CAS Care Services Limited

Amberwood Lodge

Inspection report

6 St Osmunds Road
Poole
Dorset
BH14 9JN

Tel: 01202743390
Website: www.cambiangroup.com

Date of inspection visit:
08 November 2017
10 November 2017

Date of publication:
17 January 2018

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

This comprehensive inspection took place on 8 and 10 November 2017. The first day was unannounced. This was CQC's first inspection of the service under the current provider's ownership.

Amberwood Lodge is a care home for adults with autism and associated learning disabilities. Nursing care is not provided. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Amberwood Lodge accommodates up to nine people in individual bedrooms within a single building. Nine people were living there at the time of our inspection.

The care service was registered prior to the publication of Registering the Right Support. All but one person had lived there for a number of years. Some people had come from Poole and surrounding areas, whereas others had moved from elsewhere in the south of England and the Channel Islands. They were all supported to maintain regular contact with their families. The service reflects most of the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

There was a registered manager, who had been in post for several years. 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.

The service had an informal, friendly, homely feel. People were supported with kindness and compassion by staff who knew them well and understood the care they needed.

People's needs and choices were assessed and support was delivered in line with current guidance. Their independence was promoted.

Activities at home and in the community were based on people's individual interests and needs and were encouraged on a daily basis. People were encouraged and supported to develop and maintain relationships with people who mattered to them.

Staff made sure people were included in everything and were not barred by conditions such as epilepsy. Where necessary, activities were adjusted so everyone had an opportunity to take part if they wished.

People's rights were protected because the staff acted in accordance with the Mental Capacity Act 2005. The registered manager had identified a number of people who they believed were being deprived of their

liberty, as the front door and gates to the service were kept locked and people were unable to leave unsupervised for their own safety. The registered manager had made the necessary Deprivation of Liberty Safeguards applications. There was a system for tracking expiry dates and any conditions on DoLS authorisations.

Choice was encouraged and people's preferences were respected. People were involved in decisions about their care and about how the service was run. Staff understood people's individual communication skills, abilities and preferences and supported them to express their views. Accessible information was provided to support people in making choices.

An independent advocate visited the service each month.

People were protected against the risk of abuse and avoidable harm. The service followed safe recruitment practices that helped ensure only staff who were of good character and suitable to work in care were employed. The premises and equipment were well maintained and kept clean. Staff knew how to blow the whistle and expressed confidence that the management team would act if they raised any concerns.

Risks to people's personal safety had been assessed and plans were in place to manage these in the least restrictive way possible. Where people could behave in a way that challenged, they had an individualised positive behaviour support plan.

Accidents, incidents and near misses were recorded and monitored to look for developing trends.

Peoples' medicines were managed and administered safely.

People were supported by sufficient staff with the right skills and knowledge to meet their individual needs. Staff had the support they needed to perform their roles, including training and supervision.

Varied menus with healthy options were designed to accommodate people's individual preferences and cultural and dietary needs.

People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals.

The provider's own team of health professionals visited the service regularly. We have made a recommendation regarding liaising and working with community learning disability services.

Quality assurance systems were in place to monitor the quality of the service. There was regular oversight from the provider's management team, locally, regionally and nationally. There was a programme of audits, and any shortfalls identified were addressed through an action plan.

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.

People were protected from abuse and avoidable harm.

Risks were managed in the least restrictive way possible.

There were enough staff on duty with the skills to provide the support people needed.

Is the service effective?

Good

The service was effective.

Staff were supported through training and supervision to provide the right support for people. They had a good understanding of the Mental Capacity Act 2005 as it applied to their work.

People were meaningfully involved in decisions about their care and the premises and environment.

Is the service caring?

Good

The service was caring.

People were treated with dignity, respect and kindness. Their right to privacy was respected.

People were supported to understand decisions and express their preferences and choices.

Is the service responsive?

Good

The service was responsive.

People were supported to carry out activities that were meaningful and enjoyable to them, and were encouraged to maintain hobbies and interests.

People were supported to maintain relationships that mattered to them.

Staff had a good understanding of the support people needed.

Is the service well-led?

Good

The service was well led.

There were clear governance and management arrangements. Management systems identified risks to the quality of the service.

People and staff were encouraged to give their views about the service.

Amberwood 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 was a routine comprehensive inspection undertaken by one adult social care inspector. It took place on 8 and 10 November 2017. The first day was unannounced.

