Leeds Jewish Welfare Board

Cranmer Scheme

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Cranmer Scheme is a 'care home'. People in care homes receive accommodation and personal care under a contractual agreement. CQC regulates both the premises and the care provided and both were looked at during this inspection.

Cranmer Scheme is registered to provide accommodation and personal care for up to 16 people who have learning disabilities.

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.

This inspection took place on 3 and 6 August 2018. The inspection was unannounced on the first day. This meant the staff and provider did not know we would be visiting. The second day was announced.

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

People living in the home told us they felt safe and staff had a clear understand of the procedures relating to safeguarding and whistleblowing. Medicines were managed safely however we did find some recording issues which we addressed with the registered manager. People told us they received their medicine as prescribed.

Risk assessments were carried out and reviewed regularly or when needs changed to ensure risks were minimised. Accidents and incidents were managed effectively with trends and themes monitored to prevent re occurrences. The registered manager carried out an annual review of incidents with lessons learnt to prevent this from happening again.

There was enough staff to meet people's needs and recruitment procedures were robust. Staff told us they were supported by the management team and had regular supervisions with annual appraisals to consider development opportunities. New staff completed an induction programme and staff completed training in line with the provider's policy.

Staff were caring and kind. People were treated as individuals and staff ensured people made their own decisions when possible about their care and how they wished to live.

Care plans were person centred and detailed with instructions for staff to follow. People's preferences, likes

and dislikes were recorded which helped staff get to know people and to care for them in a way they wished to be.

People were encouraged by staff to remain as independent as possible and people set themselves goals to achieve so they could fulfil their wishes.

Staff supported people with their specific nutritional needs and where a person was at risk of choking, there was clear instruction for staff to follow to prevent an incident. People living in the home had annual health checks and regular appointments with health professionals to maintain their wellbeing.

Staff told us the management team were supportive and described them as "fantastic". People living in the home felt confident any concerns raised would be addressed by the registered manager.

Audits were carried out to monitor the quality of care being provided and meetings took place with people and their relatives to gather feedback on the service being provided. This meant the provider had an insight into the improvements required within the home.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Cranmer Scheme

Detailed findings

Background to this inspection

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

This comprehensive inspection took place on 3 and 6 August 2018. It was unannounced on the first day and was carried out by one inspector. The second day was announced.

Before our inspection, we reviewed all the information we held about the service, including previous inspection reports and statutory notifications sent to us by the provider. Statutory notifications contain information about changes, events or incidents that occur at the service that the provider is legally required to send us. We also contacted the local authority, commissioners, safeguarding team and Healthwatch to gather their feedback and views about the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

Before the inspection, the provider completed a Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.
During our inspection we were informed by the registered manager that some people were not able to verbally communicate. This meant we were not able to gather every person's views verbally but we did this through observation of their interactions, behaviours, mood and relationships with staff.

We spoke with three people living in the home, two senior care workers, two deputy managers, and the registered manager. We spent time looking at documents and records relating to people's care and the management of the service. We looked in detail at three people's care plans, three medicine records, two staff personal files and a variety of policies and procedures developed and implemented by the provider.

Good

Is the service safe?

Our findings

People living at the home told us they felt safe, comments included, "Of course I do (feel safe), I like living here, its lovely" and "I don't get worried about anything, I enjoy it here." Staff had an understanding of how to protect people from possible abuse or harm and followed the provider's safeguarding and whistleblowing policies which instructed staff of what action to take in the event they had any concerns.

Risk assessments were carried out, regularly reviewed and updated when people's needs changed. One risk assessment had been updated when a person had a fall down the stairs. Following the fall, the person was encouraged to use the lift until they felt confident to use the stairs and sensors were put in place in the persons best interests so staff were alerted to their movements so they could support the person. We found the risk assessment had been effective as there had been no further falls recorded. Another risk assessment was put in place for a person at risk of choking, this provided detailed instructions for staff to follow to ensure the risk was reduced. For example, "Staff to sit with the person when eating and for 20 minutes after to reduce the risk of reflux". Thickening fluids were also used in drinks to prevent choking.

