Choice Pathways Limited

Albert Lodge

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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

This inspection took place on 4 February 2016 and was unannounced.
Albert Lodge is registered to offer support and accommodation for up to six people who have a past or present experience of mental ill health. On the days of our visit there were six people living at the home.

There was no registered manager in place. The manager told us they had sent an application in and were waiting for checks to be carried out. 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.

Staff supported people to maintain their safety. Assessments were undertaken to identify any risks to a person's safety and management plans were in place to address those risks. Staff were aware of signs and symptoms that a person's mental health may be deteriorating and how this impacted on the risks associated with the person's behaviour.
People were supported as appropriate to maintain their physical and mental health. People had care plans outlining the goals they wished to achieve whilst at the service and what support they required from staff to achieve them. The service used a recovery model in helping people to achieve their goals.
Staff were working within the principles of the Mental Capacity Act 2005 which meant that they were making sure people had support in place if they needed to be assisted with decision making.
They also worked within the principles of the Mental Health Act 1983(2007) which meant they were making sure people were safe and staff were following legal guidelines.

Staff worked in combination with the community mental health team to ensure people received adequate support. Any concerns about a person's health were shared with the person's external care coordinator so they could receive additional support and treatment when required.

Safe medicines management processes were in place and people received their medicines as prescribed. However, medicine patches were not disposed of safely and there was no signage to indicate use of oxygen. We have made a recommendation about this.

Staff encouraged people to undertake activities and supported them to become more independent. Staff spent time engaging people in conversations, and spoke to them politely and respectfully.

People were encouraged to express their opinions and views about the service. There were regular meetings with people and individual support was provided through a key worker system.

There were sufficient numbers of staff to meet people's needs. Staff had the knowledge and skills to meet people's needs, and attended regular training courses.

Staff were supported by their manager and felt able to raise any concerns they had or suggestions to improve the service.

The management team undertook checks on the quality of service delivery. A range of audits were undertaken to ensure the service was delivered in line with the provider's policies and procedures, and that people received the support they required.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe

People were protected against risks to their health and wellbeing, including the risks of abuse and avoidable harm.

There were sufficient numbers of suitable staff to support people safely and meet their needs.

People were protected against other risks.
However, people were not always protected regarding medicines as there were risks associated with the management of medicines. Medicine patches were not disposed of safely and there were no signs regarding oxygen. People received their medicines as prescribed.

Is the service effective?

Good

The service was effective.

The service used a recovery model to assist people reaching goals

People were supported by staff who had the knowledge and skills needed to carry out their responsibilities.

Staff obtained people's consent to their care and treatment. They followed legal guidelines using the Mental Capacity Act 2005 and the Mental Act 1983(2007)

People were supported to have a balanced diet. Their health and welfare was maintained by access to the healthcare services they needed.

Is the service caring?

Good

The service was caring.

People had positive relationships with the staff who supported them.

People were able to make their views and preferences known.

They were encouraged to take part in reviews of their care.

People's independence, privacy and dignity were respected and promoted.

Is the service responsive?

Good

The service was responsive.

Staff delivered care, support and treatment that met people's needs, took into account their preferences, and was in line with people's assessments and care plans.

People were able to take part in individual and group activities that took into account their interests and choices.

A procedure was in place to manage complaints, people told us they knew how to raise concerns about the home.

Is the service well-led?

Good

The service was well led.

The provider's values were clear and understood by staff. The management team adopted an open and inclusive style of leadership.

People and staff had the opportunity to become involved in developing the service.

Systems were in place to monitor, assess and improve the quality of a wide range of service components. These included regular audits and unannounced spot checks by the provider.

The manager understood the responsibilities of their role and notified the Care Quality Commission (CQC) of significant events regarding people using the service.

There was a friendly, homely and professional atmosphere in the home, which was appreciated by people and staff.

Albert 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, looked at the overall quality of the service, and provided a rating for the service under the Care Act 2014.

The inspection took place on 4 February 2016 and was unannounced. This inspection was carried out by one inspector.

Before the inspection we reviewed information we had about the service, including previous inspection reports, improvement plans and notifications the provider sent to us. A notification is information about important events which the provider is required to tell us about by law. 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. The registered provider gave us additional information on the day of the inspection.

