Mrs Kim Jomeen

# Emm Lane Care Home

## Inspection report

72 Emm Lane
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Bradford
West Yorkshire
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Tel: 01274541444

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

| | |
|---|---|
| Is the service safe? | Requires Improvement |
| 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 inspected Emm Lane Care Home on 14 June 2016 and the inspection was unannounced. At our previous inspection in April 2016 we found breaches in relation to the safe management of medicines and good governance. We issued requirement notices for the service to improve in these areas and a plan was sent to us by the provider detailing what actions were being taken. At this inspection we found improvements had been made and the service was no longer in breach of Regulations.

Emm Lane Care Home is a semi-detached period property providing care and accommodation for up to 14 adults with a mental illness. The accommodation is situated on three floors with two twin and ten single bedrooms. There are two lounges and a dining room/kitchen. The home is situated approximately three miles from Bradford city centre. On the day of our inspection there were 12 people living at the service.

At the time of our inspection the service was managed by a care manager. Due to the provider being registered as an individual, the service does not require a registered manager to be 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 2008 and associated Regulations about how the service is run. We saw the provider had daily oversight into the running of the service.

People told us they felt safe in the home. Safeguarding procedures were in place which staff understood although we saw one incident where a safeguarding referral should have been made. However, we saw a number of other appropriate safeguarding referrals had been made and these had been investigated. Accidents and incidents were documented with actions and analysis.

Medicines were safely managed. PRN processes and appropriate storage were in place, medicines records were completed and medicines were administered in a calm and safe manner. However, information about decisions regarding covert medicines needed to be fully documented.

The provider had made improvements to the environment and the service was safely maintained, although further improvements were required to lighting in some areas.

Risks to people's health and safety were assessed and risk assessments which were in place were understood by staff. People's care and support needs were regularly reviewed which ensured the service remained responsive to people's individual needs. People were involved in the planning and reviewing of their care.

The home was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) and acting within the legal framework of the Mental Capacity Act (MCA).

There were sufficient quantities of staff to ensure people were kept safe and had opportunities to participate

in activities. Effective recruitment procedures were in place. Training was in place to ensure staff provided effective care and support.

People were supported to eat and drink and maintain a healthy lifestyle with dietary needs and preferences considered.  People's health care needs were met.

People said staff treated them well and were kind and caring. They told us staff ensured their dignity and choices were respected. We saw positive relationships had developed between people and staff and the atmosphere in the home was calm and relaxed.

The service helped people maintain their independence by encouraging them to assist with daily life within the home and engaging with activities outside the service.

Complaints and concerns were taken seriously by the service, investigated and documented with outcomes. We saw these were mainly minor concerns but still treated in the same manner.

Staff told us they felt supported by management and we observed a positive culture at the service, with good staff morale. People told us they felt able to approach the care manager and provider with any concerns. Staff and resident meetings were regularly held to discuss any concerns or service information.

A range of systems were now in place to monitor the quality of the service and drive improvements.

The service rating for the service was displayed within the home and the service took steps to ensure this was also displayed on the provider website on the day of our inspection.

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

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not consistently safe.

Medicines were generally managed and administered safely by trained staff. Medicines audits were in place but needed further detail to drive improvements. The medicines policy required updating to reflect current legislation.

People told us they felt safe living at the service. However, the service needed to ensure all safeguarding concerns were reported to the local authority and the Care Quality Commission.

Improvements had been made to the environment to make it safer for` people living there. Further improvements to lighting in some areas was required.

Sufficient staff were deployed to offer safe care and support. Safe recruitment processes were in place.

### Is the service effective?

**Good**

The service was effective.

The service was acting within the legal framework of the Mental Health Act 2005. Best interest processes were in place where required.

People's health care needs were effectively met.

Staff training was up to date or planned.

### Is the service caring?

**Good**

The service was caring.

People told us staff were kind and caring. We saw good relationships had developed and there was a relaxed atmosphere in the home.

Staff respected people's right to privacy, knocking on doors and

asking permission to enter people's rooms.

Confidential records were locked away when not in use.

## Is the service responsive?

Good

The service was responsive.

People's needs were assessed and appropriate plans of care put in place. Observed care and support reflected plans of care.

Activities were offered according to people's preference. People's independence was encouraged through assisting with daily life within the home and attending activities in the local community.

