Counticare Limited

# Carlile Lodge

## Inspection report

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Date of inspection visit:
26 February 2018

Date of publication:
22 June 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

Care service description
Carlile Lodge is a service for up to ten people with learning disabilities and /or autistic spectrum disorder who may also have behaviours that can be challenging. People lived in their own flats and shared communal areas such as a kitchen, lounge, dining room and laundry room. There were eight people living at the service when we inspected.

Carlile Lodge is a 'care home'. 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. The care service has been developed and designed in line with 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.

Rating at last inspection

At our last inspection we rated the service good.
Rating at this inspection
At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

Why the service is rated Good

People were supported to recognise when they were vulnerable and how to keep themselves safe. People were involved in identifying risks and in planning with staff, how these could be minimised. People were involved in managing their own medicines and in minimising the risk of infection.
People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. When incidents or accidents occurred people and staff worked together to minimise the risk of them happening again.

People worked with staff to develop their own care plans and design their own support. People were supported to prepare their own meals. People chose what they ate and could eat in their own flats or with others in the communal dining area. People were supported to understand any health conditions and how to manage them well. People took part in a range of activities they enjoyed and were encouraged to try new things. Staff knew people well and responded quickly to any signs of anxiety or distress. Interactions between people and staff were relaxed and included lots of humour. People were supported to respect each other and appropriately challenge each other's behaviour. People used a range of tools to express themselves and information was given to them in ways they understood. People had been supported to

develop end of life care plans when appropriate.

There were enough competent, trained staff to meet people's needs and they were recruited safely. Staff told us they felt well supported by the registered manager and could put forward suggestions for improvements at any time. Staff used effective systems to communicate with each other to ensure people's needs were met. The registered manager received updates on good practice and changes in legislation from the provider and shared these with the staff team. Staff worked in partnership with other professionals to support people and understand their support needs.

Regular audits of the service were completed and used to drive improvement. People, relatives and professionals were encouraged to give feedback on the quality of the service. Feedback was generally positive and any concerns had been addressed. People were encouraged to raise any concerns or complaints and these were resolved in line with the provider's policy and to people's satisfaction. The environment had been designed to meet people's needs including adaptations to people's bathrooms when required.

Further information is in the detailed findings below.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

| | |
|---|---|
| **Is the service safe?**<br>The service remains Good. | **Good** |
| **Is the service effective?**<br>The service remains Good. | **Good** |
| **Is the service caring?**<br>The service remains Good. | **Good** |
| **Is the service responsive?**<br>The service remains Good. | **Good** |
| **Is the service well-led?**<br>The service remains Good. | **Good** |

# Carlile Lodge

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.
This inspection took place on 26 February 2018 and was unannounced. The inspection was carried out by two inspectors.
Before the inspection we looked at 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 looked at previous inspection reports and notifications we had received. Notifications are information we receive from the service when significant events happen, like a serious injury.

During the inspection we spent time with six of the people who live at the service and spoke with three of them. We spoke with the registered manager, deputy manager and two staff. We looked at two people's care plans and the associated risk assessments and guidance. We looked at a range of other records including three staff recruitment files, the staff induction records, training and supervision schedules, staff rotas, medicines records and quality assurance surveys and audits.

Good

# Is the service safe?

## Our findings

People told us staff helped them to keep safe. One person said, "I talk to staff about what I do when I go out on my own, it helps me to know that I am doing the right things and keeping myself safe."

People went out independently which could leave them vulnerable to abuse or discrimination. Staff worked with people to understand when they were vulnerable and to develop the skills they needed to stay safe. When staff felt people needed more support people had been referred, with their agreement, to local learning disability teams for their involvement. Staff encouraged people to reflect on their own behaviours and how they could impact on others. People were supported to discuss any issues with their peers and look for ways to resolve them. Staff understood their responsibilities in relation to safeguarding people and reporting any concerns.

People were involved in identifying risks and planning how to mitigate them. Risk assessments gave staff guidance about how to minimise risks and highlighted how people would prefer this done. For example, one person was at risk due to them not understanding boundaries and sometimes approaching people they did not know. They had agreed with staff how this should be addressed with them so they did not feel like they had done something 'bad'. We saw staff following this guidance when speaking to the person during the inspection.

Environmental risks had been assessed and discussed with people in house meetings. Staff encouraged people to report any issues in their flats or communal areas which could be a hazard. People were encouraged to use personal protective equipment (PPE) such as gloves and aprons when cleaning or preparing food. One person had pets that they handled and staff reminded them to wash their hands before eating.
Staffing levels were based on people's needs and activities. People continued to be involved in the recruitment process by meeting potential staff and providing questions to be asked at interview. Staff were recruited using robust systems to ensure they were suitable for their roles.