Accidents and incidents were managed effectively with lessons learnt to prevent re occurrences. The registered manager collated together accidents for each year to identify any trends and themes.

There was enough staff to meet people's needs. We checked staffing levels which confirmed this. Staff recruitment was robust with relevant checks carried out to ensure people were safe to work with vulnerable people. People living in the home were involved in the recruitment and interviews of new staff. The manager had been proactive in changing staffing levels depending on people's needs. The registered manager acknowledged that some people were waking in the night and needed support. The Registered Manager therefore approached the provider and relevant resident's Care Managers to review the service and also the individual resident's care packages; waking night staff are now employed within the service to meet the resident's care needs.

Medicines were managed safely. People told us they received their medicines as prescribed and we observed staff carrying out a medicine round when we arrived. We saw the staff member checking the MAR with a second staff member there, to witness and check that signatures have been completed to prevent medication errors.

Some people received 'as required' medicines and we found protocols were in place to inform staff of when this was needed with dosages recorded and body maps to show where creams should be applied. Covert medication was used for one person and this had been agreed following a best interest meeting. We found there were clear instructions for staff on how to covertly administer including what specific foods the medicines should be put into and at what temperature, for example, cold foods only. This was to prevent any adverse effects that food could have with the medicine.

Health and safety checks had been carried out to ensure the premises was safe for people to live in. People living in the home had Personal Emergency Evacuation Plans (PEEPs) which provided instruction to staff on

how to support people to leave the home in an event of emergency. There was an infection control policy which staff followed and we observed staff wearing personal protective equipment when preparing foods, washing their hands regularly and encouraging people living in the home to wash their hands to prevent against infectious diseases.

Good

Is the service effective?

Our findings

People living in the home told us staff had the skills and knowledge to meet their needs. Comments included, "Staff are lovely if you have any problems they sort it for you. Staff are well trained" and "They are helpful and very nice people to work with."

New staff completed a week-long induction programme at the provider's head office which included all aspects of training and then shadowing of staff in the home. The registered manager told us new staff also completed the Care Certificate and that some staff had completed additional training to become Care Certificate assessors. This meant staff within the home were able to assess if new staff had completed their Care Certificate to a high standard. This is a set of standards that social care and health workers follow as recommended by Skills for Care, an independent registered charity which sets the standards and qualifications for care workers.

Staff received regular supervisions and annual appraisals which followed the provider's policy. Staff told us they received support and were encouraged to develop their skills. For example, one staff member had ambitions to become a deputy manager and they were being supported by the registered manager to do this and to gain further knowledge by completing an NVQ.

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 that 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).

The provider was following the MCA. Where the provider had concerns regarding a person's capacity to agree to informed decisions about their care and support, care plans recorded assessments that had been completed. Where decisions were made on a person's behalf, best interest decisions were recorded. Where restrictions were needed to keep people safe, applications for DoLS had been submitted to the local authority for further assessment and approval.

People were supported with their nutritional needs and staff prepared food people had chosen. People were encouraged to provide feedback about their food experiences in a survey so any issues could be corrected immediately. People had individual nutritional plans for their needs. One person required food to be cut into small pieces and given finger foods to avoid choking. We observed lunch and saw people were given food that they had chosen and said they enjoyed. We also observed staff offering drinks and for those people at risk of choking, thickeners were added to drinks to reduce the risk.

People had annual health checks and told us if they needed to see a health professional that this was arranged. One person told us the staff booked and supported them to their appointments. We saw records

of input from health care professionals and follow up appointments being arranged when needed. People with specific needs such as diabetes or epilepsy were supported by specialists and care plans included specific instructions for how staff should support people's individual needs. The registered manager told us people were always re assessed if they had been in hospital and pre-discharge meetings held to determine their level of needs before transferring back to the service.