Complaints were taken seriously and actions taken as a result. A complaints policy was prominently displayed in the home.

## Is the service well-led?

Good

The service was well led.

Staff said they felt supported and morale was good.

People and staff praised the management team and told us they felt able to approach them with any concerns.

A range of quality assurance audits were in place to monitor and improve the service.

# Emm Lane Care Home

**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 14 June 2017 and was unannounced. The inspection team consisted of two adult social care inspectors.

Prior to the inspection, we reviewed information about the service. This included information from the local authority commissioning and safeguarding teams and notifications received from the provider. Before the inspection, the provider had 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. This had been returned in a timely manner and we took the information within the PIR into consideration when making our judgements.

During our inspection we reviewed four people's care records, some in detail and others to check specific elements of care and support, as well as other information regarding the running of the service including policies, procedures, audits and staff files. We spent time observing care and support. We spoke with the care manager, the  provider, a member of care staff and the domestic as well as five people who lived at the service and a visiting health care professional.

Requires Improvement

# Is the service safe?

## Our findings

At our last inspection in April 2016, we found shortfalls in the medicine management systems which meant people were at risk of not receiving 'as required' medicines when they needed them. The storage arrangements for some medicines were not safe, and some medicine records were not always fully completed. At this inspection we found improvements had been made and the service was no longer in breach of Regulations.

Medicines were overall safely managed and administered. Staff administering medicines had received training in the safe administration of medicines. Medicines were supplied either in boxed format or within a dosette box. Dosette boxes have compartments stocked with multiple medicines, divided by time and date to make medicine administration easier.

Medicines were stored in a locked cupboard and we saw this was kept locked when unattended. Some medicines needed to be stored in a fridge and this was also kept secure. Daily checks were made of the fridge temperature and we saw these were documented and within acceptable limits. We saw a medicines policy was in place and the service had a copy of the National Institute for Health and Care Excellence (NICE) guidelines for medicines administration. However, the medicines policy needed updating to reflect current legislation.

Some prescription medicines contain drugs that are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs (CDs). Since our last inspection improvements had been made to the safe storage of controlled medicines and we saw these were now stored in a regulatory approved controlled drugs cabinet.

People had signed consent forms to allow staff to administer their medicines. Where people were prescribed medicines, we saw risk assessments were documented and specific care plans in place where appropriate.

We observed the morning medicines round and saw people's independence was promoted with the person administering the medicines handing the medicines to the person to take themselves and checking they had done so. Medicines administration was carried out in a calm and sensitive manner.

Medicines administration records (MARs) were in place and we saw these were well completed with no gaps and correct codes used; for example, if a person had refused or were unable to take their medicines. People's photographs were attached to the front of the MAR to facilitate correct identification. We observed MAR charts were signed after the staff member had seen the person take the medicines. We saw two staff checked and administered controlled drugs, the MAR was signed and both staff signed the controlled drug register.

Protocols were in place to guide staff in what circumstances 'as required' (PRN) medicines should be given, such as paracetamol. We saw the care manager asked people if they required prescribed PRN medicines during the medicines administration round.

Some medicines can be administered as 'covert' medication. We saw where one person had covert medicines in place, a detailed best interests process had taken place. However, the decision process had not recorded the pharmacist instructions. Following our inspection, the care manager contacted the pharmacist who gave their agreement for their advice to be documented in the care record.

Some people were prescribed topical creams and inhalers. Where possible, we saw people were supported to self-administer these.

Medicines audits were in place although these were basic and would benefit from further detail. We completed a random check of medicines stock balances and found all those we checked corresponded to the amounts that should have been in place. A system was in place to safely order and dispose of medicines.

People told us they felt safe at the service and were well treated. One person commented, "Didn't like being here at first but knew I was in a safe place. Definitely feel safe here." We saw the premises was secure with locks to the outer doors and visitor's identity checked prior to entry. People were supported to keep their own bedroom door keys with the service holding a copy in case of emergency.

Staff had received safeguarding training and understood how to recognise and report suspected abuse. We saw a number of appropriate safeguarding referrals had been made and these had been investigated with actions taken. However, we saw one instance of suspected financial abuse between two people living at the service had not been reported to the local authority or the Care Quality Commission. The care manager agreed this was an omission since it was documented as a complaint rather than a safeguarding concern. From our discussions and reviewing other documented safeguarding information, we were confident this was an isolated omission. However, the service needed to ensure any future safeguarding concerns were identified and reported appropriately.