We spoke with or observed care and support given to most of the people who lived at the home. We spoke with the provider's regional manager, the home's manager, two support staff, an activity coordinator and two people who live at the home.

We looked at the care plans and associated records for three people. We reviewed other records, including the provider's policies and procedures, emergency plans, internal and external checks and audits, staff training, staff appraisal and supervision records, staff rotas, and recruitment records for five members of staff.

Requires Improvement

Is the service safe?

Our findings

People we spoke to did not comment specifically on their safety. One person said "Although I find the checks they do on me annoying, I know why they are doing them." Another person said "It's okay here."

Staff undertook observations for some people hourly to identify where people were and what they were doing. This was in place as many people were at risk of self harming.

There were sufficient staff to meet people's needs. Staff were available 24 hours a day. There were at least three staff on duty during the day and two at night, and this was increased according to people's needs.

There was a visitor's policy whereby when visitors signed in they were asked to read guidelines and 'do's and don'ts about visits'. These were to help promote safety.

Staff were available to escort people to appointments, if people requested it. Staff were available to supervise and support people as required to meet their needs and ensure their safety. Shifts were organised so that there was time for handover of information between staff to enable continuity in care and support provided. An on call service was available out of hours so staff could obtain further advice and support from a member of the management team when required.

Staff had received safeguarding training, were aware of how to raise a safeguarding alert and when this should happen. There was no current safeguarding activity.

Previous safeguarding issues had been suitably reported, investigated, recorded and learnt from. The home had policies and procedures regarding protecting people from harm and abuse and staff had received training in how to use them. They understood what abuse was and the action to take if they came into contact with it. They said protecting people from harm and abuse was part of their induction and refresher training.

People's care plans contained risk assessments that enabled them to take acceptable risks and enjoy their lives safely. These included risk assessments of their health, daily living and social activities. The risks were reviewed regularly and updated if people's needs and interests changed. There were general risk assessments for the home and equipment used that were reviewed and updated. For example one member of staff had the role to test fire alarms weekly, emergency lighting and call systems. There was also a fire safety plan for the home and staff were aware of the plan and were able to tell us the action they would take to protect people if the fire alarm went off. There were also monthly checks on hot and cold water. Staff tested the emergency lighting and call system on the day of our visit.

Staff shared information regarding risks to individuals including any behavioural issues when they occurred and during shift handovers and staff meetings. Staff received training regarding behaviour that may challenge that was based on de-escalation techniques. This included guidance regarding each person using the service. They were also aware of what was lawful and unlawful in supporting people. There were

accident and incident records kept and a whistle-blowing procedure that staff said they understood. Accidents and incidents were recorded in a way that allowed staff to identify patterns. These were available for the manager and senior managers to monitor and review to ensure appropriate management plans were put in place.

The recruitment process ensured that new staff were of good character and suitable to carry out the role. Disclosure and Barring Service (DBS) checks were completed on all of the staff. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. We looked at five recruitment files which had a full employment history, references and copies of the questions asked at interview.

The recruitment procedure recorded all stages of the process prior to staff starting in post and a six month induction/ probationary period with reviews. The home had disciplinary policies and procedures that were contained in the staff handbook and staff confirmed they had read and understood them. There were read and sign sheets attached to all documents that staff needed to look at.

Medicine was safely administered, stored in a locked facility and appropriately disposed of if no longer required. All staff who administered medicine were appropriately trained and this training was updated annually. There was external and internal training and the internal training consisted of three assessments, two practical sessions (observations) and an oral and written test. We saw that records were kept of any issues with medicines and an investigation carried out. This might mean that a member of staff was suspended from administering medicines until they had received additional training and passed further assessments.

On discussion with the manager we were told that one person received a pain relief patch weekly. We were told this was disposed of after use in the clinical waste bin. This was poor practice, pain patches should not be disposed of in this way as the pain relief is still active. We have been sent information showing a new plan for the disposal of the medicine patches. There was one person who due to their physical heath needed oxygen daily. There was no appropriate signage regarding this. Where oxygen is used and stored in homes, clear signage in the corridor near the bedroom and in the home's hallway needs to be displayed. We have been told that signage is now in place. There assessments and care plans for both the oxygen and pain relief patches.

