Crescent Trust Care Services Ltd

Rhuddlan

Inspection report

26A Wellington Street
Littleport
Ely
Cambridgeshire
CB6 1PN
Tel: 01353968143
Website: www.crescent-trust.co.uk

Date of inspection visit: 5 January 2016
Date of publication: 29/01/2016

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?	Requires improvement

Overall summary

Rhuddlan is registered to provide personal care and offers a supported living and domiciliary care service. The people who use the service live with a learning disability and autism. At the time of our visit there were two people using the service.

This comprehensive inspection took place on 5 January 2016 and was announced.

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 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.

People were kept safe as much as possible 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

Summary of findings

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 medicines were safely managed.

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 needs were met.

The CQC is required by law to monitor the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The provider was acting in accordance with the requirements of the MCA so that people had their rights protected by the law.

People had mental capacity to make decisions for themselves.

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

People were supported by kind, respectful and attentive staff. Relatives were given opportunities to be involved in the review of their family members' individual care plans.

People were supported with a range of hobbies and interests that took part in and out of the home. 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.

The provider had not submitted notifications as they were required to. This omission had reduced the provider's ability to demonstrate that they operated a transparent culture as part of their duty of candour. The registered manager was supported by a team of managerial 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 had been taken where improvements were identified.

Summary of findings

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 safe.

People were treated well and were looked after by a sufficient number of staff to meet their individual needs.

People were enabled to take risks and measures were in place to minimise these risks.

People's medicines were safely managed.

Good

Is the service effective?
The service was effective.

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

The provider was following the principles of the Mental Capacity Act 2005 and protected people's rights in making decisions about their day-to-day living.

People's nutritional, physical and mental health were maintained.

Good

Is the service caring?
The service was caring.

People were enabled to be involved in making decisions about their care.

Staff supported people to maintain their dignity and independence.

People were looked after by kind and caring members of staff.

Good

Is the service responsive?
The service was responsive.

People's individual needs were met.

People were enabled to take part in a range of activities that were important to them.

There was a complaints procedure in place and the provider responded to people's concerns or complaints.

Good

Is the service well-led?
The service was not always well-led.

The provider had not submitted required notifications and, therefore, had reduced their ability to demonstrate that they operated an open and transparent culture.

Requires improvement

Summary of findings

People and staff were enabled to make suggestions to improve the quality of the care provided.

Quality assurance systems were in place to monitor and review the standard and safety of people's care.

Rhuddlan

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 was carried out on 5 January 2016 and was announced. The provider was given 24 hours' notice because the location was a small service; we needed to be sure that someone would be in. The inspection was carried out by one inspector.

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. Also, before the 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 it does well and improvements they plan to make. In addition to this information, we sent out surveys to a person who used the service and members of care staff.

We received completed surveys from one person who used the service and from one member of care staff. During the inspection we spoke with two people who were using the service; one relative; the registered manager; the area service manager and two members of care staff. We observed care to help us with our understanding of how people were looked after.

We looked at one person's care records, their medicines administration records and records in relation to the management of staff and management of the service.

Good

Is the service safe?

Our findings

People said that they were very happy with how they were being looked after and felt safe from the risk of harm. One person said, "I feel very safe as I feel happy and with the people [staff] around me. They are polite and are really helpful."

In their PIR the provider told us that all members of care staff had attended training in safeguarding people from risk of harm. Members of management and care staff demonstrated their application of their learning. They told us what they would do if they suspected people were being placed at any risk of harm or actual harm. The actions they would take included reporting the incident to the police and local authority. They also told us that they were aware of the signs and symptoms to look out for if someone was being harmed. The area service manager said, "They [the person at risk] may recoil when someone walks into the room or their behaviour may change. They may be running out of money more frequently." A member of care staff said, "The person may become withdrawn. Maybe have mood swings and may have physical markings."

