Willerfoss Homes

Cedarfoss House

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?	Outstanding

Summary of findings

Overall summary

Cedarfoss House is a care home for up to 18 people with a learning disability or with autistic spectrum disorder. The home provides support and residential care. There are two floors and bedrooms are located on both floors. People who live on the first floor need to be able to use the stairs as there is no passenger lift. On the day of the inspection there were 13 people living at the home and one person having respite care.

At the last inspection in January 2015, the service was rated as Good. At this inspection we found that the service remained Good.

There continued to be sufficient numbers of staff employed to make sure people received the support they needed, and those staff had been safely recruited. People indicated to us they felt safe living at the home.

Staff had continued to receive appropriate training to give them the knowledge and skills they required to carry out their roles. This included training on the administration of medicines and on how to protect people from the risk of harm.

People were supported to have maximum choice and control over their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Staff were kind, caring, compassionate and patient. They respected people's privacy and dignity and encouraged them to be as independent as possible.

Care planning described the person and the level of support they required. Care plans were reviewed regularly to ensure they remained an accurate record of the person and their day to day needs.

People's relatives told us they were aware of how to express concerns or make complaints, but they had not needed to make any complaints. People were also given the opportunity to feedback their views of the service provided.

The registered manager continued to lead the team with a positive and pro-active style of management, and they went 'over and above' their duties and responsibilities. They provided us with a variety of evidence to demonstrate that leadership at the home continued to be 'outstanding'.

The registered manager carried out audits to ensure people were receiving the care and support that they required, and to monitor that staff were following the policies, procedures and systems in place.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Cedarfoss House

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 registered 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 was a comprehensive inspection that took place on 8 and 10 March 2017 and was unannounced. That means the registered provider did not know we would be inspecting. The inspection was carried out by an adult social care inspector.

Before this inspection we reviewed the information we held about the home, such as information we had received from the local authority and notifications we had received from the registered provider. Notifications are documents that the registered provider submits to the Care Quality Commission (CQC) to inform us of important events that happen in the service. We received feedback from two of the health care professionals we contacted. The registered provider was asked to submit a provider information return (PIR) before this inspection. The PIR is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. The PIR was submitted within the required timescale.

On the day of the inspection we chatted to three people who lived at the home and also carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not communicate with us. We spoke with a health care professional, a team leader and the registered manager. We looked around communal areas of the home and some bedrooms, with people's permission. We also spent time looking at records, which included the care records for two people who lived at the home, the recruitment and training records for two members of staff and other records relating to the management of the home, such as quality assurance, staff training, health and safety and medication. On 10 March 2017 we spoke with two members of staff and two relatives over the telephone to gain their feedback.

Good

Is the service safe?

Our findings

Staff described to us how they kept people safe. One member of staff said, "We check for hazards in the environment" and another told us, "If we see that people have a bruise, we always follow it up." People's relatives told us that they felt their family members were safe living at the home, and a health care professional told us, "I have seen staff using the hoist to assist people to mobilise and it has always been done safely. Staff ask for advice to make sure they are doing this in the safest way possible."

Care needs assessments had been carried out, and when risks had been identified, action was taken to minimise potential risks without undue restrictions being placed on people. We saw risk assessments in respect of choking, the administration of creams and the use of bed rails.

Staff had received training on safeguarding adults from abuse. They were able to describe different types of abuse they may become aware of and the action they would take to protect people from harm. Staff told us they would not hesitate to use the home's whistle blowing policy.

We observed there were sufficient numbers of staff on duty and this was supported by the relatives who we spoke with. Staff were visible in communal areas of the home and people received attention promptly. Standard staffing levels during the day were the deputy manager, a senior support worker and two support workers. During the night there were two support workers on duty. One person received one to one support for 14 hours a week and this was also recorded on the staff rota. Rotas evidenced that these staffing levels were consistently maintained. There was a domestic assistant and a cook on duty for five days a week; support workers provided meals over the weekends.

