Cambuslodge Uk Limited

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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 this announced inspection on 8 February 2017. At our last inspection in December 2014 we rated this service "good". At this inspection we rated this service "good".

Cambuslodge provides a supported living service to five people with learning disabilities and mental health needs. The service is located in a terraced house, and consists of five bedrooms, a staff office, a large kitchen and dining room, lounge and two shared bathrooms.

The service had a registered manager who had been in post since 2001. 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.

People were supported to plan their care through a system of person-centred reviews. This enabled people to speak up on their health, support and daily activities. There were systems in place to support people to speak up through keyworking and residents meetings, including using accessible formats such as photographs. People who used the service were involved in the day to day running of the house, including household tasks.

Where people had complained, managers had investigated the complaint and taken appropriate measures, but people were also encouraged to speak up and make complaints about other services when they were not satisfied. Managers used the review system to ensure that people and their relatives were satisfied with their care.

The provider carried out suitable checks to ensure that staff were suitable for their roles and that there were enough staff on duty. Staff received good levels of training, appraisal and supervision to ensure that they had the skills to carry out their roles, and managers gave feedback to people on their performance.

People's rights were protected by ensuring that they had consented to their care and that they had the capacity to do so. The provider ensured they could demonstrate they were working in people's best interests if they were unable to make a decision for themselves. People were supported to eat healthily, and staff provided support to people to attend health appointments and maintain good health.

Risks to people were managed in a person-centred way which promoted their independence, and there were measures for staff to follow to ensure that people were safe and independent. Risks to people were regularly reviewed by staff. Medicines were safely stored and administered, and checked by staff and an external auditor. Daily handovers were used to ensure the service was safe and that people were happy and had received the appropriate support.

People had extensive activity programmes which included trips and holidays run by the provider. They were

also involved in activities in the community, and the provider maintained good communication with the activity providers. People and their relatives told us that they were treated with respect and made choices about their daily lives and we saw friendly interactions between people who used the service and the staff team. One person told us "We get good care."

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

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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 8 February 2017 and was announced. The provider was given notice because the location provides a supported living service for adults who are often out during the day; we needed to be sure that someone would be in.

The inspection was carried out by a single inspector. Before we inspected this service we reviewed information held by the Care Quality Commission (CQC) about the service, including information about significant events the provider is required to tell us about.

In carrying out this inspection, we reviewed records of care relating to three people and three staff files and looked at records of medicines management relating to five people. We carried out observations of the support people received from staff and looked at records relating to the management of the service, including health and safety checks, rotas and records of training and supervision. We spoke with two people who used the service, the registered manager, director, deputy manager and a support worker. After the inspection we spoke with two relatives of people who used the service.

Good

Is the service safe?

Our findings

People who used the service and their families told us the service was safe. Comments included, "It's a lovely place, I'm not in any danger here" and "I feel safe, I'm happy here." One relative told us, "I think it's a safe place to live, I can't see any problems at all". A staff member told us, "It's definitely a safe place, nothing goes unattended or unseen."

Staff we spoke with had received training in safeguarding adults and were able to describe the signs of abuse and were aware of their duties to report concerns. Staff were confident that managers would respond appropriately to any concerns. Where the provider held money on behalf of people, these were stored securely and checked every handover. Staff recorded when people had spent money and transactions were recorded with receipts logged and signed off by staff. All bank transactions were recorded on a spreadsheet, with the reason for the transaction identified and checked by managers.

There were systems of health and safety checks in place to help ensure the building was safe. There were daily recordings taken of fridge and freezer temperatures, and the temperature of hot water in baths and showers was recorded weekly. These showed that temperatures were in a safe range, although there was not clear guidance for staff on what was considered acceptable, which the registered manager told us they would record in future. Food was safely stored in the fridge in labelled containers in line with food safety practice and was checked on a daily basis as part of the staff handover.

