Care Quality Commission

Prospect Housing and Support Services

Cedarwood Lodge

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

Overall summary

This inspection took place on the 5 and 6 February 2015 and was unannounced. At the previous inspection on 29 May 2013, we found that there were no breaches of the legal requirements.

Cedarwood Lodge provides accommodation and care for up to five people with learning disabilities and physical disabilities. At the time of our inspection there were five people living at the service.

The service has a registered manager who was available and supported us during the inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People's needs and wishes were understood and met by staff who had received training in communicating effectively with people. An effective system was in place to gather the views of people or involve people in the development of the service.

The provider had systems in place to make sure people were protected from abuse and avoidable harm. Staff knew how to report suspected abuse and their responsibilities for doing so.

Summary of findings

People's health and support needs were assessed and recorded. There were plans in place to reduce the risks identified in assessments.

People were supported by enough staff. Recruitment procedures were in place and appropriate checks had been undertaken before staff began work.

People were provided with a choice of healthy food and drinks to make sure their nutritional needs were met. People were supported and enabled to participate in activities of their choice.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty these have been authorised by the local authority as being required to protect the person from harm. We found the home to be meeting the requirements for DoLS.

People were supported in a way that promoted their dignity by being spoken to kindly and treated with respect. Staff were caring in their approach to people, giving them attention and not rushing people when supporting them.

Care plans were developed with people to identify how they wished to be supported and goals they wanted to achieve. Plans were regularly reviewed and up to date.

Staff told us they felt supported in their work and felt comfortable raising concerns with the manager or to suggest ideas for improvement. Staff said they found the registered manager to be responsive in dealing with any concerns raised and took immediate action.

The provider analysed and acted on information acquired from quality audits to monitor and improve the quality of care.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. Staff were recruited appropriately to ensure their suitability to work with people and to ensure they had the necessary skills and knowledge. There were sufficient staff to meet people's needs.

People knew who to speak to if they felt worried or unsafe. Staff had received training in safeguarding and knew how to report any concerns.

People had risk assessments in place to ensure their needs were met in a safe way.

Medicines policies and procedures were followed to ensure people received their medicines in a safe way.

Is the service effective?

Good

The service was effective.

Staff had received appropriate training which included specialist training to enable them to communicate effectively with people.

Staff had ensured the rights of people to make decisions were respected.

People were provided with nutritious meals of their choice.

People had access to a wide range of healthcare services to ensure their day to day health needs were met.

Is the service caring?

Good

The service was caring. All the people we spoke to told us the staff were caring or kind. Staff spoke kindly to people.

Staff knew people's personal histories well and what was important to them.

People were cared for by staff that supported people's privacy and dignity.

Is the service responsive?

Good

The service was responsive. People were provided with a range of activities they enjoyed.

People's health, care and support needs were individually assessed and choices and preferences were discussed with people, their relatives and advocates.

People's care plans had been reviewed and updated regularly. People, their relatives and the professionals involved were encouraged to provide feedback and contribute to reviews

Is the service well-led?

Good

The service was well-led.

The service had not developed an effective way to gather people's views about the quality of the service they received.

The provider carried out audits to assess whether the home was running as it should be.

Summary of findings

Records were in good order and incidents and accidents were monitored and reviewed.

Cedarwood Lodge

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 the 5 and 6 February 2015. The first visit was unannounced.

This inspection was conducted by one inspector because of the potential disruption in a small home for five people with complex needs.

On this occasion we had not asked 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.

Before this inspection we reviewed our other records to gather information. For example we reviewed the last inspection report and notifications that the provider is required to send us. A notification is information about important events which the provider is required to tell us about by law and information received from the public and healthcare professionals.

People who lived at the home communicated in different ways. For example, one person used speech and others sounds, actions and body language. We talked with people and used observation to help us understand the experiences of people living in the home. We spoke with two relatives, the registered manager, and four members of staff. We had feedback about the quality of the service from care professionals which included, a local authority care manager and a specialist learning disabilities training group.

We reviewed documents and records that related to people's care and the management of the home. We looked at four people's support plans and carried out pathway tracking for them. Pathway tracking is where we look at a person's care plan and check that this is being followed and their needs met. We did this by speaking with the person, the staff that cared for them and by looking at other records relating to the management of the home. We also looked at staff training and supervision records, three recruitment records, health appointments, risk assessments, behaviour management records, accident and incident records, visitor's comments, complaints records and maintenance records. We looked at all Deprivation of Liberty Safeguards applications (DoLS) to ensure people's rights were protected.

