Select Health Care (2006) Limited

Greenleigh

Inspection report

219 Wolverhampton Road
Sedgley
West Midlands
DY3 1QR
Tel: 01902664023
Website: www.selecthealthcaregroup.com

Date of inspection visit: 23 July 2014 and 24 July 2014
Date of publication: 02/02/2015

Ratings

Overall rating for this service	**Requires Improvement**
Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Overall summary

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, and to provide a rating for the home under the Care Act 2014.

The visit was unannounced, which meant the provider and staff did not know we were coming.

Greenleigh is registered to provide accommodation and support for 35 people.

There was a registered manager in post at the home. A registered manager is a person who has registered with the Care Quality Commission to manage the home and has the legal responsibility for meeting the requirements of the law; as does the provider.

Most people we spoke with were complimentary about the home and its staff, describing them as kind and caring. However, people, their relatives and some staff told us there were not enough staff to respond to people's needs in a timely manner and our observations confirmed this.

Summary of findings

Not all staff were aware of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), which help to support the rights of people who lack the capacity to make their own decisions or whose activities have been restricted in some way in order to keep them safe. Some people's care records lacked the correct documentation and demonstration of the legislation being properly used in order to support their rights.

Staff demonstrated awareness of what could constitute abuse and that matters of abuse should be reported in order to keep people safe. Staff were aware of how to report issues to the provider and to outside agencies.

We found that, while most of the home was well maintained, the external grounds and some parts of the home presented potential hazards to people which had not been addressed. These included areas of raised paving, an unsafe chair and tools left in a corridor area.

We observed some poor practice in respect of staff assisting people to move around the home. We found that some people's care records showed that they did not receive adequate levels of hydration in order to promote their health. There were gaps in some people's repositioning charts to shows that they had received pressure relief to maintain healthy skin. Staff did not always support people in the way described in their care plans. We saw that care was not always delivered in a way which supported people's dignity.

People who lived at the home said that they were encouraged to be part of care planning and assessments of care. The home gathered people's views in a number of ways, for example, through the use of surveys and meetings.

Staff said they received training in important areas of care, which supported them in their roles. However, we found that there were some gaps in staff receiving updated training.

People's health and well-being was supported by staff arranging appointments with external healthcare professionals when required, such as GPs.

Regular audits were carried out by the manager and by one of the provider's senior managers. However, we found a number of issues during our inspection which had not been identified by the provider's own auditing and quality processes.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The home was not always safe.

Some people's care records did not contain the appropriate documentation to support their rights and did not show decisions were made in their 'best interests'.

Staffing numbers were inadequate and did not ensure people received all the support they required to meet their needs fully.

Staff demonstrated an understanding of abuse and the need to report it.

Requires Improvement

Is the service effective?
The home was not always effective.

People were not always supported in the way their care plans said they should be. Health and well-being were not always monitored and recorded by staff so that changes could be reacted to as required.

Staff received training and supervision which meant that they knew what was expected of them in their role, although there were some areas of update training which had not been completed.

When required, appointments with external healthcare professionals were arranged in order to support people's health and wellbeing.

Requires Improvement

Is the service caring?
The service was not consistently caring.

Staff did not always support people in a way which preserved their dignity.

People who lived at the home were positive about the staff who cared for them.

We saw that most interactions between staff and people were positive.

Requires Improvement

Is the service responsive?
The service was responsive.

People and their relatives told us they were involved in planning care.

Relatives told us staff kept them informed of issues and people's well-being.

People felt confident in how to raise issues with staff.

Good

Is the service well-led?
The home was not consistently well-led.

The provider undertook various audits which looked at safety and quality. However, these were not always effective in identifying issues.

Requires Improvement

Summary of findings

The provider had implemented guidance from an outside agency.	

Greenleigh

Detailed findings

Background to this inspection

The visit was undertaken by an inspector and 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 home.

As part of our inspection process we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the home, what the home does well and improvements they plan to make. Before our inspection, we reviewed the information included in the PIR along with information we held about the home. We also contacted the local authority and the local Clinical Commissioning Group (CCG) to gain their views of the home.

We observed how staff interacted with the people who used the home. We observed people having their lunch and during individual tasks and activities.

We spoke with 15 people who lived in the home and three visitors. We also spoke with the manager and five other members of care staff. We spoke with a visiting healthcare professional.