People were involved in managing their own medicines where possible. Staff monitored that people had their medicines as prescribed. Some people were being supported to develop the skills to manage their own medicines. Assessments had been carried out of their capacity and understanding of why they took their medicines. This information was then used to form the basis of a support plan to enable the person to gradually take a more active role. When people had medicines which were prescribed for use 'as and when required' there was guidance for staff about when it should be offered, how often and maximum dosage allowed in 24 hours.

Accidents and incidents were reviewed for learning. Each incident form was read and signed by all staff members. Staff would then discuss these incidents in supervision meetings or team meetings. The focus was to reflect on what they had read, what was working and what could be improved. For example, there had been some tension about the use of the laundry room in the morning. It was agreed that staff would stay in the laundry whilst people completed their laundry to minimise the risk of other people making

negative comments or making anyone distressed. This had helped people be more confident in carrying out their laundry each day.

Good

# Is the service effective?

## Our findings

People told us they decided how their support was given and what they did each day. One person said, "I can generally do most things for myself, but when I get stressed I struggle. I just ask staff and they give me more help. They don't take over though they only do it when I need them to." Staff told us, "We know that the people we support go out independently and can be vulnerable. We have to remember they have capacity and can make unwise choices; we just offer advice and suggestions."

People were supported by staff who had the training and support required to carry out their roles. Staff received an induction which included core training and an introduction to the service. Staff were encouraged to spend time getting to know people. There was an ongoing schedule of training which was a mixture of online training and face to face courses. The training included core subjects and training which was specific to people's needs. When staff attended training courses they discussed this at the next team meeting and shared any changes in legislation or good practice with their colleagues. The staff team then discussed how this related to people's assessed needs and how it could impact on how they supported people. Staff used handovers and shift allocation sheets to ensure effective communication across the team and to ensure people's needs were met.

People chose their own menus and shopped for their own food. They could choose to prepare their own meals and eat in their flat or have communal meals with others. Staff encouraged people to have a balanced diet which met their health needs. Throughout the inspection staff spoke to people about what they were planning to eat and checked they had enough food in their flats. People chose to eat their evening meal together with staff in the communal dining room. The atmosphere was relaxed and everyone chatted about their day as they ate.

People were involved in managing their own health. Staff supported people to seek additional support when required and spoke to people about staying healthy. Some people were living with long-term health conditions such as diabetes. Staff had worked with the person to understand their condition and they now administered their own insulin, with staff monitoring and offering reassurance. Any guidance received from health professionals was incorporated into people's care plans and discussed with them by staff. One person was attending a health appointment and staff took time to check they understood where they were going and what would happen.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). No one at the service required a DoLS at the time of inspection. The registered manager had made an application for one person. However, they had been able to work with the person, an IMCA (Independent mental capacity advocate) and other professionals to identify a less restrictive way to support the person. As a result a DoLS authorisation was no longer required. People's capacity and level of understanding was reflected throughout their care plans. Staff took time to support people to understand decisions and where possible delayed decisions being made until the person had time to fully understand their choices.

The premises was clean, tidy and well decorated. People's rooms and bathrooms had been designed to meet their needs. For example, one person found it calming to splash in their bath. Their bathroom had been adapted to a wet room and the bath put back in. As a result they could splash as much as they liked without causing any damage.

Good

# Is the service caring?

## Our findings

People told us that staff were caring and knew them well. One person said, "The staff are lovely, I can always talk to them. They understand when I am sad how to make me feel better."

People were treated with kindness and compassion. Staff were patient with people and took time to listen to their concerns or worries. There had been a recent bereavement at the service and people told us staff had supported them to deal with how they felt about this. Staff told us this had been led by what people wanted and understood. One person said, "The staff have told me it is ok and normal to be sad. They give me a hug and we can talk about how I feel." One person became distressed in the afternoon, staff quickly identified that the person was upset and approached them to offer support. The person was upset because their routine had been interrupted, staff gave support and the person looked happier.

Staff were aware of people's life histories and how these impacted on them. They spoke proudly about people' progress and achievements. They encouraged people to tell inspectors about things they had learned to do and their plans moving forward. People were encouraged to express, how they felt and to plan how they would approach situations which could be stressful such as health appointments by talking to people about what would happen at the appointment and offering reassurance.