CQC was aware of a safeguarding enquiry regarding one person's care. The investigation had been overseen by the local authority. The service continued to liaise with local learning disability services regarding this person's care.

Before the inspection we reviewed information CQC held about the service. This included notifications from the service about significant events, and information from stakeholders such as local authority safeguarding officers. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also obtained feedback from five health and social care professionals.

During the inspection we met all but one of the people using the service and talked with one of them about their experience of Amberwood Lodge. We also spoke with six care and activities staff, three ancillary staff, two of the provider's visiting clinical staff, the deputy manager, the registered manager and the regional manager. We made general observations around the service. We reviewed two people's care plans and records and elements of a third person's, three staff files and other records relating to the management of the service, including complaints, quality assurance records and records relating to the premises.

Good

Is the service safe?

Our findings

People felt safe living at Amberwood Lodge. They looked comfortable and relaxed with staff, readily approaching them for assistance or conversation.

People were protected against the risk of abuse. People and staff had access to information about safeguarding and how to stay safe, including posters about how to report concerns. Staff had annual training in safeguarding people. They had the knowledge and confidence to identify safeguarding concerns and acted on these to keep people safe. A member of staff who had been designated 'safeguarding champion' had also done external training, and the manager and deputy had safeguarding training for managers.

Risks to people's personal safety had been assessed and plans were in place to manage these in the least restrictive way possible. Risk assessments reflected people's individual needs and covered areas such as choking, recognising danger, road safety, and particular activities they took part in. Records were accurate, complete, legible, and accessible to staff.

Sometimes people could become distressed and behave in a way that placed them or other people at risk. Risks associated with behaviour that challenged others were assessed. Positive behaviour support plans were individualised to the person, setting out what behaviours might mean for that person, how to support them to help prevent the behaviour, and how to support them in the least restrictive way possible if the behaviour did occur. Staff had regular refresher training in managing aggression and behaviours that challenged, including a system of physical intervention that was accredited by a national learning disability organisation. Physical intervention is the use of specific techniques to hold people safely to restrain them from hurting themselves or others. Each use of physical intervention was recorded in a log and was reviewed by the service's management to ensure it had been the least restrictive intervention possible. The service had just set up a 'reducing restrictive practice group' to help the manager and staff understand this data better. The provider's management team also monitored the use of physical intervention.

When people had accidents, incidents or near misses these were recorded and monitored to look for developing trends. The registered manager checking each accident and incident to ensure that all appropriate action had been taken to keep people safe in future. Trends were monitored both within the service and at provider level.

People were supported by sufficient staff with the right skills and knowledge to meet their individual needs. Staff told us staffing levels had improved and allowed them to provide the support people needed. The service was trying to recruit further night staff.

The service followed safe recruitment practices. A new member of staff told us their references and criminal records check were obtained before they started work. Staff files included application forms, records of interview and appropriate references. Criminal records checks had been made with the Disclosure and Barring Service to make sure people were suitable to work in a care setting.

Peoples' medicines were managed and administered safely. Medicines were supplied in pharmacy-labelled boxes. Storage was secure and the temperatures of the room where medicines were stored and of the medicines fridge were read at least daily to ensure they were within safe limits. Medicines were counted weekly to check medicines records were correct. The stocks of three medicines we checked tallied with medicines administration records (MAR). There were clear instructions for staff in relation to medicines given on an as necessary basis, otherwise known as 'PRN'. Some people required rescue medicines for epilepsy. Where these were used, there were protocols written by an epilepsy specialist nurse that specified when and how they should be used, and under what circumstances paramedics should be called. Staff were trained in how to administer them. One person had medicines administered covertly on occasions but there was no evidence on file of consultation with a pharmacist. A pharmacist should always be consulted in relation to decisions about covert medicines, also in circumstances where people choose to have their medicines administered with food. The registered manager obtained written advice from the pharmacist and placed this on file prior to the end of the inspection.

The premises were well maintained and in good decorative order. The appropriate certification for fire protection, gas, electrical wiring and portable appliance testing was in place. The service had a dedicated maintenance person. Regular health and safety checks included fire safety checks, water temperature checks and shower head cleaning to help prevent the growth of legionella bacteria, and the state of repair of the premises. Breakages and problems with the building were reported and attended to promptly. Broken equipment was replaced, such as a new fridge freezer that had just been delivered to replace a defunct unit.

