Horizon Healthcare Homes Limited

Cranmer Court

Inspection report

Cranmer Bank
Leeds
West Yorkshire
LS17 5LD

Tel: 01132370024

Date of inspection visit:
19 January 2016

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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

Our inspection took place on 19 January 2016 and was unannounced. At our last inspection on 24 September 2013 we found the provider met the regulations we looked at.

Cranmer Court is a purpose built, single storey home providing accommodation and personal care for up to ten adults with learning disabilities. It is located in the Moor Allerton area of Leeds, close to local amenities and transport links. There were ten people living at the home on the day of our inspection.

There was not a registered manager when we inspected, however the provider had recruited a manager who was already in post and whose application to be a registered manager with the CQC was under consideration. 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.

Relatives of people who used the service told us they thought people were safe at Cranmer Court. The provider had policies and procedures in place to minimise risks to people including safeguarding and risks arising from care and support needs..

We saw that recruitment was well managed and appropriate background checks were undertaken to ensure new staff were not barred from working with vulnerable people. There were sufficient, appropriately skilled staff to provide care and support at all times..

Medicines were managed ordered, stored and administered safely. Care plans contained clear information about how people preferred to be supported to take medicines.

Relatives told us they thought staff had appropriate skills to provide care and support for people. Staff told us the induction process was thorough and provided them with competencies they needed to be effective in their role. We saw the provider supported staff through the provision of regular and relevant training, and sought information from bodies such as the Autism Society.

Staff were further supported with regular supervision and appraisal.

Care plans contained appropriate mental capacity assessments and best interests decisions. Staff received training in the Mental Capacity Act (2005) and understood how this impacted on the ways in which they worked with people. The provider ensured people had advocacy support where needed. Deprivation of Liberty Safeguards (DoLS) were in place for all people who used the service. The provider was managing these appropriately.

People had access to healthcare professionals when needed, and we saw visits were documented and care

plans amended as required.

We saw evidence people were well supported with nutrition and hydration, and the provider had a policy in place to ensure mealtimes were effective and enjoyable. They included people who used the service in making choices about menus.

Relatives told us there was a caring environment at Cranmer Court and we made observations during the inspection that confirmed this. People's privacy and dignity were respected.. Families said they were involved in the care planning processes including reviews.

Care plans contained person-centred information which captured people's likes, dislikes and personality. Individual care plans contained detailed guidance to assist staff provide support in ways which the person preferred..

People who used the service were able to choose activities as they wished, both in and away from the home. We saw people could suggest ideas for days out and we saw these requests were acted on. In addition people had been asked how they wanted their rooms to be furnished and decorated and we saw they had been involved in selecting and purchasing items.

The provider had policies and procedures in place to ensure complaints and concerns were recorded and acted on. Information about how to complain and forms to capture feedback from people who used the service were available in easy read formats.

Staff told us there was a positive and 'open-door' culture in the home and said the manager supported them well. The manager told us they had good support from the provider.

Staff and people who used the service were able to contribute to the running of Cranmer Court through regular meetings, An annual survey was undertaken and the outcomes of this used as part of the business planning process.

The manager and provider undertook a rolling programme of audits which monitored the quality of the service. Action plans were put in place when opportunities to improve were identified.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

The provider had policies and procedures in place to minimise risks of harm and staff understood their responsibility to report any concerns about potential abuse.

Recruitment practices were robust and the provider involved people who used the service in the selection of staff.

Systems and processes were in place to ensure the safe management of medicines. People's care plans contained guidance for staff in identifying when people may be in pain.

Is the service effective?

Good

The service was effective.

The provider ensured staff received regular, appropriate training to enable them to provide effective care and support to people who used the service.

People were supported appropriately to make decisions using family members, independent mental capacity advisors and best interest decisions were made in line with the requirements of the Mental Capacity Act (2005)

There was a positive and effective approach to nutrition and hydration which ensured mealtimes reflected people's dietary needs and preferences.

