Craegmoor Supporting You Limited

Craegmoor Supporting You in East Anglia

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

Craegmoor Supporting You in East Anglia is registered to provide personal care to people living at home. People receiving the care have a range of needs, which includes learning and physical disabilities.

At the time of this inspection care was provided to 12 people who live with a learning disability and who may also have mental and physical health needs.

This comprehensive inspection took place on 20 July 2016 and was announced.

The provider is required to have a registered manager as one of their conditions of registration.
A registered manager was in post at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the agency. 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.

People were kept safe and staff were knowledgeable about reporting any incident of harm. People were looked after by enough staff to support them with their individual needs. Pre-employment checks were completed on staff before they were assessed to be suitable to look after people who used the service. People were supported to take their medicines as prescribed and were enabled to be independent with this if they were safe to do so

People were supported to eat and drink sufficient amounts of food and drink. They were also supported to access health care services and their individual health and nutritional needs were met.

The CQC is required by law to monitor the Mental Capacity Act 2005 [MCA 2005] and the Deprivation of Liberty Safeguards [DoLS] and to report on what we find. The provider was aware of what they were required to do should any person lack mental capacity. People's mental capacity was assessed and care was provided in their best interests. Staff were trained and knowledgeable about the application of the MCA. Arrangements were in place for external agencies to make DoLS applications to the Court of Protection [CoP]. One application was submitted and the outcome of CoP decision was pending.

People were looked after by staff who were trained and supported to do their job.

People were treated by kind, respectful staff who they liked and they were enabled to make choices about how they wanted to live. People and their relatives were given opportunities to be involved in the review of their individual care plans.

People were supported to be part of the community; they were helped to take part in recreational and work-related activities that were important to them. Care was provided based on people's individual needs. There was a process in place so that people's concerns and complaints were listened to and these were acted

upon.

The registered manager was supported by a team of management staff and care staff. Staff were supported and managed to look after people in a safe way. Staff, people and their relatives were able to make suggestions and actions were taken as a result. Quality monitoring procedures were in place and action was taken where improvements were identified.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People's individual needs were met by sufficient numbers of staff.

People were kept safe as there were recruitment systems in place which vetted prospective employees before they were deemed suitable to safely look after people.

People's medicines were safely managed.

Is the service effective?

Good

The service was effective.

The provider was acting in accordance with the Mental Capacity Act 2005 legislation to protect people's rights.

Staff were trained and supported to enable them to meet people's individual needs.

People's health and nutritional needs were met.

Is the service caring?

Good

The service was caring.

People were looked after by kind and attentive staff.

People's rights to independence, privacy and dignity were valued and respected.

People were involved and included in making decisions about what they wanted and liked to do.

Is the service responsive?

Good

The service was responsive.

People's individual physical and mental health needs were met.

People were supported to take part in activities that were important to them.

The provider had a complaints procedure in place. This enabled people and their relatives to raise their concerns and these were responded to, to the satisfaction of the complainant.

Is the service well-led?

Good

The service was well-led.

People were enabled to make suggestions to improve the quality of their care.

The safety and quality of people's care was monitored and kept under review.

The management of staff ensured that people benefited from safe and appropriate care.

Craegmoor Supporting You in East Anglia

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.

This inspection took place on 20 July 2016 and was announced and carried out by one inspector. The provider was given 24 hours' notice because the location provides a supported living service; we needed to be sure that someone would be in.

Before the inspection we looked at all of the information that we had about the service. This included information from notifications received by us. A notification is information about important events which the provider is required to send to us by law. We also looked at the number of returned surveys which we sent out before we carried out the inspection. Of the 19 surveys we sent to people who used the service and we received one of these; we sent out 23 surveys to members of staff and six of these were returned; we sent out 19 surveys to people's relatives and received none of these; eight surveys were sent out to community professionals and one of these was returned to us.

