

Carmand Ltd







Emerald House

Inspection report

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Date of inspection visit: 29 and 30 June 2015
Date of publication: 17/08/2015

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?		Requires Improvement	

Overall summary

This unannounced inspection took place on 29 and 30 June 2015. At the last inspection on 12 September 2014, the registered provider was compliant with all the regulations we assessed, this was a follow up inspection from our inspection in June 2014, where we had asked the registered provider to take action.

Emerald House is a three storey listed building, situated in the market town of Brigg. The home is situated within walking distance of local shops and other amenities including a bus route to

local towns. The service is registered to provide care for up to six people with mental health needs and learning disabilities. The home has six single bedrooms, two bathrooms, a spacious kitchen, a laundry and a large lounge and separate dining room. There is a garden to the rear of the property and car parking at the side. At the time of the inspection there were three people living at the service.

The service did not have a manager registered with the Care Quality Commission[CQC] at the time of our inspection. This means the service has been without a

Summary of findings

registered manager since February 2014. An acting manager was appointed to the post following this and submitted an application to become the registered manager. The registered provider reviewed this following identified areas for improvement at our inspection of June 2014 and a new manager was appointed to the post in August of 2014 and has responsibility of the day to day running of the service. For the purpose of the report we will refer to them as the acting manager. They are now in the process of registering with the Care Quality Commission. 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.

We found staff were recruited in a safe way; all checks were in place before they started work and they received an induction. Staff received training and support to equip them with the skills and knowledge required to support people who used the service. There were sufficient staff on duty to meet people's health and welfare needs.

Systems were found to be in place to protect people from the risk of harm and abuse. Staff had received training and knew how to report any concerns and they had policies and procedures to guide them.

We found people's health and nutritional needs were met and they had access to a range of professionals in the community for advice, treatment and support. We saw staff monitored people's health and responded quickly to any concerns.

Assessments of people's needs were completed and care was planned and delivered in a person-centred way. Risk assessments had been developed to provide staff with guidance in how to minimise risk without restricting people's independence. People had access to activities both within the service and community facilities.

We observed staff treated people with dignity and respect and it was clear they knew people's needs well. Staff helped people to make their own choices and decisions. When people were assessed as lacking capacity, staff followed the principles of the Mental Capacity Act 2005 and held best interest meetings with relevant people present, to make decisions on their behalf.

We found the environment was accessible and safe for people. Equipment used in the home was serviced and an issue of window restrictors not being in place in unoccupied rooms was addressed on the day of inspection.

There was a system of audits and checks in place which identified shortfalls within the service and to rectify them so the quality of care could be maintained and improved. This had proved effective, for example in the management of medicines.

People who used the service, their relatives and professionals were encouraged to express their views.

Summary of findings

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 was safe.

There were systems in place to safeguard people from the risk of harm and abuse. Staff knew how to recognise abuse and what action to take if they had any concerns.

Risk assessments were completed and the environment made safe for people.

Staff were recruited in a safe way and there were sufficient staff on duty to meet people's needs.

People who used the service received their medicines as prescribed.

Good



Is the service effective?

The service was effective.

People's health and nutritional needs were met. They had access to health care professionals when required and in a timely way.

People were supported to make their own decisions and when assessed as lacking capacity to do this, the peripatetic manager acted within the law to ensure their rights were upheld.

Staff received training, support and supervision in order for them to feel confident when supporting people who used the service.

Good



Is the service caring?

The service was caring.

Staff were observed as caring and considerate when supporting people.

People were treated with dignity and respect and provided with information and explanations prior to and during care support tasks.

Good



Is the service responsive?

The service was responsive.

People who used the service received care and support that was person-centred and met their individual needs.

People were supported to access community facilities and were encouraged to participate in meaningful occupations.

There was a complaints procedure provided in an easy read format to help inform people. People told us they would feel able to raise concerns and staff knew how to deal with them.

Good



Summary of findings

Is the service well-led?

The service was well led, however the acting manager was not registered with the Care Quality Commission [CQC].

Staff were supported by the peripatetic manager. There was open communication within the staff team and staff felt comfortable discussing any concerns.

Regularly checks on the quality of the service were made to make sure people were happy with the care and support they received.

Requires Improvement



Emerald House

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 registered 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.

The inspection took place on 29 and 30 June 2015 and was unannounced. The inspection team consisted of two adult social care inspectors and a specialist advisor who had knowledge and experience of working with people with mental health needs.

