EAM Lodge Community Interest Company

EAM Lodge (Trafford)

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 4 and 7 January 2019 and was unannounced.

We last inspected EAM Lodge on 18 and 19 October 2017. At that time, we rated the service requires improvement overall and identified breaches of regulations in relation to safe care and treatment and staff training. We also made two recommendations in relation to assessing people's needs in relation to the use of assistive technologies, and assessing the safety of the premises and equipment.

At this inspection we found the provider had taken action and had made improvements in relation to all the previous breaches and recommendations. The provider was found to be meeting the requirements of all regulations.

EAM Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

EAM Lodge accommodates up to five people in one adapted building. The service provides care, including nursing care to young adults who have a learning disability and/or complex heath care needs. The home provides support to people staying at the home for short breaks (respite), as well people who live at the home on a longer-term basis. At the time of our inspection there were three people living at the home on a permanent basis, and two rooms were available to people staying for short breaks. There was one person staying at the service for a short break on the first day of our inspection.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

There was a registered manager who was registered to manage the service in September 2016. The registered manager intended to step down from this position in the future, but told us they would continue in the role until the provider could find a suitable replacement. The day to day management of the home had also been supported by the registered manager working at the neighbouring service, EAM House.

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There were sufficient staff on duty to enable staff to meet people's needs. We saw staffing levels were varied dependent on the needs of people using the service. The registered manager also considered the skill-mix of

the staff team when deploying staff.

We saw any accidents and incidents were thoroughly investigated, and steps were taken to help prevent a repeat incident and to make the service safer. There was an open and honest culture, and the provider encouraged staff to reflect on how they could have done things differently when they went wrong. Lessons were learned from any incidents and this resulted in improvements being made within the service.

The registered manager and staff team demonstrated a commitment and enthusiasm for delivering quality, person-centred support. The service did not use agency staff, which helped the service provide consistent care from staff that knew people well.

Staff were kind, caring and respectful in their approach. Staff had developed close relationships with people using the service. They had a good understanding of people's needs and preferences. We observed people smiling and laughing with staff and they appeared relaxed and comfortable when receiving support.

Staff received the training and support they needed to meet people's needs effectively. The provider checked staff were competent to provide the care and support people needed.

Staff provided opportunities for people to engage in a range of activities that met their needs and preferences. People were supported to access the local community and community groups. Some people had been supported to attend events of interest to them such as music concerts and the rugby.

The service worked alongside a range of health and social care professionals in order to meet people's needs. We saw staff had developed detailed care plans that were updated as people's needs changed. Care plans reflected people's needs and preferences in relation to how their care was provided.

Relatives told us staff communicated well with them. They told us they would feel confident to raise a complaint if they had any concerns.

There were systems in place to help the registered manager and provider monitor the quality and safety of the service.

Staff understood the principles of the mental capacity act, and we saw evidence of good practice in relation to completion of capacity assessments and best-interest decisions. However, as at our last inspection, some consent forms had been signed by others when there was no evidence that they had authority to provide consent on that person's behalf.

The provider sought and acted on the views of people using the service or their representatives. They considered and acted on feedback received from relevant persons such as the CQC and the coroner.

The coroner had issued a prevention of future deaths report in April 2018 following the inquest of a child who had died when staying at the neighbouring service, EAM House in July 2016. This was relevant to this inspection because of shared processes, staff and management teams between the two services. However, we found the provider had acted on all the concerns raised in the coroner's report to make improvements at both services. We have reported in more detail on this issue in our report for EAM House published in October 2018.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

There were sufficient staff to meet people's needs. Staffing levels were varied dependent on the needs of people using the service.

Medicines were managed safely and accurate records kept in relation to their administration.

Accidents and incidents were recorded and investigated. Staff reflected on incidents and ways they could make the service safer.

Is the service effective?

Good

The service was effective.

Staff received a range of training that would help them meet the needs of people using the service. Their understanding of training was tested and their competence assessed.

Staff received regular supervision and support.

People's needs were assessed and detailed care plans developed. Staff took account of best practice guidance.

Is the service caring?

Good

The service was caring.

Staff knew people well and had developed close, caring relationships.

Staff communicated effectively with people using the service. They involved them in decisions about their care as much as was possible.

People were treated with respect and staff strove to provide person-centred care.

Is the service responsive?

Good

The service was responsive.

