Thera Trust

Thera 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

Thera East Anglia is a service that provides care and support to people living in 52 'supported living' settings, so that they can live in their own home as independently as possible. It is also a domiciliary care agency, which provides care and support to people living in their own houses and flats in the community. It provides a service to older adults and younger adults. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support.

People using the service lived in a range of single occupancy houses, houses with two people sharing and multi-occupancy houses shared by up to five people. Houses in multiple occupation are properties where at least three people in more than one household share toilet, bathroom or kitchen facilities. Not everyone using Thera East Anglia receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

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

We undertook an announced comprehensive inspection of Thera East Anglia between 28 November and 13 December 2017. At the last inspection, the service was rated Good. At this inspection we found the service remained Good.

Why the service is rated good

There was a registered manager in post at the time of our visit. 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.

Staff knew how to respond to possible harm and how to reduce risks to people. Lessons were learnt about accidents and incidents and these were shared with staff members to ensure changes were made to staff practise or the environment, to reduce further occurrences. There were enough staff who had been recruited properly to make sure they were suitable to work with people. Medicines were stored and administered safely. Regular cleaning made sure that infection control was maintained.

People were cared for by staff who had received the appropriate training and had the skills and support to carry out their roles. Staff members understood and complied with the principles of the Mental Capacity Act 2005 (MCA). People were supported to have maximum choice and control of their lives. Staff supported

them in the least restrictive way possible; the policies and systems in the service supported this practice. People received a choice of meals, which they liked, and staff supported them to eat and drink. They were referred to health care professionals as needed and staff followed the advice professionals gave them. Adaptations were made to ensure people were safe and able to move around their home as independently as possible.

Staff were caring, kind and treated people with respect. People were listened to and were involved in their care and what they did on a day to day basis. People's right to privacy was maintained by the actions and care given by staff members.

People's personal and health care needs were met and care records guided staff in how to do this. There were numerous activities for people to do and take part in and people were able to spend time with their peers and take part in cultural and religious activities. A complaints system was in place and there was information in alternative formats so people knew who to speak with if they had concerns.

Staff worked well together and felt supported by the management team, which promoted a culture for staff to provide person centred care. The provider's monitoring process looked at systems throughout the service, identified issues and staff took the appropriate action to resolve these. People's views were sought and changes made if this was needed.

Further information is in the detailed findings below

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

Thera 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 comprehensive inspection took place between 28 November and 13 December 2017 and was announced. We gave the service 48 hours' notice of the inspection visit because it provides a supported living service and the manager may have been out of the office supporting staff or providing care. We needed to be sure that they would be in.

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

As part of the inspection, we reviewed the information available to us about the service, such as the notifications that they had sent us. A notification is information about important events which the provider is required to send us by law. Before this inspection, the provider completed a Provider Information Return (PIR). 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. Questionnaires were sent to people before our inspection and we received three responses.

During our inspection, we visited six people using the service and observed how staff supported and interacted with them. We spoke with 13 members of care staff, the registered manager and the provider's representative. We checked eight people's care records and medicines administration records (MARs). We checked records relating to how the service is run and monitored, such as audits, accidents and incidents forms, staff recruitment, training and health and safety records.

Good

Is the service safe?

Our findings

The service remained good at safeguarding people from harm. People told us that they thought they were safe using the service. One person said about the house they lived in, "It's such a nice house. I would talk to [name of support worker], she would do something." In the Provider Information Return sent before our visit the provider told us there were processes in place to protect people from abuse or harm, and these contributed to people's safety. Staff knew how to protect people from harm, they told us they had received training, they understood what to look for and who to report to. The registered manager was aware of their responsibility to report issues relating to safeguarding to the local authority and the CQC. Information received before our inspection showed that incidents had been reported as required, and staff had taken appropriate action to protect people and reduce risks to them.

The service remained good at assessing risks to people. Staff assessed individual risks to people and kept updated records to show how the risks had been reduced. They told us they were aware of people's individual risks and our observations showed that they put the actions into place. Risk assessments contained enough information and detail to show how risks had been reduced. These included everyday risks, such as for showering or bathing, and for more unforeseen risks, such as for the possibility of exploitation. Assessments had also been completed for the individual use of equipment, such as wheelchairs and bed rails and identified risks such as entrapment. However, we found that for one person who used bed rails, these had not been checked to ensure gaps were within the required measurements. We spoke with staff about this, who explained the low level of risk (the bed rails were very rarely used) and advised that because of this they would have the rails removed that day. Assessments were also available to advise and guide staff on the risk to each person in the event of a fire and the need for evacuation.

