Central and Cecil Housing Trust

Compton 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

Summary of findings

Overall summary

We carried out an unannounced inspection on the 19 January 2016. At our last inspection 24 February 2015, we found that improvements were required in relation to risk assessments that were not person centred and not reviewed regularly. Care plans were not being followed and were also not reviewed regularly and a fire risk assessment had not been carried out an annual basis.

At this inspection we saw improvements had been made. We saw that risk assessments and care plans were person centred and reviewed regularly, care plans were being followed and an annual fire risk assessment had been carried out in June 2015.

Compton Lodge is a residential care home for up to thirty two older people. At the time of our inspection there were twenty nine people using the service.

There was a registered manager in place at the time of the 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.
There were systems in place to safeguard people and staff had a good understanding of the different types of abuse and how they would look out for signs.

Risk assessments formed part of the person's agreed care plan and covered risks that staff needed to be aware of to keep people safe.

People had a Personal Emergency Evacuation Plan on their record (PEEP). Their PEEP identified the level of support they needed to evacuate the building safely in the event of an emergency.

Recruitment practices ensured staff were appropriately checked prior to employment to ensure they were suitable to work with the people using the service.
There were sufficient staff available and deployed to meet people's needs.

Medicines were stored, administered and recorded appropriately by staff who had undertaken relevant training.

Staff received training and support to help them carry out their work role and demonstrated good knowledge on the subjects they were asked about, including promoting independence, choice, dignity, engagement and person centred care.

Staff had received training in the Mental Capacity Act 2005 (MCA) and the Depravation of Liberty Safeguards (DoLS) .They able to describe people's rights and the process to be followed if they were identified as needing to be assessed under DoLS.

People were supported to eat drink and maintain a balanced diet. There were menus on display in pictorial form. People were supported appropriately during meal times.

People were supported to keep well and had access to the health care services they needed.

We saw that staff received training on 'Rights, Choice and Risks' and this also included equality and diversity. Aspects of peoples unique needs relating to this were included in peoples care plans, including race, sexual orientation and beliefs.

A copy of the complaints leaflet was on display on the notice board at the service. Staff knew how to support people appropriately to make a complaint.

There was evidence of regular audits and spot checks undertaken by the management team, including checks of care records, communication and staff practice.

There were opportunities for people's voices to be heard. Meetings were organised for people using the service and their relatives.

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 knew how to report concerns or allegations of abuse to ensure appropriate procedures were used to keep people safe.

Individual risk assessments were prepared for people and measures put in place to minimise the risks of harm.

There were sufficient staff on duty throughout the day and night to meet people's needs.

There were suitable arrangements for the safe recording, storing and administering of medicines, in line with the provider's medicines policy.

Is the service effective?

Good

The service was effective. Staff received induction training and mandatory training to ensure they had the appropriate skills and knowledge to support people effectively.

People had access to a visiting GP and were assisted to receive on-going healthcare support.

People were supported safely to maintain a balanced diet as there food preferences and the support they needed to eat and drink was recorded in their care plans.

Staff had a good understanding of the Mental Capacity Act 2005 and how to support people using the principles of the Act.

Is the service caring?

Good

The service was caring. Staff understood people's individual needs and supported people in a dignified way.

Staff ensured they used information from assessments as well as talking to people about their beliefs, preferences and history to ensure equality and diversity was upheld.

Policies and procedures were in place to guide staff on issues relating to end of life care, to ensure people's wishes were

handled sensitively and staff had appropriate guidance in this area.

Is the service responsive?

Good

The service was responsive. People received personalised care that met their needs.

People's voices were heard through a number of ways including meetings between staff and people using the service. Feedback was considered and acted upon.

Information regarding how to make complaints was available to people using the service and their relatives.

Is the service well-led?

Good

The service was well-led. The service promoted a positive culture and the home was well run.

There was a clear management structure in place and people who used the service and staff were fully aware of roles and responsibilities of managers and the lines of accountability.

Audits and checks were carried out to assure quality and identify any potential improvements to the service.

Compton 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 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 inspection took place on 19 January 2016 and was unannounced. The inspection team included two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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.' We also reviewed the information we held about the service including people's feedback and notifications of significant events affecting the service.