Care plans contained details about people's likes, dislikes and preferences that would support staff to provide person-centred care.

People told us they would feel comfortable raising a complaint. The provider had appropriately investigated a complaint and we saw they made improvements to the service based on people's feedback.

A range of activities were provided to meet people's needs and interests. People were supported to access the local community.

Is the service well-led?

Good

The service was well-led.

There was an open and honest culture. The provider had put in place systems to help ensure learning from any accidents, incidents or complaints would be shared with the staff team.

The service demonstrated they had acted on the advice of others, including the CQC to make improvements to the service.

The registered manager demonstrated enthusiasm and commitment to provide a service that was caring and met people's needs in a person-centred way.

EAM Lodge (Trafford)

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 4 and 7 January 2019 and was unannounced. The inspection team consisted of one adult social care inspector.

Prior to the inspection we reviewed information we held about the service. This included the previous inspection report and statutory notifications sent to us by the service. Statutory notifications are information services such as EAM Lodge are required to send us about significant events such as safeguarding incidents. We used information the provider sent us in their Provider Information Return. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make.

We considered concerns raised in a regulation 28 report to prevent future deaths issued by the coroner in the process of planning this inspection. This report was issued by the coroner in April 2018 following an inquest into the death of a child living at the neighbouring service EAM House. It has been published online at www.judiciary.uk. Although EAM House is a separate service, parts of the prevention of future deaths report were relevant to consider at this inspection due to a shared staff and management team between EAM House and EAM Lodge. We considered the concerns raised by the coroner in relation to the lack of a 'serious untoward incident protocol', the ability of staff to recognise and act on signs of deterioration, escalating concerns for medical review, carrying out physiological observations and appropriate use of care records.

We sought feedback about the service from the local authority quality and contracts team, Healthwatch Trafford, commissioners of the service and health and social care professionals who the provider told us had recent experience working with people living at the home. We used the feedback we received to help plan the areas we would focus on during our inspection.

During the inspection we were able to speak with one person who lived at the home with the support of the registered manager. We spoke with the relative of one person living at the home during the inspection, and a further three relatives by phone shortly after the site visit. We spoke with six staff members. This included two care staff, the registered manager, the nominated individual for the provider, the physiotherapist and the registered manager for the neighbouring service, EAM House. We carried out observations of the care and support people received in communal areas of the home.

We looked at records relating to the care people were receiving, including; three care files, daily records of care and medication administration records. We also reviewed records relating to the running of a service such as a care home. This included; three staff personnel files, records of servicing and maintenance of the premises and equipment, audits and training and supervision records.

Good

Is the service safe?

Our findings

There were sufficient staff on duty to meet people's needs. We reviewed staff rotas, and the registered manager demonstrated how they varied staffing levels and considered the skill mix of the staff team, in relation to the needs of the people using the service. As at our last inspection, there was one nurse responsible for both EAM Lodge and the neighbouring service EAM House overnight. The nurse either worked a sleep-in, or waking night shift dependent on the needs of people staying at the home at that time.

During the day there was a nurse dedicated to work at EAM Lodge. In addition, there was usually additional support available from the registered manager, manager of EAM House and the provider who were all qualified nurses. We saw there had been a recent concern raised in relation to the care a person received at a time when one nurse was covering both EAM Lodge and the neighbouring service. The nurse was covering both services due to the other nursing staff taking part in on on-site meeting. The provider had responded appropriately to these concerns. This had included discussing procedures with staff for contacting other staff for support. As a result of this incident, the service had also started to identify on the rota, which staff were trained in specific care needs and were responsible for providing one to one support where this was required by people using the service.

Staff were able to identify and escalate safeguarding concerns appropriately. Since our last inspection, the provider had notified the CQC of three safeguarding incidents. These had been notified to the local authority as CQC as required, and appropriate actions taken by the provider. Safeguarding procedures and contact information for safeguarding teams was displayed within the home. People's care plans identified areas of potential vulnerability, and guided staff how to protect them from potential harm.

Medicines were being managed safely. We saw medicines were stored in lockable cabinets in each person's room. Staff monitored the temperature medicines were stored at to help ensure they were kept as per the manufacturers recommendations. There were adequate stocks of people's medicines, and we saw there was a process to monitor stock levels and identify if any medicines needed ordering.

