Valeo Limited

Cragside

Inspection report

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Date of inspection visit:
13 December 2017
19 December 2017

Date of publication:
09 February 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 13 and 19 December 2017 and was unannounced. At the last inspection on 27 June and 4 July 2017 we asked the provider to take action to make improvements around person centred care, safe care and treatment and good governance. We issued a warning notice in relation to good governance.

Following the last inspection, we asked the registered provider to complete an action plan to show what they would do and by when to improve the key questions safe, effective, caring, responsive and well led to at least good. At this inspection we checked to see whether improvements had been made and found improvements had been made, however the registered provider was still not meeting all the regulatory requirements.

Cragside is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Cragside is registered to provide accommodation for up to nine people who require nursing or personal care. It specialises in providing support for people with learning disabilities, autism, highly complex needs and challenging behaviour. The accommodation is provided in a Victorian property over three floors with five self-contained flats each with a lounge, fully-fitted kitchen, bedroom and bathroom or shower room. One flat is used for respite care. At the time of our inspection four people were living in the flats and one person was using the respite care flat.

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.

A registered manager was in place. 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.

We reviewed the systems for the management of medicines and found that systems had improved and issues from our last inspection had been addressed. Competency checks on the administration of medicines were up to date. People received their medicines safely, although some minor issues still needed to be addressed. The registered manager did this immediately.

Building maintenance, cleaning and environmental risk management had improved, although water temperature checks had not all been completed.

Emergency procedures were in place and people knew what to do in the event of a fire. Some information needed to be updated in the fire safety grab file. Risk assessments were individual to people's needs and minimised risk whilst promoting people's independence.

Detailed individual behaviour support plans gave staff the direction they needed to provide safe care. Incidents and accidents were analysed to prevent future risks to people.

Staff had a good understanding of how to safeguard adults from abuse and who to contact if they suspected any abuse and safe recruitment and selection processes were in place.

The required number of staff was provided to meet people's assessed needs. People and staff found regular use of agency staff sometimes reduced consistency, which was important for people who used the service, however regular agency staff were used where possible and recruitment for permanent staff was ongoing.

Staff told us they felt supported, however we found they were not always supported with regular management supervision. Staff had received an induction and role specific training, which ensured they had the knowledge and skills to support the people who lived at the home.

People were supported to eat a balanced diet, and meals were planned around their tastes and preferences.

People were supported to maintain good health and had access to healthcare professionals and services. They were supported and encouraged to have regular health checks and were accompanied by staff to health appointments. The registered manager was improving partnership working with community professionals and responded positively to their intervention and advice.

The service was adapted to meet people's individual needs, with specialist furniture and fittings. Whilst most flats were comfortable and personalised the respite flat was in the process of being personalised to provide a more homely environment.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice, although some best interest processes had not been evidenced. We made a recommendation about this.

Positive relationships between staff and people who lived at Cragside were evident. Staff were caring and supported people in a way that maintained their dignity, privacy and diverse needs.

People were involved in arranging their support and staff facilitated this on a daily basis. People were supported to be as independent as possible throughout their daily lives.

The management team promoted an open and inclusive culture whereby people were encouraged to express their diverse needs and preferences.

Care records contained detailed information about how to support people and included measures to protect them from social isolation. People engaged in social and leisure activities which were person-centred.

Systems were in place to ensure complaints were encouraged, explored and responded to in good time and people told us staff were approachable.

Improvements had been made to the system of governance and audits within the service, although there were some gaps. This showed that whilst improvement had been made since the last inspection, some issues relating to governance remained.

The provider was recruiting for a new permanent deputy manager at the service shared with another home and increased senior management input was supporting service improvements.

People told us the service was well-led. The registered manager was visible in the service and knew people's needs. Everyone at the home knew their roles and welcomed feedback on how to improve the service.

Feedback from staff was positive about the registered manager. People who used the service and their representatives were asked for their views about the service and they were acted on.

We found breaches in Regulations 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were managed in a safe way for people. Some records needed to be updated.

The building was maintained and managed in a safe way, but some building checks were not consistency completed.

Risk assessments were individual to people's needs and minimised risk whilst promoting people's independence and staff had a good understanding of safeguarding people from abuse.

Sufficient staff were deployed, although agency staff were frequently used and people felt this impacted on consistency.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always receive supervision and appraisal to support their professional development needs.

Staff had received specialist training to enable them to provide support to the people who lived at Cragside.

People's consent to care and treatment was always sought; however, some best interest decision-making had not been recorded.

People were supported to maintain a balanced diet and healthy eating was promoted.

People had access to external health professionals and the registered manager worked well with other services to improve outcomes.

Is the service caring?

Good

The service was caring.

Staff interacted with people in a caring and respectful way.

People were supported in a way that protected their privacy, dignity and diverse needs.

People were supported to make choices and decisions about their daily lives and to maintain and improve their independence.

