

Norfolk County Council

NCC First Support - Northern & Norwich

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

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?

Requires Improvement 

Summary of findings

Overall summary

We inspected the service on 18 and 19 October 2018. The inspection was announced so we could ensure someone would be available at the office to support the inspection.

At the last inspection we found the service in breach of two regulations of the Health and Social Care Act. Concerns were noted around the risk management systems in place and the management of medicines. We also had concerns around governance arrangements which would help the manager and provider to identify concerns and continuously drive improvement.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions safe and well led to at least good. We found some action had been taken but further action was still planned to further improve standards and meet the requirements of the regulations.

Norwich First Support domiciliary service is a short-term service providing personal care to people in their own homes. The service was provided normally for no longer than six weeks. People's need for the service was assessed at each visit. If it was assessed the service would be needed for longer than the anticipated six weeks, people were referred to different longer-term services for ongoing support.

The domiciliary care service was part of Norfolk First Response which included three other services. One service in partnership with Norfolk Community Health & Care (NCH&C), met more complex and clinical needs, another met urgently required support including support following falls or other accidents and the third provided residential based reablement. Each service was registered in isolation but were managed by the same senior leadership team and the registered managers worked closely together to ensure people's shorter-term needs were met.

The newly developed service had been added to the Norfolk first support domiciliary care which included intensive seven-day support provided to people with more complex needs including support with pressure areas, urinary tract infections and falls. People could require more intensive observations and some funding was provided from Norfolk Community Health & Care (NCH&C) who recruited the clinical staff to support people's needs as required. Each partner agency worked to support people under their own registrations.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults.

The Norwich and Northern first support team was managed by two registered managers. At the time of this inspection one of the previous registered managers was acting up into a county manager role and an acting manager was managing the Norwich side of the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social

Care Act 2008 and associated Regulations about how the service is run.

Since the last inspection improvements have been made across the board in relation to how the service is run and how it fits into the provider group. However, there is still some work to do. The management of medicines has improved with more focus on training and audit of records. This has allowed for inconsistencies to be recognised and addressed with the provider addressing issues in staff supervision and if required with additional training. This has meant the service is no longer in breach of this element of the regulation. However, the service was still in breach of the safe care and treatment regulation in respect of how they managed and mitigated risk. We continued to find inconsistencies in this area and some risks which were not suitably addressed or managed.

Good governance procedures and systems were also found to be in breach of the associated regulations during the inspection in 2017. Whilst we did see some improvements had been made in this area the regulation was found to be in continued breach. The governance framework and structure needed more thought. The collation of evidence and intelligence for service development was limited and how this was used was not consistent or monitored to drive improvement. We were aware this was acknowledged by the county managers and was being progressed internally with the senior leadership team. We found paperwork and some policies required updating and have made recommendations about this in the report.

The service was meeting the needs of a select group of people who needed specific and focused reablement services to continue to live independently. Each of the services within Norfolk first response had clear eligibility criteria. This allowed the county hub to identify and refer suitable placements to the reablement service available within Norfolk first response. People in receipt of the domiciliary care service told us they were involved with the planning of their care and that staff respected their wishes and asked their consent.

People are supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not consistently safe.

Risk assessments were not always an accurate reflection of people's needs and there were inconsistencies in records

Medicines were safely managed and staff were appropriately trained

Staff were recruited safely and there were enough staff to cover the support needs of people using the service

Staff understood their responsibilities to keep people safe and there was available information to address any safeguarding concerns

The service followed nationally recognised guidance for the prevention and control of infection and people told us staff used appropriate equipment safely

We saw action was taken where concerns were noted and steps were taken to ensure staff were made aware of important and updated procedures

Requires Improvement ●

Is the service effective?

The service was effective.

More holistic assessment or review was to be undertaken to ensure the provider met the needs of the people it supported.

Policies and procedures were being updated to ensure staff had information that was in line with current guidance. Staff training was also to be delivered to introduce changes in legislation as it happens.

Staff told us they felt supported and we saw they received comprehensive induction and regular supervision.

The service shared senior management with four other reablement and support services. Referrals and access across these services enabled a range of available support to meet

Good ●

people's immediate needs. Access to other services was managed when required.