We recommend that the provider review their policy with regard to the safe disposal of medicine patches and their policy for the safe use and storage of oxygen regarding signage where oxygen is in the building.

People were assessed as part of their recovery plans to self-administer their medicines. This was discussed with the person and a multi-disciplinary team which included the provider and external health professionals. A risk assessment was carried out and there was a five stage process for people to agree to. This started with approaching staff for their medicines without being reminded and worked towards having the medicines in their room to take themselves.

Good

Is the service effective?

Our findings

People told us they felt that staff helped them to do the things they wanted to do with their lives. One person said, "Staff are okay." Another person said, "I prefer some over others." Staff communicated with people clearly and enabled people to make their own decisions.

Staff received ongoing supervision and were given the opportunity to have time with their line manager to discuss all aspects of their role. We looked at staff files and found that staff were able to direct the supervision, covering topics where they felt they either required additional support or areas they wished to discuss. One member of staff we spoke with told us, "The supervision is helpful, but I can talk to my manager at any time if I have concerns, I do not have to wait for my one to one."

Induction and annual mandatory training was provided for staff. The induction included completing a written work book and members of staff were provided a handbook which contained information about their roles and responsibilities. All aspects of the service and people who use it were covered and new staff spent time shadowing more experienced staff. This increased their knowledge of the home and people who lived there. The annual training and development plan identified when mandatory training was due. Training included infection control, manual handling, medicine, food hygiene, first aid and health and safety. There was also access to more role specific training such as schizophrenia awareness; mental capacity and behaviour that may challenge.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff were aware of the Deprivation of Liberty Safeguards (DoLS). No one was subject to DoLS at the time of our inspection. People told us they were free to come and go from the service as they wished. One person told us they went for a walk in the community whenever they wished to. If people were to stay out after midnight a member of the staff team contacted them to ensure they were safe and free from harm.

Staff promoted decision making and respected people's choices. People's consent to aspects of their care had been recorded in their care plans. A few people had been discharged from hospital to the home under the Mental Health Act 1983/2007. Staff we spoke to were aware of any restrictions placed on people.

People were supported to make choices with regards to personal care, medicine administration, activities

and meals.

Staff had a good rapport with people and they were able to remind people about personal boundaries in a way that did not cause offence. We saw that key worker support was available regularly. A key worker is a named person that someone can approach at any time who takes a more in depth approach to the relationship. During this one to one time the key worker would work with the person on their 'wellness recovery action plan' (WRAP) or the mental health Recovery Star, which is designed for adults managing their mental health and recovering from mental illness. These tools are used with the person to help them manage and plan their goals; which could be where they are going to live and whether they are going to get paid employment.

People had good access to a range of health support services. One person on the day of our visit had arranged an appointment with their GP, they asked for a lift in the home's transport. Care planning records covered the person's physical health and mental welfare. The health plans identified if a person needed support in a particular area. Some people required specific healthcare support and there was evidence this was provided. The manager told us how the service dealt with people's changing health needs by consulting with other professionals where necessary. A few people received ongoing support from community healthcare such as diabetic nurses, others had support from psychiatrists and community nurses to help them manage their reactions to needs and aspirations.

Good

Is the service caring?

Our findings

During our visit people made decisions about the support they needed, when it should be given and how they wished to spend their time. Staff knew people well, were familiar with their life style patterns and were aware of their needs. They provided a comfortable and relaxed atmosphere that people enjoyed.

Staff had received training about respecting people's rights and dignity. Treating people with respect underpinned their care practices. People said that the staff treated them with dignity, respect and enabled them to maintain their independence. The staff met their needs; they enjoyed living at the home and were supported to do the things they wanted to. One person told us, "I like the staff. I like everyone" and described the staff as "marvellous." Another person said they got on with the staff and enjoyed having conversations with them. One person said, "You talk to staff and they talk to you back." Staff told us they enjoyed interacting with people at the service and this provided them with high job satisfaction. One person had requested to have a cat, the idea was discussed with the people in the house and the person was supported to approach a pet rescue centre. They have a cat for which they are responsible with continuing support from the rescue centre.