We looked at four people's care records to see if their records were accurate and up to date. We looked at two staff recruitment files and records relating to the management of the home, including quality audits.

Requires Improvement

Is the service safe?

Our findings

People we asked told us they felt safe living at the home. One relative of a person living at the home told us, "My relative is safe here". However, people told us there were inadequate staffing levels and they often had to wait for staff to support them when they asked for assistance. One person said, "The staff are brilliant but we could all do with more staff to help us so we don't have to wait as sometimes they forget what I have asked for".

We found that there were not always enough staff to meet the needs of people. We spent time in each of the three lounge areas of the home and noted that they were often left for periods of time without staff and people required assistance. One person told us, "If I press my call button it takes time for staff to come and see me". Another person living at the home said, "There is not enough staff to do things, but they say 'in a minute' but it takes ages for them to help us as they are so busy. People ask to go to the toilet but we have to wait". A relative of a person living at the home told us, "There seems to be a shortage of staff evening and weekends too". Another visitor told us, "My relative has been here a long time but it's the same thing; not enough staff and they are so busy". This meant that there were not enough staff to meet people's needs in a timely way. One person told us, "It's lovely here. The staff are very good, but there is not enough of them". Another person said, "It's not bad here. The staff are okay but there should be one or two more to care for us, but they are very busy". People told us staff treated them kindly, although they did not have time to sit and talk with them.

Staffing levels meant that people often had to wait for requests to be met. For example, one person asked staff for their hearing aid at 10am but had still not received it at 11.05am. We saw that staff had little time to interact with people by sitting down and speaking with them. Staff confirmed this was an issue and told us that it was sometimes difficult to fit in their rest breaks. This meant there was a risk that staff could become tired and less effective in their roles. This could affect their ability to meet people's health and welfare needs.

We observed people having lunch in the dining room. We saw that there were not enough staff to support people in the way they needed. For example, one person started to slide down their wheelchair towards the floor and it took some time before staff noticed this and assisted them. This was despite the fact that the person was vocalising loudly, "Lift me up, lift me up". At one stage during the meal two meals were taken by staff to people situated elsewhere in the home. This left one member of staff to assist people in the dining area until a senior carer arrived. This meant there was a lack of staff to assist people who required support in a safe and timely way.

We spoke with the manager about staffing levels and how they were calculated. The provider did not use a specific calculation tool for the numbers of staff required, although the manager said they considered people's dependency levels as part of staffing decisions.

These issues demonstrated a breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. There was a lack of sufficient numbers of staff to support people in the way, and at the time, they needed and people's health and welfare could be affected by this.

We saw that the home was well maintained and the provider employed a full-time maintenance officer to address repair issues. However, we found that areas of the garden was less safely maintained. For example, we had to alert staff to a chair which was broken and which could have presented a risk to anyone who may have sat on it. We also found that paving was uneven in places and this was not marked in any way to warn people of a trip hazard. We found that maintenance staff were carrying out work on site. We saw that tools, such as a drill, had been left in a corridor space which could present a danger to people. Although we alerted the manager to this issue on the first day of our inspection because of the danger, on the second day of our inspection we found that tools and debris had again been left in the same corridor area.

These issues demonstrated a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff told us that some people living at the home may not have the mental capacity to consent to specific decisions relating to their care. The Mental Capacity Act 2005 (MCA) sets out how to act to support people who do not have capacity to make a specific decision.

We spoke with staff about their understanding of the MCA and Deprivation of Liberty Safeguards (DoLS). DoLS are safeguards used to protect people where their liberty to undertake specific activities is restricted. All staff we spoke

Requires Improvement

Is the service safe?

with demonstrated that they knew how to support people's rights and that people were able to refuse elements of care if they wished to. However, we did find there were gaps in recent staff training in this area, to ensure their knowledge was up to date

We asked the manager if anyone living at the home was subject to a DoLS. The manager told us that they had not made any recent applications for a DoLS and this was confirmed by the local authority. The manager demonstrated knowledge of circumstances where a DoLS may be required. We did not observe people being subject to restrictive practices that might mean they required a DoLS to protect their rights.

We found that, where people were said by staff to lack capacity to make certain decisions, this was not appropriately assessed and recorded in their care records. There was no evidence that 'best interest' processes had been properly followed. This meant that it was not certain that all aspects of care provided were in the person's 'best interest'. However, we observed staff offering people choices and respecting the choices people made.