The premises were kept clean. Whilst people were supported to be involved in their own cleaning and laundry, the service employed a domestic worker. The domestic told us they had the time and resources to do what was expected of them. They worked to a cleaning schedule and kept a daily record of what areas they had cleaned. They oversaw the laundry and told us they washed towels and bedding at a high temperature. They said the standard of their work was checked.

The service had attained a five star food hygiene rating following an environmental health inspection a year before. All staff apart from activities staff had training in food hygiene. There were facilities for hand washing in the kitchen, laundry and toilet areas. Personal protective equipment such as disposable gloves and aprons was readily available.

Good

Is the service effective?

Our findings

People's needs and choices were assessed and support was delivered in line with current guidance. There was an holistic assessment of people's physical, mental health and social needs. Assessments were undertaken both by care staff and by the provider's visiting clinical team. The clinical team included a learning disability nurse, occupational therapist, speech and language therapist and psychology staff.

The registered manager reported that to their knowledge there had been no incidences of discrimination towards people who used the service. Staff made sure people were included in everything and were not barred by conditions such as epilepsy. Where necessary, activities were adjusted so everyone had an opportunity to take part if they wished. There had been an episode of racial discrimination towards a member of staff, which had been addressed in line with the provider's anti-discrimination policies. Social story work was done with a person who lived at the service, to help prevent this happening in future.

People were supported by staff who had access to a range of training to develop the skills and knowledge they needed to meet people's needs. Staff told us they had the training they needed when they started working at the service, and were supported to refresh this training. Staff new to care completed the Care Certificate, a national qualification based on the skills and competencies expected of health and social care workers, during the first few months of their employment. Staff completed training that included safeguarding, mental capacity, fire safety and moving and handling.

People were supported by staff who had supervision meetings with their line manager or another senior member of staff, to discuss their work and any training needs or concerns they had. Staff told us supervisions were carried out regularly and were supportive. One member of staff told us that supervision was "time to talk about everything, which is always good".

People told us they liked the food and were able to make choices about what they had to eat. People's dietary needs and preferences were documented and known by staff. There were two cooks who worked on a full time job share basis during the week. Care staff covered the cooking at the weekend, although Saturday evening was designated as Takeaway Night. People were encouraged to get involved in preparing meals. For example, there was a midweek roast dinner each week, and one of the people living at the service liked to go and buy potatoes and peel these. The weight of potatoes in a backpack provided sensory stimulation that the person found beneficial.

Varied menus with healthy options were designed to accommodate people's individual preferences and cultural and dietary needs. People had a choice of meal and an alternative would be found to suit them if they did not want either option on offer. Some people had strong preferences for certain foods. Staff were working with them to explore other healthy food options.

A person with swallowing difficulties who was at risk of choking had been assessed by the provider's speech and language therapist, who had devised a safe swallow plan. This was being followed. We saw the person using the equipment the plan said they needed, with supervision from a member of staff. Their food was

provided in pureed form, as specified in their plan.

People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals. The provider's own team of health professionals visited the service regularly; they told us staff communicated well with them, seeking advice and following recommendations. Some people also had support from local learning disability services in relation to particular aspects of their wellbeing.

Managers reported the service had good links with the community dental service. Most people living at the service were distressed by having dental treatment and required this under sedation. If people had an appointment where they were to be sedated, the dental team would facilitate care staff undertaking potentially distressing tasks such as nail cutting under sedation, in the person's best interest.

People's rights were protected because the staff acted in accordance with the Mental Capacity Act 2005. 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.

As far as possible people or their legal representatives were involved in care planning. Their consent to their care and support was sought and obtained, where they had the mental capacity to give this. If there were concerns about a person's ability to make a specific decision about their care, their mental capacity was assessed in relation to this decision. Every effort was made to support people to understand the decision being made, including providing information in a format they could understand. If they were found to lack capacity, staff made a best interests decision about this aspect of their care. Mental capacity assessments and best interests decisions covered areas particular to the person, such as washing and showering, managing money and medication.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The registered manager had identified a number of people who they believed were being deprived of their liberty, as the front door and gates to the service were kept locked and people were unable to leave unsupervised for their own safety. The registered manager had made DoLS applications to the supervisory body before existing DoLS authorisations had expired. There was a system for tracking expiry dates and any conditions on DoLS authorisations.

People were involved in decisions about the environment, both the decoration of their own rooms and of communal areas. The maintenance person and care staff had worked with people to paint and decorate their rooms, as far as they wanted. This included going to the DIY store and doing the actual brush work.