Accidents and incidents were recorded and investigated with analysis. A range of assessments were in place to mitigate risk and keep people safe. These included smoking risk assessments where people were at risk due to having been found to be smoking in their room.

Some people had their personal allowance held, with their agreement, for safekeeping by the home. We saw evidence of people's signed consent for this in their care plans. Secure arrangements were in place and when we checked a sample of people's records and balances we found these were correct.

We reviewed the staff rotas and saw sufficient staff were deployed to safely support the people living at the service. Most people were independent and required prompting or minimal assistance with their personal care. On the day of our inspection the service was staffed by a care manager and a care worker during the day and evening, with a waking staff member on duty at night who had access to an on call telephone number in the event of an emergency. In addition, the provider attended the service on a daily basis to offer support and carry out general maintenance work and a daily domestic assistant was also employed. No concerns were raised about staffing levels during our inspection. We saw staff were available to provide support to people when required and offered low key supervision in communal areas such as the dining kitchen.

Staff were recruited safely to the service. We looked at three staff recruitment files. All had completed application forms and proof of identity documents were on file. Disclosure and Barring Service (DBS) checks had been completed and references were in place to ensure people employed were suitable to work with vulnerable people.

At our last inspection we found the premises was not safely maintained, with tired and dated décor. At this inspection we found many improvements had been made although further improvements to update the décor were still required. For example, window restrictors and radiator covers were all in place, grouting in the shower rooms had been refreshed, shower heads had been replaced and a new shower chair was in place in the downstairs shower room. The large garden area had been tidied and looked like a pleasant place for people to spend time in. However, we saw some interior areas remained poorly lit, for instance, the inner landing on the first floor. We spoke with the provider who told us of their plans to update and renew the lighting in these areas.

A range of checks were made to ensure the safety of the premises, such as gas, electrical and fire systems. We found certificates which confirmed safety checks were up to date. The fire alarm was checked weekly, emergency lighting was in place in the event of evacuation due to fire and a full evacuation was carried out every six months with results recorded. People had personal emergency evacuation plans recorded in their care records. We saw the provider carried out daily maintenance checks within the home.

Good

# Is the service effective?

## Our findings

We reviewed the staff training matrix and saw training was up to date, booked or planned. This included training on; mental health, behaviour that challenges, safeguarding, dementia, infection control, COSHH, fire safety, diet and nutrition, health and safety, medication and the Mental Health Act 2005. Staff told us the training was sufficient to give them the skills to provide effective care and support. Training was provided in-house, or via work books, external training or E-Learning. Staff new to care were enrolled for the Care Certificate. This is a government recognised award designed to equip staff new to care with the required skills to carry out their role.

We saw supervisions and appraisals were planned for the year although some were overdue. We spoke with the care manager who was aware and had plans in place to ensure these were updated. From our discussions we were confident these would take place.

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). DoLS requires care homes to make applications to the local authority where they suspect they are depriving people of their liberty. Although no DoLS were currently in place our discussions with the care manager showed they understood their legal responsibilities under the Act and were able to demonstrate logical decision making processes were in place. Mental capacity assessments were carried out where appropriate. We found no evidence to suggest people living at the service lacked mental capacity regarding decision making.

We saw people could move freely within the service and come and go from the home according to their wishes. We saw good evidence of consent being sought during our inspection from information in care records and staff interaction with people living at the service. For example, staff asked for consent prior to medicines administration, assistance with food, care and support and before entering people's rooms as part of the inspection process. One person had refused consent for their room to be entered and we saw staff respected this. People had signed consent forms in their care records. Records of best interest meetings and decisions were place with relevant people involved, including the person to whom the decision related to wherever possible. Staff confirmed they had received training in MCA and DoLS and guidance was displayed for staff about the legislative framework.

People told us they were happy with the food provided at the service and had a say in what food was on the menu. One person commented, "Lovely food." Another person said, "The food is all right. We have good curries made, chapattis and English food; we get all sorts. Enough choice but I am a bit picky." We saw

mealtimes were calm and relaxed with people helping with various tasks such as setting the table, food preparation and clearing dishes away.