During the inspection we spoke with ten people who used the service and six relatives. We spoke with six members of staff including the area manager, deputy manager and registered manager. We also spoke with two visiting doctors a district nurse and gained feedback from local commissioners.

We reviewed eight care records, six staff records as well as policies and procedures relating to the service. We observed interactions between staff and people using the service as we wanted to see if the way that staff communicated and supported people had a positive effect on their well-being.

Good

Is the service safe?

Our findings

People told us they felt safe and relatives we spoke with said they thought it was a safe service. One person said, "This is a very happy place, wouldn't stay here if it wasn't." They went on to say they thought it was a safe place and their family could keep an eye on them as it was local.

Staff told us and training records confirmed that staff had received training in safeguarding people. They were able to describe the process for identifying and reporting concerns and were able to give example of types of abuse that may occur. One care worker said "I am always alert to the possibility of abuse, which can take many forms." They explained that if they saw something of concern they would report it to a senior care worker or manager, "I report all matters of concern, straight away to the senior person on duty." A visiting doctor told us, "Staff do not neglect or ignore things; they are very quick to report any concerns." They understood how to whistle blow and told us they would "Report up the line to the very top, CQC, if I thought I was being ignored."

The registered manager and deputy manager understood their responsibilities for reporting safeguarding concerns and were able to tell us they would report any issues to the local authority safeguarding team and undertake preliminary investigations. They were also clear that the local authority were the lead agency for coordinating safeguarding investigations and that they should also report concerns to the Care Quality Commission.

There were comprehensive risk assessments on each of the care records we looked at. These assessments were specific to the individual, for example, where a person requested to self-medicate, a senior care worker had risk assessed the situation and clearly documented all possible risks. Another risk assessment pertained to a person's strong wish to move around as independently as possible, despite having mobility needs. The risk assessment gave clear instructions to staff about how to enable this, whilst maximising the safety and independence of the person and the safety of the worker. A care worker told us, "Now that key workers have started to do risk assessments, I feel I know my resident even better." Risk assessments were evaluated monthly or when there had been a change in a person's condition, in line with the policies and procedures at the service. However, many of these evaluations were recorded as, 'no changes' which gave no indication of the quality or depth of review carried out. There was also a more extensive six monthly review that included feedback from people using the service, relatives and professionals where appropriate. We discussed the issues concerning the staff recording, 'no change' with the registered manager and were given assurances that this would be addressed with individuals in supervision. The registered manager explained when that improvements in monitoring and reviewing risk assessments but also that staff were still learning and gaining confidence.

We observed a potentially serious situation with one person who used the service which was handled very well by staff. Staff worked swiftly and remained calm throughout. We subsequently confirmed that whilst there were some known health related issues identified for this person in the assessment around eating and drinking, the risks associated with these issues had not been fully included in their risk assessment. We discussed this with the registered manager who told us that the person had been at the home for around

four weeks and whilst staff were clearly aware of the risks involved with eating and drinking, not all of the information around these risks had been transferred to the risk assessment. We saw that a referral had been made to the speech and language team and an updated risk assessment had been devised to reflect all risks by the end of our inspection day. The registered manager also instructed the senior care workers to review risk assessments for people who had recently come to the home to make sure all relevant information had been transferred from the assessments and risk assessments were fully updated.

We saw that people had a Personal Emergency Evacuation Plan (PEEP) on their record. Their PEEP identified the level of support they needed to evacuate the building safely in the event of an emergency.

The registered manager confirmed that there was an agreed ratio for staff to the number of people they were supporting. They also confirmed that depending on people's level of need numbers could be increased to ensure people were supported safely. People and relatives told us and from our observations, we saw there were adequate staff on duty during the day and they did not appear rushed. One care worker told us, "we are not full at the moment and I have enough time to get around everyone and do my tasks." Another told us, "I think we have people on duty to enable us to spend some time with residents."