We saw parents or carers were asked to provide information about any changes to people's prescribed medicines for people coming to stay for a short break. We noted that the medicines administration records (MARs) for people staying for short breaks instructed staff to administer medicines as per the prescription label on the bottle/packaging. This meant there was not a clear record of the dose, frequency and route of administration as recommended by the National Institute of Health and Care Excellence (NICE). However, there was no evidence to suggest people had not received their medicines as prescribed. We raised this issue with the provider who told us they would seek advice from the clinical commissioning group (CCG) medicines team. MARs for people permanently resident at the home contained these details, and we saw staff completed MARs correctly and without omission. This included following good practice such as recording the outcome of the administration of any 'when required' (PRN) medicines.

Staff assessed and managed risks to people's health, safety and wellbeing. For example, we saw staff had completed risk assessments in relation to risk of skin breakdown, seizures, malnutrition, moving and

handling, clinical interventions and use of equipment such as wheelchairs. Where risks were identified, we saw people's care plans and risk assessment documents outlined measures in place to help manage those risks, including through use of equipment and support from staff.

The provider had developed a robust approach to investigating and learning from any accidents and incidents. Staff reported and recorded any accidents/incidents, which a manager investigated thoroughly. As part of the process, the investigating manager checked whether staff had been appropriately trained, and if there had been safe systems of work in place. Staff were asked to complete reflective accounts where they considered whether they could have done anything differently to have prevented the incident. The investigating manager used this information to identify any further actions needed to help prevent a repeat incident. This had included discussing incidents in staff meetings, introducing new systems of work, and providing refresher training.

At our last inspection in October 2017 we made a recommendation that the provider reviewed guidance from a reputable source in relation to assessing and managing risks in relation to the premises and equipment, including in relation to window restrictors and bed-rails. The provider had acted on the recommendation and made improvements.

Everyone who used bed-rails had a risk assessment in place. These risk assessments were used to help staff identify if the use of bed-rails would present any specific risks to that individual. There were also frequent recorded checks of bed-rails to help ensure any defects or maintenance needs were identified promptly.

The premises were maintained in a safe condition, and required checks and servicing of the home and equipment had been carried. For example, we saw hoists and the passenger lift had received a thorough examination within the past six months, and competent persons had inspected gas appliances and electrical system. There were risk assessments relating to fire safety, and management of legionella that had been carried out by third parties. The provider had taken action based on any recommendations made by the risk assessor. Since our last inspection, the provider had changed the window restrictors to a type that could not be over-ridden without the use of a special tool.

We saw that some radiators in the home were not covered to help prevent potential burns should someone fall against them. Access to the stairs was also unrestricted. The provider told us they had considered covering the radiators, but had not assessed this potential risk, nor that of the open stairwell. However, we were satisfied that there was minimal risk to people using the service as the majority of people were not independently mobile, or were closely supervised. We asked to provider to assess these risks and take any action required to ensure people were not placed at risk of harm. Everyone using the service had a personal emergency evacuation plan (PEEP) in place that recorded the support that person would need to evacuate the premises in case of an emergency.

The provider was managing risks in relation to infection prevention and control. The environment was clean and we saw hand sanitiser was available at key points in the home. When required, staff had developed specific care plans to help minimise the likelihood of spread of infection. The provider had encouraged staff to get a flu vaccination, and had arranged transport from the home to a local pharmacy. This had resulted in a high uptake of the vaccine amongst the staff team.

Procedures were in place to help ensure staff recruited were of good character and had the required skills to carry out the roles they were employed for. Staff completed applications forms that detailed their employment history and the reason for any gaps in their employment had been recorded. References were obtained from former employers along with a disclosure and barring service (DBS) check or adult first check.

These checks provide details of whether the applicant has any criminal convictions or is barred from working with vulnerable people. Staff were interviewed as part of the recruitment process. We saw appropriate questions were asked to help the provider understand whether the applicant had the skills and competence to carry out the role, and what additional support they might require.

Good

Is the service effective?

Our findings

At our last inspection in October 2017 we found there were shortfalls in the training provided to staff. This was a breach of Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider had made improvements, and was meeting the requirements of the regulation.

Relatives we spoke with felt staff were competent and understood the care and support their family member needed. Staff were positive about the training they received and told us they felt it covered what they needed to know to provide effective care. One staff member told us, "There is 100 percent enough training, and you only have to ask if you think there's anything else [training] you need."