During the inspection we observed how staff interacted with people who used the service. We used the Short Observational Framework for Inspection [SOFI]. SOFI is a way of observing care to help us understand the experience

of people who were unable to speak with us. We spoke with the peripatetic manager, two home co-ordinators and two staff members. Other professionals were spoken with following the inspection

The two people who used the service who were present during our inspection chose not to speak with us. A third person was out at their work placement for the duration of our inspection visit.

We looked care files for the three people who used the service, their medication administration records [MARs] and accident reports. We also looked at how the service used the Mental Capacity Act 2005 to ensure that when people were deprived of their liberty or assessed as lacking capacity to make their own decisions, actions were taken in line with current legislation.

We reviewed a selection of documentation relating to the management and running of the service; including, the training matrix, staff rotas, meeting minutes, maintenance records, recruitment information and quality assurance audits.

Is the service safe?

Our findings

The professionals we spoke with told us the service had a responsible approach to risk assessment, balancing the promotion of independence without putting people at risk.

We spoke with staff about how they safeguarded people from the risk of abuse and harm. Staff confirmed they had received safeguarding training and in discussions, they were able to describe the different types of abuse and the action to take to report concerns. The acting manager had received safeguarding training and we saw they had followed policies and procedures when reporting incidents to the local authority safeguarding team. We found that when the local authority safeguarding team asked the peripatetic manager to check out incidents of concern, these were completed appropriately and in a timely way.

Behaviour management plans had been developed by the service that included guidance for staff in a relation to a range of specific situations. Risk assessments were completed to support people who used the service to minimise risks whilst helping them to remain as independent as possible. Staff could describe the risk assessments and the measures in place to guide them when supporting people. They told us they had time to read care files and changes in information were passed on to them in handovers. It was important for staff to have up to date information about people's needs to ensure their safety and welfare. The risk assessments covered areas such as behaviour management, inappropriate relationships, travelling in a car, eating and drinking and accessing the local community.

Records of incidents were reviewed and we saw that the frequency of incidents had reduced since our last inspection. Incidents had been reviewed regularly and analysed to identify trends. Following this further action had been taken to identify possible triggers and put in place management plans to reduce these behaviours.

There was evidence that learning from incidents and investigations took place and appropriate changes were implemented. Evidence showed the acting manager was monitoring incidents and action was taken where required. Records showed that the acting manager had put in place effective reporting systems; staff were reporting incidents and accidents and these records were being collected each day and reviewed at the organisation's head office by

senior managers. De briefing of staff had also been put in place following incidents. An analysis of all incidents and accidents that had occurred in the service showed the frequency of incidents had decreased, following this

We saw evidence to confirm appropriate checks had been completed before staff commenced working within the service. We checked four recruitment records and saw that before a role was offered within the service relevant checks were completed. We saw gaps on application forms were explored, references obtained and disclosure and barring checks made prior to their first day of employment in the service. These checks helped to ensure only appropriate people were employed to work with adults who could be vulnerable to the risk of abuse. Staff we spoke with confirmed the recruitment process and told us they had an interview to assess their fitness and completed an induction. They said this included a probationary period of six months, meetings to check progress, specific training, reading care files and policies and procedures, shadowing more experienced staff and observations of their practice.

Discussions with staff, a check of the staffing rota and observations of practice indicated there was sufficient staff employed to meet the needs of people who used the service. The numbers of staff on duty each day fluctuated in line with activities people completed and the one to one support they received. There were two members of staff on duty at night and an additional member of staff who completed a sleep-in duty at one of the registered provider's other units nearby. This member of staff was available to support any of the units at night as required. Staff said, "There are enough staff on duty, and if a difficult situation arises additional staff can be called on." The acting manager told us, "We have had a number of meetings with the placing authority for one of the people who uses the service and the need for additional staffing for them has been recognised, but we are still waiting for the funding, although it has been agreed at panel. In the meanwhile the organisation has provided additional staffing in line with the person's needs at their own cost."

We found people received their medicines as prescribed. Medicines were obtained, stored, administered and recorded in line with good practice. There were protocols to guide staff when people were administered medicines, 'as and when required'. These indicated what the medicine was for and the maximum dose. When we looked at the medication stored on site we found that there was a high

Is the service safe?

stock of PRN medicines. We spoke to the acting manager and staff about this and they explained they had been in discussions with their supplying pharmacy to stop further stocks being sent out. This had not been successful so they had planned a meeting with the practice manager at the local GP service in order to address this further.