Care records showed that there was clear information for staff regarding how they should approach a person if they were upset or distressed, and actions they should take if this occurred. We saw that staff put this guidance into practice. We concluded that staff managed people's behaviour that challenged or upset others well.

The service remained good at ensuring there were enough staff with the required recruitment checks to care for people. One person told us, "(There are) always enough staff, I get to go out whenever I want," when we asked if staff were always available. Another person commented that staff who visited were always on time. They received a rota of staff who were scheduled to visit and staff who visited were mostly people they knew. The rota helped them to inform the person if there was a staff member they did not know.

There were varied responses from staff members in regard to whether there were enough staff. Most staff members told us that there were enough staff available. One staff member said that there were not always enough staff, although this was due to sudden sick leave. They went on to explain that agency staff were available and often existing staff also covered at these times. This helped ensure that these staff knew people's care needs and were familiar with how they wanted to be cared for. There was a system in place to ensure staffing numbers were at the level indicated by people's needs and how many staff commissioners of care had provided funding for.

Staff members told us about the checks that had to be completed before they started working at the service. We looked at staff recruitment files and saw that checks had been returned before staff worked with people. This included asking for information about staff who had previously worked in a care position. However, when the returned checks did not provide this information, no further action had been taken to obtain the information. We spoke with human resources staff, who confirmed that they would be able to incorporate this into their current checks. New staff completed induction training and shadowed more experienced staff so that they had an understanding of how to keep people safe while providing care and support.

People told us that they received their medicines when these were needed and that staff members helped them with this. One person told us, "[Staff member], he's really good, all the time, he does that for me. I take one tablet … a day." Another person explained, "I take tablets, the carer [staff member] gives them to me, they help me with it. I take them with a drink."

Information sent to us in notifications showed that there had been a larger number of medicine errors reported to us and to the local authority safeguarding team, than by other services of a similar size. The registered manager took appropriate action for each individual incident and we identified that overall the numbers of medicine errors had reduced in the past four months. We also found that the registered manager reported all medicine errors as to the safeguarding team, which explained why the number of notifications we received was higher than expected.

The service remained good at managing people's medicines. People who needed support with their medicines received this from staff who had received training. This training and staff competency assessments were carried out by healthcare professionals if specialist medicines administration techniques were required. Other medicine training was provided by an external training provider as well as the service's own training modules. We observed that people received their medicines in a safe way and that medicines were kept securely. Records to show that medicines were administered were completed appropriately. Medicines in supported living houses were stored securely both when staff were administering and when they were being stored. Staff had appropriate guidance for people who received medicines on an 'as required' basis.

People told us that staff did all they could, such as washing their hands, using hand gel and gloves, to reduce the risk of cross infection. We saw that all of the houses we visited were visibly clean and free from malodours and that soap and hot water was available for staff, people and their visitors to use to wash their hands. A staff member told us that they had enough personal protective equipment (PPE) and cleaning equipment available. Training records showed that staff had received food hygiene training to ensure food was prepared properly. This showed us that processes were in place to reduce the risk of infection and cross contamination.

We saw that incidents and accidents were responded to appropriately at an individual level and information about these fed into broader analysis. One staff member explained that all records were looked at by staff supporting people and suggestions for improvement were made. This information was then relayed up to the Health and Safety Committee so that they could discuss themes and trends at a higher level. Any actions to be taken as a result of learning from these events were documented. The registered manager confirmed that any learning as a result of accidents or incidents was discussed by the staff directly involved with the care of the person. A staff member described to us how this had worked in practice for one person who staff had difficulty understanding. Actions taken resulted in one to one staff for the person, so that staff were able to spend time getting to know the person's unique communication style. Other staff were also made aware of changes overall through individual and group meetings.

Good

Is the service effective?

Our findings

Staff worked with health and social care professionals who visited people to provide current, up to date guidance and advice about meeting people's care and support needs. We saw this advice was available and used by staff to promote people's health and well-being. One person sometimes became distressed as a result of their living environment and after assessing the impact this had on the person, staff had been working with the local authority to change this. Another person was supported by a visiting health care professional during our visit, who also provided staff with advice and up to date guidance for supporting the person with their health condition.

The service remained good at providing staff with training and support. New staff members told us that they had received training prior to starting work. They also told us that they were able to spend time shadowing other staff and getting to know people before starting in their permanent roles. One staff member described the training they received as, "Comprehensive," while another told us that it, "Makes me sit up and re-evaluate my practice." Other staff commented that they had received updated training and had also received additional training to better support people. This included training about how to feed people through a PEG tube (a tube through the skin into the stomach) and stoma care. Staff training records showed that most staff members had received training such as first aid, health and safety, and moving and handling.

