Central and Cecil Housing Trust

Compton Lodge

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Compton 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.

Compton Lodge is a residential care home for up to thirty two older people, each accommodated over three floors with communal living space on the ground floor. At the time of our inspection there were twenty six people using the service.

This unannounced inspection took place on 10 and 12 January 2018. At the last inspection on 19 January 2016 the provider met all of the legal requirements we looked at and was rated good.

At this inspection we found the service remained Good.

The service had a registered manager in place. 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 and associated Regulations about how the service is run.

All staff we spoke with understood their duty to protect the people in their care. Staff knew what to do in order to protect people from abuse and how to identify and minimise potential risks to people's health and welfare. Medicines were safely administered, managed and stored.

There were sufficient staff to meet people's needs. People, and relatives, told us that they were happy and that staff provided safe and good care.

Care staff undertook training which helped them to carry out their role. The supervision and appraisal system also supported them to carry out their work.
People were supported to consent to care and the service operated in line with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, consulting with people and their relatives about their wishes and needs.

People were supported to maintain good health. People had access to health care services whenever this was needed and appropriate advice was obtained from healthcare professionals when required. People received a nutritionally balanced diet to maintain their health and wellbeing.

The service carried out assessments of people's needs before they moved in to make the right decision about whether the service could provide the care and support that people needed. Care plans described each person as an individual and were tailored to their unique needs. Care plans were regularly reviewed and any changes to people's needs were recognised and action was taken to respond.

The service had a clear management structure in place. The service had a range of quality assurance, consultation and monitoring systems in place. The provider listened and responded to the views of people who used the service, relatives and other health and social care professionals.

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

Compton Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 10 and 12 January 2018 and was unannounced. The inspection team comprised of an inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.' We also reviewed the information we held about the service including people's feedback and notifications of significant events affecting the service.

During the inspection we spoke with ten people who used the service, three relatives and two friends of people. We spoke with the head of a voluntary group, a visiting healthcare assistant, four members of care staff, the deputy manager and the operations manager. We also spoke with a visiting healthcare assistant from the local health centre and the chair of the "Friends of Compton Lodge" volunteer group. We received feedback from professionals who had contact with the service and also viewed the very positive report from Health Watch Camden who had visited the home in October 2017.

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

Good

Is the service safe?

Our findings

People we spoke with told us "Yes staff are very good" and that it was not noisy at night time. One person told us about pain they had been experiencing which we raised with the deputy manager so they could speak with the person. One person we spoke with was not very happy with some staff which we discussed with the deputy manager who was able to satisfactorily clarify the situation.

People were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent it from happening. All staff, and senior staff, we spoke with were clear about their responsibilities to report concerns and were able to describe the different types of abuse.

Training records confirmed that staff had completed safeguarding adults training and this was updated. Four safeguarding concerns had been raised since our previous inspection. The provider had co-operated fully with the investigation into these and no on-going or serious concern had resulted from the investigations.

The provider followed safe recruitment procedures to ensure that staff were not employed unless they were suitable to work with people. The service did not have a high staff turnover and many staff had worked at the service over a number of years. The provider's central personnel department carried out these checks and then informed the service once satisfactory checks had been received. We were told by the operations manager of the provider's clear procedures, which we viewed, for not permitting any new staff from commencing in post until full and satisfactory checks had been completed. We looked at verification of satisfactory checks for five of the most recently recruited staff. This meant that people were protected by a provider who was diligent in ensuring that staff were safe and appropriate people to support them.

People we spoke with had mixed views about levels of staffing. Some thought there were enough staff whilst others thought not always enough. We looked at the duty rota for the previous three months and saw that the staffing levels which we had been told about were the normal level. The rota and staff on duty matched the staff rostered for the day of our inspection and we saw that there was a suitable number of staff on duty to attend to people's needs. Consistently there was, aside from registered manager and deputy manager, at least one senior member of care staff and five care assistants on duty each day. In addition to this there were two domestic staff, a chef and an assistant chef working throughout each week. At night there was always a senior care worker and two care assistants. We were informed that the staffing levels were flexible and could be changed according to people's needs.

Care and support was planned and delivered in a way that ensured people were safe. The care plans included risk assessments which identified any risk associated with people's care. There was guidance for staff about how to minimise potential risks. The service had common risk assessments such as falls, manual handling and medicines. These risk assessments then went on to describe other risks associated with people's day to day needs, whether these be about people's physical and healthcare condition or in their day to day activities. Risk assessments were reviewed regularly and were updated sooner if people's needs changed.