Information was available to people in formats they understood and that was based on their needs and preferences. Some people chose to have pictures in documents about them but others preferred staff to read documents to them. Several people were supported to attend lessons to improve their reading and writing. Staff then supported people to continue to develop these skills between lessons working with them on their literacy skills and finding fun ways to use them such as making posters about events.

People could have visitors at any time and were supported to maintain positive relationships with friends and families. Staff supported people to understand the risks and boundaries around romantic relationships. People spoke to staff about potential partners and to ensure that relationships were safe and positive.

Good

# Is the service responsive?

## Our findings

People told us they took part in a variety of activities which they enjoyed. One person said, "I have two jobs. I work doing admin at the office and I also help out at the day centre. It keeps me very busy and I enjoy it."

People's care was delivered in a person centred way. Care plans were written with people and highlighted the amount of involvement people had been able to have. People were encouraged to increase their involvement in care planning each time as they became more confident in taking part. People's care plans gave staff guidance about the support each person would need on a daily basis. Guidance from professionals was highlighted in blue and risks in red, which enabled staff to see people's support needs more clearly. People could decide when they had their one to one support and could request preferred staff. For example, one person liked to do their shopping using their push bike and go for long bike rides. They told us they knew which staff could ride bikes and who could keep up with them on long rides. They planned these trips based on these staff being available.

People took part in a range of activities. Some people attended the provider's local day service, some had work and others liked to visit local places such as the library or attend groups. People were supported to work towards goals, for example getting a job or going on holiday. One person was doing voluntary work to develop needed to find paid employment. People were encouraged to try new things and their goals were reviewed with them on a monthly basis in keyworker meetings. A keyworker is a member of staff who takes a lead in a person's support. The registered manager reviewed the monthly reports to ensure people were making progress and respond to any issues.

There was a complaints policy in place which was available in an accessible format. When complaints had been received these had been responded to appropriately. When people made a complaint which related to the provider or an external agency, staff supported them to follow through the complaint until they were happy with the resolution. People had regular 'talk times' with staff which were documented which gave them opportunities to raise any concerns or plan improvements with staff. If people raised issues during 'talk time' which constituted a complaint, staff supported and encouraged them to use the complaints procedure.

People had been supported to think about end of life care and how this would look for them. Staff were dealing with this in a sensitive way and taking into account people's understanding of death. Some people would become very anxious if asked to speak about this subject so this had been recorded and this had been respected. One person had decided with their family to leave their remains to be studied after their death. The service had worked with the person, their loved ones and health professionals to ensure the process for this was recorded in their care plan and understood by all relevant staff and professionals.

Good

# Is the service well-led?

## Our findings

People and staff told us the registered manager and provider were available and supportive. People told us, "This is the best place I have lived; the manager is really good and knows me really well" and "The providers are really good, I know I can talk to them if I am bothered about anything. I know who to talk to."

There was a registered manager in post who had been at the service for a number of years and was supported by a deputy manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There was a clear vision for the service which focussed on the needs and preferences of people and constantly improving the quality of support they are given. People and staff were empowered and encouraged to have a voice in how the service was run and any changes. Staff told us there was an open door policy and they were always welcome to speak to the registered manager with ideas or to seek support.
The registered manager attended regular meetings with other manager from the provider's other services. These meetings were used to share good practice and learning. The registered manager had also attended workshops provided by local health professionals and training events.

Regular audits were completed of all areas to monitor the quality of care. Staff completed a range of audits on a weekly basis and the provider's compliance team completed comprehensive audits twice a year. Any issues found formed the basis of action plans to drive improvement. Auditing processes were reviewed and updated based on changes in good practice or legislation. For example, audits of fire systems had been updated and an external audit completed following the recent national guidance after a major fire in a block of flats. The external auditor had commented that staff had an 'excellent grasp of fire safety and their responsibilities.'

Feedback was sought from people in a range of ways. People had keyworker meetings and 'talk time' to express their views on their care and support. Previously people had attended house meetings. However, people and staff had recognised that these were not being effective and had become a list of things people should do. Staff were working with people to revamp the meetings, planning to include food and themes to make them more valuable to people. People, families and professionals also completed surveys. The information received was reviewed analysed and the outcome shared. Feedback included comments such as, "I was impressed by staff knowledge of the people they support" and "My keyworker is always very supportive."

Staff worked closely with professionals to ensure people could access the support they needed and be supported in the most appropriate way. Professionals had given positive feedback including, "The manager has maintained outstanding communication throughout the process" and "They have a great knowledge

around how to access health services for people and do so quickly." Hospital consultants had commented positively on the standard of information provided in people's hospital passports.