Is the service caring?

Good

The service was caring.

Care plans were person-centred, containing detailed information relating to peoples preferences, likes and dislikes.

We made observations that enabled us to conclude there was a good standard of care, and staff spoke knowledgeably and with fondness about people who used the service.

Staff understood the importance of respecting the privacy and dignity of people who used the service.

Is the service responsive?

Good

The service was responsive.

The care and support needs of people who used the service were assessed before admission and care plans written to ensure these needs were met.

People had access to a wide range of activities in and outside of the home. We saw people's suggestions for days out were acted on.

The provider had systems in place to ensure the complaints process was robust and understood. Information about how to complain or give compliments was available in an easy read format.

Is the service well-led?

Good

The service was well-led.

Staff told us there was a positive, 'open-door' culture and said the manager supported them well.

There were regular meetings to enable the manager, people who used the service and staff had an opportunity to share information about the running of the home.

There was a rolling programme of audit in place to measure quality of service delivery and we saw actions were taken when needed.

Cranmer Court

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.

Our inspection took place on 19 January 2016 and was unannounced.

The inspection was carried out by two adult social care inspectors. 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 the service does well and improvements they plan to make. Before the inspection we also reviewed the information we had about the service, including the last inspection report and notifications of incidents in the home the provider sent us. We contacted the local authority and Healthwatch to ask if they had any information about the service that would help plan our inspection. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. They did not provide any information of concern.

We looked at records related to peoples' care and the running of the service. We looked in detail at three care plans and the recruitment records of three members of staff. We looked around all areas of the home including living rooms, dining rooms, bathrooms, kitchens and some people's bedrooms. Due to the nature of the service people who used it were not able to tell us about their experiences, but we spent time making observations of care provision and spoke with four relatives of people who used the service. We also spoke with three staff, the manager and the provider's operations manager.

Good

Is the service safe?

Our findings

Relatives of people who used the service told us they felt people were safe. One person we spoke with told us, "There are no faults. It's a wonderful place."

The provider had policies and procedures in place to minimise the risks associated with abuse. We looked at policies covering safeguarding of vulnerable adults and whistleblowing, and we saw staff had signed these to confirm they had read and understood them. A member of staff told us, "It's our duty to protect people." When we spoke with staff we found they were knowledgeable about the types of abuse people who used the service may be at risk from, and clear about their responsibility to report any concerns to the manager. They told us they had confidence the manager would act on what they were told. Staff were also aware they could raise concerns with other bodies such as the local authority or CQC.

We looked at the recruitment records of three members of staff. We saw the provider included people who used the service in the interview process. Candidates spent time with people before a formal interview and the interviewers made observations of the quality of interactions to help decide whether an applicant had the required skills to provide effective care and support. All staff files contained references and we saw the provider made background checks with the Disclosure and Barring Service (DBS). The DBS is a national agency which holds information about people who are barred from working with vulnerable people.

We asked relatives of people who used the service whether they felt there were enough staff to meet people's care and support needs. One person told us, "There are plenty of staff, I drop in any time." Another said, "There's enough staff." Staff we spoke with also said they felt the provider planned enough staff for each shift. The manager told us they used regular bank staff to provide cover for absences. They said, "We only use staff who we and the residents know. They have the same training as our regular staff." We looked at rotas, and made observations as to how staff responded to people's care and support needs. We concluded there were sufficient staff to provide safe care.

The provider had systems in place to ensure accidents and incidents were recorded and appropriately investigated. This included making referrals to local safeguarding bodies as appropriate.

We looked in detail at the care plans of three people who used the service, and saw a range of detailed risk assessments had been carried out for each person to ensure that individual risks were minimised. These included risk of pressure sores, eating and drinking, trips away from the home and specific risks associated with a range of health conditions. The risk assessments covered the activity or condition, the specific hazards, the person or persons in danger, controls already in place and actions to take to ensure the person remained safe. We saw the assessments were kept up to date through regular review.