People supported by the service took primary responsibility for their own nutrition and hydration needs

We saw consent was acquired at start of service provision and people told us they were consulted throughout provision. At the time of the inspection there was no one using the service who lacked capacity.

Is the service caring?

Good ●

The service was caring.

Everyone we spoke with told us the staff were caring and they were appreciative of the support they received.

People told us and we saw that people were involved with agreeing their care and reviewing it regularly

People told us staff treated them with dignity and respect

People had choices as to how and when they received support, increasing it or decreasing it as they choose and their needs changed.

Is the service responsive?

Good ●

The service was responsive.

Person centred care was delivered which included people's contributions to planning their care considering their recognised strengths and contributions

Complaints procedures were in place and accessible to people. When complaints were made they were investigated and managed in line with expected procedures.

Is the service well-led?

Requires Improvement ●

The service was not consistently well led

The service vision was developing whilst other partner services were procured across Norfolk first response.

Staff felt involved in the developing vision and were clear of their role.

They felt supported.

A comprehensive and effective quality assurance system was still to be developed. Quality audit was in its infancy and not embedded to allow complete service review and continuous improvement.

Governance procedures were beginning to develop. A clearly defined quality approach was to be introduced.

People were asked for their feedback on the service they received but the findings of this was not shared. A newsletter was to be developed to be shared with staff and more considered use of the data was developing.

NCC First Support - Northern & Norwich

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.

The inspection took place on 18 and 19 October 2018 and was announced. We announced the inspection to ensure someone was available in the office to support the inspection.

The inspection was undertaken by one inspector and an expert by experience. The inspector spent the day in the office reviewing records and paperwork and took a further day visiting four people in their homes who used the service. The expert by experience who has experience of supporting people using this type of service spoke with 13 people who used the service over the telephone and to two relatives of people in receipt of the service.

Prior to the inspection we developed a plan from the information we held on the service, this included notifications received and other intelligence received from the Local Authority and the safeguarding team. Notifications are important events which the service is required to tell us about. We also reviewed any information sent to the commission from people using the service. We used the information the provider sent us in the Provider Information Return to support the plan. 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.

In the office we reviewed records for people using the service including five people's care files in detail, accident and incident records and details of any audits completed. We reviewed five personnel files for staff working at the service and other information relevant to the management of the service. When in people's homes we looked at their care files and medication information.

We spoke with seven staff including the management team at the office and two staff directly supporting people in their homes. We spoke with eight people face to face including three relatives.

Is the service safe?

Our findings

Our last inspection in November 2017 found the service required improvement to be found safe. Whilst we saw improvements had been made further action was still required and the service was still rated requires improvement to be safe following this inspection.

During the last inspection we found risk assessments were not routinely updated when risks increased including recording and managing increased risks of falls after someone had fallen. We found this was still the case at this inspection. We reviewed the accident and incident records for the three months prior to the inspection. We saw that when people had fallen records were inconsistent. Inconsistencies included if they were recorded on both an incident record and in the person's care files. We also spoke with someone over the phone who had fallen and there was not a record of that fall in the accident records we reviewed. We discussed this with the registered manager who contacted the support staff and found a record for the accident. We were assured it would be investigated.

We found records of accidents and incidents were not consistently managed to ensure all the information was collated and investigated. This did not allow the correct information to be added to the person's risk assessment and support records to reduce the risk moving forward. When looking at the assessments completed daily for people in their homes by staff we also found these did not correlate with the level of support required or provided. For example, when someone could complete something independently they were scored 0 in the assessment. When they required full assistance for the task or it was completed by someone else it was scored 4. We reviewed these assessments in the four homes we visited and found in three of them, the assessments were not consistent with the support required. The assessment was used to determine when people could support themselves independently and were not accurate. This left an increased risk of people not receiving the support they required and a risk of support being withdrawn when it was still needed.

We found the service in continued breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

At the last inspection concerns were noted in relation to the safe management of medicines. In the records we reviewed as part of this inspection we found that the service was mostly supporting people with the application of creams. People's families supported them with more comprehensive medication requirements or they were self-managed by the person using the service. Appropriate risk assessments were in place to support this.

Medication records were brought to the office at the end of each month and audited by management. Where any concerns were noted, staff were supported with a supervision or additional training. Staff had also received annual competency checks to ensure they were safe to administer medicines as required by the people they were supporting. We found the service was now meeting the requirements of this regulation.