The provider and registered managers across the provider's services had supported the implementation of a range of new training packages, which the provider told us were introduced in March 2018. This included bringing more training 'in-house' and delivering accredited training packages. New training sessions had also been introduced in relation to subjects such as clinical observations, signs of deterioration and end of life care. Records showed staff had undertaken a wide range of training that would support them in delivering safe and effective care. This included training in safeguarding, fire safety, first aid, infection control, moving and handling and also specific health conditions and clinical interventions. Staff competence was assessed following training to help ensure they had understood the topic, and to identify if they needed any additional support.

During our inspection we observed the delivery of training about tracheostomy care. We saw staff were able to ask questions, and the registered manager discussed how the training applied specifically to people who used the service. A tracheostomy is where a tube has been inserted through an opening in a person's neck to help them breathe.

Staff told us, and records reflected, that they received monthly supervisions. Nurses were provided with clinical supervision in addition to their regular supervisions. Clinical supervisions provide opportunity for staff to reflect on and review their practice and identify any development needs. Staff told us the service employed a social worker who had been developing systems in relation to effective supervision, and who provided supervision for nursing, management and senior staff. Training in the delivery of supervision was also available for staff working in supervisory roles.

Care staff told us that they had recently been assigned a single supervisor, rather than any nurse on duty completing their supervision when it was due. They saw as an improvement bringing increased consistency. Records of supervision showed staff were encouraged to reflect on their practice, any challenges they faced, and included discussion of any recent training carried out or required.

At our last inspection of EAM Lodge, we found the service had not taken adequate steps to ensure equipment required to meet the needs of people living at the home was always available. This was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found

the provider had made improvements and was now meeting the requirement of this regulation.

We saw risk assessments had been completed in relation to the potential breakdown of equipment such as suction machines. The provider also told us they now had a back-up machine to help avoid any situations where a replacement machine could not be sourced in a timely manner. We saw staff had started to monitor people's weights on a regular basis, and staff told us the service now had their own hoist scales.

EAM Lodge is a residential house that has been adapted to meet the needs of people using the service. Adaptations included a wet-room with a shower table, tracking hoists to support people with limited mobility and a passenger lift. Bedrooms we looked in were light and spacious enough to allow space for the use of any required equipment.

At our last inspection we noted the home did not have a call bell system. The provider told us few people using the service would be able to use a call bell, and risks to people's safety and wellbeing were managed through the use of routine 10-minute checks. We recommended that the provider reviewed whether the use of assistive technologies may allow for potentially less intrusive ways to monitor people's safety and wellbeing.

The provider had responded to this recommendation by introducing individual risk assessments in relation to routine checks. This allowed staff to determine on an individual basis whether 10-minute (or less frequent) checks were required, or whether there were other ways to help maintain people's safety. The provider told us they would use assistive technologies whenever it had been recommended by professionals involved in individual's care, or where the use of such technologies had been tested and was evidenced based. We saw in one case the provider had requested the CCG (clinical commissioning group) to provide equipment that they felt would help staff monitor the individual effectively, and would be beneficial for that person's wellbeing.

Staff assessed people's needs in relation to a range of relevant health and social care support needs. Staff developed care plans that provided the detail they would need to be able to meet people's needs effectively. We saw there were individual care plans in relation to any health conditions people had. These included signs staff should be aware of that might indicate that person's health was deteriorating and when further advice or support from other professionals or emergency service might be needed. We found that others involved in people's care, including health professionals and family members had been involved in developing care plans and supporting transitions between services.

People's care plans referenced relevant good practice guidance, such as that issued by the National Institute of Health and Care Excellence (NICE). This demonstrated that the provider had considered how to provide people with effective care based on good practice guidance that was evidence based. We saw care plans were reviewed and amended when people's needs changed. For example, one person returned to the home from a stay in hospital during the inspection, and we saw advice obtained from professionals at the hospital had been incorporated into their care plan when they were discharged. Records of care demonstrated that staff provided people with the support they required as detailed in their care plans. This included monitoring of people's health, including clinical observations.

People were supported to access services from a variety of health and social care professionals in order to meet their assessed and changing needs. For example, we saw people were supported to see GPs, opticians, speech and language therapists and to attend specialist clinics when required. The service employed a physiotherapist who provided both direct support to people using the service, and who worked alongside the staff team to provide advice and guidance. Staff attended appointments with people using the service,

and shortly after our inspection, the provider shared communication from the relative of a person using the service thanking staff from EAM Lodge for their support and contribution during a recent consultation for their family member.