A choice of food was on offer. For example, at breakfast, some people chose from a selection of cereals, toast or a cooked breakfast. Menus were displayed on a board in the dining kitchen and were rotated every four weeks. People got up and came for breakfast when they wanted and were encouraged to help themselves, with staff available to assist if required. We saw people were offered regular fluids or helped themselves to drinks throughout the day.

People were weighed monthly or weekly if seen to be losing weight and actions taken. Where people were assessed 'at risk' nutritionally we saw referrals had been made to the dietician team and records made of their dietary intake. We saw the service used full fat products to supplement people's diet where required.

From reviewing care records and speaking with staff and people living at the service, we saw people had access to a wide range of healthcare services. This included GP, district nurses, community psychiatric teams, chiropodists, opticians and dentists. We saw staff were vigilant regarding people's health care needs. For example, we saw a GP referral had been made after a person was becoming increasingly drowsy in the mornings, the times of medicines administration was reviewed and the person was now much more alert during the day. We also saw where the care manager had pushed for involvement of the community psychiatric team following the deterioration of a person's mental health after their medicines had been altered. This had led to a review and staff and a community professional told us the person's mental health was now becoming more stable.

Good

# Is the service caring?

## Our findings

People were supported by staff in a kind and compassionate manner. Staff we spoke with knew people well, could describe their likes and dislikes as well as their care and support needs. For example, staff told us how one person liked their toast well done in the morning and we saw this was the case when they prepared their breakfast. This information was also included in the person's care records, showing a person centred approach to care planning. Most staff had worked at the home for a considerable time which meant good relationships had developed.

The atmosphere in the home was relaxed and inclusive and we saw staff spoke with people gently and with respect. We saw some good, caring interactions and people appeared relaxed and comfortable around staff. For example, we saw staff members and people chatting with each other in the dining kitchen and sharing a laugh and a joke. People told us staff were kind and treated them well. Comments included, "I'm happy. Staff are nice; no complaints", "It's ok here; like a family. Staff are like family. We are like a family; they (staff) said that to me", "I like how we help each other out and respect boundaries," and, "Staff provide good care here."

We spoke with a visiting health care professional who told us they had no concerns about the home and felt staff were kind and caring.

People were supported to be as independent as possible. For example, at meal times some people assisted with meal preparation, others helped to set the table and others helped clear away and wash dishes. We saw one person was supported to eat their lunch at a time that suited them, rather than at a time set by the staff. One person told us the service was getting quotes for creating an en-suite and independent access to the garden from their bedroom to help with their mobility issues and promote their independence. We confirmed this with the provider and staff we spoke with. This was further evidence of a person centred approach to care and encouraging greater independence.

We saw staff respected people's privacy. For example, we saw staff knocking on doors before entering people's bedrooms. People were able to lock their individual rooms and spend time in them if they did not want to socialise in communal areas. One person told us, "Staff are very polite; knock on doors before entering." Another person told us how staff put them at their ease when providing personal care, saying, "Staff minimise embarrassment for me."

We saw people's end of life wishes were recorded in their care records. Where a person had not wanted to discuss, we saw this was recorded as evidence a conversation had taken place. This showed staff respected people's wishes.

Records were securely stored in cupboards which were kept locked when not in use. This demonstrated staff respected people's confidentiality and private information.

We saw the service took account of people's protected characteristics as set out in the Equalities Act 2010.

Protected characteristics are age, disability, gender, gender reassignment, marital status, pregnancy and maternity status, religion or belief and race. For example, arrangements had been put in place to meet one person's sexual needs and to support their social activities. We saw another person was supported with their needs in relation to their race and religion.

People told us they had been supported to vote in the recent general election. A staff member commented, "We encouraged people to vote. They were all given the choice (to vote). It was their decision." This showed the service respected people's human rights and encouraged people to make independent choices.

Good

# Is the service responsive?

## Our findings

We saw people's needs were assessed prior to admission and plans of care were put in place. Care records were person specific and contained detailed information about people's care and support needs. We saw care plans mostly reflected people's current needs although some information needed updating to ensure current information was documented. We observed care and support reflected people's plans of care, such as people being encouraged to help prepare their own meals. Throughout people's care records we saw a high emphasis was placed on maintaining and encouraging people's independence, such as encouraging outside activities, hobbies, shopping and socialising.