Staff members confirmed that they received support on a regular basis through one to one meetings and team meeting. One staff member explained that they could discuss issues and development opportunities. This gave them the guidance and support to carry out their roles.

The service remained good at providing and supporting people to eat and drink. One person said, "I do get enough (to eat)," and went on to explain that people had different menus at weekends, depending of what they liked to eat. Another person told us that staff helped them get their breakfast. We observed that refreshments were offered throughout the day. Staff talked about the menus with people and showed people the available options so that they could choose what they would like to eat and drink. Staff monitored people at risk of not eating or drinking enough and took action to reduce this. This included referring people to health care professionals such as dieticians or speech and language therapists.

Staff at the service worked closely with other organisations to ensure that the best possible quality of service was provided. For example, working with representatives from the local authority commissioning team and the quality improvement team when issues arose. Staff explained how one person had become increasingly distressed with the number of other people they were sharing a house with. They were working with the commissioning team to find alternative accommodation for the person. Care records included a 'health care passport' that was updated with new information as people's support needs changed. A health care passport is a document that people take with them when they visit health care professionals, to tell doctors, nurses and other professionals how they prefer to be supported and cared for.

The service remained good at ensuring people had advice and treatment from health care professionals.

One person explained how they were supported to visit their GP, "They (support staff) make my appointments and then I walk there." People's care records showed that they had access to the advice and treatment from a range of health care professionals. These plans provided enough information to support each person with their health needs.

The supported living services were houses with individual bedrooms and a communal kitchen, dining room, bathroom and lounge area for people to use. Few adaptations had been needed to be made to the buildings as most people using the service had good mobility. However, one person described how staff had obtained a pendant alarm for them after they had a series of falls. They told us, "I've got it around my neck."

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

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 under the court of protection were being met. Staff had received training in MCA and were able to demonstrate a good understanding to us. A staff member told us that one person felt more included and listened to since staff had received guidance in how to support them to make their own decisions. Another staff member told us that they asked people what they wanted to do and that the people the staff member supported would all say something if they wanted to take part in a different activity. This showed that people would not have their freedom restricted in an unlawful manner.

Good

Is the service caring?

Our findings

The service remained good at caring for people. People told us that they were happy with the care and support they received from the service and that they were treated with dignity and respect. We asked one person if staff were polite and respectful towards them and they responded, "Yes, they are." Another person said, "They're wonderful." We visited five people in their own homes and although not everyone was able to easily verbally communicate with us, they showed us that they liked the staff caring for them.

We saw that staff were kind and thoughtful in the way they spoke with and approached people. Staff faced people, spoke directly with them and when people were sitting at a different level, staff lowered themselves so they were not standing above the person. When people did not respond to this attention, staff members spoke to them again but did not persist if the person did not acknowledge them. This ensured that people had heard staff but also provided them with the opportunity to indicate that they did not want to engage with the staff member.

Staff knew people very well and were able to anticipate people's needs because of this. They knew what people would do, although they continued to make sure people were able to make their own decisions. Staff members described how each person may act and possible risks to them. We saw on occasions during our visits that people did act in exactly the way staff had described. Staff told us that they spoke with people about their support and each year they reviewed the person's support plan with them. Support plans were also written in an easy read format for people who were able to read this. Another staff member said that they supported one person to do their own laundry and prepare sandwiches. They explained that this helped the person to be as independent as possible and to maintain the life skills that they had already learnt.

We saw that staff members explained to people what they were going to do before doing it, which meant that people were not suddenly surprised. They were also given time to indicate if they were not happy for staff to continue. We saw that staff had enough time to spend with people to keep them company if they wanted this.

The service remained good at respecting people's right to privacy and to be treated respectfully. This was evident in the way staff spoke and interacted with people. Staff checked to make sure people were comfortable but otherwise allowed them to spend time in their own space. People were able to carry out their own routines and spend time where they wanted. One person explained that staff closed the bathroom door and, "They close the curtains." A staff member told us that none of the people they supported had any preferences in relation to the gender of staff who supported them. However, people did tend to choose which staff member went with them when they went out in the community. Staff members received training in key areas that supported people's right to respect and dignity.

People's care and support records contained information about their family and loved ones. We saw that people were able to have visitors when they wanted and that they were able to choose where to spend time with their visitors. During our visit to one house two visitors arrived unannounced. Both were welcomed and

staff did all they could to accommodate their requests and answer questions.

Good

Is the service responsive?

Our findings

The service remained responsive to meeting people's needs. One person told us that they had no concerns about their care. Another person said that they were, "Helped how I want to be helped." Staff had a good knowledge of people's needs and could clearly explain how they provided support that was individual to each person. Staff were able to explain people's preferences, such as those relating to support and care needs, or leisure and pastimes.