There was a system in place for recording incidents and accidents. This included a description of what had happened and who was involved, and action carried out in response, including seeking medical advice and updating risk assessments. Following an incident which had occurred when a person was travelling, risk assessments relating to this were updated to provide more support for the person, and these measures were reflected in instructions to staff. The provider had completed a personalised missing persons procedure in the event that a person went missing. This included a description of the person, a clear protocol on who to contact based on where they might go and when to contact the police.

Handovers were carried out between staff members on a daily basis. This included working through a list of checks, such as checking the daily diary, log book, a register of who had gone out and who remained at home, checking people's food needs and verifying that cleaning and changing of towels and floor mats had taken place. There was a cleaner employed by the building and a cleaning schedule in place; the building was in a clean condition throughout.

The provider carried out a yearly fire risk assessment and there were up to date inspections of the fire alarm system and evidence that they contacted engineers when the system was faulty. Staff recorded weekly checks of firefighting equipment and fortnightly checks of the fire alarm. Risk assessments for people included whether they could evacuate the premises safely and drills were carried out three times a year and people's ability to evacuate was recorded, with actions such as further fire training where people had not left the building promptly. There were up to date gas and electrical safety checks carried out by an appropriate contractor.

Where a risk to a person was identified, an assessment was carried out recording the severity of the risk, who this affected, what existing control measures were in place and whether additional measures were required. These were reviewed every six months. Areas of risk included ensuring people were dressed appropriately and risks from daily tasks such as cooking, washing, ironing and travelling independently. Measures were in place to mitigate risks in a way which protected people's independence and staff maintained a daily check list of these control measures. For example, for one person who travelled independently, staff recorded they had ensured that the person's mobile phone was charged, turned on, and that staff called the person to check on the progress of their journey. This also recorded how risks to health conditions were managed, for example monitoring the daily measures staff took to prevent and manage a person's constipation through their diet. For a person who wished to go on holiday without staff support, there was a detailed risk assessment of control measures in place, including a consideration of whether the person had the capacity to make this decision.

Where risks to people were identified from routine activities they carried out independently, staff observed people twice yearly carrying out these tasks to ensure that these were still being carried out in a safe way. This included observing people travelling, using cash machines, and getting in and out of the bath.

There were measures in place to ensure people were supported by sufficient numbers of staff who were suitable for their roles. Staff files showed that as part of the recruitment process, the provider obtained proof of the person's identity, address, and the right to work legally in the UK. Prior to starting work, the provider also obtained two references from previous employers and carried out a check with the Disclosure and Barring Service (DBS). The DBS provides information on people's background, including convictions, in order to help providers make safer recruitment decisions.
Staffing levels were sufficient to meet people's needs, including having one staff member who slept over every night and an early and late shift, with additional support from managers. We reviewed three weeks' rotas over a three month period and confirmed that staffing was in place as described by the registered manager.

Medicines were safely managed and checked on a daily basis. The provider had a designated medicines officer who was responsible for the safe administration of medicines, and there was a signed agreement from each person on the level of support they received with medicines and how they would like to be supported. There was a written agreement in place for handing over medicines to family members who had agreed to take responsibility for medicines when the person was going away.

We reviewed Medicines Recording Charts (MRCs) for three people over a three month period. These showed that staff had accounted for medicines appropriately. The medicines file also included a photograph of the person, information on the medicines taken including their purpose and information on people's allergies. Medicines were supplied in a medicines dosing system (MDS) by a qualified pharmacist, who also carried out a yearly audit. The most recent audit was satisfactory, although the pharmacist had made some recommendations, such as recording expiry dates of medicines, recording returns of unused medicines on the MRC and for two staff to sign when an additional medicine was recorded on the MRC, which was now taking place.

Blister packs and MRCs were checked at each handover and this was recorded on the daily handover log. Medicines were stored in a locked cabinet in the staff room, and the temperature of this was recorded daily, although there was not clear guidance available for staff on what constituted a safe temperature. The medicines officer had worked with the registered manager and the GP to complete a yearly statement of which homely remedies were stored in the service. This included guidance from the doctor on which medicines could be given safely to people, and when they should not be given, for example due to

interfering with the person's regularly prescribed medicines. Where medicines were taken "as needed", there was a clear protocol in place for when this was to be administered, with information on what the medicine was for and what its side effects were. When medicines were to be administered if a person became upset and angry, the protocol stated that this could only be given with the authorisation of the registered manager. There were records of yearly staff knowledge tests which reviewed whether staff could administer medicines safely which were carried out by the pharmacist.

