junior staff. An examination of staff records provided evidence of recent training, staffs knowledge and supervision to ensure staff were working to consistently high standards. Training was linked to key policies to ensure staff were following them.

The service had a recognised induction programme and this included a more standardised, basic induction for temporary, agency staff who worked under supervision. Staff told us when they were first employed they covered their basic training and if they were new to care completed the care certificate a recognised foundation course for care staff. Staff confirmed that they were accompanied by more experienced staff until they felt confident in their role and had been assessed as having the right competencies.

Staff were supported but the frequency of supervisions had not been well established. The new manager had just carried out annual appraisal of all staffs performance. There were also direct observations of staff practice. These were annual and regular staff meetings. The manager told us staff would have a minimum of three supervisions and an annual appraisal and dates for this had been scheduled and each staff member had already had at least one review of their performance. The manager also showed us the training matrix and how any training gaps were being addressed.

People's health care needs were met by staff as staff were familiar with people's needs and were able to

recognise changes in needs and refer these changes either to the district nurses or GP

We spoke with a number of people about their health care needs, One person said to us, "It's easy to see the doctors and the chiropodist comes round, staff help with this." Another person told us, "I have seen the GP, the chiropodist and optician recently. " One person told us that staff arranged health care appointments for them and said they were getting to know the staff and had nothing to worry about. One family member told us about their relative. "They have multiple health issues but we feel staff are on top of them." Another said they were not always informed of changes but they could look in their daily notes.

Staff monitored people's health care needs to ensure their health care needs were met. For example if a person was slightly off colour and not eating or drinking enough for their needs staff would monitor this by putting charts in place to see what they were actually eating and drinking alongside records of the persons weight. People had health care action plans which were informative.

We spoke with the GP who told us they visited every two weeks and knew most people using the service. District nurses were in more often and would raise issues with the doctor if more urgent. The Doctor said the staff always had to hand the information they needed and were knowledgeable about people's needs.

Some staff told us that they checked peoples blood sugar levels as part of the management of diabetes and to ensure blood sugar levels were within an acceptable range. The manager confirmed this would only be done by the Team Leaders and they had undertaken specific training to do this. However there was no documentary evidence to support this so the manager has contacted the District nurses for verification and said they have asked for refresher training so they can update the training matrix. The GP told us they had provided some training to staff which helped reduce their time at the service such as how to recognise a urinary tract infection.

Staff told us when required they would accompany people to hospital but would usually expect where people had family or a named contact that they would support the person. Following admission to hospital depending on the nature of the admission and complexity they would reassess before the person was discharged.

A number of people had chosen not to be resuscitated and there were forms in place for this with the appropriate authorisations.
Staff had sufficient knowledge of legislation relating to the Mental Capacity Act 2005 and the Deprivation of Liberties safeguards. Staff had received training and we observed staff offering people choice and consent was sought for care. Where a person was unable to consent processes were followed to ensure decisions were made in the persons best interest and the processes were transparent. A number of people had deprivation of liberty safeguards in place which were standard authorisations from the Local Authority to detain people against their will. This meant it would not be safe for people for people to leave independently and the least restrictive option was in place to prevent them. Door codes were in place but only on the extra support unit and where people were not deprived of their liberty they had the key codes. A number of people were too frail to assess their capacity. This was recorded and application to the court of protection had been made. For other people who lacked capacity, assessments had been completed and there was information of relatives who held enduring power of attorney for care and welfare and finance or both. Guidance was seen around legislation relating to people's decisions which showed changes in policy/case law were brought to staffs attention.

The service supported people as far as reasonably possible with their dietary needs. The service had a facility in which people could receive a hot meal during the day for which they paid for and were assisted by

outside catering staff. Domestic staff employed by Norse care provided lunch time supervision. People could chose to eat in a communal dining area or in their own flats with or without staff support depending on their assessed support needs.

Staff monitored people's weight and food and fluid intake if there was a concern about this area of support. This was monitored by the team leaders and referrals were made to the district nurses, GP and other health care professionals where they might be a concern people were not eating and drinking enough for their needs. A handover sheet indicated need to know information from care staff to catering staff such as any allergies or specific dietary requirements. Relatives told us from the daily notes they were able to see how often and how their family member was being supported, along with the specific care plans in place.