People had access to a variety of activities that staff supported them to take part in. Staff helped people to access their local community where they were able to shop for food, clothing, have a coffee or visit people they knew. Some people had routines where they would visit places on a regular basis, while other people had more flexible visits out to the community. One person told us that they liked to go to the cinema or into the local town.

We looked at people's care and support plans and other associated records. All files contained details about people's life history, their likes and dislikes, what was important to each person and how staff should support them. Plans were written in detail to guide staff members' care practice and additional care records were also completed. Information about people's lives provided detailed histories that were set into sections of daily routines for morning, afternoon and evening. This provided staff with a timeframe for when people preferred to complete specific events, such as personal care or taking part in activities.

Plans for the care of more individual needs, such as for behaviour that may challenge or upset others, were written in detail. These provided clear guidance regarding changes in people's behaviour, what might precede this and actions staff could take to reassure and calm the person. Staff we spoke with had a very good understanding of people's needs in this area. We saw the plans were reviewed on a regular basis to ensure they met people's support and care needs. Daily records provided evidence to show people had received care and support in line with their support plan.

The service remained good at managing complaints. People told us they would be able to speak with a member of staff if they were worried about anything. Staff confirmed they knew what action to take should someone in their care want to make a complaint and were confident the registered manager would deal with any given situation in an appropriate manner. There were copies of the service's complaints procedures in each person's home. These had also been written in pictorial and Makaton (form of communication for people with a learning disability) formats.

People had their end of life care wishes recorded as part of their support plan, where this had been identified as a need. For example, for people who were getting older or who had deteriorating health conditions. Information was recorded about preferences for such things as who was important to the person, where people wanted to be and what they wanted to happen after they died.

Good

Is the service well-led?

Our findings

Staff told us that there was an expectation for them to deliver good quality care and support. There was incentive to do well and the provider had organised an award system for staff to nominate their peers who they felt had met these expectations. They told us that communication between the registered manager and all levels of staff was good. There were a number of opportunities, such as staff meetings, to discuss the running of the service. Staff were supported by senior staff and felt they could discuss any issues or concerns they had. They were further supported in one to one meetings, where they were able to discuss their performance.

There was a registered manager in post. 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. The registered manager was supported by operations managers and by community support leaders. One person spoke to us about the management structure and which member of the management staff they would contact if needed.

The views of people, their relatives and staff were obtained on a regular basis through a questionnaire or through meetings. The information was then collated and a summary of the findings made available. The survey results from the 2016-2017 'Our Driving Up Quality Report', showed a high overall satisfaction rate. It identified what people wanted, which included being more involved in staff recruitment and wanting more male staff members. Actions had been identified to develop these changes. The staff survey similarly identified what staff were happy or less happy with and identified actions to address this. However, we found that the actions were a little broad and did not contain enough detail to show how this was to be achieved.

Staff told us that spot checks were completed by the operations manager three to four times a year. This was so they were able to see how support was carried out when staff had not expected them to visit. An action plan was developed following these visits and this information was made available to staff members. The operations manager then checked on the progress of the action plan every month until the changes had been made. A whistle blowing policy was available and staff told us they were confident that they could tell the registered manager something and it would be dealt with. This meant that the organisation was clear in their expectation that staff should use this system if they felt this was necessary.

The service remained good at assessing and monitoring risks to people and the quality of the service. The registered manager used various ways to monitor the quality of the service. These included audits of the different systems used by staff, such as the care records, people's finances and medicines. The audits identified issues and the action required to address them. We saw, however, there had not been consistent follow up of actions for a few medicines audits. This had resulted in updates not always being completed as quickly as possible. The overall analysis of audits and any trends or themes were cascaded up to Board level and down to all staff members in the form of a regular report. This meant that everyone in the organisation was aware of the same information and the actions to address these.

During the inspection the provider's representative told us that they were aware of the CQC guidance of 'Registering the Right Support.' This is the CQC policy on the registration and variations to registration for providers supporting people with a learning disability. The provider's representative also confirmed that they were signed up for 'The Driving Quality Code.' This code was developed following the Winterbourne review that identified abuse of people with learning disabilities at Winterbourne View. The government and many other organisations that support people with learning disabilities are taking action to make sure that this never happens again.

Information available to us before this inspection showed that the staff worked in partnership with other organisations, such as the local authority safeguarding team. We saw that the registered manager contacted other organisations appropriately and in relation to safeguarding, investigated the issue and took action where this was required. We saw that information was shared with other agencies about people where their advice was appropriate and in the best interests of the person.