The service employed a chef who worked across both EAM Lodge and the neighbouring EAM House. Meals were prepared at EAM House and brought across to EAM lodge when ready. We saw meals were a social occasion, with staff sitting down to eat with people using the service when this was possible.

Some people living at or staying at EAM Lodge received their nutritional support via a PEG (percutaneous endoscopic gastrostomy). This is a tube that is inserted into the stomach, often to provide food, fluids or medicines to people who are not able to take them orally. We saw care plans were in place in relation to people's requirements when receiving their nutritional intake via a PEG. Some of these care plans could have contained additional detail that would have been helpful if staff did not know these people well. However, when speaking with staff, we found them knowledgeable about the care and support people needed in relation to their PEGs. In one case we saw details about a person's requirements did not match those in their hospital book, although the correct details were recorded elsewhere. This information was updated promptly after we pointed this out.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).
We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

We found evidence of both good practice and areas where the service could improve in relation to implementation of the MCA. Staff understood the principles of the MCA, and talked about considering the views of the person and acting in their best interests if they needed to take a decision on behalf of a person lacking capacity. Care plans outlined any impairments that could affect people's capacity to make informed decisions, although they stressed that it should not be assumed that the individual lacked capacity and that a capacity assessment should be completed if required in relation to any significant decisions.

We saw staff had completed capacity assessments in relation to specific decisions, such as making a safeguarding referral, and in relation to clinical interventions. Where the person was found to lack mental capacity, best-interest decisions had been recorded. This was good practice and demonstrated the service considered issues around capacity and consent appropriately. However, as at our last inspection, we continued to find consent forms signed by peoples' relatives when there was no evidence they had lawful authority to provide such consent (for example, a lasting power of attorney). These consent forms related to decisions such as contact with a person's GP, provision of first aid and trips off the premises. The provider told us consent would always be sought appropriately, and that the use of these forms enabled them to involve relatives in decisions about their family member's care.

The registered manager had recognised when potentially restrictive practices might amount to a deprivation of liberty and had made applications to the supervisory body (local authority) as required. We saw re-applications had been made in a timely way when authorised DoLS were due to expire.

Good

Is the service caring?

Our findings

Our observations showed that staff had developed close, kind and caring relationships with people living and staying at the home. The service did not use agency staff, which helped ensure people received consistent support from staff that knew them well and understood their needs. One relative told us, "They don't use agency, so you get that continuity." The registered manager from EAM House told us the service had held a charity coffee morning and that a visiting professional had commented on the 'love in the building'.

We saw people smiling and laughing with the staff supporting them. It was apparent that people were comfortable and relaxed receiving support from staff at the home. We saw staff used appropriate touch to comfort and reassure people, and they acted compassionately when they saw people were unhappy or upset. We observed one staff member was talking with a person and picked up from their facial expressions and body language that they were not comfortable. They got them a pillow and supported them to reposition in their chair. At another point in the inspection, the registered manager recognised one person was becoming worried, and acted to provide reassurance and to address their concerns.

We were able to speak with one person who lived at the home with the support of the registered manager. It was apparent from the interactions between the registered manager and this person that they had a close, caring relationship. The registered manager demonstrated an in-depth understanding about the way this person communicated, and supported and encouraged them to independently provide us with their views about their home and the staff the provided them with support.

Relatives told us their family members were treated with kindness and respect. Comments received included, "Staff are kind and caring; they involve [person] in the home", "The staff are wonderful, no complaints at all about the staff", "[Person] loves it [EAM Lodge]. They don't communicate much, but when they go, [Person] is laughing and all the staff know them" and "Staff are absolutely kind and caring… I have said when I'm over that they are more like her close family. I have confidence in them and their decisions."

Relatives told us they were involved in the care of their family member and that staff communicated well with them about any concerns or changes in people's care needs. We observed staff discussing the care of a person who lived at the home with their family member during our inspection. Other relatives told us they had been involved in planning the care of their family member and that they could visit when they wanted. There was a book of compliments that relatives and professionals involved in people's care had written in. One relative had written that they had been anxious about their relative coming to stay at EAM Lodge, but commented, "[Person] couldn't have come to anywhere better. The staff are wonderful and always treated myself and [person] with the utmost care and professionalism. They are always welcoming and pleasant."