Medicines policies and procedures were in place for the service. Medicines were stored securely in a locked trolley in the home's clinical room. Medicines that needed to be kept cool were stored appropriately in a locked refrigerator in this area. The temperature in the clinical room and the refrigerator was checked and recorded on a daily basis. Medicines were in date and stored correctly.

Medicines were being administered correctly to people by trained senior care workers and controlled drugs required checking by two trained staff and these drugs were held securely. The majority of medicines were administered to people using a monitored dosage system supplied by a local pharmacist. We observed the medicines round on the first day of this inspection. The senior care worker that carried this out ensured that they focused on one person at a time, did not rush anyone to take their medicines and cleaned their hands between visiting each person. They then signed the medicines record once they knew the medicine had been taken. Senior care staff were trained in medicine administration, and competency assessments were conducted annually to ensure their practice was safe, or more frequently if the weekly audit of medicines had identified any issues.

The home had a call alarm system and although people had mixed views about how quickly the call bells were answered it was evident that call bell response times were monitored. One person said their call bell was not working which the operations manager immediately went to check on when told this. The problem was remedied quickly. Aside from call bells in bedrooms there were also pendant call alarms that people could wear when they were around other areas of the building. This helped to make sure that people could summon assistance wherever they were.

The home was clean and we saw it being cleaned throughout the day by dedicated staff. Infection control measures were in place and staff used gloves and protective clothing appropriately. Each person using the service had a Personal Emergency Evacuation Plan (PEEP) on their record.

Systems were in place to ensure that all equipment was maintained and serviced. A regular programme of safety checks was carried out. For example, gas safety, fire alarm detection and warning systems, electrical safety and day to day building safety checks were all carried out. There were arrangements in place to deal with foreseeable emergencies.

Good

Is the service effective?

Our findings

People were supported to have their assessed needs, preferences and choices met by staff that had the necessary skills and knowledge. Care staff told us that they received training relevant to the work they did and found the training to be beneficial to carrying out their work and maintaining their knowledge and skills. All staff we spoke with were complimentary about the range of training options available, not on training that they were required to do but also other training that they could apply to do. One member of care staff told us "there is so much training, sometimes it feels like too much but we do get the training we need most definitely." Another told us training "is truly excellent."

In total 96 % of the care staff team had obtained the Care Certificate. This is a core training programme qualification for people working in social care. None of the more recently recruited care staff were on duty during our inspection but training records showed that those recruited had all completed induction, both corporate induction with the provider and induction to the home.

Training records showed that staff were trained and had attended courses relevant to their role. Training included understanding duty of care, dignity, safeguarding adults, dementia, end of life care and moving and handling.

When we asked care staff about whistleblowing they were all aware of what this meant and none told us that they would have any hesitation to raise concerns.
All staff we spoke with felt supported by management. They confirmed and records showed that they had regular supervision sessions with their line manager, averaging every two months. Staff told us that this did happen and they believed it was an important aspect of their work as well as having their performance and development reviewed through annual appraisals.

When we asked people about food they told us "Food is lovely", "Food is ok" and "Quite good, it's very good." One person thought the lunchtime meal on the day was not as good. We told the deputy manager about this order for them to ask the person about it, which they did. The area operations manager informed us that a catering company was used and the chefs were supplied by the caterers. They went on to say that the provider had taken a decision to bring all catering under their control later this year, although the standard of food was usually complimented, they think it would be preferable to have this in house .

People were involved in making decisions about the food they ate and were asked each day what they wanted, which we observed happening. If needed people were supported to eat and drink. We saw this happening for one person who left the table when a member of staff got up to get something. The care staff member saw this and returned to encourage the person to continue their meal, which they did when the member of care staff sat with them. We later asked the deputy manager about the person and they said that they seemed to quickly forget they were eating a meal and needed encouragement to focus on doing this. People were free to eat their meals either in the dining room, lounge on a tray or in their own room if they wished. If anyone chose not to eat at the set mealtime they could eat it later. People were supported to eat and drink in order to maintain a balanced diet and promote their health and wellbeing. The menu was

devised in consultation with people. People told us they usually liked the food and relative's also thought the same with minor exception from one who told us their relative did not like a particular type of meal. Real thought went in to the choices and food was all freshly cooked on the premises which was appreciated by people.

People were supported to maintain good health, have access to healthcare services and receive on-going healthcare support. The care plans we viewed showed that people received support from healthcare professionals when required. For example, the palliative care team, speech and language therapists and visits from district nurses to assist with clinical care needs. These needs included giving insulin and pressure area care. A healthcare professional that had contacted us said that pressure area care had been causing concern last year but this had improved and was not now of concern.