Good

Is the service safe?

Our findings

One person told us they felt safe living in the home. We asked them what they would do if someone upset them and they told us they would "tell him" indicating the manager. Relatives told us they felt their family member was safe, one said they felt their family member was safe because the care was "excellent." People had their right to feel safe and raise concerns explained to them by staff directly. Where people had different communication needs staff also used other methods to support the person to understand their rights. For example, by also using pictorially supported leaflets about reporting abuse. Staff told us that where people had limited communication they looked out for signs of abuse by observing their body language and mood. Health care professionals told us they felt people were safe and well cared for. They also said they had no concerns about this home and we know how to report and would report any concerns they had.

The registered manager had systems in place that ensured safeguarding concerns were reported appropriately to the local authority safeguarding team. There were policies to inform and direct staff and posters advertising places to report abuse and people to contact for support. Staff received training in safeguarding adults and this was refreshed as necessary. Discussions with staff showed their training had been effective. This was because staff demonstrated a good understanding of their own responsibilities in reporting any abuse they suspected and knew how to do so. Staff told us that if they suspected abuse was taking place they would not hesitate to report it to the manager, the local authority and notify the Care Quality Commission which was in line with the home's safeguarding policy. There were procedures to report staff to the Disclosure and Barring service (DBS) where appropriate. DBS checks identify if prospective staff have a criminal record or have been barred from working with children or vulnerable people. There were procedures to report staff to the DBS where appropriate

Assessments were undertaken to identify any risks to people and these provided clear information and guidance to staff to keep people safe. For example, there were assessments to identify risks in the community, for activities, falls and any other risks they may present to themselves and others. The assessments were regularly reviewed and updated. Staff knew about these and its guidance and demonstrated this in discussions with us. A healthcare professional told us that ''people's assessments and care plans were recorded clearly and I was impressed with the level of detail''.

The registered manager told us they had external support from psychiatrists to develop positive behavioural plans to support people with behaviour that challenged others. This provided specialist input to provide guidance for staff regarding how to keep that person and others safe. We saw the guidance about behaviour that challenged others. We asked staff to describe some of the guidance. They showed knowledge of the guidance and demonstrated they knew things that might trigger the behaviour and what to do if an incident arose. For example, they told us one person does not like loud noises so they avoid them or situations and places that will be loud, they then described making eye contact and distracting the person, reassuring them and removing them from the situation.

Staff took appropriate action following accidents and incidents to ensure people's safety. Where needed medical attention was sought and the incident reported. Staff recorded all incidents to help identify any patterns or trends. Staff told us they always met with the manager after an incident to look at the possible causes and how to avoid them in the future. A plan was then produced to reduce the risk of incidents reoccurring in the future. One example they gave was of an accident involving a person falling in the bathroom. They told us the updated action was for two people to support them at these times in the future. We saw that risk plans had been reviewed and the plans updated with new information where needed.

There were adequate staffing levels in place. People's relatives told us there were enough staff. Staffing was based on historical requirements made by the placing authority. The registered manager conferred that they would ask for a review form the placing authority if anyone's care needs increased. There were three staff each shift during the day and at night, one working and one sleeping in. There were additional staff for activities when needed. Staff rotas confirmed this level of staffing. Staff told us they thought there were enough staff and we saw that staff provided support when people wanted it and without delay.

There was a safe recruitment process in place and the required checks were undertaken prior to staff starting work. Recruitment files included evidence that

Good

Is the service safe?

pre-employment checks had been made including checks with previous employers and satisfactory Disclosure and Barring Service (DBS) checks. Health screening and photographic evidence of staff identity had been obtained. Staff files included copies of the staffs qualifications and training. These showed that staff were appropriately qualified and had the necessary knowledge, skills and experience to meet people's needs.

All the staff that administered medicines had received training to ensure the safe management of medicines. Medicines were stored safely and securely. Staff were aware of what medicines people needed and when. We looked at the records of medicines administration and found they had been kept securely and recorded appropriately. Medicine Administration Records were used to record if people had taken their medicine or not. There were no omissions and recent records were clear. There were appropriate return procedures for unused medicines and there were none out of date in storage.