Good

Is the service effective?

Our findings

Staff received suitable training and supervision to carry out their roles effectively. A person who used the service told us, "We have good care." Comments from staff included, "It's really good, you do training all the time" and "On my one to one, managers ask me if I need any more training."

Staff received an induction before working in the service which included an introduction to the service's documentation, recording, policies and procedures and the safe management of medicines. There was also a schedule in place for new staff to visit activity centres that people who used the service attended in order to become familiar with these. New staff also undertook the Care Certificate. The Care Certificate is a set of standards that social care and health workers stick to in their daily working life. It is the new minimum standards that should be covered as part of induction training of new care workers.

Staff were required to undergo three-yearly first aid training and yearly training across a range of subjects. These included care planning, communication, control of substances harmful to health (COSHH), data protection, dementia, equality and diversity, fire safety, health and safety, infection control, manual handling, nutrition, risk assessment and safeguarding. Managers maintained a log of training that staff had undergone, this showed that staff were generally up to date with their training, although some courses had not been undertaken by everyone. For example, some staff had not had dementia training, but it was not directly relevant to their present roles. All staff held or were working towards a level 3 National Vocational Qualification in care.

Staff received monthly supervision from managers. Prior to supervision an agenda was agreed and the actions from the previous meeting were checked and reviewed. Supervision was used to discuss responsibilities and actions and to review the individual staff member's training and development. Supervision files showed that managers had observed people's performance within the service and gave effective feedback to staff on how they had supported people and managed particular situations.

The provider was meeting its requirements under the Mental Capacity Act 2005 (MCA). 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 are called the Deprivation of Liberty Safeguards (DoLS).

People's capacity was assessed in line with the requirements of the MCA with regards to particular decisions and to making decisions about their day to day care and support, which was reviewed yearly. People were able to leave the service as they chose and there were no restrictions placed on their movement. At the end of people's twice-yearly meeting, they completed and signed a form with staff which verified whether they were happy with the arrangements for their care and the decisions that were made. A similar form was also

completed by family members and other people that had attended the review. There were no recorded instances of people not having capacity to make decisions, however these records would have provided evidence that the provider was working in line with people's best interests if this was necessary. People had consented to have their pictures used on the provider's website.

People told us they had received support to make healthy choices about food, including unhealthy food they had agreed to stop eating. One person told us, "We're trying to eat healthy food" and a relative told us, "They encourage [my family member] to eat fruit and salad which they never used to touch." Risk assessments identified when people may be at risk of malnutrition, and everyone's weight was recorded weekly, with changes in weight recorded and acted on if there were concerns. People's meals were recorded on a daily basis and this showed that people had a varied diet and ate separate meals of their choice. There was a personalised menu planner with pictures for each person in the kitchen. The kitchen was large and had two ovens, which helped people to cook separate meals of their choice.

People told us that they were supported to health appointments by staff. Where people attended medical appointments, staff recorded when this had taken place, who had accompanied the person, the reason for the appointment and outcomes from this. There was evidence of people being supported to attend for regular checks with their GP, optician and dentist, as well as to follow up on particular issues. Where people required hearing aids, there were records of advice they had received from audiology and records of the maintenance of their hearing aids. Reviews included a discussion of people's health issues, changes to medicines and what was on people's health action plans. Health action plans were developed with the person's GP. People's health needs were discussed during staff handover, and were covered in detail during monthly staff meetings. For one person, after working in partnership with the person's dentist, the provider had drawn up a "mouth map", which was a personalised plan for ensuring oral health. This drew attention to areas of the mouth that the person did not always brush and contained a plan for addressing areas of concern, which was displayed in the bathroom the person used. One person was at risk of constipation, and the provider showed us a plan about how this was managed with the aid of diet and fresh fruit, which was monitored by staff.