Following an environmental audit and discussion within a resident's forum, the provider had made changes to the environment based on peoples wishes. For example, people living in the home had picked what wall paper they wanted in the lounge before this was decorated. People also request for their names to be put on their doors during the resident's forum and this was in place when we inspected. The home had made reasonable adjustments with widened corridors and doors for those people who used wheelchairs. This made it easier for people to move around the home without incident.

Good

Is the service caring?

Our findings

People told us staff were caring and kind. One person said, "Everything about this place is nice, staff are excellent and I have good relationships with them." We observed staff being respectful when supporting the person with their diverse needs and when assisting with personal care. Staff were aware of the persons individualised needs and this was observed.

We found people were involved in making decisions within the home. People were encouraged to attend a 'resident's forum' to give their ideas and the registered manager and provider gathered feedback from people about what worked well and what didn't. We saw evidence that people had been consulted about how care plans should be written to ensure people understood them. We also saw people had been consulted on the decoration of the home. People living in the home had requested training on first aid and this was arranged by the registered provider and positive feedback was obtained from the people that attended.

Staff respected people's privacy and dignity. One person told us staff always knocked on their door before entering. Staff told us they would always ask for consent before carrying out any personal care and if people declined support, they would respect this decision.

Staff encouraged people to remain independent. One person told us that they were no longer able to use the buses to get around due to their mobility but they continued to go out independently by using taxis to go shopping. A staff member told us about one person who was previously very dependent on support but through encouragement from staff they had built upon their independence skills and were now able to do most things for themselves.

Some people living in the home were not able to verbally communicate and the provider carried out assessments to determine how best to communicate with people. For example, some people communicated with facial and hand gestures, other people used objects to communicate and one person had identified their own means of communication with signs and words. We saw staff over time had understood the person's own language used. Staff also devised a list for staff and others so they could understand the needs of the person. For example, the care plan stated, '[Name] can let others know when they wish to do something and also when they don't. [Name] is unable to read or write. [Name] prefers pictures and photos. Placing a fist in palm, this means [Name] would like some bread, this could be a slice of bread, toast or a sandwich.'

One person living in the home struggled to communicate and the registered manager told us they were very isolated. The staff considered ways to improve this person's quality of life. The staff knew the person previously had a cat and bought an interactive cat (a cat that has a computerised system so it reacts like a real cat would) for the person. This had been effective as the person spent time engaging with the cat, improved communication with staff and reduced isolation. The registered manager told us that because it had been so effective they bought another interactive cat for others to use in the home.

Some people living in the home had an advocate to help them make decisions about their care. We saw people's advocates and (RPR) Relevant People's Representatives were involved in reviews of care and at best interest meetings to ensure the person's wishes were reflected in meetings. The registered manager told us the they used advocacy services and closely liaised with them about people's care.

Information about people was kept securely in locked cupboards and the provider was compliant with the Data Protection Act. Staff told us they were aware of keeping personal information confidential and they knew how to access this information.

Good

Is the service responsive?

Our findings

Initial assessments were carried out to ensure the provider could meet people's needs before moving into the home. We looked at three care plans which were very person centred and reflected people's preferences, likes, dislikes and goals to be achieved. For example, one person who had previously fallen on the stairs set themselves a goal to start using the stairs to build upon their confidence, mobility and independence which had been achieved. We saw staff had recorded people's favourite foods and things they didn't enjoy which staff respected and were aware of.

Reviews were individualised and staff met with people living in the home to discuss what goals they wished to achieve and what their good and bad days looked like so staff could support them in a person-centred way. Reviews took place regularly with relatives and other health care professionals invited to attend.

People were encouraged to participate in activities they enjoyed and some people regularly attended local day services. One person told us they attended a drama class and participated in pantomimes every year. The person said they enjoyed their activities and said they had been doing this for many years. They also told us about the holidays they went on and that it was their choice on which destinations they went to.