The provider had contingency plans which gave guidance to staff about what to do in emergency situations to continue to provide safe appropriate care. This included for example, what to do in the event of the loss of heating and power or severe weather conditions affecting access to the home. This provided sufficient arrangements to provide safe and appropriate care through all reasonable foreseeable emergencies. This also included a pre-arranged place of safety should the home temporarily become unusable for use. Staff had a good understanding of these plans and were able to tell us about them and what to do in an emergency.

Good

Is the service effective?

Our findings

One person told us the food was "Good", and they got enough and that they liked it. They also told us they could have their favourite food every morning which in their case was treacle on bread. People's relatives told us that their family member visited the doctor when they needed to, and had good access to health care and check-ups like the dentist and opticians. A relative told us the home ensured all their family members' health needs were met.

Staff had received training in interacting with people who have communication needs. However, Tthey had not received specialist training further training to enable them to put this into practice. This enabled staff toStaff did not have the necessary skills to communicate effectively with people in accordance with the communication and support needs. , and this limited staff's understanding of what some people were communicating to them regarding their needs and wishes. The registered manager was aware of this shortfall and had not planned any training for staff in this area.

New staff received a two to three month induction depending on what they needed. This included training in for example, health and safety, handling and lifting, safeguarding and whistleblowing. This induction also involved staff getting to know people and their needs by reading the care plans and guidelines and talking to staff. This gave staff a basic level of knowledge needed to provide safe care before they worked with people. Staff then went on to complete the Skills for Care common induction standards programme. These are the standards staff working in adult social care need to meet before they can safely work unsupervised. The registered manager confirmed that as Skills for Care has now been replaced with the care certificate, this will be introduced to all existing staff and new staff will use it for their induction when they join.

Staff we spoke with confirmed that had all had an induction that was monitored by the manager. The manager told us staff induction was monitored through one to one supervision sessions. Staff supervision records showed they received regular monthly recorded supervision and on going appraisals regarding their performance, conduct and training needs. These were more frequent up to weekly or when needed for new staff to monitor their induction. There was a staff training programme in place. The manager had a matrix showing what training staff had received and what training was out of date or needed. The training matrix showed that staff were up to date with planned training and refresher courses were booked to ensure they built upon their skills and knowledge. Staff also had access to some specialist training that related to individuals needs, for example intensive interaction training. Staff were supported to achieve qualifications such as National Vocational Qualifications or the new replacement level 2 Diploma in Health and Social Care. These were work based awards that were achieved through assessment and training. To achieve these candidates must prove that they have the ability (competence) to carry out their job to the required standard. There were staff meetings that discussed the running of the home so that they could contribute to improving quality. Staff told us they felt involved and their ideas were listened to.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty these have been authorised by the local authority as being required to protect the person from harm. We found the home to be meeting those requirements. There were no restraints being used on people. Although there were few restrictions needed most situations were managed with staffing as opposed to restrictions where possible. For example, risks that some people presented to themselves or others when in the kitchen were managed with sufficient staffing to supervise the area appropriately as opposed to locks on the kitchen or cupboards. Where people required some restrictions to be in place to keep them safe, the provider must submit applications to a 'Supervisory Body' for authority to do so. In this case the Supervisory Body was the placing authorities. The home had made appropriate applications in line with DoLS. For example applications regarding the front door being locked to keep people safe had been submitted. Staff had been trained on the Mental Capacity Act (MCA) 2005.We spoke to the registered manager and staff and they demonstrated a clear understanding of the MCA and how to make sure people who did not have the mental capacity to make decisions for themselves were not unlawfully restricted.

Where people had been assessed as lacking capacity to make specific decisions about their care, the provider complied with the requirements of the Mental Capacity Act

Good

Is the service effective?

2005 (MCA). The MCA is a law that protects and supports people who do not have the ability to make specific decisions for themselves. Where people lacked capacity to make specific decisions staff acted in accordance with the principles of the MCA. This included an assessment of the person's mental capacity, discussion of their care needs in a best interests meeting with those best able to represent the individual, such as family, health professionals and care staff, and the decision reached. Records showed that these involved family members, independent mental capacity advocates where needed, and social workers.

During our inspection we observed that people's consent was sought. For example, staff asked people before providing support or moving their wheelchairs.