The environment was seen to be safe for people who used the service. Equipment used there was maintained and serviced in line with manufacturer's instructions. All people who used the service had evacuation plans to guide staff and emergency services in how to move and handle people safely and quickly when required. Staff had completed first

aid training and there was a first aid kit in the service. The close proximity of the registered provider's other services meant these could provide temporary support in emergency situations.

We noted a lack of window restrictors in two unoccupied rooms. When we spoke to the peripatetic manager they showed us this had already been identified through the environmental audit system for the service. They arranged for maintenance team to complete the work immediately as one of the doors to an unoccupied room had been left unlocked. This work was completed within an hour of their call to the maintenance team. We saw the service was clean, tidy and well maintained throughout.

Is the service effective?

Our findings

Professionals told us that as a result of a more stable staff group over the last year, the staff approach had improved as they had developed a better understanding of their client and this had had a positive effect on the individual.

We saw people's nutritional needs were assessed and kept under review. Staff told us they worked with people to produce menu plans at their weekly house meetings and encouraged healthy eating. Once agreed menus were prepared for breakfast, lunch and the main meal in the evening but they told us these were subject to change if people who used the service wanted something else. We saw there was a good range of food and drink supplies in the service.

People who used the service were encouraged and supported to be involved in shopping for food. Observations showed people chose to eat their meals in different places, some people preferred to eat in the kitchen, while others preferred to use the dining room. Staff recorded the meals and fluids each person consumed each day and commented on whether they liked particular foods or disliked others so a preference list could be maintained. We noted in the care records for one person they had previously eaten a very restricted diet, but their diet was much more balanced and varied at the time of our inspection. We saw people had their weight monitored and appropriate action had been taken when there were concerns.

We saw the health care needs of people who used the service were met. They had been referred to health professionals for assessment, treatment and advice when required. These included GPs, dieticians, emergency care practitioners, podiatrists, dentists, and opticians. Records indicated people saw consultants via out patient's appointments, accompanied by staff, and had annual health checks. We saw each person had a health action plan which detailed their health care needs and who would be involved in meeting them. Where a person had declined to attend screening checks we saw that a best interests meeting had been held to discuss this and agree further action.

In discussions with staff it was evident they knew people's health care needs and they described the professionals involved in their care. Comments included, "We have

health action plans and annual health checks." and "When [Name] first came here, they would not access any health checks or appointments. We have worked with them and they have just had check-ups at the opticians and the dentist." Records seen confirmed this.

The Care Quality Commission is required by law to monitor the use of Deprivation of Liberty Safeguards [DoLS]. DoLS are applied for when people who use the service lack capacity and the care they require to keep them safe amounts to continuous supervision and control. The registered manager was aware of their responsibilities in relation to DoLS and had made an application to the local authority but this had not been finalised and authorised at the time of our inspection.

Staff had received training in the Mental Capacity Act 2005 [MCA] and they were clear about how they gained consent to care and support prior to carrying out tasks with people who used the service. Staff said, "Everyone has had capacity assessments and information about this is in their care files. If a decision needs to be made and the person is considered not to have capacity, a best interests meeting will be planned to discuss the issue." "If someone doesn't want to do something for example personal care, I would support them, sit and talk to them explain why it's necessary and give reasons. I might also ask another colleague to assist as sometimes a change of face makes a difference." We saw there were records of assessments under MCA and best interest meetings had been held when people were assessed as lacking capacity, to make important decisions.

Staff had access to a range of training relevant to their roles to help them to feel confident when supporting people who used the service. This included training considered essential by the registered provider such as safeguarding, fire safety, first aid, principles of care, basic food hygiene, moving and handling, person-centred care, safe handling of medicines and infection control. Other service specific training included; mental health awareness, conflict management, and MCA/DoLS.

Training consisted of e-learning, practical instruction and face to face training. The training records were held electronically and there was a system to alert the registered manager when refresher courses were due. Records indicated some staff had completed, and others were

Is the service effective?

registered to start a nationally recognised qualification in health and social care. We saw newly appointed staff members had dates for their training planned on the staffing training plan.

An action plan seen showed that staff had been listened to and arrangements made for them to attend the training identified. A supervision and appraisal plan had also been developed and staff confirmed they were now receiving

regular supervision. Staff told us they felt supported by management and had regular supervision meetings and annual appraisals. Records confirmed supervision meetings included discussions about training, what was working well for the member of staff and any issues relating to people who used the service. Staff told us they felt their opinions were valued and they were listened to.

Is the service caring?