The registered manager told us the service often arranged an array of activities with other care homes managed by the organisation to ensure people were not isolated. Some of these included sponsored walks and a 'bake off' with other services in the local area. People were also encouraged to continue to have relationships with friends and family. One person told us they regularly write to their sister who lives in another country, with support from staff.

People were treated as individuals and were offered choices. Care plans instructed staff on how people's individual needs should be met. For example, one care plan stated '[Name] has shown a preference to have a bath in a morning on waking up. Staff will need to run the bath and check the temperature.' Another care plan stated, '[Name] will choose his clothes.'

The registered manager was aware of the Accessible Information Standard that was introduced in 2016. This standard aims to make sure that people who have a disability, impairment or sensory loss get information that they can access and understand. They told us they provided and accessed information for people that was understandable to them.

Complaints were managed with appropriate actions taken to ensure these were investigated and resolved. People told us they felt their concerns would be listened to and managed effectively. The registered manager kept a log of all complaints and compliments. In the main entrance there was a book 'tell us what you think' and within this, comments included, '[Name]'s relative said that it is absolutely fantastic and is positive that the care [Name] receives contributes greatly to [Name]'s longevity' and '[Name] views the care in the home to be very person-centred. Documentation reflected personalised aspects of client's needs. Staff clearly care about the residents and their wellbeing, very impressed.'

Good

Is the service well-led?

Our findings

There was a registered manager who had been working at the home for many years and knew people well. Staff told us they were fully supported by the registered and deputy managers. Staff told us, "The support is amazing, fantastic and they are all really approachable." Staff and the management team all believed in the same values and beliefs that people living in the home were at the centre of everything they did. Staff said, "We are a strong team and always there for each other. This is such a good home and everyone gets high quality care. People here really do get good care."

We saw monthly staff meetings had taken place. One staff meeting had focused on the CQC key lines of enquiry to ensure staff had an understanding of what is to be expected when delivering care. The provider used the word 'screw' which was a shortened term for safe, caring, responsive, effective and well led. The deputy manager said the philosophy for the service was "The screw in the wood holds the home together."

Resident meetings took place monthly and relative meetings were held. The meetings asked people for their views in order to improve the service. The meetings documented 'what we said, what we did and what to complete.' One person had asked to have bird feeders put in the garden and this had been completed. People had asked to be involved in the management of the health and safety of the home and this had been agreed.

The provider had positive community links with other services. The Deputy Manager told us they were currently planning for a pony to be brought to the service after they had contacted a local service. People in the home also told us they attended several day centres and groups within the community which they enjoyed.

The registered manager said they were always looking to improve the service and in recent times had made reasonable adjustments due to people's needs becoming more complex. For example, they had recently employed waking night staff as some people now required support in the night. At the last inspection all medicines were stored in a cupboard in the office however, there was now a medicines trolley which was kept locked and attached to an anchored lock when not in use. This improvement meant staff could bring medicines to people rather than them having to come to the office upstairs.

The registered manager told us that they often used lessons learnt to drive improvements within the home. During one incident where the lift was faulty, and people living on the top floor could not use the stairs, they acknowledged the need for further equipment. In order to support people out of the building. an 'E-vac' chair which can be used to support people downstairs should they not be able to use them, was purchased and installed.

The Quality Assurance Team and the registered manager carried out audits to monitor the quality of care being provided. We saw regular audits for medicines, staff recruitment, care plans, mattress audits and infection control. The audits highlighted areas for improvement and found actions had been taken to address these. For example, in one side of the home there had been medication issues we saw at the next

audit these had been addressed with improvements made.

At the last inspection we found the provider had not completed surveys to gather people's views and told us this would be looked at. At this inspection the registered manager told us they gathered people's views and feedback during one to one time and in resident meetings. People living in the home told us should they need to raise any concerns they would all feel comfortable to discuss this with the registered manager.