The provider completed a provider information return (PIR) and sent this to us before the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Prior to the inspection we made contact with a local authority monitoring office; this was to help with the planning of the inspection and to gain their views about how people were being looked after.

During the inspection we visited the service's office and two of the homes where people lived. We spoke with five people and one relative. We also spoke with the registered manager and three members of care staff.

We looked at four people's care records, medicines administration records and records in relation to the management of staff and management of the service, including audits.

Due to their complex communication needs some people were unable to say to us about their experience of being looked after. Therefore, we observed care to assist us in our understanding of the quality of care people received.

Good

Is the service safe?

Our findings

During our last inspection, which we carried out on 18 and 23 June 2015 we found that the provider was not ensuring that people were protected from unsafe management of their medicines. This was a breach of Regulation 12(2) (g) HSCA 2008 (Regulated Activities) Regulations 2014: Safe Care and Treatment. The provider wrote to tell us what action they intended to take to meet the requirements of the Regulation as described above. They told us that this action would be completed by 30 September 2015.

At this inspection of 20 July 2016 we found that the provider had followed their action plan to meet the shortfalls in relation to the requirements of the regulations described above.

In their PIR the provider wrote, "Medication audits are completed monthly and action planned to maximise the person's independence within this area of support." Their PIR also provided information to tell us that all of the staff responsible in managing people's medicines had undergone training in this field. The local contracts monitoring officer told us that they found the medicines administration records were complete and accurate.

Our examination of two people's medicines administration records [MARs] found that these were completed and were checked each day for accuracy and completion. The registered manager carried out audits on MARs and said, "I do these about every seven to ten days. There's been an odd missing signature but I have found that the tablets have been given." People and a relative told us that they, or their family member, had their medicines as prescribed and said that they received these when they needed them. People were also enabled to be independent in the management of their medicines; the records demonstrated that assessments and checks were in place. This was to ensure that people were safe with this self-care practice and that they had taken their medicines as prescribed. Care staff told us that they had attended training and were assessed to be competent before they were allowed to support people in taking their prescribed medicines. 'As required' [PRN] medicines were given to people and these were in line with the provider's protocols. The PRN protocols provided staff with the guidance of when these PRN medicines were to be used. This included, for example, medicines for pain relief and for reduction in levels of anxiety. These findings provided evidence that improvements had been made to ensure that people were protected from unsafe management of their medicines.

Procedures were in place to keep people safe from the risk of harm. People told us that they felt safe and gave their own reasons for this. One person said, "It's because I have friends and I know where the staff are." One person's relative told us that they felt their family member was kept safe because staff treated them well.

All of the returned surveys told us that people were kept safe and that staff were aware of their roles and responsibilities in keeping people safe. The provider wrote in their PIR that members of staff had attended training in safeguarding people from the risk of harm. Members of care staff confirmed they had attended this type of training. They were able to demonstrate their knowledge; this was about the different types of harm that people may experience and the signs that people may show if they were being harmed. One

member of care staff said, "The person could have gone quiet or gone off their food." Another member of care staff told us the same and also added that, "There could be marks on their [person's] skin; depression; an unwillingness to engage [with people or activities]."

The provider had submitted notifications to us when there were occasions of people being placed at risk of harm. The information detailed in the notifications told us that appropriate actions had been taken to protect people from the risk of recurring harm. The registered manager also gave examples of measures taken to mitigate the risks of similar occurrence; this included ensuring that staff were available for when people returned home from their day out. Another measure was the provider's disciplinary procedure; this would be used should any staff member fail to keep people safe from harm. This told us that there were systems in place to ensure that people were kept safe as practicably as possible.