People had individual bedrooms, and could have a key if they wanted. There were two kitchen dining rooms, a larger one where most people ate, and one where meals were prepared. People who preferred to eat quietly could have their meals there. There was a sensory room with coloured lighting, soft cushions and a water bed; staff told us people often used it in the evening to relax. People also had access to a media room with computers and a television. Outside was a secure garden area with a summer house, garden furniture and a swing, which some people liked to use for sensory stimulation.

Good

Is the service caring?

Our findings

People were treated with kindness and compassion. People told us they liked the staff. All of the interactions we observed were warm and respectful and people's dignity was upheld. Staff interacted with people as adults and spoke about them with affection. They recognised when people appeared to be upset or concerned about something and were prompt in providing assistance.

People were supported to express their views. Staff knew about people's individual communication skills, abilities and preferences. There was clear information in people's care plans about their preferred manner of communication. Most people living at the service needed additional support with communication. For example, some people used little verbal communication and had their own unique sign languages. Some people used a system of pictorial symbols; there were books available for people to use with symbols on particular themes, such as illness and pain. The provider's speech and language therapist assessed people's communication needs and advised staff on how these could be met.

Information was provided to people in a way they could understand. The provider's speech and language therapist worked on providing accessible information for people. There was extensive use of easy read and symbol communication. For example, there was a noticeboard with photos of the staff on duty that day, including activities and ancillary staff. There were easy read symbol instructions in the laundry explaining how to operate the machinery. Some policies and procedures were written in easy read format, such as the complaints procedure and information about what people could do if they were feeling sad or worried.

Information about advocacy services was available to people. An independent advocate visited the service each month. This had been arranged by the provider.

People received care and support from staff who had got to know them well. People's records included information about their personal histories, backgrounds and likes and dislikes. Staff were knowledgeable about people, their daily routines and things they found difficult. For example, the cook told us about different people's routines. They said how they expected people to return hungry from the morning's activities and wanting to eat straight away; this was indeed the case.

Choice was encouraged and people's preferences were respected. Care plans promoted choice and daily notes reflected that people had made choices and at times had changed their mind about things. People chose where they spent their time, whether in their rooms or in communal areas, including the garden. Care staff talked about the importance of people being involved in decisions and their choices being respected. In addition, the maintenance worker told us, in relation to personalising people's rooms, "I try and involve residents as much as I can." The domestic knew people well and had a good understanding of their preferences for how their rooms should be cleaned, such as someone who did not like their magazines to be moved.

Good

Is the service responsive?

Our findings

A person told us staff gave them the care and support they needed. We observed that people were busy with things at the service, were supported by staff to go out and that staff promoted their independence.

Care plans were personalised and the files seen contained information about the person's likes, dislikes and people important to them. They had been kept under review. Care plans covered areas such as health, eating and drinking, communication, personal care routines, sleep and activities. Staff were able to tell us about how they should support people.

Handover between staff at the start of each shift ensured that important information was shared, acted upon where necessary and recorded to ensure people's progress was monitored. Handovers included ancillary staff when they were working.

People were supported to follow their interests and take part in social activities, education and work opportunities. There were two full-time activities staff, who had helped people find new community-based activities. Activities at home and in the community were based on people's individual interests and needs and were encouraged on a daily basis. People took part in these with support from staff, both individually and with other people from the house. Examples of activities included social clubs, swimming, pottery classes and night fishing. A person living at the service had a goal of finding employment and had started some domestic work experience at the provider's sister service in Bournemouth. Activities staff evaluated each activity, considering how people responded to it, what went well and anything that could be improved. People's views on activities were sought at house meetings.

People were supported to develop independence at home and in the wider community. They were encouraged to get involved in household tasks such as cleaning their rooms, doing their laundry and going shopping. One person told us how they had painted their room, with the support of the maintenance worker. People used local community facilities such as shops, the library, sports centres, a dry ski slope, the nearby church and a local hairdresser who had a good understanding of the needs of people with autism. There was an easy-read symbol list in the hallway of things for people to remember to bring with them when they were going out.

People were encouraged and supported to develop and maintain relationships with people who mattered to them. Some people's families lived a long distance away. Staff helped people to keep in touch in a way that suited them, such as travelling with them or supporting them to make phone or video calls. For example, one person went on the bus each month to meet a family member and also had overnight visits with them. A member of staff explained how they kept the family of the person they key-worked informed about what was happening. They said they had a lot of contact with the family, including emailing updates weekly or fortnightly. They had worked with the family to make plans for the person's Christmas.