People we spoke with told us they were supported with creams. One person said, "I have a painful neck from

the sling I have to wear. Staff rub volterol in for me. I think they write it down when they have done it." Another told us, "I do look after my own medicines and take my own tablets but they always ask if I've taken them."

Environmental risk assessments were completed for each home, where staff supported people. These were comprehensive and included areas to note including fire hazards and prevention and the safe use of equipment. We were told by the provider following the inspection that the location of key points such as the water stop tap and electric meter were also to be included on these assessments moving forward.

Staff we spoke with had a good understanding of safeguarding and keeping people safe from abuse. There were records available in peoples' homes of who to contact when staff were concerned and staff were regularly trained in this area. Referrals had been made to the safeguarding team as required.

There had been a new system introduced to organise rotas and allocate staff to calls for delivering support. When talking to people in receipt of services and staff, this had proved problematic. We were told regular staff had not always been allocated their regular call and when staff were on leave they had still been on the rota. One person in receipt of services told us that irrespective of the difficulty with the system it had little impact on the provision of services. They said, "The staff are excellent and know instinctively if something is not right. [Regular staff member] phoned me to say they would still be coming but might be a little late due to another call they did not usually do but would be with me. They came and only half an hour late which was fine."

Some others had concerns, one person said, "I have a lot of different carers and they do not all come on time. But they all stay the full time and do not rush me. All the staff chat and are very pleasant and friendly."

Staff told us they had regular calls they completed and people in receipt of services told us they liked the staff who regularly supported them. We were told staff covered for each other whenever possible.

We looked at five personnel files and reviewed procedures for staff recruitment. Staff were recruited in a fair and equitable way with applications and interview notes on file. Checks had been made with the DBS (Disclosure and Barring Service) to ensure the person was suitable for the role and references had been sought from previous employers to ascertain their suitability for the role for which they applied.

The provider was working within nationally recognised guidance for the prevention and control of infection and people using the service told us guidelines were followed. Staff wore appropriate protective clothing when undertaking clinical and personal care tasks. Waste was disposed of in line with guidance and care was taken when staff were responsible for the cleanliness of people's homes.

One person told us, "They wear gloves and change them between tasks and I hear them washing their hands in the kitchen. They wear an ID badge mostly on a string around their neck and are always in uniform."

Records were kept of incidents, complaints and feedback from people using the service and we saw action was taken to reduce concerns and issues. In the year since the last inspection there had been an incident where staff had been unsure how to react to a situation. We saw the service had investigated and reviewed the findings. Actions were developed and discussed in teams. A set of cards identifying steps to take in a number of different scenarios had been developed and were issued to all existing staff and to new staff at induction. This gave staff the confidence in the steps to take in the identified scenarios. Additional training had been provided and the annual update included slides on the journey the service had taken, to embed better practice.

Is the service effective?

Our findings

The last inspection rated the service as good in this key question. This inspection found one area which required attention but still found that overall the service was good in the effective key question.

We saw and were told that staff completed a comprehensive suite of mandatory training. This included safeguarding, data protection, fire safety and medication. It was noted there were between two and three-year intervals between the required training. Within the last three years there had been fundamental changes in legislation and best practice guidelines in some of the associated areas. Staff would not have the updated knowledge without additional training at the time of any changes. We recommend the provider reviews their training policy to ensure staff have the up to date knowledge required to deliver services in line with current legislation and guidance.

People we spoke with told us that regular staff would sometimes come with trainees who were just starting in the job. One person said, "They have had a couple of trainees with them on occasions. They have mentioned they have been on a training day that week so I do think they get training with the organisation."

We saw records of comprehensive induction and regular supervision for staff which showed us they were well supported by each other and the management team.

People using the service had pre- assessments completed of the identified areas where they required support. We found staff were aware of people's assessed needs and provided support in these areas for which people shared their gratitude. However, we did find occasion where other support needs were not being met. For example, one person we visited had been without pain medication for nearly a week and their family member was struggling to access their partners medication. We discussed this with the staff on site and were told the family managed this. It was clear they required support in this area. We discussed this with the provider and registered managers who told us this was being addressed at the annual update training which was being delivered shortly after the inspection. We were told the completion of holistic assessments was to be reinforced ensuring existing and emerging support needs were checked.