The provider had safe systems in place and thorough recruitment checks were carried out before staff started working at the home. Staff files contained completed application forms which included references to their previous health and social care experience, their qualifications, their employment history and explanations for any breaks in employment. Records had in-date Disclosure and Barring Service certificates (DBS), two employment references, and proof of identification. In addition, where relevant, records contained evidence of a person's right to work in the UK.

Medicines policies and procedures were in place for the service. Medicines were stored securely in a locked trolley in the home's clinical room. Medicines that needed to be kept cool were stored appropriately in a locked refrigerator in this area. The temperature in the clinical room and the refrigerator was checked and recorded on a daily basis. Medicines were in date and stored correctly. There was a supply of medicines that needed to be returned to the pharmacy and the senior care worker told us that this was done on a regular basis. The last recorded date was in January 2016. We were assured that returns would be done the next day to avoid keeping unused medicines onsite. Records were easy to follow and included individual medicine administration records (MAR) for each person using the service.

Medicines were being administered correctly to people by trained senior care workers and controlled drugs required checking by two trained staff. The majority of medicines were administered to people using a monitored dosage system supplied by a local pharmacist. We spoke with the senior care worker, they told us that staff were trained in medicine administration, and competency assessments were conducted annually to ensure their practice was safe. This was evidenced on training records we saw. Medicine audits were carried out weekly by the senior care workers and also by the registered manager. A six monthly audit was also carried out by the local pharmacy who supplied the home.

The home was clean and we saw it being cleaned throughout the day by dedicated staff. Infection control measures were in place and staff used gloves and protective clothing appropriately.

Good

Is the service effective?

Our findings

People and their relatives told us they thought the service was good and staff had the knowledge and skills to support them effectively. One person said, "This is a place of refuge, not everyone's cup of tea but I find it passable." They went to say that whenever you have any concerns they get dealt with quickly. Care workers understood people's behaviour and responded promptly when people became unsettled.

Staff had the knowledge and skills to enable them to support people effectively. Staff told us they received training and support to help them carry out their work role. This was confirmed in the training record we saw. All staff were required to complete an induction programme which was in line with the Common Induction Standards (CIS) published by Skills for Care. The area manager told us how the CIS was replaced by the Care Certificate Standards (CCS) for all newly recruited staff, "From October 2015; managers have been trained to be assessors for the CSS." One care worker told us they had achieved a National Vocational Qualification level 3 and said, "It gives us worth, self-confidence and relatives love it."

We saw certificates on people's records to evidence training they had done, amongst which included safeguarding of vulnerable adults, Mental Capacity Act 2005, manual handling, pressure care, infection control and first aid. Staff told us, "There is a reasonable amount of training; to be honest, some of the quality is better than others." Another member of staff told us, "The training is good." The management team told us they were looking at ways to ensure training was more effective for everyone and that staff felt able to raise concerns they might have. They mentioned introducing reflective practice and sessions to look on new systems and processes introduced, like writing care plans and risk assessments.

We saw evidence of annual appraisals on staff records. They told us they received supervision. One staff member told us, "It is very useful; I like to know how I am doing and I get this from my supervision." Supervision records followed a standard format covering strengths and development needs, training and discussion about their work. The registered manager told us it was the company's policy for staff to have six supervisions per year, "But it's not always happening with such frequency." Staff records we looked at confirmed that staff had received between four and seven one to one sessions over the past twelve months. We also saw that team meetings were happening on a monthly basis and in June 2015 there had been two meetings held. The registered manager told us that due to sickness, annual leave and maternity leave it was sometimes difficult to ensure that individual supervision was happening but team meeting were always held monthly, if not more to support staff. They went on to tell us that a new supervision matrix had been introduced and that sessions had been planned in advance for the coming year. The matrix was displayed in the staff room and office to ensure staff knew well in advance of the dates.

Care records contained signed consent forms for a number of areas including consent to care and treatment, medication and sharing information with other professionals as required. We saw how people had a clear choice of whether they wished to consent or not; there was good recording for one person who declined their consent to share information. There were also properly completed DNR (Do Not Resuscitate), including discussions recorded on people's records, with a note on one which said, 'not yet ready to discuss this matter'.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf for 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 lacked 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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure is for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Staff were familiar with the Mental Capacity Act 2005, and the need to obtain consent from those who used the service. A visiting doctor told us, "Staff really respect people's wishes; for example, if a person wishes to remain in their room for the day, then they can, even though it is likely to increase the workload for staff." Throughout the day, we heard care workers offering choices in many areas to people, including activities, music, food and drink.