Is the service responsive?

Good

The service was responsive.

Care plans were detailed, person-centred and individualised.

People were involved in regular activities inside and outside the home in line with their care plans.

People told us they knew how to complain and that staff were always approachable.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The service had improved since the last inspection; however some issues with governance remained.

The registered provider had an overview of the service; however this system had not identified and addressed some issues we found.

The culture was positive, person-centred, open and inclusive. The registered manager was visible in the service and knew the needs of people.

Cragside

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 13 and 19 December 2017 and was unannounced. The inspection was conducted by two adult social care inspectors 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. Their expertise was as a family carer of a person with a learning disability.

Prior to our inspection we reviewed all the information we held about the service. This included information from notifications received from the registered provider, feedback from the local authority safeguarding team and commissioners. Prior to this inspection we received concerns from three community professionals that improvements had not been made at the service since our last inspection in relation to the governance of the service and keeping people safe. A number of alleged safeguarding incidents were being investigated by the local authority safeguarding team. On this occasion we did not ask the provider to complete 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.

Some people who used the service used nonverbal, as well as verbal communication methods. As we were not familiar with their way of communicating we used a number of different methods to help us understand people's experiences. We spent time observing the support people received, although this was limited due to people living in individual flats and this being intrusive to their privacy, as well as potentially leading to avoidable distress. We spoke with three people who used the service and two of their relatives. We spoke with three support workers, two senior support workers, the temporary deputy manager and the registered manager, the locality manager, the operations director and the quality manager. We looked in the flats of three people who lived there with permission, as well as the respite care flat. Following the inspection we received feedback from one community professional.

During our inspection we spent time looking at four people's care and support records. We also looked at

four records relating to staff supervision and training, three recruitment records, incident records, maintenance records and a selection of audits.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe at Cragside and the relatives we spoke with told us they felt confident their family member was safe. One relative said, "I feel [my relative] is much safer now they have increased the security at the home. I'm also quite happy that when I'm with [my relative] in the flat, that staff are supporting me and [my relative] to keep safe. The staff are well trained and react professionally, when a situation arises where I have to leave the room for my own safety. They carry out support in a calm and relaxed way, to make sure I don't get hurt and [my relative] stays as calm as possible."

At our last inspection we found the management of medicines had not been consistently safe and audits had not picked up the issues to drive the necessary improvements. At this inspection we found improvements had been made.

Medicines were managed safely. We saw the registered provider had an up to date policy and information leaflets for all the medicines prescribed for people living in the home were retained, so staff could readily consult relevant information about the medicines they administered to people.

Medicines were managed only by staff who had been trained and assessed as competent to administer medicines. Since our last inspection medicines competency assessments had been undertaken by the manager and we saw the policy of the service had been updated. We saw one staff member had completed training but was waiting for a series of competency assessments to be completed before they could administer medicines unsupervised. This showed us the service had acted on previous inspection findings to improve medicines safety.

The service had a system in place to ensure medicines were ordered and supplied in time to be available when the person needed them. We saw the amounts supplied had been recorded on the medication administration records (MAR) and the count of any remaining tablets was brought forward when appropriate. The MAR had been printed by the dispensing pharmacy and included known allergies, the person's name, date of birth and GP details.

Medicines were stored in a locked wall mounted cupboard in each person's flat. The temperature in the cupboard had been checked each day to ensure it did not exceed the safe maximum.

We checked the actual count of two medicines and it matched the expected count. We observed medicines administration for one person. The carer asked the person if they were ready for their medicines then checked the MAR and prepared the medication. They signed only after the person had taken their medicines. The persons file included an up to date list of names and initials of staff competent to administer medicines. This meant people were protected against the risks associated with medicines because the provider had appropriate arrangements in place.

Medicines with a 'when required' dose can be prescribed to treat short term medical conditions or long term conditions when people experience "flare-ups" such as medicines for people with asthma. The service had a

clear policy for the use of 'when required' medicines including the creation of a support plan detailing why and when the person might need their medication and signs and symptoms specific to the individual. One person had been prescribed three 'as required' medicines. We saw a support plan was in place for two medicines and when these had been given, the reason had been documented on the reverse of the MAR with the date and time. The third 'when required' medicine care plan required updating, as it was previously prescribed twice daily and the care plan had not been changed to 'when required'. Staff were aware of when it should be used and the person was also able to ask for it when required.

We reviewed the MAR for another person who did not use verbal communication and saw their 'as required' medication plans were extremely detailed and provided staff with all the information they needed to know. Staff discussed other ways of helping the person when they became agitated, so offering medication was only used as a last resort.

Medicines were audited weekly by the registered manager or deputy manager and any issues found had been addressed with staff. The above demonstrated the home had medicines governance systems in place, but they were still in the process of addressing some minor recording issues.