There were robust systems in place to monitor and support people from the risk of financial harm. Records showed that financial transactions were recorded and receipts were obtained. In addition, people who were assessed to be at risk of financial harm, were supported with the management of that risk. This included, when out shopping, providing people with information about costs, which included electronic and computer items. This was for them to make a decision about their intended purchase and to ensure they were not placed at possible financial risk of doing so.

In their PIR the provider wrote, "Risk assessments are used to minimise the risk to both service users [people who use the service] and staff whilst maintaining independence." Members of staff were aware of people's risks. One member of care staff said, "We look at risks with [name of person] as they could easily be abused by others." Another member of care staff expanded on this. They told us that risks were managed by staff supporting people on a one-to-one basis for them to gradually become confident and independent with taking part in activities. This, in turn, reduced their vulnerability and had made them safer. People told us that they were supported by staff on a one-to-one basis when necessary. However, they told us that there were times when they felt confident and safe to use public transport and access community facilities which included local shops and were able to do so independently.

The provider told us in their PIR that all job candidates were required to undergo checks to assess their suitability to look after people. The area service manager described the recruitment process. They said, "We go through completed application forms. If there are any employment gaps we explore these at interview and the candidate has to reach a certain score (to be successful). We check they have a DBS (Disclosure and Barring Service) check, proof of ID (identification) and two written references. One has to be from the previous employer." A member of care staff described their recruitment experience and also told us of the checks that they needed to have; these were obtained before they were allowed to commence their employment. Staff recruitment files confirmed this.

There were sufficient numbers of staff to support people with their 24 hour needs. One relative said, "The staff are with [family member] all of the time. I've been very pleased that permanent staff have been recruited and that they have been matched well with [name of family member]." During our inspection there were two people using the service and both of the people had one-to-one support from a member of care staff. This had enabled each person to be engaged in recreational, social and work-related activities.

Measures were in place to cover staff absences or vacancies with the use of agency or bank staff who were employed by the same registered provider. Furthermore, permanent staff told us that they worked extra shifts if there was a need. One member of care staff said, "There's plenty of staff and we work well as a team. Over Christmas we chipped in together and covered the shifts."

People were enabled to be independent with their medicines based on assessments of their abilities. One person told us that they knew when they needed to take one of their prescribed medicines. They said, "When I'm chesty or my chest feels 'tight' and I am breathless, I take it (prescribed medicine) then." They also told us that the staff supported them to take their other prescribed medicines. They said, "I get them on time and when I need them." Their medicines administration records and daily records showed that they had taken their medicines as prescribed. Another person said, "The staff get them (prescribed

Good

Is the service safe?

medicines) out for me and they then give me them when I need them." Members of staff demonstrated their understanding as to when people were encouraged to take their 'as required' medicines, such as those to reduce peaks in levels of anxiety.

Where the provider was responsible for the storage of people's medicines, there were satisfactory arrangements in place for maintaining the security of these. Staff members who were responsible for the management of people's medicines had attended training specific to this part of their role. The area service manager advised us that competency assessments, in handling people's medicines, had been carried out to check that staff members were safe in their practical skills. However, the records to confirm that these assessments had been carried out, were not available for inspection.

Good

Is the service effective?

Our findings

One relative said, “So far, all of the staff I have met have been very professional and had the training and getting more training. They generally want to learn about [family member].”

Staff told us that they had the training to do their job. One member of care staff, who was also a trainer, said, “I have had previous training in management and I have a certificate in teaching adults. I have also had refresher training.” Members of staff had attended training, which included induction training, in safeguarding people at risk, management of medicines, first aid and looking after people living with epilepsy. They and people’s care records demonstrated how their theoretical knowledge was applied into their practice. This included, for instance, making people safe with the management of their medicines and the first aid action they had taken in response to people’s changes in their medical condition.

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. 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. We checked whether the service was working within the principles of the MCA. Processes were in place, along with risk assessments, which showed how people were enabled to take risks and make decisions (within the MCA). At the time of our inspection all of the people who were using the service had the mental capacity to make informed decisions for themselves. They told us that there were able to freely come and go. The area service manager was aware of the procedure to follow should any person require an assessment to lawfully deprive them of their liberty.