The provider told us that there were robust recruitment systems in place and wrote in their PIR, "Safer recruitment processes offer assurance that all our staff team are 'safe' to work with vulnerable individuals such as 2 references/enhanced DBS [Disclosure and Barring Service] etc." One member of care staff described their experience of when they were applying for their job: they said, "There was an on-line assessment and application form. The assessment was basically how you would handle certain situations and I passed this. I had a face-to-face interview and references from a friend and a previous employer. I had a DBS and I provided ID [identification] with my DBS." The registered manager said, "We are on a big recruitment drive at the moment. For one person [staff member] we are just waiting for their DBS before they can start [to work] and another [staff member] we are just waiting for another reference. We check their [prospective staff members] right to work; their DBS; medical checks and references - one from their last employer. The on-line application asks the candidates about their values and attitudes and tests how they would react during certain scenarios. They have to have a 50% pass rate before they can continue with their application." This showed that the recruitment procedures protected people from unsuitable staff.

We checked and found that people were looked after by sufficient numbers of staff. People's care records detailed the number of staff that they needed to keep them safe and to meet their needs. This included, for example, one-to-one staff ratio to support people going out in the community. Members of care staff and the relative agreed that there were enough staff to look after people at all times. We saw that people were relaxed and had members of staff available to talk to and ask for their support when this was needed.

Measures were in place to cover staff vacancies or staff absences and to ensure that people received a continuity of care. One member of care staff told us that they had agreed to work extra hours to cover staff absences. The registered manager told us that there was one agency member of staff used and said, "[This is] so that [name of person] has got that consistency. [Name of person] was really settled and happy [when being looked after by the member of agency staff]." However, the relative told us that they had some concern about the turnover of staff as changes caused their family member to be unsettled due to the changes of staff leaving and new staff starting. Nevertheless they were positive that it was a matter of time for their family member to become used to, and feel less anxious, with new staff.

People's risks were assessed and measures were in place to mitigate the risks. These included, for example, risks of financial harm. One person told us that they were happy that members of staff supported them with managing their personal finances and said, "I can't count money very well." Checks were carried out each day to ensure that people's monies were accounted for and records demonstrated that the risks were effectively managed. One person's care record also showed how their behaviours, which posed a health and safety risk to others, was managed and the actions that staff were to take if the risk of harm became significant. The actions included contacting management staff and the police if this action was justified by the high level of risk. Another example of managing people's risks was found in each person's care file; these

contained a personal emergency evacuation plan in case there was a need to keep people safe in the event of, for instance, the outbreak of a fire.

Good

Is the service effective?

Our findings

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in registered services are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

During our last inspection, which we carried out on 18 and 23 June 2015 we found that the provider was not ensuring that people were protected from unlawful care as their mental capacity to make decisions had not been assessed. This was a breach of Regulation 11(3) HSCA 2008 (Regulated Activities) Regulations 2014: Need for consent. The provider wrote to tell us what action they intended to take to meet the requirements of the regulation as described above and this would be completed by 30 September 2015.

At this inspection of 20 July 2016 we found that the provider had followed their action plan to meet the shortfalls in relation to the requirements of the regulations described above.

The registered manager advised us that they had made contact with the appropriate authority. This was to gain their advice in relation to making DoLS applications: one DoLS application was in progress although the outcome the decision made by the Court of Protection was awaited. The provider told us in their PIR that staff had attended training in the application of the MCA. All of the staff in their surveys told us that they had attended training in the application of the Mental Capacity Act 2005 [MCA]. Members of care staff also told us that they had attended this training and demonstrated an awareness of the application of this piece of legislation. One member of care staff said, "[The MCA] is just making sure that people have an understanding in what is going on with their lives. If they can give consent to what is happening to them. Such as medical treatments and their finances." Another member of care staff told us, "[The MCA] is put in place to enable people to live as independently as possible but also not to endanger themselves if they lack [mental] capacity. You have to assume that they have [mental] capacity unless proven otherwise." The provider told us in their PIR that, "Revised documentation has now been developed and rolled out to ensure that capacity/consent issues are addressed appropriately." People's care records showed that people's mental capacity was assessed: areas where the person lacked capacity, they were supported with their care as this was in their best interest. This included, for instance, support with managing their personal finances. These findings showed that the provider had made improvements and was aware of their responsibilities in keeping people safe legally.

