# East Living Limited

# Coxley House

## Inspection report

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## Ratings

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

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|---|---|
| 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

We carried out an unannounced inspection on Coxley House on 2, 6 and 7 February 2017. Our last comprehensive inspection took place on 28 October 2015 where we found a breach of the regulation in relation to the safe management of medicines. The provider submitted an action plan telling us how they were going to make improvements to the service. During this inspection, we found that the provider had made improvements however, we identified a further concern in relation to the safe management of medicines and have made a recommendation in relation to this.

Coxley House provides accommodation and support for up to 13 people with mental health needs. The home comprises of 13 self-contained flats, and is situated in the London borough of Tower Hamlets close to community facilities. At the time of our inspection there were 10 people living in the home.

The service had a registered manager. 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.

Safeguards were in place to protect people from abuse. Risks to people's safety and welfare were identified and actions put in place to minimise these risks.

The provider checked the suitability of staff employed by adhering to their recruitment procedures. There was enough staff employed to ensure people received safe care. Staff received training that met the needs of the people they cared for in the home.

Safe medicines practices were not always followed in relation to recording medicines that were administered. All the staff had received medicines training with the exception of one member of staff.

People were involved in planning their menus and enjoyed the meals that were provided. They had the appropriate facilities to prepare and store their own foods. Staff supported people to attend their medical appointments.

The provider ensured lessons were learnt to improve the standards of the services provided. Prevention measures had been put in place to minimise future re-occurrences of incidents. The service was quality assured to meet the specific requirements of people's care.

People's rights were protected in accordance with the Mental Capacity Act 2005 (MCA) and staff were knowledgeable about the requirements of the Act and the Deprivation of Liberty Safeguards (DoLS).

Staff interacted with people in caring way and the importance of ensuring people's dignity and privacy was a priority on the provider's agenda. People's relationships with their families and friends were valued.

People's care plans captured their experiences and were reviewed when their needs changed. The provider sought different ways to engage people that took into account their diverse needs.

We have made one recommendation in relation to safe care and treatment.

## 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

Aspects of the services were not always safe.

Medicines administration records were not always completed by the appropriate person to ensure there was a clear record or who had administered people's medicines.

Staff had an understanding of what abuse was and their responsibilities to act on concerns. Risks to people were identified and actions put in place to reduce these risks.

Staffing levels were sufficient to meet people's needs. The registered manager had good systems in place for the recruitment of new staff.

### Is the service effective?

Good

The service was effective.

People had access to sufficient food and drink and were supported by staff who had received appropriate training.

The service was acting in accordance with the principles of the Mental Capacity Act 2005.

People attended regular appointments to discuss matters affecting their health with a range of professionals.

### Is the service caring?

Good

The service was caring.

People received good care from staff who understood their needs.

Staff took the time to support people in a caring and reassuring manner. People were encouraged to maintain contact with family and friends.

People were supported by staff who were committed to the promotion of privacy and dignity, and their rights were

respected.

## Is the service responsive?

Good

The service was responsive.

People's needs were assessed prior to receiving a service. Staff took account of people's preferences in the delivery of care.

Staff recognised and celebrated the diverse needs of people.

People told us they had no reason to complain and were aware of whom to raise their concerns to. Information was available for people about how to complain.

## Is the service well-led?

Good

The service was well-led.

Arrangements were in place to monitor and improve the quality of the services and ensure that lessons were learnt.

The provider worked in partnership with other organisations to develop new ways of providing care.

# Coxley House

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the 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 the 2, 6 and 7 February 2017. The inspection was unannounced on the first day and we announced to the provider we would be visiting on the following two days. One inspector carried out the inspection.

Before the inspection, we checked information that the Care Quality Commission (CQC) held about the service including their previous inspection report, their action plan and notifications sent to CQC by the provider. The notifications provided us with information about changes to the service and any significant concerns reported by the provider, and health and social care professionals.

During our inspection, we spoke with six people using the service and one visiting health and social care professional. We attended a staff handover meeting and observed the interaction between staff and people who used the service. We also spoke with eight staff including four support workers, one senior support worker, the director of care and support, the regional business manager and the registered manager. We looked at the care records for six people, five staff files, and other records relating to the management of the home.

Good

# Is the service safe?

## Our findings

At our last comprehensive inspection on 28 October 2015, we found staff did not consistently follow safe practice in relation to the safe management of medicines. The provider's medicines policy required updating in line with how staff administered medicines in the home.