Complaints and concerns were taken seriously and used as an opportunity to improve the service. There was one formal complaint on file after the service had changed ownership in late 2016. This had been

investigated thoroughly and the complainant, who was not person who used the service or a relative, was offered a meeting to discuss their concerns. A person told us they could talk to someone at the service if they were not happy with their care and support.

Good

Is the service well-led?

Our findings

The service had an informal, friendly, homely feel. Throughout the inspection, people went out on a range of activities, supported by staff. There was a sense of bustle and excitement as they got ready to go and as they returned. Staff were enthusiastic about their roles and spoke highly of their managers and colleagues. They described the family feel of the service and said they found their manager and colleagues supportive. Comments included: "It's a very warm house, like a family environment", "It's like a family", "Feels really homely, like a big, happy family", "Excellent team here, even the new staff", "Management are good here", "Everyone's been really helpful and supportive… I feel I can go to anyone if I've a problem", "Lovely place to work – I feel really supported", "From week one I felt like I've fitted in", "I love it", "I love working here" and, "It is a good organisation."

People were involved in decisions about how the service was run. There were monthly house meetings where people were supported to hear news of forthcoming developments, give their views on these and raise any issues of concern to them. Staff worked through the agenda with each person on an individual basis, using easy-read symbols and pictures. Minutes were also produced in an easy-read format. Things discussed included preferences for activities, decoration and furnishing of communal areas and staff changes.

Staff had opportunities to discuss the service during their one-to-one supervision meetings and at regular staff meetings, as well as through ad hoc discussions with managers. Matters discussed at the last meeting in October 2017 included completing daily care records, safeguarding, health and safety, staffing and training.

The registered manager and provider valued feedback from staff and took action if staff reported concerns. The provider had a whistleblowing policy. Staff were aware of how to blow the whistle about wrongdoing and poor practice. A member of staff told us that when they had reported concerns to the managers of the service these were taken seriously and acted upon, commenting, "You can trust them." Other comments from staff included: "If there's an issue I'll go straight to them [managers]. They respond well… They're there like a shot if we need their support on the floor" and, "Any problems whatsoever, both [registered manager] and [deputy manager], they'll go into the office and sort it out."

People and those important to them had opportunities to feed back their views about Amberwood Lodge and quality of the service they received. This happened through key worker meetings, ad hoc discussions with the registered manager, and through an annual quality assurance survey. An independent advocate visited the service monthly, to encourage people to voice any concerns they had.

Quality assurance systems were in place to monitor the quality of the service. There was regular oversight from the provider's management team, locally, regionally and nationally. The registered manager reported weekly on key performance indicators set by the provider. These related to matters such as occupancy, staffing levels, accidents and incidents, safeguarding, the use of physical interventions, complaints, and staff supervision and training. The regional manager discussed this at a weekly telephone conversation with the

senior management team, providing updates on any items deemed to indicate a risk. There were quarterly senior management meetings, where the regional manager gave updates about how services had been supported to improve. The registered and regional managers also attended the provider's monthly governance meetings.

There was a programme of audits, and any shortfalls identified were addressed through an action plan. The registered manager conducted and oversaw audits within the service, including monthly health and safety and medicines checks, and unannounced night checks. The provider's quality team audited the service every quarter or so. An audit in June 2017 had reviewed care records and staff training. Actions identified had been completed. The regional manager advised us that the provider's internal audit team had checked residents' monies, petty cash and payroll records a month before, and were happy with the measures in place.

The service worked closely with its sister service in Bournemouth; both services were overseen by the same regional manager. If additional staffing was required, care staff from one service would work additional shifts at the other. The maintenance worker from the sister service provided cover if the service's maintenance person was on leave, and visited Amberwood Lodge on the second day of the inspection.

The provider's own team of health professionals visited the service regularly. Consequently, there was less liaison with local learning disability services than there might otherwise be. Two community learning disability professionals informed us that in their view the service had sometimes been slow to return calls or provide documentation, and could be more proactive in requesting assistance and sharing information. However, another health and social care professional commented that staff were always good at communicating with them. A member of the provider's clinical team commented that they had identified that there was scope for closer working with local learning disability services.

We recommend the provider reviews procedures at the service for liaising and working with community learning disability services.

The registered manager had notified CQC about significant events. We use this information to monitor the service and ensure they respond appropriately to keep people safe.