Covert administration is the term used when medicines are administered in a disguised format, without the knowledge or consent of the person receiving them. Administering medicines in food or drink can significantly alter their therapeutic properties and effects so that they become unsuitable or ineffective. Pharmacist advice is always necessary.

At our last inspection we had concerns about the covert medication procedures for one person. At this inspection we found advice had been sought from the pharmacy and the issue had been addressed, however there was still some inconsistent information in the records, and the relevant mental capacity assessment and best interest records had been archived; we saw this information on the second day of our inspection. The locality manager was waiting for a reply from the GP to complete the process and told us they would collate the relevant information into one accessible place to ensure evidence of adherence to their covert medicines policy and nationally recognised good practice was readily available.

At our last inspection the home was not meeting the regulations related to managing risk because not all health and safety risks had been robustly assessed. At this inspection we found improvements had been made and measures had been taken to reduce risks to people.

People who used the service, staff and visitors were protected against the risks of unsafe or unsuitable premises. Checks had been completed on fire safety equipment, emergency lights and the fire alarm and action taken to rectify any issues. We saw evidence of service and inspection records for gas installation, electrical wiring and portable appliance testing. A series of risk assessments were in place relating to health and safety.

We found water temperature testing, checks on window restrictors and checks on the contents of first aid kits had not been completed in recent months and this had not been picked up by the registered providers audit system. The registered manager forwarded the water temperature checks taken on the day of our inspection after our inspection and these were within the safe range. We saw from team meeting minutes they had allocated a staff member to complete these checks, however the person had been moved to a different service. The registered manager allocated this role again after our inspection and sent evidence the checks had been completed and no concerns were identified.

People had an individual personal emergency evacuation plan (PEEP) in their care records and also located

in a grab file by the exit door to the home. PEEPs are a record of how each person should be supported if the building needs to be evacuated. We found the PEEPs for people using the service for respite care were present in their care records, but were not always placed in the grab file by the door at the time they were staying at the service. The registered manager addressed this straight away. Fire drills had been completed and staff and people were aware of the procedure to follow. This showed the home had plans in place in the event of an emergency situation.

The above issues with audit and keeping accurate and up to date records contributed to a continuing breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we found accidents and incidents were recorded, but the recording lacked evidence of a thorough investigation and analysis to ensure lessons could be learnt to prevent further episodes. At this inspection we found improvements had been made.

Staff told us they recorded and reported all incidents and people's individual care records were updated as necessary. We saw in the incident and accident log that incidents and accidents had been recorded and an incident report had been completed for each one. Staff were aware of any escalating concerns and took appropriate action. All incident records were detailed and contained a debrief for staff on what was learned from the incident. The incident records showed the event was subject to senior staff review with any lessons learned translated into care plans.

The registered provider had an overview of incidents and accidents which meant they were keeping an overview of the safety of the service.

Staff we spoke with understood their role in protecting people from abuse and discussed how knowing people well meant they could detect changes. They told us they had received training and showed they understood different types of potential abuse and their role in preventing it. Staff understood how to raise concerns both within their organisation and beyond, should the need arise, to ensure people's rights were protected. We saw information around the home about reporting abuse and whistleblowing, including in an easy read format.

Records showed complex safeguarding incidents had been dealt with appropriately when they arose and measures were put in place to ensure people were kept safe. Safeguarding authorities and the Care Quality Commission (CQC) had been notified. This showed the registered provider was aware of their responsibility in relation to safeguarding the people they cared for.

Comprehensive risk assessments were in place in areas such as absconding, sharp implements, behavioural support, self-harm, road safety, finances, medication, and additional person specific assessments, for example; for specific health conditions. The risk assessments were legible and up to date and were available to relevant staff so they could support people to stay safe. Staff said they read people's care files and always had pre shift handovers, which had enough information to enable them to care for people safely. This showed the registered provider had an effective system in place to reduce risks to people.

Risk assessments and care plans also contained information about how staff would care for people when they experienced behaviours that may challenge others and the action staff should take in utilising de-escalation techniques. When we spoke with members of staff they were aware of this information. One staff member said, "We look for signs of agitation. If [name of person] gets excited they will ask for PRN ('as required' medication). I would rather try to calm them down verbally." We saw a person become distressed during our visit and staff followed the behavioural support plan completed in conjunction with community

professionals to try to prevent escalation or incidents that may challenge others. This showed the service responded to changes in the behaviour of people who used the service and put plans in place to reduce future risks.

People and three out of four staff we spoke with told us there were enough staff on duty. The registered manager told us each person who used the service was allocated staff according to their assessed needs and we saw this was reflected in their care records and tallied with the number of staff on duty. We observed there were appropriate staffing levels on the days of our inspection which meant people received sufficient support.