During this inspection, we found that the provider had followed all the requirements in their action plan to address the shortfalls in relation to this regulation; however, we identified further concerns in relation to safe management of medicines.

Our previous inspection identified that staff had not signed the medicine administration records (MARs) to ensure that people's medicines were accounted for. At this inspection, we looked at the MARs for seven people and found that staff had signed the records to show they had administered the medicines correctly. However, we identified that a member of staff had signed the MARs for people over the course of one day when they had not received medicines training. The registered manager told us the member of staff accompanied another trained member of staff, but did not administer the medicines.

Medicines administration records (MARs) should be an accurate record of what has been prescribed, prompted and administered and by whom. It is important to know which staff member administered a particular medicine at a particular time. Therefore, the staff signing the MAR should be the person who administered or prompted the person with the medicines. The registered manager acknowledged this was an error on their part and took full responsibility for their actions. They told us the staff member had been booked to complete the required mandatory medicines training and records we looked at showed discussions had been held in relation to this.

We recommend that the provider seek advice from a reputable source about appropriate and accurate medicines recording.

Our previous inspection identified the medicines policy was not related to the residential service and was not in keeping with how staff administered medicines in the home. There was no protocol that covered how people should be supported with covert medicines. At this inspection, we saw the medicines policy had been updated to reflect how medicines were managed within a residential home. Information was documented in the policy about covert medicines and how this should be managed, such as, in consultation with health professionals and in accordance with the person's best interests. There was a guide to the handling of medicines errors and near misses, and minutes of team meetings showed that staff had been informed of the new procedures and to read these new policies. At the time of the inspection, the registered manager told us that no one in the home was supported to take their medicines covertly.

Some people were prompted to take their medicines and their records contained key information about their medicines. This comprised of the name of the medicines including 'as required' medicines, how they were dispensed, the person's photograph, details of health care professionals and if people did not require any support with taking their medicines. One person told us, "The GP changed my medication this week,

staff support me with it and I sign for it." This demonstrated that the provider took into consideration people's ability to self-administer medicines and the type of support they required. We observed a staff member supporting people with their medicines. We saw that medicines were stored appropriately within locked storage cabinets in their rooms. They were clearly marked with the correct dosage and correlated with the individual MAR. Where one person refused their medicines, this was noted. The staff member said, "Medication is one of the most important areas of their care." People's medicines had been reviewed and records showed that where staff supported people with their medicines they had received the appropriate training.

Risks to people's health care needs were reviewed to ensure people received safe care. Risk assessments contained information in relation to all aspects of their care and support. This documented people's levels of engagement with their care, the environment, medicines, finances and their physical and mental well-being. Written guidance was included for staff to follow, such as what behaviours the person could display that may indicate when they became emotionally distressed or physically unwell. Staff regularly asked people about their welfare when carrying out 'safety and welfare' checks. New risk assessments had been produced with eight key themes relating to risks. Important guidance was contained in the assessments to show how these risks should be recorded and managed. This summarised any historical and current risks, if the person had capacity to manage the risk and took into account the views of relatives and health professionals involved with their care. The registered manager explained staff were due to undertake further training to clarify they understood how to complete the assessments before they were rolled out.

Recruitment records held background checks about employees' suitability. These checks included evidence of the candidate's experience, good character, right to work and criminal record checks. We checked the rota and found there were enough staff to support people in the home. The registered manager explained as the home was not yet fully occupied; the recruitment drive was based on the assessed needs of people when they are referred into the home. The provider was in the process of recruiting two members of staff and in the interim used agency staff to cover any additional shifts.

People told us they felt safe and supported in the home, they commented, "I like it here, the staff are lovely, they make me feel safe" and "There is always staff about so I feel safe." The provider was committed to raising awareness about safeguarding concerns within the organisation. Safeguarding champions were available for people to talk to about their concerns. There was a safeguarding policy that guided staff as to the correct steps to take if they had a concern and staff knew how to access this. They described how they would escalate concerns both internally through their organisation or externally should they identify signs of abuse. Records showed that some staff had completed safeguarding training and others were due to attend a refresher course. There had been no recent safeguarding concerns at the home; the registered manager understood their responsibilities in the event any concerns should arise.

We found the environment safely met people's individual needs. Servicing was carried out on gas, water and electrical equipment and installations. During our inspection we saw the housing officer and contractors arrive on site to carry out any improvements that were needed. Following a fire safety inspection in September 2016, we found that the provider had completed the actions that were recommended by the Fire Safety Officer. Fire tests and drills were carried out and individual personal emergency evacuation plans (PEEPS) were completed and kept in people's files. Grab bags were on hand with emergency supplies in the event of an incident that required urgent action.