We checked the recruitment records for two members of staff. These records evidenced that references and a Disclosure and Barring Service (DBS) check were in place prior to people commencing work. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and helps to prevent unsuitable people from working with children and vulnerable adults. This meant that only people considered safe to work with people who may be vulnerable had been employed at Cedarfoss House.

Each person who lived at the home had a medicines information sheet that recorded their prescribed medicines, any allergies and known side effects. We saw that medicines were stored safely, obtained in a timely way so that the person did not run out of them, administered on time, recorded correctly and disposed of appropriately; this included the management of controlled drugs (CDs). Audits were carried out and any shortfalls were recorded in an action plan; staff were informed so that corrective action could take place.

Accidents and incidents were recorded, were analysed each month and were audited to identify any patterns that might be emerging or improvements that needed to be made.

There was a contingency plan that provided advice for staff on how to deal with unexpected emergencies,

and each person had a personal emergency evacuation plan (PEEP) in place that recorded the assistance they would need to evacuate the premises. Fire drills were undertaken to ensure people knew what action to take in the event of a fire.

We reviewed service certificates and these evidenced that equipment and systems had been appropriately maintained. This included the fire alarm, fire safety equipment, mobility and bath hoists, the electrical installation, the call system, portable electrical appliances and gas safety. Weekly and monthly checks carried out by the home's maintenance person were clearly recorded.

Everyone who we spoke with told us that the home was maintained in a clean and hygienic condition and we observed this on the day of the inspection. A relative told us, "When I visited [Name of family member] the other day their room was beautiful."

Good

Is the service effective?

Our findings

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw the DoLS applications that had been submitted to the local authority for authorisation. The registered manager told us they were still waiting for these to be authorised.

Staff had received training in MCA and DoLS and we found that they had a good understanding about people's rights and the importance of obtaining people's consent to their care. It was clearly recorded when decisions had been made in the person's best interest when they did not have the capacity to make the decision themselves. Staff described to us how they helped people to make day to day decisions, such as which meal to choose, what clothes to wear and what activities to take part in.

Staff received two days induction training with the home's trainer when they were new in post. Staff who were new to the caring profession were also required to complete the Care Certificate; this ensured that new staff received a standardised induction in line with national standards.

Training records showed staff had completed training on the topics considered essential by the home, including MCA / DoLS, nutritional needs, epilepsy awareness, moving and handling, first aid, fire safety, food hygiene, infection control, safeguarding adults from abuse and health and safety. Staff who had responsibility for the administration of medication had also completed training on that topic. Records showed that staff had completed some additional training such as dementia / autism awareness and nutrition / diabetes. The notice board displayed details of eight training sessions booked for staff during March and April 2017.

We saw evidence to show that staff received regular supervision (including a supervision meeting during their induction period) and a six monthly appraisal. This meant staff had the opportunity to meet with a manager to discuss any concerns and their development needs. Supervision meetings were also designed to test staff's knowledge on certain topics, such as whistleblowing and health and safety.

People were supported by GPs, community nurses and other health care professionals and all contacts were recorded. We saw any advice sought from health care professionals had been incorporated into care plans. One health care professional told us, "Staff always ask for a copy of the paperwork so they can add it to the person's care plan."

People's special dietary requirements and their likes and dislikes were recorded in their care plan and we saw people had appropriate nutritional assessments and risk assessments in place.

There was a menu on display that included words and pictures to help people understand the meal choices. The registered manager told us the menu was based on people's likes and dislikes. We observed the serving of lunch. Some people did not require any assistance, some people had adapted crockery so they could eat

their meal independently and other people were assisted to eat and drink to ensure they received sufficient quantities and that they received their meal safely. People's food and fluid intake was recorded when this had been identified as an area of concern.

The home had no passenger lift and people who had rooms on the first floor were able to use the stairs without assistance. We observed that people who could mobilise independently walked around all areas of the home without restriction and had no problem with finding their way around. There was a lounge with a TV and a quieter lounge with music playing; this gave people a choice about where they would like to spend their day.

Good

Is the service caring?