Our findings

During the inspection we used the SOFI [Short Observational Framework for Inspection] tool. SOFI allows us to spend time observing what is happening in the service and helps us to record how people spend their time, the type of support they received and if they were positive experiences. We spent time in the kitchen and noted staff interacted well with people in a relaxed and supportive manner. It was evident that positive relationships had been built and staff were aware of people's interests and personal needs.

We observed staff interactions and we saw these were positive with staff speaking to people in a caring way. It was clear some staff had developed strong relationships with the people they supported; when individual staff approached them, they smiled and they were clearly happy to see them. Staff were seen to respond to people's queries and explain the purpose of our visit when they were asked. One person who had difficulty in accepting unannounced visitors to the service was seen to be offered reassurance and given an explanation of our visit. They were seen to be reassured by this and returned to their bedroom. When we conducted a tour of the service we saw further explanations and reassurances were given to people before we accessed different areas.

People were treated with dignity and respect during our inspection. During discussions with staff they told us how they would treat people with respect and maintain their dignity. Comments included, "I treat people as I would expect to be treated and as an individual." "I always knock on doors and explain to people why I am there, I never just walk in." and "I give people the time they need to respond to questions and new situations."

We saw people who used the service looked well cared for, were clean shaven and wore clothing that was in keeping with their own preferences and age group. Staff told us the people who used the service were always supported to make their own selections of clothing and other purchases for example toiletries.

Staff told us about the importance of maintaining family relationships and supporting visits and how they supported and enabled this; in home visits and sending

birthday cards to family members. They told us how they kept relatives informed about important issues that affected their family member and ensured they were invited to reviews.

When we spoke with staff about the needs of each individual we found they had a good understanding of their current needs, their previous history, what they needed support with and encouragement to do and what they were able to do for themselves. The continuity of staff had led to the development of positive relationships between staff and the people who used the service. We observed one service user greet staff as they came on duty and tell them about their home visit and chat to them about their planned activities for later in the day. Staff confirmed they read care plans and information was shared with them in a number of ways including; a daily handover and team meetings.

During discussions with staff, they were clear about how they promoted people's independence; this included supporting people to develop more independent living skills in preparation for moving into their own flat at some point in the future. For another person, this was about encouraging them to participate more in activities outside of the service and being involved in doing their own food shopping. As each person had individual staffing in place to support them, this gave people who used the service the opportunity to choose their preferred activities and when they wanted to engage in them.

Staff we spoke with told us that on occasions the people they supported may at times become withdrawn, but they were able to identify patterns of these behaviours emerging quickly and take appropriate action to engage and support them during these periods. We later looked at care records and these showed the actions described by staff were appropriate and in keeping with the protocols within their care plan.

Records showed that people were supported to access and use advocacy services to help them to make decisions about their life choices.

Each person had their own bedroom, which afforded them privacy and space when they wanted to be alone. The bedrooms were personalised and decorated with pictures and items of their choice and interest.

Staff used an office to hold telephone conversations or meetings with people in private to ensure these were not

Is the service caring?

overheard. Care files were stored in a locked cupboard and staff personnel files were held securely at the head office. We saw computers were password protected to help safeguard personal information.

Is the service responsive?

Our findings

Professionals we spoke with told us the service was responsive and they listened to engaged with people in decision making about their care and development.

We looked at the care files for each of the people who used the service and found these to be well organised, easy to follow and person centred. People's care plans focused on them as an individual and the support they required to maintain and develop their independence. They described the holistic needs of people and how they were supported within the service and the wider community. They also contained details of what was important to people such as their likes, dislikes preferences, what made them laugh, what made them sad and their health and communication needs. For example, their preferred daily routines, what they enjoyed doing and how staff could support them in a positive way.

Individual assessments were seen to have been carried out to identify people's support needs and care plans were developed following this, outlining how these needs were to be met. We saw assessments had been used to identify the person's level of risk. These included identified health needs, nutrition, road safety and travelling in a vehicle. Where risks had been identified, risk assessments had been completed and contained information for staff on how the risk could be reduced or minimised. We saw that risk assessments were reviewed monthly and updated to reflect changes where this was required.

Staff completed daily records, which prompted them to include specific information. We saw this included what people had eaten for their meals, what their general health was like, how they had spent their day, what contact there had been with family and friends, what activities they had completed and any community facility they had accessed. Staff also recorded any marks they found on people on a body map and monitored people's weight and their bowel function to alert them to concerns which might need speedy action.

We saw evidence to confirm people who used the service and those acting on their behalf were involved in their initial assessment and on-going reviews. Records of 1:1 meetings with people who used the service and their keyworker were seen. Similar records of items they wished to discuss at their reviews were also in place.