People were having their needs met by staff who were trained to do so. The person in their survey told us that, in their view, the staff were supported and trained to a standard that enabled staff to meet their

individual support and care needs. In addition, the community professional told us in their survey that people's needs were met by staff who were trained and competent to do their job. In their PIR the provider told us that all of the care staff had attended an induction training course. One member of newly appointed staff told us that their induction training included 'shadowing' more experienced staff members to gain an understanding of their roles and responsibilities. We saw that they were being introduced to people they had not yet met by a more experienced member of care staff. Another member of care staff told us that they, too, 'shadowed' more experienced staff members when they first started their job. They told us how this helped them and said, "It benefitted me considerably as the introductions [to people] helped with getting to know them. And it definitely worked the other way!"

The provider told us in their PIR that staff had attended training which included first aid; managing people's behaviours that challenge and fire safety and an "Introduction to Asperger's Syndrome and Introduction to Autism." The registered manager and members of care staff confirmed that staff had attended this training

People benefitted from being looked after by staff who were supported to do their job. Members of care staff told us that they had the support to do their job, which they said they enjoyed doing. Four of the staff surveys told us that the respondents received "regular supervision and appraisal which enhances my skills and learning" although the remaining two staff surveys were unable to agree with this statement. However, staff who we spoke with said that they had attended one-to-one supervision during which aspects of their work and training and development needs were discussed. One member of care staff said, "It [supervision] is definitely a two-way process." The registered manager advised us that the current schedule of planned supervisions needed to become more formalised as part of their improvement strategy in managing and supporting staff.

We checked and found that people were helped to maintain their nutritional health. People told us that they had enough to eat and drink and chose when and where they wanted to eat. Members of care staff were fully aware of encouraging people to eat healthily but respected and valued people's choices in eating less than healthy foods. One member of care staff said, "We encourage them [people] to eat a healthy diet but it is entirely up to them what they want to eat." The relative expressed some concern that their family member often liked to eat out and eat 'fast foods.' However, they said that they understood that it was their family member's choice to do so.

In one of the homes where we visited, people showed how they chose from an easy-to-read menu planning book. They told us what they had agreed to eat and who was to make the evening meal. People were looking forward to eating home-made fish pie which was due to be prepared and cooked by one of the people. In the other house which we visited one of the people told us that people cooked their meals individually and when they wanted to do this. Daily records showed that people's food and drink intake was recorded and medical records noted that people's weights were stable.

People's mental and physical health care needs were met by a range of health care professionals. Females were offered the opportunity to attend well-women screening services and were given the information in a way that helped them make their decision about whether they wanted to attend these. One person told us that they had attended one such screening service and had no reservations about going. Other health care services included opticians; audiology services; GPs; hospitals and psychiatric and psychology services. One person told us that they had recently had their eyes tested and showed us their new spectacles. They told us that they had needed new spectacles as a result of the optician's findings.

Good

Is the service caring?

Our findings

We found that people were being looked after by kind and caring staff who respected people's rights. The local contracts monitoring officer told us that they found when they visited some of the people that there was a warm and welcoming atmosphere. They also told us that members of care staff involved people in making decisions about how they wanted to spend their leisure time. This was also confirmed by a community professional who wrote in their survey, "The client [person who used the service] has full choice in all aspects of [their] life."

It was clear that people, not staff, made day-to-day decisions about how they wanted to spend their day and how they wanted to be looked after. One person said that they liked staff to wash their hair but they chose, and were able, to be independent with all other aspects of their personal care. Another person told us that they had decided to change the days on when the wanted to be at home and when they engaged with activities in the community. They explained their structured routine, which included visiting the local library and visiting a relative, and this had helped them feel happy. One member of care staff confirmed that the person had made these decisions and the structured routine had made the person feel safe and calm.

