J.E.M. Care Limited

# Ann Challis

## Inspection report

128 Stretford Road
Urmston
Manchester
Greater Manchester
M41 9LT

Tel: 01617483597
Website: www.jemcareltd.co.uk

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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

Ann Challis is a residential care home which provides care and support for up to 23 older people some of whom are living with dementia. There were 20 people living at the home at the time of our inspection.

The provider had a registered manager in place as required by the conditions of their registration with the Care Quality Commission (CQC). 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. The registered manager was responsible for all the services delivered by the provider.

The home was previously inspected in September 2014 and was compliant in all the areas we looked at then.

People were cared for by staff who knew how to recognise the signs of possible abuse. Staff were able to identify a range of types of abuse including physical, financial and verbal. Staff were aware of their responsibilities in relation to keeping people safe. They were able to explain the process which would be followed if a concern was raised and said they felt confident using the process should they need to.

Risk assessments were in place and reviewed monthly. Where a person was identified as being at risk actions were identified on how to reduce the risk and referrals were made to health professionals as required.

Safe recruitment practices were in place and records showed appropriate checks had been undertaken before staff began work. There were sufficient numbers of staff on duty to keep people safe and meet their needs.

Policies and procedures were in place to ensure the safe ordering, administration, storage and disposal of medicines. We observed medicines being administered and staff doing this safely. The manager completed an observation of staff to ensure they were competent in the administration of medicines.

Consent to care and treatment was sought in line with legislation and guidance. Capacity assessments had been completed appropriately for people and were in their care records. Staff we spoke with understood the principles of the Mental Capacity Act 2005 which meant staff understood the importance of ensuring people's rights were protected.

Staff had undertaken appropriate training to ensure that they had the skills and competencies to meet people's needs. New staff undertook a comprehensive induction programme which included essential training and shadowing of experienced care staff.

People were supported to maintain good health and had access to health professionals. Staff worked in collaboration with professionals such as GPs and district nurses to ensure advice was taken when needed and people's needs were met.

People received enough to eat and drink. People who were at risk were weighed on a monthly basis and referrals or advice were sought where people were identified as being at risk.

Family and friends were able to visit without restriction and relatives told us that staff were always welcoming and happy to spend time speaking with them about their family members. Relatives told us that they felt involved in the care their family member received.

We have made recommendations to ensure people who are living with dementia are supported in an environment which is appropriate to their needs and is clean and tidy, and have person-centred care plans which outline how much support they need in relation to their dementia care.

We also recommend that the provider ensures there are more formal systems in place to ensure the quality of the care people receive is regularly reviewed and monitored.

## 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 always safe.

Some areas of the home were in need of redecoration and tidying.

Staff had received safeguarding training and knew how to recognise and report abuse.

There were sufficient numbers of staff to make sure that people were safe and their needs were met.

Risk assessments were in place and were regularly reviewed to ensure that they reflected people's current level of risk.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

The home was not dementia friendly and improvement was needed.

People's rights were protected as the principles of the Mental Capacity Act and the requirements of the Deprivation of Liberty Safeguards (DoLS) were
followed.

Staff had received training as required to ensure that they were able to meet people's needs effectively.

People were supported to maintain good health and had regular contact with health care professionals.

### Is the service caring?

**Good**

The service was caring.

Staff were kind, caring and offered reassurance to people when needed.

People were treated in a dignified and respectful way.

People and those that mattered to them were involved in their care.

## Is the service responsive?

**Requires Improvement**

The service was not always responsive.

Improvement was needed to ensure the care plans for people who were living with dementia were more person-centred.

There were  activities for people to take part in but more work was needed to support activities for people living with dementia.

The service worked well with other agencies, services and families to make sure people received care in a coherent way.

## Is the service well-led?

**Requires Improvement**

The service was not always well led.

Informal quality assurance processes were in place to allow the provider to ensure the quality of the service however improvements were needed in this area.

Staff felt supported and were able to discuss any concerns with the registered manager.

People and their relatives were positive about the quality of care delivered.

# Ann Challis

**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.

Before the inspection, we checked the information that we held about the home and the service provider. This included previous inspection reports and statutory notifications sent to us by the provider about incidents and events that had occurred at the service. A notification is information about important events which the provider is required to tell us about by law. We also reviewed feedback from healthcare and social care professionals. We used all this information to decide which areas to focus on during inspection.

We did not ask the provider to complete 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.

The inspection took place on 5 April 2016 and was unannounced. This meant the provider did not know we were coming. One adult care inspector carried out the inspection along with an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience on this inspection had cared for an older relative.