Good

Is the service caring?

Our findings

The service was inclusive of the people living there. People told us about the monthly meetings. One said, "We can bring up suggestions and are listened too. " We asked what sort of things they discussed they said, "Activities, meals, care. " Staff supported people to socialise where they wanted to and recognised barriers to communication and tried to support and facilitate people. For example people used audio tapes instead of books where required. Staff spoken with adapted different activities to suit the needs of people and focused on what they could do. Staff we spoke with talked about alleviating social isolation and showed a good understanding of people's individual needs. They saw part of their role as helping people develop meaningful relationships with other people using the service and helping them to maintain family relationships.

People said the staff were very kind and caring. One person told us, "Really brilliant." Another said, "Nothing is too much trouble, lots of lovely staff." Another said, "Staff get on well, no arguments, they are wonderful."

Staff had positive relationships with people and this was evident in their interactions with people. One staff member said, "Coming here is my highlight, I love the tenants."

One person told us, "I would not wish to live anywhere else but went on to say, I wish there was a volunteer who could take me out." They said they were reliant on staff to take them out and this was not possible. We spoke with the manager about this and they told us they previously had a befriender working at the service with a person and used to have young people doing their duke of Edinburgh awards. The manager told us people could book the flexi bus and they had links with Age UK and age Norfolk who were able to support people around specific issues. This information was included in their newsletter.

We spoke with relatives about the support provided to their family members. One relative told us, "Staff are kind and respectful. No concerns. They talk to people well and are very cheerful." A family told us how they had observed a person becoming really distressed and told us, "The staff were really patient and thoughtful, offering reassurance."

The service was inclusive with individual reviews taking place which involved families. In addition there was a newsletter, regular activities and opportunities for people to socialise. There were tenant meetings and feedback forms annually to gauge people's option of the service. The manager told us they had an open door policy and they acted on individual feedback and feedback received as part of the meetings held with tenants. In addition they told us some people using the service had been involved in the interviewing of new care staff and had influence over who was being appointed.

Good

Is the service responsive?

Our findings

People spoke highly of the service. For example one person told us about the staff, "They are really brilliant, some people here have dementia and can shout out but the staff manage this really well," Another told us, "Lots of choice, carers will give you a hand massage, each carer will support an activity. These are advertised in the newsletter." A relative told us, "Brilliant place, very efficient."

Before anyone was provided a service an assessment of need would be completed. People would have to be registered on a housing list and have a social work assessment. The care/housing providers would complete their own assessments. People had clear information about the level of service they could expect and what actions would be taken, if the service fell below expectation. However one relative told us that although things were explained to them before the person moved in. When they had moved in their relative did not get enough support around day to day things they would need to know such as lunch times, arrangements for laundry and activities. They thought this should have been clarified and the person supported to a greater extend on moving in which they felt might have helped them settle better

The service was flexible in terms of how it met people's care needs, housing needs and they also facilitated people's social needs by providing communal spaces for people to meet, have lunch, and socialise. We met a number of people who had met for coffee and benefitted from the mutual support they got from each other and shared life experiences. On a second day, we saw another group of people who were knitting and making decorations for a tree festival taking place locally. People who might otherwise be socially isolated were joining others. This was particularly evident at lunch time when most people came and ate a hot meal in the dining room. People were sat in sociable groups and the atmosphere was inclusive. The food was cooked by an outside catering company. They were aware of people's dietary needs. Domestic staff supported people in communal areas and care staff supported people with their meals in their own flats if they needed it.

There was a separate indoor area, with seating, a television and plants. This area had been designed and volunteers fundraised for the benefit of people using the service. The manager told us they were going to host dementia friendly events which would be inclusive of other members of the community who could use this resource. There were publications about how life use to be which helped stimulate people's memory and share experiences of their past.