One person said, "Yes staff are good here, but I don't always get staff I like, I don't like it when they change and I want people who have left to come back. I don't like new staff because I don't trust them." People and staff found regular use of agency staff sometimes reduced consistency, which could be problematic for people who used the service. One staff member said, "Our lads can't cope with changes and new staff." A second staff member said, "When people ring in sick at the last minute staff are stretched. You always get days off but they often ring on your days off for cover if they can't get agency. A floating staff member would be a good idea."

The registered manager told us some staff had been moved to another service by the registered provider and agency staff were used most days until posts could be filled. They said staff recruitment was a continuous process due to the high support needs of people using the service and four new staff members had been recruited and were awaiting a start date.

One person had formally complained about being frequently allocated agency staff, however records showed they had rarely been allocated agency staff. Agency staff were usually deployed in the respite care flat depending on the needs of the person using it or worked with a more experienced staff member who knew people's needs well. The registered manager and registered provider did acknowledge, however, that consistent staff benefited people and plans were in place to improve recruitment and retention, with enhanced incentives and more management time and support allocated to the service.

We reviewed recruitment records for three staff who had been recruited since our last inspection. Appropriate Disclosure and Barring Service (DBS) checks and other recruitment checks were carried out as standard practice. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups. This showed recruitment systems were robust.

The home was visually clean and smelt pleasant and fresh. No cleaning staff were employed but staff said they cleaned or supported people to clean individual flats. Staff had access to personal protective equipment (PPE) and discussed when they used gloves and aprons and when they washed their hands to prevent infection. This helped protect people from infections that could affect both staff and people using the service.

Requires Improvement

Is the service effective?

Our findings

Relatives told us they were confident the staff team at Cragside could meet their family member's needs. One relative said, "My [relative] is still in a situation where their mood is still up and down, but I feel that the staff that support them are trained and able to manage the more difficult times and periods in their life. I would say that [my relative's] moods and behaviour have improved slightly since being here."

At our last inspection on 27 June and 4 July 2017 we found the registered provider was not meeting the regulation related to staff training and supervision. The registered provider sent us an action plan outlining the improvements they would make. At this inspection we found improvements had been made in staff training, but not in staff supervision and appraisal.

Staff told us they now felt supported and some staff told us they had received recent supervision. Supervision and appraisal are used to develop and motivate staff, review their practice or behaviours, and focus on professional development. The registered provider's policy was to complete supervision between four and six times a year. We reviewed the matrix used by the registered manager to track staff supervision and appraisal and checked four staff files. In two of the staff files we reviewed no supervision had been completed since January 2017, a period of 11 months and no staff appraisals had taken place in 2017. This meant staff did not receive appropriate support, supervision and appraisal necessary to enable them to carry out the duties effectively.

This was a continuing breach of Regulations 18 (2) (a) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us the two senior staff who previously completed supervision with care staff had been moved to another service. The temporary deputy manager had started to undertake supervision with staff and they told us they were concentrating on issues staff wanted to address and providing support to them. Following this inspection the registered manager sent us evidence staff supervision was being completed.

All staff completed a comprehensive induction, and did not work unsupervised until they and their manager were confident they could do so. Staff had completed an induction based on the Care Certificate. The aim of the Care Certificate is to provide evidence that health or social care support workers have been assessed against a specific set of standards and have demonstrated they have skills and knowledge to ensure they provide high quality care and support. Induction records showed staff had training in fire safety, manual handling, infection prevention and control, emergency procedures, safeguarding and handling people's personal finances. This demonstrated that new employees were supported in their role.

We saw staff had received a wide range of training to ensure they had the knowledge and skill to care for people living in the home. This included mental health awareness, autism, dementia, epilepsy, self-harm and personality disorders, sensory interaction and engagement, DoLS, medication administration and Maybo techniques to support people if required using minimal touch and force. Training included electronic

learning and face to face methods. We saw a training matrix was used to track training and updates. We spoke with staff who said they felt they had enough training to care for people effectively and said the manager prompted them when e-learning updates were due. This demonstrated people were supported by suitably qualified staff with the knowledge and skills to fulfil their role.

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 so they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. We asked the registered manager about the MCA and DoLS and they were able to describe to us the procedure they would follow to ensure people's rights were protected. Three people were subject to DoLS authorisations, some of which had conditions attached, and one person had been assessed as having the mental capacity to decide to live at the home. People who used the respite service also had DoLs authorisations in place where required.

One relative said, "My [relatives] health and well-being is taken care of by staff. My [relative] is unable to make any decisions about support verbally, however I do feel staff work with [my relative], and plan activities."

It was clear from observations people's autonomy, choices and human rights were promoted. Staff we spoke with had a good understanding of the MCA and DoLS and they understood the concept of least restrictive methods and how people could often continue to make simple, everyday decisions even when they lacked the capacity to make complex decisions.