The person told us in their survey that staff enabled them to remain as independent as possible and was treated well. Moreover, information in all of the returned staff surveys told us that people were enabled to be as independent as possible. One member of care staff said, "The people here have come on so much from when they were living in residential care to supported living. Residential care is so routine and now, here, it's [the care] about people's choice. And reminding them they have more choice. People have more of a voice. They now say more things and they will speak up. They sort out the rota for cleaning and what cleaning they want to do between themselves. If they choose not to do it that day, it's their choice."

People's right to independence was promoted and maintained with a range of practices. These included managing personal finances; medicines; making their own health care appointments; domestic tasks and going out into the community.

People told us that that they had forged friendships with each other and people who lived in the community. They were also helped to maintain contact with members of their family. The relative told us that their family member visited them each week. The registered manager told us that two of the people had independently used public transport. The aim of this was to visit their relatives and that they would return home when they wanted to.

The community professional told us that people were looked after well by staff who respected the person's privacy and dignity. The provider told us in their PIR about how people's rights were valued and said, "The aims and objectives for Supporting You in East Anglia is to ensure that the people we support lead fulfilling lives and to have as much control of their lives as possible. The key principles that form the foundation of our support delivery are autonomy and choice, dignity, privacy, attainment and realising potential, citizenship, equality and diversity, safety and well-being and inclusion." All of these findings demonstrated that people's rights were respected and upheld.

The provider wrote in their PIR that people had the right to be independently represented and this was done by the use of advocacy services. Information in the PIR read, "Advocacy services are actively encouraged for the people we support who have a small/limited circle of support to ensure they receive the support and guidance they need in relation to their lives and the choices they wish to make." One member of care staff gave an example of when advocacy services were used to support a person in making their decision about going on holiday. Advocacy services are organisations that have people working for them and who are independent and support people to make and communicate their views and wishes.

Good

Is the service responsive?

Our findings

People's individual physical and mental health needs were met. People's continence needs were reviewed and assessed to determine if the cause was behavioural or physical. Guidelines were put in place for staff to follow and evidence suggested that these were adhered to. The person's continence needs were being well-managed.

Members of staff were aware of how to manage people's behaviours that challenge. The registered manager told us that diversion strategies were used to re-direct the person's focus from an anxiety-producing situation. This included encouraging the person to remove themselves to a quiet place where they felt safe or to take a walk in the neighbouring countryside. One member of care staff also explained how they supported people with such behaviours and said, "People's behaviours are managed by being aware of the triggers and not allowing them to build up. This is being aware of the use of language and also helping an upset person to have contact with their family. It's giving reassurance and it's effective in reducing the person's stress levels."

People were treated as unique individuals and this was supported by people's detailed life histories held within their care plans. The relative told us that one long-standing member of care staff knew their family member very well. They said that, because of this relationship, it made their family member feel safe, confident and trusting in the presence of the member of care staff. The relative added that, due to a change in staffing, their family member was taking time to have a similar, and therapeutic, relationship to forge the same level of trust and confidence in newly appointed care staff. Our observations of staff interacting with people found that staff knew people as individuals and socially discussed their activities and interests with them.

There was a range of interests which mattered to people and they were supported in following these. These included, for instance, eating out; bowling; arts and crafts; voluntary work; fishing; shopping and going on holiday. One person told us that they had just returned from playing bowls. Another person said that they had attended day services where they learnt about the weather in the USA. A third person told us that they had been working at a local museum.

People's right to be included in planning and reviewing of their care was valued. One person told us that they had recently attended the review of their care and the records confirmed this was the case. Changes were made to how they spent their leisure time and these were based on what the person wanted. The relative told us that they had attended their family member's care plan reviews. They advised us that their family member was present as were health and social care professionals. Following this actions were taken to improve their family member's access to transport.

People were protected from the risk of receiving inappropriate care as care plans and risk assessments were kept under review by care and management staff. One member of care staff said, "Care plans are up-dated from information we give to the registered manager."