During our tour of the building, we observed the home was clean, bright and spacious; however, one bathroom on the ground floor was not free from malodours. The registered manager told us the current bins were inappropriate for use and replacements had been ordered in relation to the disposal of clinical waste.

We checked infection control audits and found these had identified this as an issue to be addressed. Where improvements were needed in the home these were noted for action to be taken, for example, more hand hygiene signs to be displayed in the home. Cleaning rotas and environmental checks were undertaken to ensure hygiene and maintenance in the home met the required standards. The noticeboards on the ground floor displayed information to keep people informed of their rights and responsibilities whilst living in the home. However, the noticeboards on the first floor displayed information that was out of date, the registered manager stated these areas of the home were not frequently used but agreed to update them. People's records and any personal information relating to their care was maintained and stored securely on the premises.

Good

# Is the service effective?

## Our findings

Staff encouraged people to eat a well-balanced diet. People were involved in developing the menu, and care records noted their preferred choice of meals. One person said, "We have cooked meals here once a day, the lunch is a cooked meal, and in the evening we have sandwiches and sometimes cook ourselves in the evening. I go to the meeting, there is one at seven o'clock today and talk about what we want for the rest of the week." We observed during the lunchtime meal, that people took part in preparing the dining tables with cutlery and condiments. Staff offered one person the opportunity to join the dining table; however staff respected the person's decision to eat on their own. Alternative options of meals were available and people were asked if they would like second helpings. One person commented, "It's very nice food, I like the sausages and mash." People, were able to shop, cook for themselves, and had facilities in their flat to heat and store their foods. One person said, "I cook North African food, yam and plantain." In addition, they were encouraged to participate in meal preparation in the shared communal kitchen to show how meals could be prepared in a healthy way. To ensure the safe handling of foods staff followed food hygiene procedures and had received training in this. The provider offered opportunities for people to socialise with guests from the providers' other homes. This was called 'come dine health with me'. People were asked to fill out a form and tell the provider about the food they wished to cook and the person they would like to invite from another care home, in order to prepare a healthy meal for their guest.

There were suitably qualified staff to meet the diverse needs of people. Staff understood that learning was a continuous process and felt fully supported with the necessary training that was required. Some staff were in the process of completing the Care Certificate training. The Care Certificate is a set of minimum standards that should be covered as part of induction training of care workers and aims to equip staff with the knowledge and skills to provide safe care. Records showed staff had participated in support planning, mental health awareness, infection control, fire safety, moving and positioning individuals and back care, health and safety, promoting continence, and positive behavioural support. Systems highlighted when their training was in progress, completed or had expired. Staff told us they received regular supervision and appraisals, which encouraged them to consider their care practice and identify areas for development. They were offered professional development training to increase their knowledge and skills and to enhance the quality of their work.

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 are called the Deprivation of Liberty Safeguards (DoLS).

The registered manager confirmed that no one in the service was subject to a DoLS authorisation and we did not observe any restrictions on people during the inspection. Staff had completed MCA and DoLS training and were knowledgeable about the requirements. One staff member said, "They all have capacity

here, we give people choice, they know their wants and needs." Care records showed that staff had been involved in discussions with health professionals and their next of kin regarding people's capacity to make decisions about their care and support.

A visiting professional told us a best interests meeting was to be held with one person. This was to make decisions in their best interests in relation to staff keeping the person's items in the office. Where people were able to consent, their opinions had been recorded and signed by the person. For example, people's capacity to consent to living in the home, to access different care interventions, and consent forms had been signed for the staff to monitor their finances. One person had appointed a professional to act on their behalf in regard of any records held about them.

People's care records held information about their healthcare needs and what staff needed to do to support them to maintain good health. Care files showed people had attended regular appointments with a range of health professionals, to discuss matters affecting their foot care, oral hygiene, continence care, medicines and other aspects of their health needs. We observed where people had refused to attend appointments that staff had phoned health professionals to inform them, discussed this with other members of the team and recorded this in the daily records. Plans had been put in place to show how staff should provide support, for example, when people had attended the memory clinic, opticians and screenings for diabetes. Where people had requested staff to accompany them to attend Care Programme Approach (CPA) meetings this had been acted on. CPA meetings are used to ensure that services are assessed, planned, co-ordinated and reviewed for someone with mental health problems or a range of related complex needs.