We found there was evidence of good practice in the assessment of mental capacity for important decisions, such as coming to live at the service, finance, administration of medicines, medical treatment and deciding to consume alcohol. We found where mental capacity assessments had been completed; however, best interest discussions had not always been recorded to show the person's representative had been consulted. The registered manager told us they always discussed decisions with people's representatives and they would arrange to record best interest discussions with them as soon as possible. We asked them to send us evidence of this following our inspection when consultation had been completed.

We also found the mental capacity assessment and best interest discussions regarding use of covert medicines for one person had not been regularly reviewed in line with good practice, although it was clear from records the person's needs had not changed. We asked the registered provider to send us evidence when a review had been completed.

We recommend the registered provider consults best practice to ensure mental capacity and best interest processes are always recorded and reviewed when decisions need to be made on behalf of people who may lack capacity.

Physical, mental health and social needs had been assessed and care plans included guidance and information to provide direction for staff and ensure care was provided in line with current good practice

guidance. Technology was used effectively to meet people's complex needs, for example, staff were able to turn off the water supply remotely for one person who was at risk of flooding their flat.

Each person living in the home had different food prepared in their own flat. One person said, "I do some cooking sometimes with my staff. I buy the food from the supermarket. We look at how much money I have to spend and do the shopping." Another person said, "I do some food in my room, but I like takeaway."

One person was supported to prepare some meals themselves which they planned with staff, who told us they tried to help the person eat a more balanced diet by introducing fruit and more vegetables. They said they encouraged the person to find recipes to make fresh food which they enjoyed. We saw the person had been supported to plan menus and a shopping list for the week. One person's care plan said they enjoyed spicy food and we saw they had been supported in their choice on a regular basis. We saw the individual dietary and cultural requirements of people were catered for in relation to one person's cultural background.

We saw records of food temperature checks when hot food had been prepared for people to ensure it reached a sufficiently high temperature to prevent contamination. Meals were recorded in people's daily records. This included a record of all food consumed, including where food intake was declined and details of the food eaten, although there were some minor gaps in recording. People were weighed monthly to keep an overview of any changes in their weight. This showed the service ensured people's nutritional needs were monitored and action taken if required.

The advice of professionals was included in people's care plans and we saw staff following people's care plans and advice from professionals on the days of our inspection to help people to achieve good outcomes. The service was improving relationships with some community health professionals through meetings and discussions. One of the professionals who raised concerns prior to the inspection told us they felt this had helped to improve channels of communication.

Records showed improvements in the consistency of communication within the team and effective team-working was promoted.

One person said, "I go to the local doctor's surgery, they're all right there." Records showed people were supported to access external health professionals and we saw this had included GP's, psychiatrists, community nurses, psychologists, chiropodists, dentists and speech and language therapists. People also had an up to date health action plan in their care records and a hospital passport. The aim of a hospital passport is to provide hospital staff with the information they need to know about a person with a learning disability when they are admitted to hospital. This showed people received additional support when required for meeting their care and treatment needs.

The design and layout of the building was conducive to providing a homely, safe and practical environment for people who used the service, although the respite care flat was not as homely. People's individual flats were spacious and well maintained and personalised to people's tastes. Specialist furniture and fittings helped to keep people safe.

In the respite care flat picture frames had been added to the walls, where personalised pictures could be added during each person's stay, however these had not yet been utilised. There had been problems with the curtains which had been temporarily tacked up for the dignity of people using the flat. New curtains were on order and by the second day of our inspection a high curtain wire had been utilised to enable the curtains to open. This showed the registered manager was taking action to ensure the safety and privacy of

people using the service. The registered provider had arranged for a quality advisor to support the personalisation and homeliness of the respite care flat and they met with the registered manager as planned during our inspection.

Good

Is the service caring?

Our findings

People told us the staff were caring. One person said, "I sometimes speak to staff. We work on strategies to help me to manage my anger. Staff are all right. I like them all." A second person said, "Staff listen to me. I ask about things and they sort it."

One relative said, "I feel the staff that support [my relative], care for them, and I feel confident that if I wasn't happy with any support they received, I would be able to phone up and speak to staff to voice my concerns. I feel that the staff don't just care for my [relative] but will often ask about myself and my [family member] and what's happening in is our lives, which I feel is really important."

People told us they liked the staff and we saw there were warm and positive relationships between them. Staff we spoke with enjoyed working at Cragside and supporting people who used the service. One staff member said, "You are helping people and making a difference. It's rewarding." A second staff member said, "I love the people that live here."

We observed staff speak to people gently or with appropriate humour and they were kind and compassionate. We asked staff to talk about individuals living in the home and they talked with genuine care and concern, which assured us they knew people well. They used this knowledge to engage people in meaningful ways, for example, with conversations about activities or music they knew the person liked. We saw people laughing and smiling with staff.

When a situation arose where one person became upset and anxious, staff remained calm and supported the person through redirection and reassurance.