The provider had policies, systems and process in place to ensure the safe management of medicines. During the inspection we observed a medicines round and saw each person's medicines were checked against the medicines administration record (MAR) prior to being administered. We saw the staff member stayed with the person to observe they had taken the medication before recording this on the MAR sheet.

They spoke discreetly to people and demonstrated they understood the way in which each person preferred their medication to be given, for example with water or juice and how much encouragement people needed and preferred. The staff member told us, "We keep a record of the day's medication rounds during the day, then night staff check what has been given. They update tally sheets so we know our stocks are right every day." We checked the stocks of three people's medicines and found they were correct.

Some people were prescribed medicines to be taken when required, also known as 'PRN' medication. The member of staff administering medicines was knowledgeable in how they would know if people who could not communicate needed these medicines." We looked in people's care plans and found detailed, clear information relating to individual support needs for medicines and the management of pain. For example one care plan contained information for staff including, 'I cannot communicate verbally that I am in pain but can let staff know by mannerisms and the noises I make.' There was also a description of the specific ways in which the person communicated pain and discomfort.

In the PIR the provider told us about their commitment to the safety of the environment in the home and said, 'The home completes all necessary equipment checks including gas safety, fire alarm, emergency lights and extinguishers, LOLER, PAT and legionella checks.'

We looked around all areas of the home including bathrooms, communal areas, toilets and some people's bedrooms. We found the home was cleaned to a high standard and well maintained, with paperwork in place to evidence regular and in date servicing of equipment such as fire systems, hoists and gas fittings. Soap, paper towels and personal protective equipment was available and we saw staff making use of these. We looked at records relating to the testing and maintenance of equipment and fixtures in the home. We concluded people were protected from risks associated with equipment and the prevention and control of infection.

Good

Is the service effective?

Our findings

People we spoke with told us their relatives were cared for by appropriately skilled staff. One person said, "The staff are very good." Another told us, "They are very good, I'm very happy."

We looked at the provider's training records which showed staff had completed a range of relevant training which included an introduction to learning disabilities, autism, mental capacity, conflict management, equality and diversity and safeguarding. There was a plan in place to ensure that mandatory training was updated at regular intervals and we saw all staff were up to date with training. One member of staff we spoke with told us, "There is lots of training, we are well supported in this respect." We saw the provider had systems in place to ensure training was in line with current good practice wherever possible, for example we saw the training to enable staff to support people with autism was devised in line with standards identified by the Autism Society.

In the PIR the provider told us, 'All staff follow a closely monitored twelve month probationary period. All staff complete a Skills for Care induction appropriate to their work grade, this includes training in first aid, moving and handling, equality and diversity, food hygiene, infection control, fire safety, safeguarding and mental capacity. Staff who administer medication are provided with specific training and obtain competence before carrying out this task.'

Staff we spoke with said their induction had been thorough and equipped them with skills and competencies to provide effective care and support to people. One member of staff said, "The induction was very good. I was supervised and never left to do anything I wasn't sure of. You're not asked to do things by yourself until you are comfortable with what you are doing." We looked at records of induction training and the provider's Induction Policy and saw staff completed a comprehensive programme including training in duty of care, equality and inclusion, privacy and dignity, fluid and nutrition and infection prevention and control.

We looked at the supervision and appraisal records of three staff and saw each had signed a contract with the provider which stated they would have six annual supervisions, and we saw evidence that these were taking place at the agreed frequency. We saw there was a set agenda in place, meaning supervisions were carried out to the same standard with all staff. The records we reviewed showed discussions were detailed and meaningful with a clear action plan arising from each meeting. Staff we spoke with told us they valued the supervisions. One member of staff said, "They are regular and I appreciate being able to let off steam when I need to, and make suggestions about how I am going to get support to keep developing my skills. When you ask for something like extra training it gets acted on." We saw all staff who had been employed for over a year had received an annual appraisal which reflected on achievements and objectives for the coming year.

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.