Some people living at the home were unable to tell us about their experiences; therefore we observed care and support in communal areas. 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 could not talk with us. We spoke with six people living in the home, three relatives, a visiting healthcare professional and six staff including the cook and the registered manager. We also spoke with the owners of the home who were visiting at the time of inspection. We spent time looking at records. These included six care records, three staff records, medication administration record (MAR) sheets, staff rotas, complaints, quality assurance audits and other records relating to the management of the service.

Requires Improvement

# Is the service safe?

## Our findings

We asked the people living at the home what made them feel safe. One person said, "there's a lot of people around which makes me feel safe". Another person told us, "I don't think about safety because staff listen to you and take notice if you are worried about anything."

People were cared for by staff who knew how to recognise the signs of possible abuse. Staff were able to identify a range of types of abuse including physical, financial and verbal. Staff were aware of their responsibilities in relation to keeping people safe. Staff felt that reported signs of suspected abuse would be taken seriously and knew who to contact externally should they feel their concerns had not been dealt with appropriately.

Systems were in place to identify risks and protect people from harm. Risk assessments were in place and reviewed monthly. Where someone was identified as being at risk, actions were identified on how to reduce the risk and referrals were made to health professionals as required.

Before people moved to the home an assessment was completed. This looked at the person's support needs and any risks to their health, safety or welfare. Where risks were identified these had been assessed and actions were in place to mitigate them. There were risk assessments regarding falls and for the moving and handling of people.

Policies and procedures were in place to ensure the safe ordering, administration, storage and disposal of medicines. We observed medicines being administered and staff doing this safely. Medication Administration Records (MAR) were in place and had been correctly completed. Medicines were locked away and stored appropriately and safely.

The registered manager completed an observation of staff to ensure they were competent in the administration of medicines. We saw evidence of this captured within supervision notes we reviewed. This meant people receiving their medicine could be confident that they were being supported by staff who were appropriately trained. People we spoke with told us they received their medicine on time each day and were happy with the support they received.

Safe recruitment practices were in place and records showed appropriate checks had been undertaken before staff began work. We looked at the recruitment procedures in place to ensure only staff suitable to work in the caring profession were employed. When we checked the records for four members of staff we saw that Disclosure and Barring Service (DBS) checks had been done. The DBS helps employers make safer recruitment decisions and helps to prevent unsuitable people from working with vulnerable people.

There were mixed responses from people who used the service about whether they felt there were enough staff but most people we spoke with said they were happy with the level of staff. One person said "they've so much to do; they're always in a hurry. They don't sit and talk very often but there is always someone around." Another person said, "it seems the staff cope very well. They have peaks and troughs, they have

busy times." We asked people if staff came when needed. They told us, "Yes, staff come when needed, we have call bells and there is always someone around."

Staff we spoke with told us they felt there were enough staff on duty. We observed that people were not left waiting for assistance and people were responded to in a timely way. We looked at the staff rota and saw that the staffing levels on the day reflected the staffing levels detailed on the rota. The rota included details of staff on annual leave or training. The registered manager told us that they rarely used agency staff as they liked to ensure that staff had a good understanding of people's needs and the care they needed. Relatives told us there was a consistent staff team and this allowed them to feel confident that staff knew their family member well.

We looked at the environment and saw some areas of the home were cluttered with wheelchairs which were not in use. We also saw some areas of the home were in need of redecoration. We spoke with the owners of the home who discussed with us the improvements they were planning to make. We saw people's bedrooms were clean and tidy but found improvements were needed to ensure all areas of the home were clean, tidy and clutter free to ensure people were kept safe.

Requires Improvement

# Is the service effective?

## Our findings

We found consent to care and treatment was sought in line with legislation and guidance. 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 make 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 in order 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).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Capacity assessments had been completed appropriately for people and were in their care records. This showed that people's ability to consent to care and treatment had been considered. The registered manager told us that DoLS applications had been made for six people living at the service. We looked at the care records for these people and found the correct process had been followed which meant people's rights had been protected.

We spoke to staff about their understanding of the MCA. They told us, "If people are restricted and are unable to tell us what they want then we will have a meeting to decide what is in their best interest." We asked staff about restrictions. They told us, "Anything like bed rails and pressure mats, lap belts and chairs which tilt back." What they told us meant they understood the principles of the MCA and the importance of using DoLS to keep people safe and protect their rights.

Staff had undertaken appropriate training to ensure that they had the skills and competencies to meet people's needs. Staff spoke with us about the range of training they received which included safeguarding and medication training. Staff we spoke with told us, "yes we have lots and lots of training, some is done on line but we often get people in like the speech and language team (SALT) and the infection control man. We are having some [training] next week."

The deputy manager spoke with us about the training they provided and told us "we never stop learning". New staff undertook a comprehensive induction programme which included essential training and shadowing of experienced care staff. New members of staff shadowed existing members of staff to ensure that they were confident before supporting people living at the home.