We saw that the home was well maintained and the provider employed a full-time maintenance officer to address repair issues. However, we found that areas of the garden was less safely maintained. For example, we had to alert staff to a chair which was broken and which could have presented a risk to anyone who may have sat on it. We also found that paving was uneven in places and this was not marked in any way to warn people of a trip hazard. We found that maintenance staff were carrying out work on site. We saw that tools, such as a drill, had been left in a corridor space which could present a danger to people. Although we alerted the manager to this issue on the first day of our inspection because of the danger, on the second day of our inspection we found that tools and debris had again been left in the same corridor area.

We found that there was a lack of accessible call bells for people with mobility issues in communal areas. For example, in one of the larger lounge areas there was one call bell fixed to a wall, but some people could not reach it. People told us this was an issue for them as there were often times when staff were not present. We spoke with the manager who told us they would address this. On the second day of our inspection we spoke with an external contractor who the manager had called in to increase the number of call bells in the home.

We observed several people being assisted to move. We saw one person being lifted by a member of staff applying pressure to their armpit area. This can cause injury to the person being lifted in this way. Staff we spoke with were able to tell us this was a prohibited move which was not taught during training. We informed the manager of this and they undertook to address this issue. The manager also raised a safeguarding alert to the local authority in connection with the matter.

We asked staff about different types of abuse and what they would do if they suspected abuse was happening at the home. Staff were aware of the need to report suspected abuse and said they would report the issue to a member of the management team. Staff also knew how to report abuse to external agencies.

We saw that incidents and accidents were reviewed to ensure risks to people were reduced. We found, for example, that people had been appropriately identified as being at risk of falls. Their care records contained guidance to staff on how the risk of reoccurrence of falls could be reduced, as a result.

We looked at the way in which the provider recruited new staff. We saw, and staff confirmed, that they were subject to a number of checks before they were employed. These checks included one to see if they had been criminally prosecuted and employment history checks. We did find that one person had been employed without a reference from their last employer. There was no risk assessment to show how any potential risk this might present was managed or that the issue had been discussed with the staff member. The manager undertook to address this issue.

Requires Improvement

Is the service effective?

Our findings

People gave us a variety of answers when we asked them about the effectiveness of the care they were provided with. One person told us, "Staff make sure that I always have my pressure cushion".

People we spoke with were positive about the quality of food and the choice of meals. One person told us, "The food is good". Another person said, "The food is okay and we do have several choices from the menu".

We looked at the fluid intake records of one person. We saw from this person's care records that they should drink 1.5 to 2 litres of fluids per day in order to keep them hydrated and to support their well-being. We saw that their fluid records showed fluid consumption which was well below the recommended amount. The record did not record that, for example, the person had refused fluids offered or offered any other explanation for the low fluid levels they had consumed. We visited this person in their bedroom. We saw they had a beaker of fluids on a bedside cabinet, but would have been unable to reach it. We asked them if they were thirsty and they indicated they were not. We looked at their daily journal of care and saw that, on some days where they had poor fluid intake, staff had written that their intake was "good".

We raised this issue with manager, alongside that of another person whose records showed low intake of fluids. The manager undertook to ensure that all people who were cared for in bed, as these people were, should be supported by staff hourly for the purpose of ensuring they had the opportunity to drink enough fluids to support their health. The manager also raised a safeguarding with the local authority.

People we spoke with gave a variety of answers when we asked them if they were provided with their choice of drinks. One person told us, "We only have hot drinks at certain times of the day, but have squash at times as well". Another person told us, "I got up this morning at 5am. but I didn't get a hot drink until 7am. All the staff were drinking their tea or coffee but not me". One person said, "Another thing is if I want a hot drink I have to wait until the tea trolley comes around at 'tea round time' as we have set times for our hot drinks". It was a hot day on the day of our inspection and we observed people in communal areas being offered cold drinks throughout the day.

Staff had not provided care and monitoring of health in line with guidance received from a healthcare professional in the case of one person whose records we looked at. This meant that that issues related to the health of people using the home were not being monitored which placed them at risk.