The provider had access to nationally recognised best practice guidance upon which the delivery of the service was managed. At the time of the inspection more focused policies were being developed on the service provided.

As the service supported people in the short term they were primarily supported with temporary physical and personal care needs. At the time of the inspection the service was not supporting anyone with specific nutritional needs. Staff ensured people ate what they wanted and that it was prepared as they would like.

Food and drinks which were supplied were recorded in daily logs and any issues would be recorded if people were not eating as expected. At the time of the inspection there were no concerns in this area. Staff heated up prepared foods, prepared and cooked meals for some people and made light meals or snacks for others. Staff had information cards and one of these related to malnutrition. The card identified signs to

look out for including loose jewellery and lack of appetite. Action to take was recorded on the card.

Norfolk and Norwich first support were managed and overseen by the county team who also managed four other reablement services. These ranged from intensive support following acute needs, short term residential services and immediate support for accidents or incidents. Access to any of these services allowed referral to one of the other and we found integration of the services gave people access to the required support dependant on their assessed immediate and short-term needs.

The service also referred people to external services if this was required for their longer-term needs. People told us, the GP was called when required. One said, "[staff member] has been on the phone to the medical centre at least two times trying to get a doctor to see me."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 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.

People in receipt of services from Norfolk first support were living independently or supported by family members. The provision of the service was for a short period of up to six weeks. At the time of the inspection there was not anyone living with limited capacity. We were told how in the past the service had referred to social workers to complete capacity assessments when required and had been involved in best interest decisions. This included assessments for lockable cabinets to support people with managing their medications.

Everyone using the service could make decisions around the service they received and were assessed daily upon service delivery by the reablement team or support workers. We saw consent was sought at the beginning of service delivery for the sharing of information and if required for the service to manage medicines for individuals. Assessment was completed by the county team for suitability of the service.

People told us that they were contacted regularly by both the office staff and the reablement worker to ensure the service continued to be appropriate. We were told staff asked for consent prior to delivering support at each visit.

Is the service caring?

Our findings

The last inspection found the service was good at providing a caring service which involved people in the development of the support provided. We found this was still the case at this inspection where the rating for caring remains good.

We asked people what they thought of the service they received, whether they felt involved and listened to in respect of their care and support. People were positive about the service they received. We were told by one person, "They are good, I could not wish for anything better. If I want a shower they will do that for me and cream my legs. They always talk and chat." Another person said, "The carers are all ok but [two named staff members] are excellent. Nothing is too much trouble. They seem really experienced and plan their time here. One just comes in and gets in done including emptying the bin. [staff member] has an amazing bedside manner and know what she is doing. Everyone is respectful of my home and they understand they are in my home."

People accessed the service when they required temporary support to enable them to remain living independently at home. They were assessed by the county team and decisions were made with the individual as to what they needed and for how long. We saw the service communicated with people about the service provided and encouraged them to become independent as they became ready. One person we spoke with told us, "The staff do what I expect of them and at a level I would expect."

The service provided was reviewed daily via assessment of the level of support required. This was signed by people using the service and left in people's homes. Some people told us they did not read the assessments prior to signing them and everyone we spoke with told us staff did not complete the assessment with the person. We discussed this with the registered managers and senior management team. A service update was to be delivered the following week and we were assured the involvement of people in these assessments would be discussed and then reinforced in supervisions.

Reablement staff reviewed the support provided approximately every two weeks and we saw the records of these were inclusive. People told us they were involved with these reviews and felt listened too. One person told us, "They do a brilliant job, I am grateful for their help. I have had a shoulder operation and they help me to wash, get my clothes on and undress in the evening. They are a group of lovely girls. They chat. It is quite nice because they might be the only people I see all day. They are trying to let me see what I can do for myself. It is frustrating for them when they see me struggling as they want to help me but I need to try and do it myself. If I really need help they will help me."

When staff were supporting one person it was acknowledged their partner may also benefit from some support. This was immediately assessed and provided the next day. This allowed the initial recipient of support better opportunity to recover and become independent again.

We were told that people primarily received support from the same group of carers and even though provision was time limited they developed positive and respectful relationships. One person told us. "The

best thing about the service is I know [staff member] is coming and I can ask them whatever I need to know. Any questions or concerns I have are responded too."