There was a formal supervision and appraisal process in place for staff and action which had been agreed was recorded and discussed at each supervision meeting. Staff received supervision every eight weeks and also received an annual appraisal. Staff confirmed that they had regular supervisions and told us that they found these helpful.

People were supported to maintain good health and had access to health professionals. Staff worked in collaboration with professionals such as doctors and the falls prevention team to ensure advice was taken

when needed and people's needs were met. People's healthcare appointments were recorded in a diary which acted as a reminder to staff when appointments were due. We spoke with a visiting healthcare professional who told us they were happy with the home and confirmed they acted promptly when referrals were needed or they had any concerns about the people living there.

We observed the lunchtime experience and saw people were supported to have enough to eat, drink and maintain a balanced diet. People told us they had enough to eat and drink, comments included, "it's very nice, and I get a choice, if I don't like it I refuse it". And, "I've never been hungry and if you want a drink you can have one".

The meal was served on small plates and everyone we spoke with said they had enjoyed their meal and they had had enough. Pudding was rice pudding with jam. The people we spoke with who had left some pudding said they were full and couldn't eat any more, but they had enjoyed what they had had. They said, "I get plenty and have no complaints."

People who were at risk were weighed on a monthly basis and referrals or advice was sought where people were identified as being at risk. The cook was aware of people's dietry needs and a record was kept in the kitchen outlining each person's needs or food preferences.

We spoke with the registered manager and the owners about plans they had to make the home more 'dementia friendly'. A dementia friendly environment is an environment which takes into consideration the needs of people living with dementia and allows them to find their way around the home safely and independently. They told us they were keen to improve the environment and recognised work was needed in this area.

We found people's bedrooms were personalised with possessions such as pictures, bedding and furniture but there was no pictorial signage to help orientate people around the home. People were encouraged to mobilise independently and clear signage would assist people who were living with dementia to remain independent.

We therefore recommend the home accesses and utilises current guidance in relation to dementia care to ensure people at the home who are living with dementia receive effective support in an environment appropriate to their needs.

Good

# Is the service caring?

## Our findings

People spoke positively of the caring manner of staff. We were told, "Staff are very nice, and they're always pleasant." And, "Staff are polite and kind, they listen to you, they're very good and they do what they can. If they can't help they refer it to the manager." Another person told us, "Staff are very nice, they're like friends".

We spent time observing care practices in the communal area of the home. We observed staff maintained people's privacy and that they knocked before entering people's bedrooms. A member of staff told us, "we want to keep their dignity. I knock on their door first; I will ask if they want support, I give them choices about what they want to wear." Throughout our inspection we observed people's hair was brushed, that they were wearing glasses as needed, hearing aids were in place and watches were set at the correct time.

People's care plans contained guidance for staff on how to maintain people's dignity while supporting them with personal care tasks. We saw that people's care plans contained guidance which reminded staff to promote people's independence and the level of support they would need with each task. People's care plans detailed daily living tasks and whether people were able to carry these out independently or if support was needed.

Relatives told us that they felt involved in the care their family member received and that they had regular reviews with the registered manager. We were told "they've always kept us informed." We saw that people's care plans were signed by their family member or advocate to indicate their involvement and understanding. Family and friends were able to visit without restriction and relatives told us that staff were always welcoming and happy to spend time speaking with them about their family members. On the day of the inspection we saw there were plenty of visitors and that people could spend time with their relatives in the lounge area or in the privacy of their own rooms. We saw positive interactions between visitors and all people living at the home, not just people they were visiting. The registered manager told us, "it's like a big family, people look out for each other, and it's lovely."

Throughout the day we observed positive relationships between people who used the service and saw friendship groups were encouraged by staff. This was done by enabling people to sit together if they chose to. The registered manager also told us about the importance of promoting equality and diversity and respecting people's individuality and preferences by ensuring people had private time if they needed it.

Where appropriate people had a Do Not Attempt Resuscitation (DNAR) order in place at the front of their care plan. A DNAR is a legal order which tells medical professionals not to perform cardiopulmonary resuscitation on a person. This showed us that the home understood the importance of ensuring people's wishes were respected at the end of their lives.

Requires Improvement

# Is the service responsive?

## Our findings

People's care plans contained a section detailing communication with healthcare professionals such as the GP and some care plans contained information on people's life history which gave staff information about the person's life before they moved into the home. Care records also included copies of social services' assessments completed by referring social workers and these were used to inform people's care plans. However we found only one care file contained a dementia support plan, which had been done by the local authority, and was specifically tailored to meet the needs of that person. Person centred plans are important for people who are unable to tell staff about their needs. Dementia support plans are important because they contain crucial information about the person before they had dementia. Quite often people living with dementia become stuck in a time or place from their past and relate people in the present to those they recognise from their past. It is therefore important for staff to know about people and things which were important to them during their lives as this may be their reality now. The registered manager told us that most of the people who used the service were living with dementia.