The MCA provides a legal framework for making particular decisions on behalf for people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lacked mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The service was clear about obtaining consent to care and had done so in all of the care plans that we viewed. Relatives were consulted about care assessments and if legally permitted to do so, gave consent if their relative was unable to do so themselves. People had differing degrees of mental capacity, some having full capacity and some having required assessment of mental capacity due to a diagnosis of dementia. Where people were thought for their own safety to have their liberty restricted this was assessed. If the application for assessment for someone being subject to DoLS was approved by the local authority the provider had then notified the commission as required. If decisions needed to be made on a person's behalf the service consulted people and others correctly, including relatives who had been granted lasting power of attorney. We observed care staff offering people choice and respecting the choices they made. Each member of staff we spoke with was aware of people's right to be involved and as far as they possibly could and to refuse care if they chose to. This was not, however, an issue for anyone currently living at Compton Lodge.
One thing we noted about the building was the toilet opposite the office. The toilet was clean, the soap dispenser was in reach but the hand towels were too high up for anyone using a wheelchair to reach without help. We raised this with the operations manager who thanked us and said they would get this looked at and see what could be done resolve it.

Good

Is the service caring?

Our findings

People told us that staff were "Very good and helpful and caring, patient and kind." Another person told us they didn't think they could make a comment but they "Never have to ask staff for anything."

Relatives told us they "Couldn't ask for more, the staff feel like a part of our family" and "Staff care so very much, we can sense that every time we are here."
Care staff were aware of people's support needs and what they would do to encourage continued independence. Staff were aware of the information which needed to be recorded such as accidents, incidents, risk management and safeguarding concerns. They were also aware of how to report any changes in care needs. Care plans described people as individuals, for example, what the person preferred to be called and their life story. Care plans were reviewed every month with the involvement of people who used the service where possible and their relatives, if they wished. They were reviewed and updated more frequently if people's needs changed.

An unfamiliar visitor came for the first time to see someone and care staff checked with the person's relative to see if it was ok. The visitor was offered a cup of coffee, while care staff went to see the person and ask if they wanted to see the visitor, which they did. This demonstrated that staff considered people's wishes about who they had contact with, not least when unfamiliar visitors came to the home.

Our conversations with staff demonstrated that they knew people well. Staff spoke about people with respect and compassion and told us that this was what people had the right to expect.

Care staff told us that they made efforts to explain what they were doing with people, encouraging people to be as independent as they could and to make choices. We observed this during our inspection and staff supported people in a gentle way. People were free to choose if they took part in an activity, whether they wished to spend time with others or alone in their room. People were free to choose when to get up or go to bed, when to have their meals and where they ate.

All staff continued to have training about people's rights and how to maintain respect and dignity for each person the supported. People's personalities, background and life story were included in care plans and these gave a good overall picture of people's life experiences as well as how they now choose to live their lives.

One person told us "I go to the Church of England Service once a fortnight."

Good

Is the service responsive?

Our findings

A relative told us "Our [relative] has become unwell, they had done so before and the staff do keep us informed." The person said this as their relative was prone to having colds and chest infections, which they thought the service did keep an eye on and responded to well.

Care records contained a pre-admission assessment. There was a record signed by the person, or their relative, which confirmed that they had been involved in the decisions about their care plan. Care plans described the person not just the care they needed and were detailed, person centred and provided good information for staff to follow. For example, one described how the person had a daily routine that they had followed when they were living independently and how they were supported to maintain what was familiar to them. People had a wide range of support needs but were encouraged to maintain their independence by engaging in external activities without the need for staff support and doing small things to help out around the home .

The operations manager told us that the home had not received many referrals from people who were not of white British or European descent. People's rights were acknowledged and recognised in terms of their heritage, culture, religion and personal lifestyle choices. One person who had been living at the home for a number of years was not of white British descent. The home had worked well with the person and their family to ensure their needs were met. Although most people were of the protestant faith and attended services held at the home, the service had long established contact with ministers of religion and places of religious worship, for example catholic churches and synagogues. The staff team were knowledgeable about people's cultural and religious needs and had the information and relationships with external organisations to ensure these needs could be catered for.

Care staff, whether they worked days or nights, wrote a daily update about each person in their individual daily record book. Any activity they had participated in, appointments they had attended other events or visits from people were also recorded. The information that was recorded was detailed enough to give a good overview of how the person was and how their needs were being met. This was also supported by staff communication at the handover between each shift. We saw the deputy manager looking at each of these books in the morning of the first day of this inspection. She told us this happened every day so that people's progress could be monitored and any action that may be needed could take place. It was evident that close attention was being paid to how people were and what could be done to respond and improve people's daily life experience at the home.