Staff we spoke with were able to tell us how the MCA applied to people who used the service and how family members or independent mental capacity advocates (IMCA) were involved in supporting people to make decisions about their care and support. One member of staff told us, "We can't stop people making an unwise choice, but we can offer alternatives to help the person. The care plans have information about who helps people with decisions if they haven't capacity themselves." Care plans we looked at contained detailed assessments of people's mental capacity which evidenced regular review. We saw a number of specific consents had been documented and signed for including those for care and treatment, dental treatment, information sharing and photography. Where people did not have capacity to make some or all decisions we saw best interest decisions had been made and appropriately recorded. Best interests decisions had been made in consultation with the person where possible, members of family or advocates. Where an advocate had been used there was documentation to show how that person had been selected. The manager told us, "An advocate comes every six weeks to see people who do not have any other support."

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. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. In the PIR the provider told us, "In the next 12 months we will keep high on staff agendas awareness of the Cheshire West case and DoLS." We saw care plans contained individual mental capacity assessments and that people who used the service were appropriately supported.

At the time of our visit all the people who used the service had a DoLS in place, and we saw that these had been completed correctly. We saw staff had received training to support their understanding of the implications of people having a DoLS in place and those we spoke with demonstrated they were aware of how these affected individual people who used the service.

People's health needs were met with input from a wide range of healthcare professionals including GPs, dieticians and speech and language therapists. Visits were documented and care plans adjusted as required in response to external input.

The provider supported people to have a healthy diet which met their needs and preferences, detailed in the 'Meals and Mealtimes' policy. This contained information to ensure the approach to nutrition and hydration was effective and enjoyable. For example the policy stated, 'This home believes that every service user has the right to a varied and nutritious diet that provides for all of their dietary needs and offers health, choice and pleasure. To accomplish this each resident will be asked for their individual food preferences as well as their cultural, religious or health needs and these will be taken into account when planning menus.'.

Care plans contained nutrition assessments which listed any known allergies, general appetite, favourite foods and known digestive problems together with guidance for staff enable them to provide effective support with food and drink. We saw planned menus were referred to an external dietician to ensure dietary value was maintained. The manager showed us a large variety moulds which they had purchased so that food which had been softened could be shaped to reflect what it was, meaning people who needed a softened diet were served meals which could be given a more appealing appearance to stimulate appetite.

We saw meals were prepared in a homely kitchen and people who used the service were able to observe or participate in the process if they chose to. The manager showed us a range of easy read cookbooks which supported people to retain or develop independence with cooking and baking if they wished.
One person who used the service had been appointed a 'food champion', and was actively involved in asking people what they wished to see on menus.

Good

Is the service caring?

Our findings

People we spoke with said their relatives lived in a caring environment. One person told us, "When I took [name of person] back after taking them out she didn't hesitate to take her seatbelt off. I could see from her reaction how happy and settled there she is." Another person said, "It has all been very positive so far. After a number of years I can finally relax." People told us they knew who their relative's key worker was and most said they had regular contact with them. One person said, "They keep us updated with how things are going." Another person told us it was the manager and not the key worker who updated them when needed. Staff we spoke with were able to tell us in detail about the care and support needs, likes and dislikes and preferred routines of people for whom they were key worker. A key worker is a member of staff who works more closely with a person using the service. They spoke with fondness about people who used the service and we observed caring and patient interactions throughout our inspection.

People who used the service were provided with an easy read format service user guide. This meant the information was presented in an accessible, easy to understand way appropriate for people with learning disabilities. Information included detail as to people's rights whilst using the service, and what they could expect from living there.

Care plans contained detailed information as to people's likes and preferences and we saw these were being update to ensure they were all written in the person's voice, for example using phrases such as 'I like' and I prefer' rather than '[name of person] prefers.' Most were already written in this way. Information emphasised people's individual character and was arranged under headings such as 'What people like and admire about me', 'What is important to me', and 'How best to support me.' Staff we spoke with told us they found this information useful in forming positive relationships with people who used the service and we saw evidence that it was reviewed and updated regularly. One member of staff said, "We discuss strategies for getting to know people, there's a real sense of pride when we establish good communication with someone."