Staff communicated clearly with people and involved them in decisions about their care and how they spent their days as far as was possible. For example, we heard staff discussing people's plans for the day and giving them different options about what they did. We observed staff supporting a person using a hoist. They ensured this person was comfortable, put on music that they liked and talked through what they were doing

as they operated the hoist.

Staff understood the importance of supporting people to be as independent as they could and to develop new skills when possible. Staff told us they would support people to make their own decisions and choices whenever possible, such as deciding what they ate and what clothes they wore. Staff had considered if people could 'move on' from the service, or whether their needs and independence might be better supported by a different type of service. They had made appropriate referrals where this was the case.

Staff respected people's privacy by ensuring doors and curtains were closed when providing personal care. They told us they would make sure people were covered when possible whilst proving personal care, and that they would provide other care in private areas when this was required to protect people's dignity. We saw care records were kept locked away securely when not in use.

Staff had received training in equality and diversity, and we saw the provider had relevant policies in place to support positive practice in relation to equality and diversity. Staff told us that any specific needs people had relating to protected characteristics such as age, disability, race, religion and sexual orientation would be identified as part of the assessment process. They told us that if needed, a care plan would be put in place to meet that person's needs in a person-centred way.

Good

Is the service responsive?

Our findings

Staff supported people to engage in activities that met their needs and interests. We saw each person had a personalised activity planner in their care files. This was used to guide staff about the activities each person might enjoy. One relative told us, "What they [staff] do really well is they cater for [person's] needs activity wise. They know [person] likes music and DVDs and put them on for them."

During the inspection we saw someone came to the home to support a person who had an interest in sewing to take part in this activity. Another person was supported to go out for a walk in the local area, and a third person was offered percussion instruments that fulfilled a sensory need. Other activities took place in the home on a group basis such as music sessions, arts and crafts, and a disco that people from the neighbouring home were also invited to.

Staff supported people to access community groups and facilities. For example, some people went to a wheelchair dancing group at a local church. Staff had supported other people to attend events of interest to them including music concerts and the rugby. The registered manager was making arrangements to take some people on a trip to the pantomime during our inspection. One relative and one staff member commented that whilst staff supported people to access the local community, they thought more trips out would be good. The service had the use of a mini-bus, and the provider told us public transport or taxis would be used in the absence of staff who were able to drive the mini-bus.

Staff helped prevent people from becoming socially isolated, which included supporting them to maintain relationships that were important to them. Staff had supported one person to visit their family over Christmas. They supported another person to keep in touch with both a relative and staff working at the neighbouring home, using email. When reviewing a third person's daily records, staff had recorded that they had supported that person to the conservatory area to 'see everyone and to socialise'.

Care plans were person-centred and contained detailed information about people's likes, dislikes and preferences. Staff we spoke with had a good knowledge of people's preferences and interests as documented in their care plans. Staff recorded people's preferred routines in relation to how they received their care. This would help ensure people consistently received personalised care that met their needs. Records showed staff reviewed people's care plans to ensure they were up-to-date or if people's needs had changed. Staff we spoke with told us they were given opportunity to read people's support plans before they worked with them, or if there had been any changes made to them.

People's care plans recorded how they communicated or could be supported to communicate their needs, wishes and emotions. Support plans also prompted staff to consider whether they might need to request extra time at appointments for example, so that people could be supported to engage as fully as possible in such settings. Staff had also recorded people's communication support needs in hospital books, which could be taken with people if they needed to be admitted to hospital for example. This would help ensure other professionals were aware how to communicate effectively with that person.

We saw the service was able to provide information in accessible format if needed. For example, we saw people had pictorial activity planners in their care files. The provider had gathered resources such as easy read and pictorial guides in relation to different health conditions, clinical procedures, safeguarding and DoLS for example, that staff could use to help explain these different areas to people using the service if needed.

There was a robust process in place for managing complaints and using feedback to drive improvements. Since our last inspection the service had received one formal complaint. We saw this had been investigated appropriately and actions taken to address the concerns raised, including a lessons learned exercise. We spoke with the person who had raised the complaint who told us they had been satisfied with the outcome and the way it had been handled. Other relatives we spoke with all told us they would be confident to raise a concern or complaint with the registered manager, provider or another staff member. One relative told us, "I'd feel confident to raise a complaint. You get the odd issue, which is easy enough to sort out. I just speak to [registered manager]… Once I've spoken to them, there are no issues." Complaints and compliments were shared with staff at team meetings to help all staff learn from such incidents.