Activity programmes were detailed on a weekly activity noticeboard. We saw there were activities scheduled every day. People did not make any real comment about activities when we asked about these. However, we saw an interaction where one person had hoped they would have talking books. We found out later that the person had received them. They said they did not like using the headphones. The operations manager, on hearing this, arranged for the person to listen to the talking book CDs in the lounge near the office. They then also set up the home's tablet computer so the person could hear the talking newspapers. He then showed staff how the IPad worked in order to listen to the daily papers.

On the day of our inspection, the only activity we saw was an arts and crafts workshop was taking place in the morning. We spoke with the operations manager about the variety of activities and he accepted that more could be done. There were however visits from school children, both junior and secondary schools. The secondary school children worked with people on their life story. Later in the day there was a regular weekly social event that was organised by "The friends of Compton Lodge" which we were told by the leader of this voluntary group was attended by relatives as well as people living at the home. This group also arranged other events such as garden parties and themed social events aside from the weekly gathering. There was a hair salon in the home and the hairdresser was visiting on the first day of our inspection. A volunteer from a charity which tutors people in the use of computers, visited twice weekly. In addition to a desktop computer, the home had two computer tablets for people to use. The operations manager told us that the home had recently begun a dementia experience programme to review and develop the ways in which the home worked with those with dementia. It was too early to assess the impact of this but encouraging to see that thought was being given to how to make improvement in this area.

Meetings were organised for people and their relatives on a regular basis. People and their relatives were consulted on issues about the day to day operation of the home and were encouraged to share their views. There was good communication with relatives and some relatives of people, that used to live at the home, were very supportive and active in the "Friends of Compton Lodge" voluntary group.

A copy of the complaints leaflet was on display on the notice board at the service. Staff told us that if anyone wished to make a complaint they would advise them to speak with the registered manager or pass on the complaint themselves. The complaint records showed that there had been fourteen complaints in the past year and these had been recorded, investigated the outcome was feedback to the complainant. Complaints were of a minor nature and were easily resolved and the service recorded any comments made regardless of the nature of the complaint. We saw that any learning from complaints had been taken into account and used to make improvements to the service provided for people. For example changes to how particular things were done and how people preferred to be cared for. There were also a number of compliments from people and their relatives, thanking the staff team for their support.

The home provided end of life care to people with the support of the district nursing service and "Treat" team who were a locally based hospital team that provided advice to care services. All care staff received training in end of life care. Compliments had been received by the home about the way relatives felt their loved one had been cared for when receiving end of life care in the home.

Good

Is the service well-led?

Our findings

It was evident from the range of comments that we received about other areas that people had no concern about how the service was managed.

The manager was supported by a deputy manager and a team of senior staff. Staff told us they felt well supported by each other and the management team. Staff contributed to how the service was run, through regular staff team meetings and daily handover meetings. The staff we spoke with knew their roles, the lines of accountability and what was expected from them. A member of care staff told us that if they had any concern about the service they felt able to raise this if they needed to with the operations manager as well as the internal home management. Another member of care staff told us "I would raise concerns [with the provider] but I hope I would also be able with the management here, but I have never had to."

The provider continued to promote a positive learning culture. There was a commitment to continuous improvement and keeping the quality of the service being delivered under review and not being averse to make changes as and when needed. One example was the catering service that the provider plans to make changes to. We saw how management encouraged care staff to take responsibility for their keyworker role and for ensuring people they supported were closely supported. A keyworker is the word used to describe a member of staff who is assigned to each person to oversee their care plan and progress.

There was evidence of regular audits and spot checks undertaken by the management team, including checks of care records, night time unannounced visits, communication and staff practice. Outcomes and learning from audits as well as incidents and investigations were shared with the staff team in one to one supervision and team meetings. Day to day matters were also discussed at the take 10 meeting, which was a daily meeting held after people had breakfast, where events and the plans for the day were organised.

The quality of the service was monitored through the use of surveys, although it was evident from conversations we had with people that this was not the only time that they were asked about their views. The provider also had a system of regulatory governance audits at least twice each year. We viewed those that had taken place in the last twelve months. These audits measured the service in the five key questions that CQC regulate against. The performance of the service and any service improvements that were required were commented upon and action was taken. Therefore, the provider had mechanisms in place to assess the quality of the service and evaluate its performance in order to improve the quality of the service provided to people.

The provider had clear procedures for maintaining people's privacy and for ensuring personal care records were kept securely in order to protect people's confidentiality.