People told us they were supported with aids such as glasses and hearing aids ensuring that they were in good working order. People we spoke with felt listened to and we were told they could choose the gender of the staff member providing support with their personal care needs if they wished. We saw the service had access to information in different formats including different languages or in braille.

We saw one staff member in the home of someone supported. They told us how they provided support in a dignified and respectful manner. As the service had progressed there had been a slow and measured return to independence with the person becoming more responsible for their own needs. We discussed this with the person who agreed they were respected and felt valued in the decisions made about their care. They acknowledged they would need longer term support but felt they had been given the opportunity to develop confidence and were now aware of their limitations through the support provided.

Private areas were used for the delivery of personal care and other sensitive support. Curtains were drawn and where appropriate people were left alone but in ear shot of staff in case they required additional support.

Is the service responsive?

Our findings

The last inspection rated the service as good at being responsive to people needs. We found further work had been completed to develop the responsiveness of the service and it was still good in this key question.

As a domiciliary care agency Norfolk first response provided care and support to people in their own homes. This support varied from the delivery of personal care to support with people's medicines. The service was a specialised and short-term service with a primary aim of returning people to independent living.

People told us how the service had enabled people to come home from hospital promptly when they no longer required the support provided in hospital but still needed support to come home. People told us they were very grateful of this. We were told, "They were able to start immediately after my husband came out of hospital and because they did he was able to come home sooner."

Referral to the service was made to the county hub by professionals with contact with people needing the service. Reablement staff went to assess people in hospital or immediately after any incident or accident had happened which meant the person required more support. They then visited them again in their homes shortly after the service began. We were told people and their relatives where appropriate felt involved with this. We were told and saw that staff always wrote in the folders every day and they were asked to sign the record. One person said, "[staff member] came in when I got home and did all the writing and setting up the documents, she listened to what I felt I needed and then helped."

We saw care files which included information about people's lives and how they had ended up in receipt of the service. We saw aims and goals were recorded on the assessments and there was a clear plan on achieving these.

People were supported with their personal care needs in a sensitive manner ensuring that enough support was provided whilst allowing the person to gain confidence in completing things independently.

Daily assessments were completed by staff on the level of support needed to ensure each staff member was aware of how people had improved and in some cases declined. It was noted that some people in receipt of the service were going to continue to need support at home for them to remain living at home independently. We were told this conversation was held respectfully and people were made aware of other services who may be able to support them moving forward and on a longer-term basis. Support from first support would not be stopped until other more permanent provision was set up. Norfolk first support provided each person with a list of local services they may benefit from and once chosen liaised with them ensuring continuity of provision.

We reviewed the complaints held by the service and found they were mostly in relation to when people had to begin paying for the service. This happened when people were assessed as requiring ongoing support beyond the service specified six weeks. The provider would investigate and apologise to the individuals involved. People we spoke with told us they would know how to complain and that they were given

information at the start of their support in the information pack. One person told us, "If I was not satisfied I would tell them as I am a very straight forward person. I would recommend them to anybody."

Complaints were reviewed and discussed in team meetings and the annual service update delivered to all staff included a synopsis of concerns raised and how the service had both managed them and improved practice following investigation of what went wrong.

End of life care was not provided by the service and people receiving palliative care would not be eligible due to a reduced risk of their health improving to live independently within the service time length of six weeks.

Is the service well-led?

Our findings

The last inspection rated the service as requires improvement for the well led key question and we found work was still to done to improve this area. Norfolk first support remained rated as requires Improvement for being well led.

We reviewed the available monitoring and audits undertaken of the service provided. Once a service commenced reablement practitioners regularly reviewed the paperwork in people's homes. Once the service was finished the complete file was brought to the office for review and audit by service managers. There was not a developed system to collate the findings of these audits nor an embedded procedure for actioning any required changes to policy, procedure and practice.

When people in receipt of the service were involved in an accident or incident an initial report was completed by the staff present this was then escalated to reablement practitioners for recording on the system. We found occasions when this was not done. We also found that once completed there was not a system in place to collate this information, identify themes and trends and develop actions from the outcomes and findings of the audit.

There were other systems in place including monitoring of missed and late calls, medicines administration records and the collation of basic data from service key performance indicators but, we did not find a developed or embedded system to measure the quality of the service provided. We noted from service manager meeting minutes that this was acknowledged and a quality review was to take place with new systems and procedures to be implemented.