People who used the service looked well cared for, with clean, well presented clothing and personal grooming attended to. This is achieved through good standards of care. We observed people were relaxed and comfortable in the presence of staff throughout the inspection, and saw staff were patient with and focused on the person they were assisting or socialising with. People were free to choose how and where they spent their day, for example one person decided to retire to bed in the afternoon, and another asked members of staff to play cards with them.

Relatives of people who used the service told us the provider involved them in the care planning processes. One person said, "They tell you what's going on. We get invites to meetings to review [name of person]'s care."

Staff we spoke with had a good understanding of how to respect people's privacy and dignity, and told us about ways in which they were mindful of this as they worked. One member of staff said, "I always make the person aware of what I'm going to be doing, and ask if it's ok with them. I talk them through whatever it is

and keep watching their reactions so I can make sure I pace it all to suit them." Another told us, "I make sure I knock on doors, close curtains when I need to and ensure they are always covered with a towel as much as possible when they are having a bath." We observed staff interacting with people who used the service throughout the inspection. We saw they spoke to people with respect and patience, and used appropriate touch and humour to enhance their communication. We saw staff routinely knocked on people's doors and asked people what they would like to do.

Good

Is the service responsive?

Our findings

In the PIR the provider told us about how they kept up to date with and promoted good practice and the work they were undertaking to become accredited with relevant bodies. They said, 'Our deputy manager is completing a level five diploma in Health and Social Care. This is to ensure they maintain their skills and good practice to enable her to develop. There are eight members of staff completing level two or three diplomas at present. An award is given to a member of the staff team as employee of the month – achieved by showing dedication, respect, dignity and person centred care. We are in the process of accreditation with the National Autistic Society to gain more knowledge and experience about the specifics of autism.'

Care plans showed the provider undertook a detailed assessment of people's needs before they started using the service. This included assessments of physical care, nutrition, continence, mobility, communication and tissue viability. This meant the provider was able to determine whether they could meet a person's care and support needs before they started using the service.

Information from initial assessments was used in developing a range of individual care plans to ensure people who used the service had their current care and support needs met. The provider told us in the PIR, 'If a service user's needs change, appropriate advice from professionals is sought and where necessary staff training is provided.' We saw care plans included a range of person specific care plans covering areas such as night care, dementia care, pain management, personal care needs and intellectual and social care needs, which also covered any support the person needed to meet their religious needs. These individual care plans had information to help them understand how each person liked to be supported. For example we saw in one person's medication care plan, '[Name of person] likes their medication to be given on a spoon. Care workers should explain what the medication is. [Name of person] will like a drink afterwards.'

We saw people were well supported if they had to go into hospital for a period of time. Hospital passports were in place to ensure that important information about people's health, care and support needs was handed over to hospital staff in an effective way. In addition the manager told us, "When someone has to go into hospital a member of staff will also go and stay with them the whole time to make sure there is someone familiar there to support them."

We looked at records which showed people had access to a wide range of meaningful activities. There was a regular programme of 'Big Days Out' including trips to the theatre, football, concerts, spa breaks and short breaks. People who used the service were encouraged to suggest ideas for these days out. One person had been supported to undertake voluntary work with a charity and we saw people had opportunities to participate in other regular activities such as horse riding, gardening, cookery, head massage, aromatherapy and music therapy along with activities within the home which they could choose at any time. Care plans included an evaluation of activities including outcomes and ambitions. We saw in one person's care plan they had enjoyed a number of activities and expressed a wish to go out more. There was a plan in place to achieve this which included monitoring the improvements to their health and well-being as a result. The manager told us, "Activities are a way of giving people choice and control. Seeing people grow in confidence and try new things is so important."