The provider told us in the PIR that members of staff had attended training in the application of MCA. Members of care staff and their training records confirmed this was the case. Members of staff showed their understanding of the application of the MCA. One member of care staff said, “The person who you may have concerns about must be deemed to have mental capacity until they have been assessed otherwise.”

People’s nutritional health was maintained and people were encouraged to eat a healthy diet. A member of care staff told us that when people shopped for their food, staff members advised them on the nutritional and calorific content of the food. This was so that people could make an informed choice in managing their dietary intake. One relative told us that members of care staff were helping their family member to “manage their diet.” One person said that they always had enough to eat and drink. They also told us that they could choose what and when they wanted to eat; their daily records confirmed this was the case.

People were looked after in a way that maintained their health and well-being. People told us that they visited GPs, practice nurses and psychiatric services when they needed to. Incident records showed that members of management and care staff had followed appropriate procedures in the event of a person requiring urgent medical assistance or advice. There was a stable staff team which enabled people to receive care from people they knew and reduced unsettling changes. One person said that they knew the members of staff who looked after them and they were very happy with this arrangement. One relative said, “I think [family member] is being looked after very well.” Members of care staff and care records demonstrated that members of staff had used various strategies to improve people’s physical and sense of well-being. This included, for example, encouraging people to take exercise in the gym, visiting places new to them and learning new skills to boost their self-esteem.

Good

Is the service caring?

Our findings

People said that they liked the staff and how they were being looked after. One person said, "Staff treat me perfectly and they are helping me. Staff help me if I ask them."

There was a process in place which introduced new members of staff to people before they were looked after by those staff. One relative told us that they were satisfied with how the staff were matched with their family member. They told us how this had started to build a trusting and therapeutic relationship between staff members and their family member.

We saw people were treated by kind and attentive staff. When asked or required, members of care staff attended to a person's emotional and physical needs. People's independence was maintained and promoted by patient members of management and care staff and by various means. This included supporting people to be independent with their daily living skills, such as cooking and cleaning and with their personal care.

People were treated in a dignified way as they were enabled to make choices. One person told us that they had the freedom to do what they wanted. One relative also told us that their family member made their own decisions and informed the staff about how the wanted to be supported. This included, for example, decisions about their recreational activities. Care records showed that people's choices were valued and respected, which included when they wanted to go to bed and the time of when they chose to eat.

People told us that they were involved in developing their care plan. We saw that they had signed, when possible, to signify that they had been consulted and agreed to the planned care. People also signed their daily records to show that members of staff had discussed their day with them.

People were enabled to maintain their contact with members of their family and friends. They also had made new friends and had community based social contacts, which included people working in local cafes and religious organisations.

Members of care staff had a clear understanding of the principles of caring for people who they looked after. One member of care staff said, "The care is to make people as independent as much as possible. To make sure the support plan supports the person in what they want, not what the staff want. To give them a purpose in life." Another member of care staff said, "This job is very rewarding and watching [name of person's] progress. The job is about giving people the best quality of life; build up their level of independence and grow in character."

People were able to make day-to-day decisions about how they wanted to spend their life. However, advocacy services were used to support people with more complex decisions. This included, for example, where to live. Advocates are people who are independent and support people to make and communicate their views and wishes.

Good

Is the service responsive?

Our findings

People told us that the staff knew them as individuals and their needs. Members of management and care staff showed their understanding of people's individual needs and their life histories.

The area service manager explained that pre-assessment information had been received from placing authorities. This was used as a base to determine the suitably of the service in meeting people's assessed needs. Following a person's acceptance to use the service, there was an on-going process to assess people's needs and for staff to get to know them as people and vice versa. One member of care staff told us that, due to the one-to-one support they provided, this had enabled them to get to know the person they looked after. It had also enabled them to monitor the person's progress. They said, "They are now much more confident and want to explore new things."