However, at the time of the inspection a system was not developed to ensure the service delivered was in line with people's expectation. We also found that monitoring and audit was not embedded for a quality audit system. This meant that the provider did not have clear records and evidence to ensure concerns were identified, investigated, analysed and used to drive improvement. This was identified at the last inspection and is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The provider had sent the commission an action plan from the feedback provided following the inspection. Most areas covered in this report were available on the plan and actions were developed with timescales for implementation. We were assured this would be further developed following receipt of the report.

Information available to people in receipt of the service was out of date and did not include all the information people needed to help them to make informed and timely decisions. This was specifically relevant to contracts that did not include when the service may become payable to the people using the service. We discussed this at length with the provider and registered manager who were aware this had been problematic. Staff had been prepped to discuss the service and its constraints with people at the beginning of provision. However, it was clear this did not always happen. We were assured more clarity was going to be added to the contracts including the updating of the detail around the regulations as at the time of the

inspection there was still reference to the national minimum standards.

The Local Authority no longer delivered residential adult social care services and the development of other provision was beginning to increase. The updating of policies and procedures relevant to adult social care provision was required without delay. We discussed the process for this and understand there was a ratification process and final sign off by the quality team. We were assured by the provider that there would be real attempts to speed up this process.

At the time of the inspection there were only a minimal number of focused, formal policies and procedures dedicated to whole service provision. We discussed this with both the registered and senior managers of the service. We were assured this was being considered and would be addressed. We recommend the provider ensures legal documents including the service contracts are bought in line with current best practice guidelines as a priority.

Norfolk first response had been developed as a reablement brand under which this service sat. Norfolk first support was an assessment and reablement service which provided support for up to six weeks. During that six weeks, assessment would determine, if longer term support was required or if the person supported could continue independently. An ethos was developing with the introduction of services, of a provider meeting needs that required a rapid and short-term response. Reablement provision was delivered to support people back to independence following accident or illness. Norfolk first response provided services to meet people's needs that required shorter term support. Those needs included shorter term accommodation based reablement, services provided for 24 hours to meet unplanned social care needs and the recent development of service in partnership with healthcare teams to reduce hospital admissions.

There were two registered managers for the service, one of whom was acting up into a county manager role. Their post was covered by an interim manager. The hierarchy of the services under the first response umbrella was interlinked with services provided by the county hub which included the swift response service. The management structures and CQC registrations were not clearly defined to recognise the brand Norfolk first response. This was discussed with the county manager and nominated individual. Following the inspection this piece of work should begin with the registration team and inspectors as required.

Staff told us they felt supported and we saw meeting minutes, training and supervision records to support this. Staff had also been provided with a portable card index with cues for support provision. These included signs to be aware of and things to consider; when people were at risk of falls, malnutrition, showing potential signs of stroke or sepsis. The cards also included practical information around fire safety, implementing the Mental Capacity Act and safeguarding procedures.

Where concerns were noted within information returned to the office the registered manager or reablement practitioners would meet with support workers to discuss any issues and help drive improvements.

There has been a recent introduction of further technology including the implementation of computer packages to support the service with keeping the office up to date with changes in support needs and staffing requirements. At the time of the inspection a pilot was ongoing providing reablement practitioners with mobile printers to allow for both the office and home records to reflect the same information

At the time of the inspection there were new roles developing to support the delivery of provision. The roles included responsibilities to enable better and more direct supervision and support structures for staff working with people using the service.

People told us they were asked their opinion at each assessment completed by the reablement practitioner and this helped gauge the ongoing requirement of the service or further assessment for other services to deliver ongoing packages. Norfolk first support provided services until people were either living at home independently or in receipt of other longer-term services to meet their needs.

Family and friend's questionnaires were also distributed to people at the end of the service and shorter feedback reviews were available in the service user information packs.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The provider did not have effective systems to protect people from risks. We found risks were not always correctly assessed and when assessed were not managed appropriately. This included a lack of identified action to reduce risks.</p> <p>Regulation 12 (1) (2) (a) (b)</p>
Regulated activity	Regulation
Personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>There was not an effective embedded quality audit or assurance framework in place.</p> <p>Regulation 17 (1) (2) (a) (b) (c) (e) (f)</p>