We observed staff engaging people in conversations, and speaking to them politely. Staff were quick to respond if people requested help, and gently encouraged them to undertake specific tasks. Staff were also aware of when people wanted space and took direction from the person as to whether they wanted to engage in conversations. Staff respected a person's privacy. Staff did not enter a person's bedroom without their permission, unless there were concerns about their safety.

The patient approach by staff to providing people with care and support during the inspection meant that people were consulted about what they wanted to do, where they wanted to go and if they wished to be accompanied or not.

People were encouraged to do activities if they wished but not pressurised to do so. Staff also made sure people were included if they wished to be and no one was left out. Staff continually made sure people were involved, listened to and encouraged to do things for themselves.

People were asked by a staff member if they would like to speak to us or not and given the time to decide for themselves. Some people decided they were happy to chat, whilst others declined. Staff facilitated good, positive interaction between people using the service and promoted their respect for each other during our visit.

The home also had a confidentiality policy and procedure that staff said they were made aware of, understood and followed. Confidentiality was included in induction, ongoing training and contained in the staff handbook.

Daily records were maintained and demonstrated how people were being supported. The records told staff what people had eaten and drunk the previous meal, how their mood was, any activities they participated in

and if they enjoyed them. The records communicated any issues which might affect people's care and wellbeing. The staff told us this system made sure they were up to date with any information affecting a person's care and support.

People's bedrooms were individualised and reflected people's preferences. People were able to choose the colour of their rooms and decide how their rooms were decorated.

Good

Is the service responsive?

Our findings

People said that the home's manager and staff asked for their views and opinions and we saw this happen during our visit.

Each person had a care plan in place for each identified support need. The care plan identified each person's needs and their short and long term goals. Information was included in people's records about how the person could support themselves and how staff could support them to achieve them goals. We saw from daily records how staff supported people, and that people were supported in line with the information in their care plans.

Copies of reports from meetings people had with the healthcare professionals involved in the treatment of their mental health were kept in people's care records. Information was provided to staff about what increased a person's anxiety and how the person was to be supported to reduce their anxiety. Staff encouraged people to talk about their feelings and any changes in mood. For some people this helped them to manage their behaviour.

Staff were knowledgeable of people's needs. They were able to tell us what support people required from staff and the reasons why. For example, one person had limited mobility due to breathing problems and this sometimes affected their ability to undertake their personal care. Staff were aware of what this person was able to do independently and offered support with anything they were unable to manage on their own.

Information was provided to staff about maintaining appropriate boundaries in order to encourage people to do things for themselves and become more independent. For example, making it clear that the staff's expectation was that people be responsible for their own personal care.

We saw that some people had built friendships with the other people at the service and enjoyed spending time together. There was a computer that could be used by people using the service and staff. There was an issue about the length of time some people spent using the computer and the manager negotiated a solution to ease the issue.

Meetings were held with people using the service. These meetings gave people the opportunity to discuss any concerns they had or what they wished to receive whilst at the service. These meetings were often used to discuss the service's menu and the activities on offer. The activity coordinator told us that activity participation varied. They were pleased that on the baking day recently one person who never attended spent a large portion of the time helping them in the kitchen.

One person told us they had made complaints and the manager had responded to them. We reviewed the complaints received in the last year. We saw that all complaints had been investigated and the complainant was responded to with the outcome of the manager's investigation. We saw that complainants were invited to meet with the manager if they wanted to discuss their complaint further. One complaint related to the vegetables and the same ones being on the menu every week. The manager responded about more variety

being included in the menu discussion at the house meetings. Staff were also aware of their duty to enable people using the service to make complaints or raise concerns.

People were provided with written information about the home and organisation that outlined what they could expect from the home and what the home's expectations of them and their conduct was.

The home provided care focussed on the individual and we saw staff put into practice training to promote a person centred approach using mental health recovery tools. People were enabled to discuss their choices, and contribute to their care and care plans, if they so wished. The care plans were developed with them and had been signed by people when they wanted to. The care plans were underpinned by risks assessments and reviewed monthly or as required.