Good

# Is the service caring?

## Our findings

People told us they were happy in the home and were supported by caring staff. One person said, "I'm quite happy here, they care for me" and another person commented, "I like the staff they are like my next family."

Members of the staff team actively worked to make sure people received good care. One staff member was proactive in ensuring a person had the appropriate toiletries and clothes after they had been discharged from hospital with no personal belongings. Staff made frequent contact with health professionals over the phone to discuss people's care and wellbeing. We observed that people appeared settled, content and relaxed within the communal areas. They were able to walk around freely and interact with each other and staff as they wished. One staff member said, "We are giving people, the care and attention to enable them to have their care fulfilled. People are stigmatised by their condition, we have the opportunity to help how best we can."

People were involved in making decisions about their care, treatment and support. We saw people asking staff for personal items that were held securely in the office. We noted these items were kept in the office with the consent of the person and noted in their records. In all these instances, we observed staff responding to people's requests without limitations. One staff member explained, "This place is why people don't feel institutionalised, they have their own keys, their own freedom, risk taking is absolute." People accessed the community independently and guidance was in place to promote their welfare, which enabled them to be independent to leave the home without the support of staff.

Staff recognised the importance of companionship and keeping relationships with those who mattered to them. People told us, "I am independent, my family come and visit me" and "I can have visitors." Care records noted that there were no restrictions on relatives or friends visiting the home. Where people had frequent visits from relatives or friends this was documented about how involved they were in people's care. There was a computer on the first floor and staff told us they were in the process of setting it up so people could speak to their family or friends abroad via skype. People were protected from the risk of social isolation. To reduce social isolation the home had access to mental health peer recovery workers to do bespoke sessions such as befriending people in the home. One person was supported by a befriender who helped them to access the wider community.

People's privacy and dignity were respected and promoted. Staff respected people's flats as being their own personal space. Décor and furnishing reflected their individual tastes and interests. We noted staff did not enter a person's bedroom until they had knocked on the door and introduced themselves. Staff said, "We have to respect their dignity and space. We prompt with personal care, we use a towel to cover their dignity" and "We ask them first before carrying out any personal care." Records noted how people might respond to questions about their continence care, to ensure that staff approached this in a sensitive manner.

The provider had signed up to the dignity charter. Dignity champions were in place and designed so staff could also sign up for this. Records showed that the registered manager sought to identify two people in the home to nominate themselves for these roles, attend practice meetings and advise on different ways of

engaging with people. Dignity month was promoted to focus on a dignity challenge about respecting people's privacy without fear of retribution and empowering people to develop positive self-esteem. Services were encouraged to apply for funding from the provider to involve people to star in a short film aimed at promoting dignity and what it meant to them. This was to be used to develop further training for staff about the importance of carrying out care in a dignified manner.

Good

# Is the service responsive?

## Our findings

People's care needs were assessed to ensure the home was responsive to their needs. A thorough background assessment of people's needs had been carried out by health professionals before accessing the home. People's records also included an assessment, which had been completed by the staff. This was to make sure the provider was confident that they were able to meet the needs of the person, whilst keeping in mind the impact a person may have on those already living in the home. To make sure people were satisfied with what the home had to offer, they were invited for a short stay. During our inspection, a person was visiting for two nights to see if they were happy with the home and we saw that they joined others during their lunchtime meal, which they told us they enjoyed.

People's assessment of the care they required had been used to develop their care plans and these were reviewed when their needs changed. Care plans captured information about the person, which included their interests and pastimes along with information about their lifestyle choices. They were supported to remain as independent as possible, one person told us, "I mop my room and keep it tidy and do all the things that are necessary." The recovery pathway approach was used to show people what they had achieved and where they wanted to be in the future. Reference was made to people's strengths, views and levels of independence during one to one discussions with staff. One staff member said, "We have key work groups to build a strong rapport, this helps by talking about concerns and any issues, they have the meeting where they choose to."

Records showed that people were supported to take part in activities of interest, which included visiting family, knitting, art and crafts, table tennis and shopping. One person said, "I go to the bingo, you can win creams and soaps." We observed that this took place in the home. Another person attended a day centre to socialise with people from the same cultural background. The registered manager told us about activities held such as the tea dance and other events, but a few people chose not to attend or spend time in their rooms instead. They explained they were working on improving on the scope of activities within the home to include play therapy, music, and engagement for people who had been in hospital for long periods of time. One person we were introduced to played us their harmonica, told us about their love of music and how they required a mouthpiece for another musical instrument that was in their room. We heard them singing frequently throughout the home during the days of our inspection.