At the time of our inspection, no-one using the service was receiving end of life care. Records showed staff had received training in end of life care. Some people using the service had DNACPR (do not attempt cardiopulmonary resuscitation) directions in place. We looked at one person's care records who had a DNACPR in place, and saw the original form was kept prominently at the front of this person's file where it could be easily located if needed. This person's care plans also made reference to the presence of a DNACPR, which would help staff understand what emergency care should be provided to this person.

Good

Is the service well-led?

Our findings

There was a registered manager in post. They were registered by the CQC to manage this service in September 2016, and there had been no change in registered manager since our last inspection. The registered manager intended to step-down from the position, but told us they would remain in post until the provider could find a suitable replacement manager. The registered manager from EAM House, the service located next-door, had been supporting the management of the home in the interim.

The management team had a range of skills and qualifications. For example, the registered manager was a learning disabilities nurse who worked alongside other members of the team who were registered general nurses, children's nurses, a social worker and physiotherapist. The registered manager spoke about the strengths different members of the team could bring to the service to provide positive outcomes for the people using it.

Staff told us the registered manager and the rest of the management team were approachable and that they would have no issues raising any concerns they might have with them. There were monthly team meetings. These covered topics including safeguarding, dignity, activities, the needs of people using the service and any feedback from compliments, complaints or visits from external professionals.

As at our last inspection in October 2017, we found the registered manager knew people living at the home or using the service very well. From our observations of their interactions, and discussions we had with them, they continued to demonstrate a commitment to, and enthusiasm for, providing people with good quality, person-centred care. Staff told us they were happy in their jobs, took pride in their work and said they would be happy for a friend, family member or loved one to use the service.

Staff told us they felt they were treated fairly, and said they would feel comfortable to act openly and honestly if they had made any mistakes. Staff were asked to complete reflective accounts if they had been involved in complaints or incidents, which helped the staff member and the provider identify what (if any) additional support, training or other guidance they might need. One staff member told us, "I think I would be offered training etcetera [if they made a mistake]. The issues happen if things are hidden as then they can't be fixed." A second staff member said, "The provider listens to me… They are passionate about creating a no blame culture." The open and honest approach of the service was also reflected in the sharing of, and discussion about complaints, accidents and incidents, along with any lessons learned at team meetings.

In March 2018 a coronial inquest concluded in relation to the death of a person who was living at the neighbouring service, EAM House. This inquest raised concerns about areas including staff training and competence, and managing serious incidents. We found the provider had acted on these concerns, and the learning and improvements from this incident had been implemented at EAM Lodge. This included the introduction of revised policies for incident reporting and hospital discharge, and revised processes around staff recruitment and competency assessment for example.

EAM House is a separate service that is registered under a different provider. Two of the directors for EAM

Lodge CIC are also directors for EAM House Limited. The concerns were of relevance to this inspection due to a shared staff and management team between the two services. We have reported in more detail about our findings in relation to this matter in the inspection report for EAM House (Elizabeth Marland Children's Respite Care Limited) published in October 2018, which is available on the CQC website.

There were systems in place to help the provider monitor and improve the quality and safety of the service. The registered manager carried out monthly audits of medicines stocks, care records and care plans. Tracking was also in place to monitor the incidence of any pressure ulcers or falls that occurred on a month by month basis. Lessons learned exercises were carried out following the receipt of any complaints, or after any significant accidents or incidents. Changes were made to systems and processes because of these exercises, and learning was shared with the staff team to help improve the service.

The provider sought the views of people using the service acted on their feedback. We saw people and their representatives were routinely asked for feedback on their last stay if they came to the service for a short break. The provider sent surveys to the representatives of people using the service to ask for their views. The most recent survey had taken place in August 2018, and asked for people's views in relation to a range of areas including staffing, activities and the home environment. We saw the provider had undertaken an analysis of this feedback, from which they had identified actions for how they could make further improvements to the service.

Services such as EAM Lodge are required to display their performance rating from their most recent inspection report both in the home, and on any websites they have. EAM Lodge was meeting both these requirements. We cross-referenced records of accidents and safeguarding and found statutory notifications had been submitted to the CQC as required. Statutory notifications are information the provider must send us about specified events such as police incidents, serious injuries and safeguarding.