We saw some people had plans of care in regard to behaviours that challenge, including risk assessments and behavioural management plans. These were detailed and person specific. One person told us how the staff had helped them to become calmer and work through their feelings and commented, "They have helped me loads, to find out what's wrong mentally. I'm now much better. Used to be aggressive; now better."

The care manager told us some care records were used as a tool to educate new staff about how to maintain people's mental state. For example, we questioned why a particular care record was still relevant about one person's ability to express themselves verbally when recent reviews had showed an improvement with their communication. The care manager explained this was still relevant since their associated plan of care and actions had impacted upon this and all staff needed to be aware so improvements could be maintained. This showed the service focussed on improving and maintaining the well-being of people living at the service.

Care records were reviewed at least six monthly or if people's needs changed. For example, we saw one person's care plan and falls risk assessment were reviewed following a recent fall. We saw people signed to show they were involved both in the planning and review of their care.

The provider's complaints policy was on display in a prominent position in the entrance to the home which detailed how people could make a complaint. We saw complaints were investigated, including low level concerns, and actions were seen to be taken. We spoke with the care manager about the need to recognise if a complaint required further actions such as notifying the local authority and the Commission and from our discussions felt confident this would be done.

We saw evidence of activities taking place according to people's wishes and choices. For example, on the day of our inspection some people were going out independently, others were accompanied by a staff member for a walk in the park and two people chose to sit in the lounge and watch television. We saw people were asked if they wanted to take part in activities and their choices were respected. For example, one person was asked by staff if they wanted to go to the park for a walk and they declined, saying they wanted to spend time in their room instead. However, we saw staff encouraged people to keep occupied and made suggestions as to what people might like to do. For example, we saw one person went to social clubs in the local community and the care manager had suggested other venues they may wish to attend.

This was evidenced by information in the person's care records, the activities book and by speaking with the person and the care manager.

An activities board was displayed in the sitting room and an activities book was completed on a daily basis. This showed people were engaged in activities such as dominoes, visits to the local library, knitting, spending time in the garden, cycling and watching films. Records showed a flexible approach to activities rather than a rigid structure. The care manager told us, "Most people come and go as they please." Comments from people included, "We celebrate birthdays together. We get a cake for our birthday and sing 'Happy Birthday'", "We do activities, some things I don't want to get involved in," and, "Activities are very low key. I do activities on my own."

Good

# Is the service well-led?

## Our findings

At our previous inspection, we found there were a lack of systems and up to date controls in place to assess and monitor the quality of the service. At this inspection we found improvements had been made and the service was no longer in breach of Regulations.

A range of audits and checks were undertaken including audits of medicines, infection control, environment, care records, accidents/incidents and complaints. Although these were basic in nature, we concluded they were appropriate for the size of service. Water temperatures were checked weekly which showed they were within safe perimeters. In addition, the care manager completed a daily quality assurance checklist which looked at various elements of the service including environment and fire safety. We saw examples of actions taken as a result of audits, such as reviews of medicines and people's care plans. These showed audits were being used as a working quality tool to help improve service provision and keep people safe.

A monthly provider audit was undertaken which focussed on the environment. We saw evidence of actions taken as a result of these. In addition, the provider was present on a daily basis to offer support to the care manager.

People and staff all praised the management team and the provider and expressed no concerns about how the service was run. Staff told us they felt supported and comments included, "I'm very happy. Any problems, I go to [provider name] and he sorts them out straightaway," and, "[Provider name] is supportive. He speaks to people and is here all the time; does everything that needs doing; asks if we're okay." A care professional commented, "[Care manager] is really open." A person told us, "[Care manager] is brilliant."

We saw the service had a cohesive and stable team structure and staff worked well together. There was a positive culture at the home and staff morale appeared good. During our inspection we found staff open and the care manager and provider open to suggestions on how to improve the service.

People were involved in aspects of the service through regular meetings. We saw various people living at the service acted as chairperson for these meetings during which items such as concerns, activities and menus were discussed. We saw evidence actions were taken as a consequence of these meetings, such as increasing available snacks and including people's suggestions on the menus. People signed their attendance which ensured they retained ownership of the meetings.

Although the service had a small staff base and staff chatted on an informal basis about the service and matters arising, formal staff meetings took place every few months. We saw agenda items included discussions about any concerns, updates, CQC inspection information, activities and planned trips. Staff told us they felt able to discuss any concerns at these meetings.