Our findings

We observed that staff were kind, caring and patient. Our chats with people who lived at the home indicated they were happy with their care. Comments from relatives included, "The staff are really good with [Name of family member]" and "[Name of family member] loves it at Cedarfoss." A health care professional had recorded in the compliments book, 'Staff are caring, compassionate and knowledgeable about service user needs" and a paramedic had recorded, "We found staff very supportive and caring during a very stressful time." A member of staff said, "We are genuinely caring people."

The SOFI inspection we carried out showed that staff interacted with people appropriately and continually checked that they were happy and their needs were being met. They encouraged people to interact with books and equipment specific to their needs to provide them with stimulation.

People had been allocated a key worker. A key worker is someone who takes a special interest in the person and is their main link with the staff group. There was a record of the 'quality' time people had spent with their key worker.

A relative told us that staff respected people's privacy and dignity. They said, "I have never heard or seen anything to concern me." A health care professional told us that they were always found a space where they could talk to people privately. Relatives told us that staff also promoted people's independence. One relative described to us how their family member was encouraged to take part in activities and to attend a local day centre, "Otherwise they would prefer to stay in bed each day." One person had Sky TV installed in their bedroom and received the Sky TV magazine every week, so they could choose the programmes they wanted to watch.

Relatives told us they were kept informed about their family member's well-being. Comments included, "I was even telephoned about a period of bad weather when the electricity supply failed and told that [Name of family member] was fine" and "The staff always keep me informed of GP and dentist appointments." One relative told us they received a progress report about their family member. A newsletter had been produced for Cedarfoss House and their 'sister' service and this included information about staff champions, improvements to the environment and activities.

Although people who lived at the home were not formally involved in staff recruitment, they were asked for their opinion about prospective applicants. This involved them in making decisions about some aspects of how the home was operated.

The notice board included information about Independent Mental Capacity Advocates (IMCAs). IMCAs provide support for people who lack the capacity to make their own decisions and have no-one else to represent them.

We saw that written and electronic information about people who lived at the home and staff was stored securely. Staff were required to sign a statement when they commence employment at the home to record

they understand the importance of confidentiality.

Good

Is the service responsive?

Our findings

Relatives told us they were consulted about their family member's care needs when they moved into the home, and advice was also sought from health and social care professionals. This helped the service to develop an individual plan of care under the headings 'Information you need to know about me' and 'Information about how to support me'. We checked the care plans for two people who lived at the home. We found they included information that described the person's personality, individual care and support needs and their previous lifestyle in a 'one page profile'. A 'circle of support' document recorded health and social care professionals who were involved in the person's care plus family contact details.

Care plans were reviewed each month by staff and more formal reviews were held with commissioners and relatives. This provided an agreed and current record of each person's care needs. A new care plan summary had been developed which made it easier for staff to keep up to date with people's care needs. Daily handover meetings ensured staff were provided with the latest information about each person who lived at the home.

When a person displayed behaviour that could put themselves or others at risk of harm, advice had been sought from health care professionals about how best to manage the behaviour. This was recorded in the person's care plan so it was available for all staff to follow.

People were supported to keep in touch with family and friends. Some people visited their relatives and other people were supported to keep in touch with family and friends by telephone.

Activities were carried out by care staff as part of their day to day duties. There was an activities plan on display; activities included arts and crafts, boccia, trips out, bingo and an exercise class. There was a slot on the board for the dates of residents meetings and people's birthdays to be added when relevant. Activities were carried out by care staff as part of their day to day duties.

A relative told us, "People at the home are getting older now so it is more difficult to engage them in activities. Staff used to take [Name of family member] out but they are not interested in going out now." This was also raised by a member of staff. They told us that they were looking again at activities to make sure they were age appropriate.

There were policies and procedures in place that informed people how to express concerns or make a complaint. We checked the complaints log and saw there had been no formal complaints during the last year. One person who lived at the home had expressed a concern and there was a record of how this had been dealt with to their satisfaction. Relatives told us they would not hesitate to speak to the registered manager or deputy manager if they had any concerns, and they were certain they would try to help. One relative said, "I would speak to one of the managers. They would listen to me and try to put things right."