We saw people had been supported to personalise their rooms, planning colour schemes and going out to buy accessories and furniture. We looked in a number of rooms and saw each one reflected individual personalities, with evidence of activities the person had participated in. One bathroom had been fitted with a sensory bath which was equipped with water jets and lights which responded to music which was chosen by the person using it. This meant people who used the service could enjoy a very personalised therapeutic experience.

The provider had a robust complaints policy in place, and we saw they had made this available to people who used the service in an 'easy read' format. There were also easy read complaints and compliments forms which supported people who used the service to be independent in giving feedback. We spoke with relatives of people who used the service and asked about their experiences of making complaints. One person told us, "I would speak to the manager – I have raised an issue in the past and the provider listened and took action." Another told us they had made a complaint by phone and said they had received an apology and an assurance that action would be taken.

We saw that people who used the service and their relatives were consulted about their experience in a number of ways. For example three monthly resident meetings and an annual survey. We saw meetings were used as an opportunity to discuss a number of things including the running of the home and making suggestions for further improvements and activities. We looked at the record of the most recent meeting and saw people had been asked in turn about their aims and ambitions and we saw evidence the comments captured were used in the planning of the 'big days out' programme. In addition we saw there had been a discussion about abuse and what people who used the service could do if they suspected they or another person were being abused. At the time of our inspection the outcomes of the most recent survey had not yet been collated but the area manager told us, "They are being prepared now so that they are available to the manager when we start the next business planning activity for 2016-17."

A comments book had been placed in the entrance hallway and we looked at the feedback people had left. This was all positive and included. 'Superb care for all clients – beautiful home and very caring staff,' 'Fab home, always a clean and happy environment and the friendliest staff around,' and 'What a lovely visit I had with [name of person].' Some comments had been left by visiting professionals including, 'The staff here are very attentive to service user's needs and willing to learn new skills. A pleasure to be involved.'

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Good

Is the service well-led?

Our findings

At the time of our inspection the manager was not registered with the CQC, but we saw evidence an application had been submitted and was under consideration. Staff we spoke with told us they had confidence in the manager and felt the service was well led with a positive and supportive culture. One member of staff told us, "The culture here is excellent. I was supported so well when I started. It's so good I feel like I'm at home when I'm at work." Another said, "It's an open-door culture here. The manager is easy to talk to." Staff spoke in positive terms about working in the service and told us they enjoyed and took pride in what they did. The manager told us they had regular visits from the provider's senior management who they described as 'encouraging' and 'supportive.'

The manager ensured staff had an opportunity to attend meetings to discuss operational issues and contribute to the running of the service. We saw these meetings happened regularly and looked at the minutes of the most recent meetings. There was a comprehensive standard agenda which covered items including infection control, the role of champions within the service, training and shift cover. Meetings also evidenced discussion and open communication about incidents and other current issues within the home. Minutes were produced and circulated which ensured transparency and good communication within the service. We saw the manager asked staff to sign to confirm receipt of and agreement with the minutes. Staff told us they found the meetings useful and felt they could speak openly. One member of staff told us, "Everyone is very free to speak and we know we are listened to."

We saw evidence people who used the service were involved in the running of it. For example people were routinely involved in the interview process for new staff and one person had been on the interview panel when the manager was appointed. In addition people who used the service had ongoing active roles as 'champions', meaning they had opportunity to be consulted about and influence specific areas of the service delivery. For example there was a food champion who helped the provider understand what people who used the service liked to eat, and a photography champion who documented activities and special occasions within the home. People were supported in activities associated with being a champion with equivalent champions from the staff team.

The manager and provider worked together on a rolling programme of audits to measure and improve the quality of delivery in the service. We saw people's care and support needs were regularly reviewed along with their finances and there were processes in place to ensure outcomes of audits were analysed to ensure that any trends were identified and lessons learnt. Audits included accidents and incidents, medication, infection control and cleanliness. The provider also made regular audit visits and we saw action plans were in place where needed to drive improvements in the service.