People's diverse needs were respected and care plans recorded the gender of carer they preferred to support them, as well as their religious, cultural and sexuality related needs. Staff told us they respected people's diverse needs by ensuring they understood the person through their care plan, talking with them and their families and supporting their cultural and lifestyle choices. This demonstrated the service respected people's individual preferences.

We saw staff at Cragside were responsive to people's needs, asking them questions about what they wanted to do and planning future activities. Staff were patient with people, and listened to their responses. This meant that the choices of people who used the service were respected.

People were supported to make choices and decisions about their daily lives and care records evidenced this. People told us they had a choice of meals, what time to get up or go to bed, clothing, activities or when to have a bath or shower. One staff member said, "[Person] decides where he wants to go. You go with him."

Accessible communication was promoted throughout the service. Staff used speech, gestures, and facial expressions to support people to make choices according to their communication needs. Staff told us they showed people a choice of clothing or food to support them to make every day decisions if they

communicated none verbally. One staff member said, "[Name of person] will point to the clothes they want if you put a choice on the bed. [Name of person] also uses cards with pictures and numbers on to communicate." One person used pictorial and graphic support strategies on the walls of their flat to plan their timetable and remain calm and in control of their time and their mood. Information was presented in easy read formats to promote good communication and care plans contained details of how to recognise when a person was unhappy or happy using non-verbal cues. One person happily signed they were going out, using Makaton sign language.

One staff member said, "We ensure privacy and dignity by always knocking on people's door before going into their flats." We saw staff knocked and asked permission before entering people's flats and gave people privacy and space when it was safe to do so. People's private information was respected and records were kept securely.

People appeared well groomed and looked cared for, choosing clothing and accessories in keeping with their personal style. People's individual flats were personalised to their taste with furniture, personal items, photographs and bedding they had chosen.

People were encouraged to do things for themselves in their daily life. One staff member said they encouraged people to do their own cleaning in line with their care plans, "[Name of person] did clean their own flat. I gently encourage, but avoid triggers. Sometimes you have to do it for [them]." We saw staff discussed with a person when they wanted to take their medicines and when they wanted to go out that day. A graph celebrated the tasks the person had achieved, including managing their anger, keeping their flat clean, listening and working with staff and completing household chores like washing up and laundry.

Care plans detailed what people could do for themselves and areas where they might need support. People were encouraged and supported to increase their independence, for example with an independence plan, which structured support to ensure people felt safe and confident go out of the home independently to meet their goal. This showed us the home had an enabling ethos which tried to encourage and promote people's choice and independence.

Relatives told us they were welcome to visit any time and staff supported people to see their families as often as desired. One staff member said, "I get attached to (the people living here). They know I want what's best for them. [Some people] lack family and friend's support and need a human touch. I really feel for them." Two people were signed up to a dating agency for people with learning disabilities in order to achieve their goals and aspirations and a dating agency Christmas event was planned on their time table to ensure it was prioritised. This meant people were supported to develop positive relationships and to maintain contact with people who were important to them.

Advocacy and eligibility to vote information was on display to promote people's citizenship and human rights. Three people had independent mental capacity advocates and staff were aware of how to access advocacy services for people when the need arose. An advocate is a person who is able to speak on a person's behalf, when they may not be able to, or may need assistance in doing so, for themselves.

Good

Is the service responsive?

Our findings

People told us they were involved in their care plans and we saw people were consulted on every aspect of their support. One person said, "I have the support plan, and staff and me talk about it."
One relative said, "If they need to contact me regarding [my relatives] health and it's something they feel I should know they contact me and discuss whatever they are worried about. I'm able to visit any time."

The staff we spoke with had a good awareness of the support needs and preferences of the people who used the service. We found care plans were person-centred and explained how people liked and didn't like to be supported. Entries in the care plans we looked at included, "I do not like; Changes in my timetable." And for another person, "I do not like; Being told what time to go to sleep." "I enjoy; Playstation, cinema and football." This helped care staff to know what was important to the people they supported and helped them take account of this information when delivering their care. We found staff were aware of this information and people were supported according to their preferences, for example we saw the registered manager changed one persons allocated staff member on the first day of our inspection, after consulting the person about their preference. One person told staff they didn't like being alone in their flat in the evening and so their support was allocated differently to provide social contact at this time. The temporary deputy manager had devised a keyworker chart alongside people and they told us they changed one of the pictures on the list in response to a person's preference.

We looked at four people's care plans. Care plans were very person-centred and contained detailed information covering areas such as evening routine, mobility, living safely and taking risks, hygiene, communication, medication, everyday tasks, decision-making, money and, family and relationships. They included long term goals the person was working toward. We saw action had been taken to support people in their goals, for example, one person who wanted to move to a shared home to have more social contact with peers and share daily living tasks had a meeting planned with their social worker to discuss this.