Records showed people had visits from or visited health professionals including; psychologist, psychiatrists, community nurses and chiropodists, where required.

When there had been changes to the person's needs, these had been identified quickly and changes had been made to reflect this in both the care records and risk assessments where this was needed, this ensured their choices and views were recorded and remained relevant to the person. Staff told us, "We use the support plans more than ever. Everyone follows them so they work better now." and "We have more information about the clients now than ever before."

We spoke to the acting manager and staff and they were able to provide a thorough account of people's individual needs and knew about people's likes and dislikes and the level of support they required whilst they were in the service and the community.

Staff we spoke with described the progress and achievements of the people who used the service and comments included, "[Name] engages with us better now, at one point they were quite obsessive about particular activities and just wanted to do this all the time. However, now we are able to discuss things with them and they will go away and consider these and then come back to us with suggestions of new things they would be willing to try. As a staff team we are so pleased to see his progress and the improvement in his engagement with us."

Records of activities people had participated in were also seen to be completed. One person had their own car and used this independently, while another person had their own mobility car which staff used to take them out. After the individual's needs had changed and they found it more difficult to get in and out of the care, we saw a best interest meeting had taken place to discuss the purchase of a more suitable vehicle.

During the two days of our inspection we observed a number of activities taking place both within the service and the local community. These included people being supported with shopping, caring for their pet rabbit, being supported with household tasks, going on their work placement and going out in the local community.

The registered provider had a complaints policy in place that was displayed within the service. The policy was available in an easy read format to help people who used

Is the service responsive?

the service to understand its contents. We saw that few complaints had been received by the service, but where suggestions had been made to improve the service these had been acknowledged and action taken.

Is the service well-led?

Our findings

Professionals told us the appointment of the acting manager had made a difference to the service and was what had been needed in their opinion. They told us the peripatetic manager contacted them regularly and kept them informed about all aspects of their clients care and wellbeing.

We spoke with the peripatetic manager about the culture of the organisation and their management style. They said, “We have an open and transparent culture where we seek staff views and they can put them across”, “I try to be enabling; I am visible within each of the services so staff can approach me and I attend as many house meetings as I can so we can discuss issues as they arise.” and “I have five services to manage so I try to move around them all to see the service users and the staff.” The peripatetic manager described how there had been communication issues, low staff morale, staff changes and dynamics that required attention to ensure the team worked well together, when they were first appointed to their role. Once this had been identified they had met with staff on a regular basis to identify problems and had put an action plan in place to address and improve these areas.

We found the acting manager was aware of their role and responsibilities and notified the Care Quality Commission, and other agencies, of incidents which affected the welfare of people who used the service. Our records showed us notifications had been received regarding incidents which had occurred and what action had been taken following this.

We saw staff were able to express their views in team meetings, supervision sessions, appraisals and on a day to day basis. Staff told us, “I’m very happy, the manager is available for support and advice when needed, and she is very easy to talk to” and “Our opinions are valued and listened to.” Another member of staff said, “We are more supported now than ever, the on call systems work and they always answer.” There were various methods of

ensuring information was passed on to and between staff. These included handovers at each shift, a communication book, briefings, newsletters, team meetings and via emails. The peripatetic manager told us all staff had access to a portal on the computerised IT system; this enabled them to access policies and procedures and to record their training information.

Staff rotas were looked at and we noted that senior staff had time planned into their weekly rota to complete audits of the service. The peripatetic manager told us the audit system had been re-introduced after their appointment in order to identify any shortfalls promptly and agree appropriate action quickly in order to rectify this.

We looked at the processes in place to monitor the quality of the service. We found the acting manager completed regular audits in areas which had been highlighted at the last inspection. These included care plans, health and safety, maintenance, fire, fire risk assessments, supervision, staff competency checks, audits of care records, activity planning and complaints.

Governance meetings were held monthly with the provider and directors. Records showed these meetings were a forum to review incidents, accidents and discuss people's changing care needs. Additional areas of the organisation including: training, incidents, safety, staffing, and feedback from people who used the service and to review national clinical good practice guidance, were also looked at.

An assistant psychologist took responsibility for sending out surveys periodically to people who used the service, relatives and professionals and collating the information from these in order to develop appropriate action planning where this had been identified. For example, a previous survey had identified that staff did not feel they had received enough support or relevant training to enable them to carry out their roles.

We saw there were improved systems in place to monitor people's health and welfare and these systems had been maintained and had influenced the care provided.