There was a procedure in place to listen and respond to people's complaints. People told us that they would speak with members of care staff if they were unhappy about something. The person who completed our survey said that, although they did not know how to report their concerns to the office, they were aware of the care staff who they would speak with. When they had done so, they were satisfied with how this was managed. Members of care staff knew how to support people if they were unhappy about something. One member of care staff said, "It would depend how much I needed to be involved. I would listen and find out first what the problem was." They told us that they would inform the management team should the concern be considered a complaint that needed to be responded to in line with the provider's complaints procedure. The provider told us in their PIR that three complaints had been received in the previous twelve months. All of these had been responded to and resolved in accordance with their complaints procedure. We checked the record of complaints and found that these were responded to in line with the provider's complaints procedure.

Good

Is the service well-led?

Our findings

The manager was registered with the CQC on 9 June 2016 and had been working in their role for four months at the time of our visit. They had previous experience in managing services and looking after people with a learning disability. The registered manager was supported by their regional manager, a locality manager and a team of care staff. Our observation told us that people knew who the registered manager was. One member of care staff described the registered manager as being "approachable". The registered manager had made sure that that they had submitted notifications as required which demonstrated that they had an understanding of their legal responsibilities as a registered person.

People were provided with opportunities to tell the provider their views about their experience of the service. The one person who returned their completed survey to us said that the provider asked for their views and experience of the quality of the care that they had received. These views were recorded during monthly and annual reviews of their care. Suggestions they had made were acted on, which included, going on holiday or having a change of a member of staff. The relative also told us that their views were obtained during their family member's care plan reviews. They said that they were satisfied that action was being taken to improve the quality of their family member's social life.

Four of the completed staff surveys told us that the respondents were "confident" in reporting their concerns to the management of the service. One of the remaining two surveys told us that the respondent did not know how to raise their concerns. The last respondent told us that they were not "confident" in reporting their concerns to the management of the service. Because of these variations we asked members of staff about their views in relation to this matter and found no concerns. Members of care staff told us that they saw the registered manager on a regular basis when they visited people's homes. We saw that the members of care staff interacted with the registered manager without reservation. In addition to this observation, members of care staff were aware of the whistle blowing procedure and said that they would have no reservations in using this. One member of care staff said, "If there was malpractice by a colleague I would speak to my [registered] manager or use the whistle-blowing line."

Three staff surveys told us that communication was good between them and office-based staff. However, the remaining three staff surveys said that the communication was not provided when they needed it. The registered manager told us that, before they started their role, there was one office-based member of staff who also worked in other roles and was not always available. Nevertheless, since the registered manager started their job, this concern had diminished. We saw that the registered manager had effective telephone communication systems in place. One member of care staff said that the registered manager was "always on the end of the 'phone."

In their PIR the provider told us that there were quality assurance systems in place to monitor, review and improve the standard and safety of people's care. The PIR read, "Quality assurance systems/audits are in place, both locally and corporately to enable effective monitoring of management /internal action plans/compliance and quality." The provider also identified, for example, an area for improvement: they wrote in their PIR, "Approaches learnt through the training will enable the service to continue to improve the

quality of service delivery." The registered manager told us that they had identified areas for improvement. These included training of staff in autism; continued reviewing and monitoring of people's care and their records; recruitment and retention of permanent care staff and developing a structure for planned staff supervisions.

To ensure that people were in receipt of safe, quality care, the registered manager carried out both announced and unannounced 'spot checks'. These were to observe the quality and standard of members of care staffs' work. Feedback was provided, if needed, to improve their working practices. This included, for example, making sure that the valuing of people's rights were maintained, including the right to make choices about the make of a vacuum cleaner to be used in their home.

The aim of people's support and care was to value their rights to make choices, decisions and independence. In addition to this, people were effectively supported to be integrated into the community. This was by taking part in work-related and recreational activities that were important to them.