People's choices were included by providing documents in ways that suited people's individual needs and their preferences. For example, pictorial or audible formats or they were read out and explained by a key worker. We observed staff used a pictorial meals menu to assist one person make choices about their meals and talk to another person about the meal options and their preferences, Where records showed people needed full support this was given when needed and at the persons own pace. When people needed less support they were supported to be independent. For example by staff filling the cup and then giving the person the cup to hold or staff placing the food within reach. People were supported and informed about nutrition and health but were also supported to make their own choices. We saw people being offered choices of drinks and food through our visit.

People were provided with food and drinks they liked and when they liked. Menus showed a variety of food was on offer which included vegetables and fruit and these were available in the home during the inspection. We saw records of risk assessments regarding food and healthy eating and noted management plans were in place regarding this. People had been referred to speech and language therapists where needed for any swallowing difficulties and to identify solutions. Staff showed knowledge of people's dietary support needs for example they told us about one person's need to have their food cut up. Food was monitored and people's weight periodically recorded to identify any changes. There was equipment to help people be as independent as possible with meals.

People were supported to maintain good health. Peoples care files contained, for example, daily records to show what care had been provided, There was a 'what I did today 'record so that staff could monitor the persons activities to ensure they were effective, There were dietary guidelines so staff knew people's dietary needs. People had a person centred plan to show staff what support they needed and how the person wanted it to be provided. There were best interest meetings records for example for dental treatment, risk assessments, a hospital passport, communication guidelines that showed how a person that did not use words to communicate chose to communicate. These all gave staff the information they needed to care for people effectively. We saw that these plans were regularly re-assessed and updated. Care records showed that when needed, referrals had been made to appropriate health professionals. When a person had not been well, their doctor had been called or they had visited the doctor and treatment had been given. The manager told us that people were made aware of the treatment choices by the staff talking to them.

Good

Is the service caring?

Our findings

Relatives said staff were kind and treated their family member with dignity, respect and spoke kindly to them and with courtesy. Relatives also told us they thought the staff treated their family member well, were caring and gave them the time they needed. One relative told us "the staff were always first rate, in particular the key worker was wonderful, so kind, thoughtful and considerate always". Another relative told us they found everything to do with their family members care was excellent and the staff were always first rate. They also said their family member experienced the best possible quality of life. Care professionals we spoke to told us that staff treated people with respect and people seemed happy.

Staff supported dignity and privacy by asking before supporting people with meeting their needs. For example, ensuring people's room doors were closed while providing care and by offering people choices. Our observations showed that people were supported in a way that promoted their dignity by being spoken to kindly. Staff were caring and supportive in their approach to people, giving them attention and by not rushing them with support. Healthcare professionals who visited told us the staff interacted with people in a caring way.

People had their own detailed and descriptive plan of care. The care plans were written in an individual way, from the person's own perspective and explained how they preferred care to be carried out. The information covered all aspects of people's needs and gave clear guidance for staff about people's likes and dislikes and how to meet people's needs.

Staff knew people's preferences, likes and dislikes and gave us examples of how people preferred to be supported in a way that was different to others. For example one person did not like loud noises and another did not like cold food. This was confirmed when we looked at care records. Staff told us that many of them had worked with the people for many years and knew their likes and dislikes well, but they also recognised that they may change.

People's independence was supported, for example, a person was supported to get the wheelchair they had asked for so they could be independently mobile inside the home.

People's achievements, birthdays and their special events were celebrated and people had holidays abroad.

People had the opportunity to make their views known about their care, treatment and support through weekly meetings. Relatives told us that care plans and care planning were always discussed with them and their family members to support their involvement in decisions regarding care. Where people did not have known relatives the manager set up a project to find as many as possible. This resulted in some previously unknown relatives being discovered. Records also showed where none could be found advocates had been applied for to support those people.

Good

Is the service responsive?

Our findings

One person told us about outings, trips abroad and activities they enjoyed. They told us about their relative abroad and how they had been supported to contact them and sent letters and pictures to each other. They also told us how their relative visited and was coming again soon.

A social work care manager told us the registered manager was responsive to issues raised and would take action to make changes where required. They also told us they were impressed with detail of behaviour charts, records and care plans.