Staff had received training in the Mental Capacity Act 2005 (MCA) and the Depravation of Liberty Safeguards (DoLS) .They able to describe people's rights and the process to be followed if they were identified as needing to be assessed under DoLS. At the time of the inspection there were eight DoLS authorisations in place and applications had been submitted for a number of others. Staff kept this under constant review

People were supported to keep well and had access to the health care services they needed. Advice from other healthcare professionals was incorporated in to care plans to ensure that people received appropriate care and treatment. For example, records confirmed people had seen an optician, chiropodist, community dentist and district nurse where appropriate. Other specialists were consulted for specific medical problems as required, for example the speech and language therapy team (SALT).

People were supported to eat drink and maintain a balanced diet. There were menus displayed in the dining room. These had a written description of what was on offer, as well as a photograph of the plate of food. This made it easier for people to understand the different food choices. We saw that the picture menu's had been implemented as a result of feedback from people that was regularly sought via a feedback book kept in the dining room. People were offered assistance to complete it after each meal.

Good

Is the service caring?

Our findings

People and their relatives told us staff were caring. One person said, "I like it here; we can live out our lives peacefully." I'm not over the moon happy but who is. Staff interacted with people in a kind and respectful way. For example, each time staff passed close to a person, they were greeted, using their name and asked how they were.

We saw from the interactions that the staff team were thoughtful and promoted positive caring relationships between people using the service. Staff took time to engage with people, and demonstrated flexibility when asked for assistance by person or respond to a question. We saw staff taking time to engage in conversation with people, informing them of items of interest.

We observed lunchtime in a small dining area. Staff assisted two people to eat in a kind and caring way. They explained what the food was and gave lots of encouragement to the person to eat and drink. Their positioning in relation to the person was safe and supportive and there was no sense of rushing the meal. Additionally, the activity was relaxed and the care worker conversed with the person directly, chatting about a variety of matters and current affairs.

Staff gave us examples of how they respected people's dignity by making sure they were covered during personal care activities. A care worker told us, "I let the person take the initiative and encourage them to do as much as they can for themselves; this is what makes me feel good." Another told us, "I like my job, taking care of people is very fulfilling."

We saw that staff received training on 'Rights, Choice and Risks' and this also included equality and diversity. Aspects of peoples unique needs relating to this were included in peoples care plans, including race, sexual orientation and beliefs. Staff told us this was an important part of supporting people and ensuring their needs were met.

The GP told us they had the impression that the care workers knew people very well and they heard lots of positive feedback about the staff.

We saw there were advance care plans on some people's records. This included clear and concise instructions by the person as to how and where they wished to be treated at the end of their life. We also saw a note made by a keyworker on a person's record, 'resident really does not want to discuss this yet, they said they had no intention of dying anytime soon'. There were policies and procedures in place in place relating to end of life care for staff to follow.

Good

Is the service responsive?

Our findings

The care plans included information and guidance to staff about how people's care and support needs should be met. They also contained the person's life story, which contained a wide range of information from place of birth, education, employment and family.

Care records contained a pre-admission assessment, which a care worker told us "Formed the basis of the person's care plan." There was a record signed by the person, or their relative, which confirmed that they had been involved in the drawing up of their care plan. Care plans were detailed, person centred and provided good information for staff to follow. For example, one included the specific temperature which a person wanted their bath water to be at. Another specified that they did not want to be checked during the night by night staff, and there was a signed notice to this effect on their record. We saw that people were weighed on a monthly basis, or more frequently if required. The visiting doctors told us that staff were very good at weighing people on a regular basis, or more frequently if they recommend. They said that staff were really "on the ball" and they were always notified if, for example, a person had a fall.