Good

Is the service caring?

Our findings

People told us that staff were kind and caring. Comments included, "We choose what we do" and "They talk to me". Comments from relatives included, "I'm absolutely thrilled my [family member] is so happy and everything is so well catered. It's really wonderful" and "I've seen them in the supermarket and [the person] has been looking at different foods, and telling [the registered manager] what they like and don't like." A staff member told us, "I'm most proud of the fact that the clients call it home, it's not just somewhere where they come and go." We observed many kind and good-humoured interactions between staff and people who used the service.

The service had a pet dog, who was on good terms with people who used the service. People took it in turns on a daily basis to take the dog for a walk, one person told us, "I like taking her for a walk" and a relative said, "It's nice [my family member] can take her for a walk." The provider told us that one person had joined the service from a long-term institution, and had difficulty forming attachments, but that they adored the dog. This person's plan stated that they liked to be woken by the dog when it was time to get up, and this was illustrated by a photograph of the person cuddling the dog in their bed.

The provider used accessible formats to effectively communicate information and involve people in their decisions. This included personalised menus, activities boards and a pictorial rota which displayed who would be working each shift during the week. This was maintained by one person who used the service who worked as the house representative. Staff we spoke with had a good understanding of people's communication needs, including whether they required visual cues in order to understand what was being discussed.

There were tools in place to support people to speak up, including reviews and residents meetings. Meetings were taking place monthly, and minutes of these were recorded and provided in an accessible format using Makaton. Makaton is a language programme designed to provide a means of communication for individuals using signs and symbols. These meetings were used to discuss plans in the house, including activities and weekend plans, and to discuss health and safety issues. People were asked if they were happy with the current activities and schedules, and a recent meeting had been devoted to planning future trips. People were supported to discuss upcoming elections and were encouraged to make up their own minds on how they intended to vote. There was evidence people had been supported to participate in the general election and the EU referendum.

There was a keyworking system in place whereby people met with their allocated keyworkers on a weekly basis. People's views were recorded, and these included whether their current programme was leaving them feeling tired at a particular point, how their goals were met and progressing, any health issues and their planning for their review. Keyworkers signed off a weekly checklist, this included checks of the person's room, nails, weight, finances, personal items and medicines. When a person changed keyworker, a handover document was produced by staff outlining their current needs, goals, views and progress.

The provider had carried out an advance care plan for people except one person who was new to the

service. This was an accessible document which outlined their wishes if they became seriously ill, including their views on whether they would like to receive life-prolonging treatment, whether they wished to be resuscitated and their wishes for after their death, including funeral wishes and whether they had a will.

Relatives told us that they felt the service promoted independence. One relative told us, "They do try to make them as independent as possible which I think is excellent". A staff member told us, "The easiest thing is to do things for people, but we are here to enable them to develop." Plans included details on what people could do for themselves and skills that they wished to develop, and staff we spoke with were familiar with how to support people to learn skills. For example, one person's review identified that they wished to develop their writing abilities. Reviews also contained information on how people were supported with their cultural needs, including building a relationship with the local church.

Good

Is the service responsive?

Our findings

People who used the service told us that they were happy and enjoyed the activities they did. Comments from relatives included, "[my family member] absolutely loves it…they have little parties regularly, anything like that I'm invited round" and "I think people are given choices."

The provider based their care around an individual service plan. Reviews of this were carried out every six months, and were planned with the person through keyworking sessions. Reviews were supported using a computer screen which contained a presentation about the person's needs and wishes, illustrated by pictures of them undertaking their regular activities and attending appointments. Subjects covered at these reviews included detailed information about their daily routine, the support they received with personal care, their health needs (including opticians and dentistry) and their activities. Everyone attended a varied system of day activities in the local community, including activity centres, community theatre groups and community access. The provider sought feedback from these groups about the person's progress, significant achievements and their goals which were discussed at the review.