Daily notes identified any activities that people had attended and events of importance that staff coming on duty needed to know about. The daily records were used to record what they had been doing and any observations about their physical or emotional wellbeing. These were completed daily and staff told us they were a good tool for quickly recording information which gave an overview of the day's events for staff coming on duty. The care plans were live documents that were added to when new information became available. There was also a document to be used when someone went to hospital which would give hospital staff clear instructions on how to care for someone.

Each person had a keyworker picked from the staff team whose role was to lead on support for that person to stay healthy, to identify goals they wished to achieve and to help them express their views about the care they received. Each of the key workers carried out a monthly review with the person of their needs; their progress towards any goals identified and sought the person's views about their support.

People had responsibility for some household chores such as cleaning the smoking area or doing their laundry. These and other tasks helped their life skills for example, purchasing food items, clearing the table after meals and keeping their rooms tidy.

Good

Is the service well-led?

Our findings

People told us the manager was approachable and made them feel comfortable. During our visit the home's culture was an open and listening one with staff, the manager and owners paying attention to and acting upon people's views and needs. It was clear by people's conversation and body language that they were quite comfortable talking to the manager and the staff team.

The organisation's vision and values were clearly set out. Staff understood them and said they were explained during induction training. The management and staff practices reflected the vision and values as they went about their duties. People were treated equally, with compassion, listened to and staff did not talk to them in a demeaning way. There were clear lines of communication within the organisation and specific areas of responsibility that staff had and that they understood.

A member of staff said the manager was very supportive. Their suggestions to improve the service were listened to and given serious consideration. They said they really enjoyed working at the home. A member of staff said, "I had never worked supporting people with poor mental health, the team is supportive, I would not do anything else now." The records we saw demonstrated that regular staff supervision, staff meetings and annual appraisals took place.

There was a clear policy and procedure to inform other services of relevant information regarding changes in need and support as required. Our records told us that appropriate notifications were made to the Care Quality Commission in a timely way.

The home used a range of methods to identify service quality. These included regular audits and unannounced spot checks by the provider. There were home meetings. Quality audits took place that included medicine, health and safety, daily checklists of the building, cleaning rotas, infection control checklists and people's files were audited. Policies and procedures were audited annually. The manager showed us examples of weekly and monthly reports they submitted to their line manager. These included any actions that had been identified. We were able to track though to see where actions had been identified, when they had been actioned and signed off as completed.

The provider had 'expert auditors'. They were people currently using the service and they visit homes that belong to the provider in the local area and complete a report from which they make a rating and comment on areas of the home such as: introduction and meeting people, environment, menus/food, activities, discussions and observations of staff supporting people any areas for action or improvement are discussed by the manager with people using the service.

Day to day communication systems ensured any issues were addressed as necessary. For example people told us they felt the manager and staff acted on their views. The manager was always available and also spent time supporting people.

Staff we spoke with responded positively to the manager and regional manager's style of leadership. The

regional manager visited regularly every month and staff felt they could go to them at any time if they had a concern about people's care, and felt they were kept up to date and informed. They said they had a good relationship with the manager, and described them as being "great" and communications as "good". There was an opportunity for staff to engage with either the manager or their line manager on a one to one basis through supervisions and informal conversations. Observations and feedback from staff showed us the home had a positive and open culture. One staff member said, "There have been some changes in management but [name] and [name] are both good."
The manager understood the responsibilities of their role and notified the Care Quality Commission (CQC) of significant events regarding people using the service.

Staff relayed their enthusiasm and ambition for the people using the service and were very passionate about protecting them from abuse and ensuring they could lead the life they wanted to.

Staff logged accidents and incidents. These logs would be analysed to identify any trends for behaviour incidents, and if needed the manager would have discussions with individual staff members and other professionals.

The manager encouraged an open, transparent and inclusive culture whereby both staff and people were actively encouraged to go to the office and share their views and be part of the 'team'. Staff confirmed this when they spoke with us and we saw examples of staff and people using the service seeking guidance from the manager during the inspection.