Relatives told us that when they had raised any minor concerns or issues with staff they found the staff listened and were responsive to them. The registered manager told us, that upon his commencement to the post, he introduced reviewing behaviour monitoring charts which also was reviewed by the psychiatrist. For example, it was identified that for one person they would benefit and enjoy trips out in the vehicle to enhance their well-being. Staff changed the support provided to ensure they included this support. The registered manager feedback this had a positive impact on the person's well-being.

The provider responded to concerns and promptly. For example, where concerns were identified about the quantity and quality of activities, the registered manager took prompt action to individualise and increase activities. There was a formal complaints procedure with response times. Where people were not satisfied with the initial response it also included a system to escalate the complaint to the provider. Although relatives told us they knew how to complain, there were no complaints.

Assessments were undertaken to identify people's care and support needs. Care plans were developed detailing how these should be met and were written with the involvement of the person and their relative. Care plans were person centred and reflected people's wishes. For example 'I like a cup of tea before my bath.' People had their own detailed and descriptive plan of care. The care plans were written in an individual way, from the person's own perspective and explained how they preferred care to be carried out. The information covered all aspects of people's needs, included a compunction profile of the person and clear guidance for staff on how to meet people's needs One person told us they got support the way they wanted.

Relatives told us that staff had shown them the care plan, kept them informed and involved them in the care planning and reviews. One relative told us ''they look after my family member well and attend to all their health needs well''. Another relative said, "they keep me informed and let me know what's happening".

The care plans were available in larger print with supporting pictures so that people understood them. Care plans contained a personal history, cultural preferences, information about people's likes and dislikes, how people communicated, how they expressed pain, as well as their care needs. Care plans were reviewed as people's needs changed so that staff always knew what support people required. Staff were able to tell us detailed information about people's care needs. For example one person's need for particular support with the risk of falls and another's need for more support with meals. This was confirmed when we looked at care records. This meant that staff had knowledge to ensure that people received care that is centred on them as an individual.

Good

Is the service well-led?

Our findings

The service had developed ways to communicate with people, due to the complex communication needs of the individual's living at the home. Staff use various strategies to enable them to effectively communicate with people and to understand their needs and preferences. We found there were systems in place to capture people's voices about the quality of the service and care provided. There were no systems in place to enable people to have an active role in contributing to the development of the service.

The service also sent annual quality assurance questionnaires to people's relatives, advocates, and health care professionals. Relatives told us they had quality questionnaires where they could raise quality issues and could always raise anything with the staff at the home if needed. Records of the actions required to improve quality from the analysis of questionnaires were kept and action was taken. Some of these were more activities. Relatives said the home had a nice atmosphere and when they visited they were welcomed by staff who were always polite and courteous. The service's quality questionnaires for relatives showed most relatives felt the home had a homely atmosphere.

Care professionals we spoke to told us the staff were welcoming. A Local authority care manager told us that the registered manager knew their job well and had made many improvements. For example, what was and how things were recorded and the level of detail. Staff told us they liked working at the home. One told us that "it was rewarding to work where they were supported to provide the best care".

We saw people were confident to enter the registered manager's office and stay there and spend time with them socially. One person took their tea in to the office and teased the manager in a friendly way about them having a hot drink while the registered manager only had water.

The service had policies and guidance for staff regarding safeguarding, whistle blowing, involvement, compassion, dignity, independence, respect, equality and safety. We spoke with staff who showed an understanding and ownership of these values. For example, they knew the importance of supporting people's choices. There was a grievance and disciplinary procedure and a sickness policy. This ensured there were clear processes for staff to account for their decisions, actions, behaviours and performance.

There were processes in place for reporting incidents and accidents. Incidents were reviewed by the registered manager to identify any patterns that needed to be addressed. For example when there was an accident there was a review of the incident and any recommendations to avoid the incident in the future. The service met CQC registration requirements, including the submission of notifications to us. This meant that we could monitor incidents in the home.

There were records of audits to assess whether the home was running well. There was external auditing of finances. There was an annual audit by a senior quality assurance manager that covered the whole home including people's care records, reviews, complaints, activities and staffing. There was a twice yearly health and safety audit. The registered manager did a monthly audit called a manager's report and other audits on an annual basis, for example, complaints. These audits were evaluated and, where required, action plans were in place to drive improvements.

Records were kept in the office only and were easily and promptly located by staff when requested. We noted that records were in good order and easy to navigate so as to find information efficiently. We saw they were kept securely and confidently within the office.