Records contained a daily support plan which contained people's unique information, including choices and preferences and how they wished to be supported. This information was used by care workers to ensure people were supported in a person centred way. It was especially useful for people with communication difficulties and dementia as it minimised the risk of people receiving inappropriate or non-person centred care. Daytime care workers and night duty care workers wrote a comprehensive update on each person in a person's individual daily record book. One care worker we spoke with told us, "This is a person's diary, it's great, as it gives us all an up to date account of what a person has done throughout the day and night." It included an account of a person's mood, diet and general well-being. Any activity, unusual occurrence or visit was also recorded. Information written in these books was comprehensive and was an important record for each shift about the presentation of person on that particular day.

Activity programmes were detailed on a weekly activity noticeboard. We saw there were activities scheduled every day. On the day of our inspection, the afternoon music and movement run by an external person was cancelled due to illness. A care worker ran a yoga session to compensate for this cancellation. People were engaged and told us they liked the sessions as it helped them to relax. The area manager told us that nearly all of the staff had now been trained in running yoga sessions. There was a hair salon in the home and we saw a notice up informing people that the hairdresser would be in on the following day. A volunteer from a charity which tutors people in the use of computers, visited twice weekly. In addition to a desktop computer, the home had two computer tablets for people to use in a place of their choosing. We were told this was of particular advantage for a person whose health had recently deteriorated and enabled them to 'Skype' their relatives from their bedroom. One person told us, "Some people don't have anyone, which is sad. Although increasingly people do have video calls so there will be someone to call and there are the grandchildren, if they have any".

People told us they were listened to and there were opportunities for their voices to be heard. Records showed that meetings were organised for people and their relatives on a regular basis. People and their

relatives were consulted on issues such as new staffing structures and were actively encouraged to be involved in deciding what a new structure should look like. There was good engagement with relatives and we saw that some ex relatives were very supportive and were still involved in a 'house committee'. They met regularly to arrange activities like, garden parties, assisting with escorting people on outings and shopping trips and also arranged regular entertainment on a Friday evening that people told us they really enjoyed.

A copy of the complaints leaflet was on display on the notice board at the service. Staff told us that if anyone wished to make a complaint they would advise them to speak with the registered manager as usually any concerns could be addressed by them promptly. The complaint records showed that there had been three complaints in the past year and these had been recorded, investigated the outcome was feedback to the complainant. We saw that any learning from complaints had been taken into account and used to make improvements to the service provided for people. There were also a number of compliments from people and their relatives, thanking the staff team for their support.

Good

Is the service well-led?

Our findings

People and their families and friends told us they thought there was appositive culture at the home and it was well run. One person told us "This place has been well recommended and I too would recommend as the management are flexible and have a can do attitude."

There was a clear management structure in place and people, who used the service and staff, were fully aware of the roles and responsibilities of managers and the lines of accountability. We saw how the senior care workers provided a good and effective link between management and the care workers.

A care worker told us, "I feel comfortable to ask the manager or deputy for things; they are both very approachable" and "the home is very well organised, we all know our specific roles." Another said, "The management team is really good." Visiting professionals told us they had every confidence that arising issues would be dealt with and the manager and deputy had high standards.

The registered manager and deputy manager promoted a positive learning culture. We saw how the focus on continuous improvement contributed to the quality of the service being delivered as well as empowering staff to achieve individual and organisational goals. One member of staff told us how they had left the organisation for a short time to work for a different company and returned very quickly as they missed the team and felt the service was a good and well run and people were receiving good quality care. We saw how management encouraged care workers to take responsibility for their keyworker role and for ensuring people they supported were confident knowing they had a designated care worker to confide in and work closely with around planning their care. The registered manager and deputy manager told us of plans to do some more training with staff around care planning to ensure continuous learning and to support staff confidence in their role. Care staff we spoke with told us they felt encouraged and valued in this role as it felt it was central to providing person centred, good quality care.

There was evidence of regular audits and spot checks undertaken by the management team, including checks of care records, communication and staff practice. Outcomes and learning from audits as well as incidents and investigations were shared with the staff team in one to one supervision and team meetings. Checks were also carried regularly by the area manager, who told us about a new initiative involving home managers conducting peer reviews across each other's homes. He explained that this would also promote a more consistent approach to care and support across the organisation.