People's individual needs were monitored, reviewed and were met which included their physical, emotional and social needs. Action was taken in response to a change in the level of a person's needs. This included, for instance, a change in the condition of their skin or feelings of sadness. Actions taken in response to such changes included the involvement of health care professionals. Staff also used a range of strategies to improve people's level of needs, which included offering a range of social and recreational activities. Care records were reviewed and up-to-date to provide staff with the guidance in how to meet the people's individual needs.

People took part in a range of work-related, social, educational and recreational activities. They told us that they enjoyed taking part in these and had gained benefits from doing so. One person described their educational activities as "very helpful". They also told us of the pride they had felt with their achievements and accreditation in literacy and food hygiene skills. They said, "I'm really happy about it." Opportunities were also created for people to voluntarily work at horse riding stables and a local café. Social opportunities included shopping trips, attending religious services, visiting family and friends and frequenting local clubs and pubs.

People were encouraged to practice their daily living skills. One person said, "I like cooking and I do the cleaning." A member of care staff told us how the person had progressed in their independent living skills and was now able to make a wider range of meals to eat. A member of care staff told us that people were enabled to make furniture items for their home and garden. Care records confirmed this was the case.

People told us that they knew how to make a complaint. One person said, "I'd speak to [name of area service manager]." They told us that they were satisfied with how their complaint had been handled and was satisfied with the provider's response. One relative said, "I am aware of the complaints procedure. The staff are really listening to what is being said." The provider and the record of complaints told us that one complaint had been received and this was dealt with in line with the provider's complaints policy. Action was taken in response to the complaint and to the satisfaction of the complainant.

Requires improvement

Is the service well-led?

Our findings

Records demonstrated that there had been two notifiable incidents and this was confirmed by the area service manager and registered manager. However, our records showed that we had not received notifications about these incidents. Both of the managers confirmed that they had not been aware of the requirement to submit notifications, in relation to these events, to the Care Quality Commission. This had reduced the provider's ability to demonstrate that they operated a transparent culture as part of their duty of candour. (Nevertheless, we were satisfied that the provider had taken the appropriate steps in informing other and appropriate external agencies, to manage people's risks of harm).

The service was managed by an area service manager who was in turn supported by the registered manager. People said that they knew who was in charge and they would be the person they would contact if they needed to. This included both the area service manager and registered manager. Members of care staff had positive comments to make about both managers. One member of care staff said, "[Name of area service manager] is very good. They are very approachable, are 'hands on' and has a lot of knowledge." They also described the registered manager as "approachable". One relative also told us that the area service manager was approachable and had listened to their suggestions and comments in respect of their family member's care. This included, for instance, encouraging and supporting their family member to eat a healthy diet.

People told us that their views were obtained in relation to their experiences of the service. This included day-to-day review of their activities and records confirmed this was the case. Members of staff were also enabled to share their views and make suggestions to improve the quality of people's experiences of using the service. One member of care staff told us that they had suggested introducing carpentry skills for one of the people to practise; they advised us that the area service manager had agreed to their suggestion. Care records showed that one of the people was supported to make a wooden bench for the garden area.

Members of care staff were aware of the whistle blowing procedure and said that they had no reservations in reporting any concerns to the registered or area service manager. In addition, they gave examples of when they would follow the whistle blowing policy and the protection this gave them. One member of care staff said, "Even though you are telling on your colleagues, because of the law, I cannot be sacked or (be) detrimentally treated."

There were quality assurance systems in place which included the use of an external, independent quality assurance assessor. Reports of these demonstrated that remedial actions were to be taken where there were deficiencies identified. The area service manager told us that actions had been taken to address the deficits. These included, for example, ensuring that members of staff were trained in management of people's epilepsy and their medicines. The PIR was sent to as requested and this showed that there was a quality assurance system in place which continually reviewed the standard and quality of the service provided.

People were supported to be integrated into the community as part of their recreational and work activities. In addition to these, there were links with a local religious organisation which offered both religious and social activities.