Care plans contained information in an accessible format with photographs of staff and the person to support involvement. One staff member said they regularly met with the duty manager and other staff to discuss support plans and issues affecting people living in the home and developed strategies and plans to improve the way people were supported. One person didn't like to be weighed and so this was added to their monthly time table in order to plan and prepare for being weighed and enable the person to integrate it into their routine without anxiety.

The manager told us, and we saw from records, reviews were held and care plans were reviewed and updated regularly or when needs changed. These reviews helped monitor whether care records were up to date and reflected people's current needs so that any necessary actions could be identified at an early stage.

Daily records were also kept detailing what activities people had undertaken, what meals had been eaten, their mood and any incidents.

One person said, "I go and see my [relative] and [my relative] comes to see me." Relatives told us they were welcome to visit any time and staff made them feel welcome. This meant staff supported people with their social and emotional needs.

One person said, "I like to go to the pub and drink. I go in to town to shop and go out for lunch. I joined a dating agency and I'm hoping to meet a girl there." A second person said, "I like to do drawing. My [relative] draws things. I'd like some pencils for Christmas."

One relative said, "[My relative] enjoys going out, I'm not really overly sure where he goes and what he does now, but I'm quite sure they manage his time well."

Staff spoke with good insight into people's personal interests and we saw from people's support plans they were given opportunities to pursue hobbies and activities of their choice. For example, going to town and to the cinema, out for lunch and on trips further afield, enjoying table top games, water play and sensory items. One staff member said, "[Name of person] likes to listen to music on their tablet. [Person] loves water and will jump in any water to play with it. [Person] likes jigsaws." We saw the persons interests were structured into their time table and we saw they were using a new jigsaw on the day of our inspection. One staff member told us how they made a monthly plan with the person they supported about the activities they wanted to do in the next month. We heard how people were being assisted to lead fulfilling lives and picked the things they wanted to take part in. Records showed each person had an individually planned holiday and one person was being supported to plan their first holiday abroad.

One person said if they were unhappy about anything, "I go and speak with [name of manager]. I just go and tell her and if she's not in, I speak to other staff and things get sorted."

The relatives we spoke with told us staff were always approachable and they were able to raise any concerns. One relative said, "On occasions where I have had to make complaints or make observations, mainly about [my relative's] security, I feel that I've been listened to and that they've sorted any of my issues."

People's views were sought by the registered manager through meetings and one-to one conversations. We saw there was an easy read complaints procedure in people's care files. Staff we spoke with said if a person wished to make a complaint they would facilitate this. We saw complaints had been dealt with appropriately when they arose and complaints from people using the service and community professionals had been recorded, thoroughly investigated and responded to appropriately. The registered manager was clear about their responsibilities to respond to and investigate any concerns received and demonstrated learning from complaints was implemented to improve the service.

Some people and their relatives had discussed preferences and choices for their end of life care including in relation to their spiritual and cultural needs. This was clearly recorded and kept under review. This meant people's end of life wishes were clearly recorded to provide direction for staff and ensure people's wishes were respected.

Requires Improvement

Is the service well-led?

Our findings

People told us the home was well led. One person said, "I like [name of manager]. I ask her if I'm not happy, to sort things for me." A second person said, "She helps me, she's okay."

One relative said, "I feel I have a relationship with both staff and management, although I've not met [the registered manager] yet due to our commitments, I have spoken to her on the phone. I feel the organisation is well organised and I'm happy that [my relative] is happy in the home. On the whole I'm really pleased with the care and support my [relative] gets." A second relative told us they thought the registered manager was lovely and they were really happy with the support provided.

One community professional fed back, "Positive progress is recognised in relation to; management availability and engagement, staff attitude and morale, support available from senior management. I believe that an area still needing significant development is staffing and use of agency; however I recognise the current plan that is in place, and that this will take time to recruit good quality staff and improve retention. I am keen to keep the momentum of change going and that current actions proposed to address concerns come to fruition."

Staff told us they felt supported by the registered manager and management team, who acted on their concerns. One staff member said, "The manager is good, she listens." A second staff member said, "Things are a lot better. The manager and deputy are engaging more with the staff team and I feel a bit more confident things will continue to get better. Staff meetings were rare, but now there is more structure." A third staff member said, "It is moving in the right direction."

The registered manager had started working at the service for three days a week in August 2017 and a new temporary deputy manager was currently at the service for three days a week to support with improvements in governance.

At the last inspection on 27 June and 4 July 2017 we found the registered provider was not meeting the regulations related to good governance. We told the registered provider to make improvements and they sent us an action plan to show what they would do and when they would meet the regulations. At this inspection we found improvements had been made in almost all areas, although some issues with governance still remained.

The registered provider's action plan to improve staff supervision and appraisal had been signed off as completed in October 2017; however we identified a continuing breach of the regulations related to staff supervision and appraisal. This meant robust action had not been taken to improve staff supervision and appraisal.