People had an opportunity to express their views on the care and support provided at monthly 'resident' meetings. The minutes showed that menus and activities were discussed, and that people were asked if they

were happy with their care. The minutes were produced in pictorial format.

Outstanding ☆

Is the service well-led?

Our findings

There was a registered manager in post who was registered in December 2012. 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. This provided consistency for people who lived at the home in respect of management style and the home's values.

We asked for a variety of records and documents during our inspection, including people's care plans and other documents relating to people's care and support. We found that these were well kept, easily accessible and stored securely. In addition to this, the current ratings for the service awarded by CQC were clearly displayed in the home, as required.

Staff told us they were very happy with how the home was managed. Comments included, "We are listened to" and "The home is well managed and the manager would always try to put things right." A health care professional told us that the registered manager and deputy manager were very involved in people's day to day care, so they were aware of people's individual care needs. They said, "Whatever I do with staff, the manager and deputy always ask for feedback."

At the last inspection of the service we rated the well-led section of the report as Outstanding. This was because the registered manager demonstrated they went 'over and above' to advocate on behalf of people who lived at the home to ensure they received an excellent level of care.

A this inspection it was clear that the registered manager continued to be proactive about supporting people who lived at the home. They had devised a form to record each task people needed assistance with, how many staff needed to carry out these tasks and how long they took. The outcome was used to demonstrate to the local authority that the home needed additional funding to support some people with a learning disability and additional needs to receive optimum care, and this additional funding had been agreed. This had enabled staffing levels at the home to be increased to support people who were living with a learning disability and additional disabilities associated with advancing age. The registered manager told us that the local authority had been impressed with how they had carried out this analysis and had asked if they could discuss the format they used in some forthcoming training. The training had been arranged to discuss the needs of people who were living with a learning disability and additional needs throughout the local authority.

The registered manager was also proactive in assisting the relatives of people who lived at the home. A relative told us that the registered manager had helped them to complete some benefits information for their family member and that they had appreciated this support. They felt that this was 'over and above' the registered manager's role.

The registered manager told us they were always looking for ways to improve. They showed us their

reflective diary. This recorded any areas for learning following training, incidents that had occurred at the home and discussions with health and social care professionals. For example, a staff member from the local authority had suggested that, when people lacked capacity, their care plan should not be written in the first person. This had resulted in some people's care plans being partly reviewed and re-written to reflect that the person lacked the capacity to make some decisions and they would have to be made in the person's best interests.

The registered manager carried out quality audits to monitor that systems at the home were working effectively and that people received appropriate care. These included audits on care plans, health and safety, infection control, accidents / incidents and safeguarding. Some audits included questioning staff about the policy and procedures in place to test out their knowledge and ensure this was reflected in the way they supported the people who lived at the home. The registered manager confirmed that any actions required were followed up in the next audit to ensure they had been completed. We discussed with the registered manager that the accident / incident and safeguarding audits would be improved if they included the details of the actual incidents and the action taken, and this was acknowledged.

The registered manager periodically visited the home unannounced during the night so that they could check the night staff team were adhering to the home's policies and procedures. They felt it was important to check that the excellent care provided to people during the day continued during the night.

The registered manager told us the values of the home were 'To provide a happy home with a safe environment where service users received high quality personalised care'. Staff told us they were a professional team of staff. They said they could question their colleagues practice without them taking offence. They added, "We're a good team of staff. We can talk about anything" and "Good team work is the key." Staff meetings were held on a regular basis and staff told us they had the opportunity to express their views, ask questions and make suggestions at these meetings.

Satisfaction surveys were distributed to health and social care professionals, staff, people who lived at the home and relatives. The survey for people who lived at the home included symbols to aid their understanding. A relative told us, "I receive surveys quite regularly. I have just sent one back." We did not see any analysis of these surveys (although we noted that no issues were raised), but the registered manager told us that feedback was shared with people in 'resident' and staff meetings.