We spoke with staff who knew and understood about the needs of people living with dementia and could give us examples of how they supported people with their individual needs and things that were important to them. For example staff told us about one person who was content to 'rummage' through drawers and they had created a 'rummage drawer' for this person. Another person carried a bag of 'trinkets' around with her which staff knew were important to her. This meant that some people were receiving care which was responsive to their needs because staff knew them well.

We recommend the home accesses and utilises best practice guidance on dementia care planning to ensure people living with dementia receive person centred care.

People were able to make choices about the care they received. A member of staff spoke with us and told us they tried to encourage people to make choices about their daily routines. They told us "we want them to live like they're in their own home and we want them to make them comfortable." Another member of staff told us how they supported people to make choices "we ask the residents what they would like to wear. (Person) likes to wear trousers".

We asked people about activities which they could do in the home. Comments included, "knitting, but I get fed up." And, "I just sit around, I've noticed someone colouring, but I haven't done that." Another person said, "colouring, I draw, knitting, I knit for premature babies." And, "I sit here, but I don't get bored there is always something going on." Relatives told us, "they do singing, there's an activity coordinator who works between the [provider's] two homes and she comes a couple of times a week."

Other people we spoke with told us, "we go to a church to a luncheon club and have trips out to the country and the seaside." And "We have entertainers and singers sometimes, I like that."

On the day of inspection we observed staff were kept busy with tasks such as personal care, medication and mealtimes. We saw people colouring and chatting together in small groups and staff were present within all

areas of the home, but there was not much one to one interaction between staff and residents throughout the day.

We spoke with the registered manager about household tasks or jobs people may like to get involved in. They spoke to us about the possibility of people being involved in the development of a newsletter which was something they would look into. We found this would be a good way of utilising the skills of people who use the service and finding out about any interests they may have or have had.

Requires Improvement

# Is the service well-led?

## Our findings

The registered manager told us they carried out quality assurance checks on the quality of the service provided. The registered manager told us they also carried out informal checks on the quality of food, care plans and infection control, however there were no written records of these checks for us to review. They told us that they spoke with people who used the service on a daily basis to gain their feedback on these areas and if concerns were raised action would be taken.

We spoke with people who used the service about the registered manager, they told us, "someone asks me if I am alright but I don't know who it is". And, "Yes, we see the manager a lot; she can see I'm alright".

The registered manager told us that responsibility for quality monitoring would be delegated to a senior staff member and that the person responsible for this had recently left. We found improvement was needed to ensure the registered manager had oversight of the quality of the whole of the service and that a more formal system should be introduced to enable regular monitoring and auditing.

A monthly accident and incident audit was in place and detailed the name of the person, time and date of accident, injuries sustained, and the action taken to reduce the reoccurrence. This system for monitoring accidents and incidents meant that the registered manager could identify trends and concerns and could make any necessary improvements to the home.

Regular team meetings were held and this ensured that staff had the opportunity to discuss any changes to the running of the home and to feed back on the care individual people received. Staff were aware of the whistleblowing policy and knew how to raise a complaint or concern anonymously. The registered manager felt confident that staff would report any concerns to them. Staff we spoke with confirmed they would.

Staff told us they enjoyed their work and felt supported by the registered manager. A member of staff told us "it's a nice home, I love working here, the manager, she's nice you can talk to her. She supports us a lot; she's easy to talk to". Another member of staff told us "she's always here and you can talk to her". People confirmed they saw the manager almost daily and relatives said they also felt that the manager was approachable and easy to speak to.

The registered manager was able to describe the vision and values of the home. They told us "we run as a big family. We offer people the best care we can, they are to be comfortable and we respect their privacy and dignity. We give them choice." The registered manager spoke with us about the importance of involving relatives in the decisions about the family member's care and also the running of the home which they did via feedback from questionnaires and regular reviews and assessments.

People and relatives spoke positively of the care provided and told us that staff knew people well and there was a consistent team within the home. One person told us "it's a lovely home."

The registered manager told us relatives were asked for feedback annually through a survey. The 2015

quality assurance survey asked relatives for feedback on how the home promoted and respected people's privacy, choice, dignity and independence. All the relatives who completed the survey gave positive feedback. The registered manager told us they did not hold relatives' meeting as they preferred to speak to relatives when they visited and feedback was sought from people living at the home on an informal basis. The registered manager told us they would be reintroducing residents' meetings in the near future so there would be more involvement of people who used the service as to how the service was run.