There was also an overview of the person's income such as their benefits, any changes which had occurred and how the provider was supporting the person to save for items they needed and for holidays. This was presented in a format applicable to the person. For example, one person was saving for a holiday to the Caribbean, and the provider told us they illustrated this with the country's flag as this was something that the person recognised. Clear goals were agreed at reviews, and staff we spoke with were familiar with people's goals and their progress was discussed at staff meetings and in keyworking sessions.

There was a board in the staff room which clearly illustrated people's activities and the person's requirements, including the time they needed to leave and what they needed to take with them. This also recorded people's involvement in the running of the house, and household tasks that they needed to carry out, such as ironing, laundry and walking the dog. Additionally, people went on day trips around London during the weekend, and there were pictures of these trips displayed on boards throughout the house. This included pictures from the annual group holiday, where people who used the service had agreed to go to the seaside for the week with support from the staff team, registered manager and director.

Staff referred to a care standards manual, which included detailed information of the support each person received and required, including personal care, diet, medicines and maintaining their daily routine, and this detailed people's current skills in areas such as reading, writing, undertaking tasks and using public transport independently.

Daily recording logs showed the support people had been given, and this was in line with people's plans. Staff handovers were used to ensure that each person's support was delivered appropriately, for example whether a person had carried out their daily exercises, eaten sufficient amounts of fruit and carried out their daily tasks such as laundry. These were also used to discuss the person's current wellbeing, including how well they had slept the previous night.

The provider told us it was their policy to support people should they have to stay in hospital, and that the previous year they had stayed with one person for three nights. The registered manager said it was because they could ensure that the person received the right support during this time, and that this person would not be able to cope being in a hospital environment without support from people they knew well.

People told us they knew how to complain, and the provider maintained a complaints policy which all people had signed to indicate they understood. Relatives told us they had never needed to complain, but were confident they knew who to complain to and that their complaints would be taken seriously. Comments included, "There was never a time I wasn't happy, I'd go first to [the director], I can't imagine that something wouldn't be done about it quickly" and "I think they'd take it very seriously."

Complaints were recorded by the registered manager, and this included actions that the service had taken to investigate and address the complaint. The complaints log also included complaints that people had made about other services and professionals involved in their care who were employed by the provider, and detailed how the provider had supported people to speak up and had worked with the person to resolve the complaint. Records showed that people were praised by staff for complaining about a situation they were not happy about.

Good

Is the service well-led?

Our findings

People who used the service had a good rapport with managers, including the registered manager and director who had a strong presence in the service. Comments from relatives included, "I know the managers, they often ring me" and "They're a good, happy bunch there." The registered manager was involved in every part of the running of the service including directly supporting people and keyworking one person.

Comments from staff included, "Managers are really helpful" and "The quality standard here comes from being small."

Managers carried out a monthly meeting of the staff team, including discussing issues such as compliance, policies, finances, reviews and annual leave. This also involved a detailed discussion of each person's month, including periods of illness, changes to their routine and their feelings and wishes. This was also used to share information from the residents meeting and meetings with other agencies involved in the person's care, for example the local GP service. When mangers had concerns about the performance of the service, they organised a staff meeting and used this to clearly outline staff responsibilities including an action plan to improve the performance of the staff team and to recruit new staff as needed.

Staff had read and signed the Dignity Pledge in which they undertook to treat people as individuals and with dignity and respect. Staff also received a yearly appraisal, which recorded their progress in a number of key areas of their professional development, any challenges they had faced over the year and any additional training or development needs they may have. We saw evidence of this being used to give feedback to staff about how they had managed certain situations.

Managers also sought people's views on the service, particularly by asking people to complete a satisfaction survey twice yearly at the end of the person's review. This was completed by the person using the service, their relatives and any other attendees, and asked them to rate their satisfaction on the condition of the service, the amenities, the welcome they received, and if there was any aspect that concerned them. We reviewed a sample of these forms, which showed that people were satisfied with the service.

The registered manager had implemented a robust system of checks to ensure that information was well shared amongst staff and that people's support was being correctly carried out.