Residents' meetings were held to hold conversations with people about their experiences using the service and take on board their suggestions to improve the quality of the home. Themed months were being promoted to involve and raise awareness with people in the shaping of services. This included dignity, disability awareness, equality and diversity, safeguarding, and health and well-being. One member of staff said, "We have residents meetings as a group to make sure people are heard."

The provider was committed to promoting equality and diversity. They offered a range of opportunities people could participate in to meet their diverse needs. People could take part in competitions to hold events and activities on equality and diversity themes in the home. Black history month was recognised and celebrated and the registered manager showed us posters sent to people to promote the event. One staff

member showed us pictures where people were involved cooking foods to celebrate the person's favourite national dishes, such as Cantonese cuisines.  Where people had chosen to no longer practice their religious beliefs this was documented in their care records. This showed us that people's cultural and spiritual identities were recognised and valued.

We asked people what they would do if they had concerns. They told us, "I would know who to speak to, the manager" and "I have no concerns, everything is ok." Information about how to complain was displayed in the main entrance of the home for people to access. We looked at the complaints file and saw that no complaints had been made and the registered manager confirmed this. The director of care and support told us they were in the process of producing a second film about promoting how the complaints process is used.

Good

# Is the service well-led?

## Our findings

The provider carried out audits and had an action plan in place that identified who would make the improvements and by when. For example, the registered manager was to review support plans and advise staff about how to make these more person-centred. The provider's 2016/17 service plan made reference to actions required in respect of the improvements identified for the home. These covered areas of improvement such as, recruitment, risk management, partnership working, assessment planning and incorporating the organisation's values and culture into team meetings. The person responsible for the actions was recorded along with the timescales for completion.

We asked staff for their views about the management and leadership of the home. Staff told us they felt the home was well run and this was partly due to the strengths of the staff team. They said, "I think the home is well led, we have to go with the changes", "I get a great deal of support from the manager and staff", "It's been lovely, the team is very contented, we have six to seven permanent staff including the manager, it's very easy to build a rapport," and "We have fostered a supportive culture and the organisation is good." However, one member of staff was not confident about the manager's ability about responding to concerns in a timely way.

Staff we spoke with told us they attended meetings that were regularly held and they were actively encouraged to share their views about the service. The most recent staff meeting minutes were available and detailed any changes regarding the home. Discussions were noted about the challenges they faced and any current developments. We observed a handover meeting where conversations were held in relation to people's health and wellbeing during the day. The registered manager told us about the 'huddle procedure' whereby if staff were not able to attend handover meetings that the key tasks carried out during their shift must be documented for the other staff in the team to read. This was to ensure staff could respond effectively to people's needs.

The provider was committed to reviewing the delivery of care against current guidance and ensuring lessons were learnt. Accidents and incidents were analysed by the provider to identify where improvements to care could be made. For example, the annual board report showed how the safeguarding committee had analysed trends over the past 12 months. This related to vulnerable adults and children to include a breakdown of cases by groups, types and perpetrators. The report identified where cases were related to safeguarding people's finances, this was discussed with teams across the organisation and a monthly theme would be introduced in relation to protecting people from financial abuse. In the event the majority of incidents were related to exploitation, the theme of the month would be held in home about 'mate crime.' Mate crime is a form a crime in which a perpetrator befriends a vulnerable person for the purpose of physical, sexual or financial gain.

New procedures were drafted based on incidents that were identified, such as a review of the policy and procedures, morning welfare checks for people who did not respond to morning calls and clear case reviews to be held after a person's death. The service had an internal quality team to conduct validation visits. There was a centralised system to record all medicines errors and the quality team monitored this.

The organisation was actively involved with working in partnership with external stakeholders. The registered manager attended skills for care meetings such as the registered manager's network. The director of care and support showed us information about the joint working initiatives they were part of to deliver new assistive technology to people to allow them to remain independent in their homes. They also worked with an art group to deliver key messages to people using theatre performances and roadshows.

The provider was committed to working alongside the CQC to meet the regulatory requirements. The registered manager showed us the new support plans that had been developed that were aligned with the CQC five key questions. Furthermore, a handbook had been produced for managers and staff to help them prepare for CQC inspections and the things they should consider. They were aware of the requirement to notify the Care Quality Commission of important events affecting people using the service. We had been promptly notified of these events when they occurred.