Staff were rostered to meet people's physical care needs but also took turns to help run and facilitate an activity and felt their ideas were supported and encouraged by the manager. Some people not wishing to leave their flats were supported by care staff going to them and enabling them to participate in crafts or other things in the comfort of their flats should they wish.

The manager told us the service was flexible around people's needs and people had set support hours that was funded each week If this was exceeded there would be a re-assessment of a person's needs to decide if extra funding was needed in the short term or if the placement was suitable. It was also possible at times for the service to work with other providers so the person could stay in their own flat with an adequate support

package around their needs. The service was well supported by GP, and district nurse teams. We spoke with one person who regularly required variable levels of support. They told us they were allocated one shower a week which was not what they were use to and did not feel that the timing of the support provided always meet their needs. The manager was looking at timings of people's support.

We looked at three support plans and daily notes which were put together following an assessment of the person's needs. These gave a good account of what support a person needed whether they could consent to care and what their care preferences were. Risks were highlighted as well as what the person could do for themselves what support they needed and any equipment the person needed. A family member told us initial information was provided and they were asked for their input. They said. "All about me." was in place giving a breakdown of the person's life history and family support. We asked why this was important and they said, "So staff know what their needs are and are able to respond appropriately.

The care plans showed at least an annual review unless a person's needs were changing rapidly. Staff kept daily notes and handover sheets recorded ongoing needs of concern. The team leaders said they reviewed these and any other records such as turn charts and fluid charts to ensure people have the care they needed. Daily notes did not always tell us what care had been delivered for each area of care identified in the care plan. We spoke with a relative who said in the last year they had been invited into two reviews. They said staff always kept them updated about any changes and said notes are kept in their flat so they can see how they have been.

The service had a complaints procedure and an open door policy. People said the manager and deputy manager were visible and listened, although one person felt actions were not always taken. They gave us an example. One relative told us they had complained about a member of staff, (temporary) and this was dealt with immediately. Another family told us about an incident which had occurred, CQC were not aware of this and should have been notified. However the family told us the service immediately put actions in place to safeguard the person.

Good

Is the service well-led?

Our findings

The management of the service had undergone a recent change. A new registered manager and deputy manager have been in post at this service in the last year after longstanding management left. Both the manager and deputy manager have worked in care for a long time and demonstrated their commitment and understanding of the care sector.

We asked staff, relatives and people using the service about the current management arrangements. One person told us, "The manager is accessible, very open and able to raise concerns."

We spoke with staff about management. One staff member said, "It's a nice team, manager and deputy are very approachable and responsive to new ideas, lovely."

People received care from Norse care services LTD and housing from another provider. The manager told us that regular, monthly tenant meetings occurred so people could discuss their needs in respect to their care or housing. A recent issue was around the heating system. Although the providers had different responsibilities they met together so they were both aware of what the issues were. Open days were held for people wanting a prospective tenancy and the service could meet both a housing and a care need a person might have but not everyone had a care need.

The service was inclusive and we saw examples of joint working between the care and housing provider. The service worked closely with family members and the local community. The scheme included a visitors flat to enable relatives and friends to stay over if they wished. There was contact with voluntary groups and schools for the common good of the people living at the service including fundraising and support around social provision. There were different activities planned for Christmas including a visiting reindeer and school children. The manager told us people sat with volunteers and children using tablets to google things 'in the past' such as where they lived and interesting facts about the area in which they lived. Recently there had been a baby shower for one of the staff and Halloween celebrations in which people told ghost stories of Norfolk. People told us how much they enjoyed the engagement with staff and how different activities helped promote their well-being.

There were good systems of support for care staff from other health and social care professionals so people's needs could be met as cohesively as possible.

The manager told us that there were audit tools in place to judge the quality and effectiveness of the service they provided. They completed a health and safety audit each month and there was joint working with the housing provider to ensure needs were met. They regularly received feedback from people using the service and their relatives to ensure a high quality service. This year's annual review was being collated. Norse care send out questionnaires to family and people using the service to ascertain their views about the service provision so they knew what if anything required action.

Another relative raised concern about the general appearance and maintenance of the communal areas

which we did raise with the manager to pass over the concerns to the housing team.