There were some incomplete or inaccurate records, which the registered manager rectified immediately, however these had not been picked up by the system of audit, for example, we found the medicine care plan in the office for one person using the respite service was not fully completed. The relevant information was,

however contained on the MAR and medicines record in medicines cupboard in the respite care flat. The registered manager told us they would address this and they sent us the updated care plan after the inspection.

An agency staff file contained profiles of each person's needs, including people using the respite care service. We saw one respite care user didn't have a profile in the agency staff folder, however an agency staff member was working with the person on the first day of our inspection and we saw they had a more detailed care plan with them in the flat. When we spoke with them they knew the person's needs and we heard the senior on duty sharing information with them and introducing them to the person at the start of the shift. The registered manager told us they would add the profile of the person to the agency folder for future use.

There were recent gaps in water temperature checks, checks on window restrictors and checks on the contents of first aid kits. This meant the systems in place to monitor the safety and quality of the service had not identified and addressed the issues we found.

The above issues were a continuing breach in Regulations 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection the registered manager sent us evidence all outstanding issues had been addressed. The deputy manager had also improved the daily handover records to incorporate more routine checks and audits that were scheduled each day.

The registered provider had introduced a new system across all its services in 2017 to ensure all management information was kept in one place and was easily accessible. Daily audits were completed on finances, and medicine stocks were checked three times a day and we saw action was taken when issues arose. This showed staff compliance with the registered provider's procedures was monitored, although the system had not been effective in picking up issues we found with some records and audits. The locality manager had identified some issues with the new audit system and fed this back to the registered provider, who was currently reviewing the system.

Staff told us the locality manager visited frequently and was approachable. The regional director told us the registered provider had reduced the number of services covered by the locality manager to enable them to focus on improvements to the service. The registered manager told us she felt supported by the provider, and was able to contact a senior manager at any time for support. The registered manager worked to an action plan completed in conjunction with the locality manager and we saw most action had been completed within the timescales set. This demonstrated the senior management of the organisation were reviewing information to drive up quality in the organisation, however, whilst improvements had been made, this system had not effectively addressed the issues we found in relation to staff supervision and records.

Information was passed to the registered provider in a monthly report in areas including incidents and accidents, safeguarding, training compliance and recruitment. Senior managers also held a quarterly quality compliance risk overview meeting. This demonstrated they were keeping an overview of the quality and safety of the home.

The registered manager could demonstrate an in-depth knowledge of the needs and preferences of the people at Cragside. The registered manager told us she attended managers' meetings, training and events to keep up to date with good practice, and they were currently completing a level 5 qualification in care

management. This meant they were open to new ideas and keen to learn from others to achieve good outcomes for people using the service.

The registered manager and management team were improving partnership working with community health professionals to meet people's needs and drive up the quality of the service. We received feedback from one community professional following our inspection that improvements had been made, however there was still work to do. We found there was never any delay in involving partners to ensure the wellbeing of the people living at the home.

People who used the service and their representatives were asked for their views about the service and these were acted upon. Service user forums had been held in July and November 2017 and November topics included safeguarding, Christmas arrangements, use of agency staff and furniture. One person asked for service user forums to be held in their flat. One staff member said, "We have had one meeting with service users. It was brilliant. [Name of person] needs to feel they are being listened to and [name] needs to feel they are in control. I am encouraging [name of person] to go to the next one." We saw action had been taken by the management team in response to points raised at the meetings and more forums were planned onto people's timetable.

Questionnaires had been sent out to family members and professionals in November 2017 but none had yet been received back. We saw from records the registered manager had responded to any feedback or concerns raised by community professionals.

Staff said they now had staff meetings regularly, and talked about what was good and what could be improved. Meetings were held every month and the registered manager and temporary deputy manager had addressed issues, such as medicines management and health and safety. New guidelines for keyworkers had been introduced, including a checklist of responsibilities, to support them in their role. Other topics discussed included team working, staff training, individual resident's needs, smoking, safeguarding, learning from incidents, missing person's policy, records, use of agency staff, recruitment updates, and the development plan for the service. Staff meetings are an important part of the provider's responsibility in monitoring the service and coming to an informed view as to the standard of care for people living at the home.

The registered manager said they operated an 'open door policy' and people were able to speak to them at any time. People we spoke with confirmed this and we saw the registered manager engaging with people throughout the day. The registered manager was visible in the home and had an in-depth knowledge of the needs and preferences of the people they supported.

The registered manager understood her responsibilities with respect to the submission of statutory notifications to the CQC. Notifications for all incidents which required submission to CQC had been made.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance An effective system was not in place to monitor the safety and quality of the service and up to date records were not always kept. 17 (2) (a) and (c)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not receive appropriate supervision and appraisal necessary to enable them to carry out the duties effectively. 18 (2) (a)

The enforcement action we took:

Warning notice issued to comply by 2 February 2018