One person required regular pressure relief through repositioning. This was to help them maintain healthy skin as they were vulnerable to areas of sore skin. We saw that a repositioning chart was used so that staff could record that this person had been repositioned at the prescribed intervals. We saw three consecutive entries which showed that this person had remained in the same position for six hours. They were supposed to be repositioned every two hours. We saw two consecutive entries which showed this person had been sitting, but did not show they had received pressure relief through being mobilised. We looked at another person's repositioning charts which also showed consecutive entries where the person was in the same position. This meant that people were put at risk of developing sore areas of skin. We spoke about this issue with the manager who raised a safeguarding alert with the local authority based on this information.

These issues demonstrated a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw that people had 'hospital passports' in their care records which could accompany them if they were admitted to hospital. We saw that these contained information which would allow hospital staff to understand the needs of people. We also found that the information in the 'hospital passports' was personalised and reflective of the person. For example, we saw detail in one person's 'hospital passport' of how they preferred to communicate. This reflected our own observations of this person when we had spoken with them.

We looked at staff records and saw that new members of staff had to complete induction training. Staff we spoke with confirmed they had received induction training and periods of 'shadowing' experienced members of staff. This meant that new staff knew what was expected of them and were assessed as having the necessary skills to carry out their role. Established staff told us they received update training in important areas of care. We looked at staff training records and found that some areas of update training had been completed by most staff, such as

Requires Improvement

Is the service effective?

infection control and moving and handling. There were gaps in other areas of training, such as training in the Mental Capacity Act, where less than half of the staff group had completed recent update training. Staff told us they felt skilled and confident in their roles.

Staff told us, and records showed that they received regular supervision meetings. Staff told us they could raise concerns during these meetings and that is was also an opportunity to look at their training needs and discuss their performance. We saw from records that management dealt with issues of performance, where necessary, to ensure staff remained competent and appropriate to care for vulnerable people.

Requires Improvement

Is the service caring?

Our findings

People and their relatives were positive about staff and described them as being caring. One person told us, "It's good here". We observed staff interacting with people. Most interactions were positive and caring. One person was distressed about a personal issue. We saw a member of staff speak in a kindly way with this person and take steps to try to address the issue. They reported back to the person to let them know what they had done to try to help which gave comfort to this person.

While most interactions between staff and people were caring and positive, we did see one staff member respond inappropriately to a person. This person told the staff member they found it difficult to get the staff's attention while they were in the lounge area, because staff were not often in the lounge. The staff member pointed to the single call bell in the area and told the person to use this. The call bell was out of reach of this person and they told the staff they were unable to walk to reach the bell. The staff member did not respond in a positive way to this person.

We observed staff supporting people in a way which did not always preserve their dignity. For example, we saw one person being assisted to mobilise with the use of equipment called a hoist. We saw that, when the person was lifted in the hoist, staff had not adjusted their clothing or used a blanket or screen and the person's undergarments were on view in a communal area. This compromised their dignity. We observed that another person's catheter bag was visible while they were sitting in a communal area.

One relative said that the person they visited was not always well presented. They told us, "Staff do look after my relative well, but [person's name] is often in a bit of a state and staff don't always put my relative in clean clothes probably because they are so busy".

These issues demonstrated a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People and their relatives told us that staff sought their views on the care provided. We observed staff offering people day to day choices and respecting people's responses. We also saw staff talking with visitors; providing appropriate updates on people's health and wellbeing and listening to what relatives had to say. Records confirmed that people were part of their own care planning process.

Good

Is the service responsive?

Our findings

We asked people how responsive staff were to requests they made. One person told us, "They try and help". We saw that one person had requested a meal which was not on the menu just before lunch was served. We saw that this person was eating the meal of their choice during lunch. This meant that staff had responded positively and quickly to them, and had respected the person's choice.

Care records contained information about how staff should support people. These included people's likes, dislikes and personal preferences. Staff interactions with people demonstrated they had knowledge of people and their needs.

We asked people and their relatives whether they were encouraged to be involved in decisions about care. Relatives we spoke with were positive about the amount of involvement they had in people's care. One relative told us, "Staff always keep me informed of any changes to the care plan or medication. If I'm not here they will call me at home and discuss the situation and tell me what happens next".

Records confirmed that people and their relatives were involved in assessments of their care. One person told us, "My relatives were involved also. We all contributed to the building of my personal care plan so everyone knows how to look after me and provide the proper care". The manager told us that care plans were reviewed monthly, or sooner if required. We saw that people's records were regularly reviewed to ensure staff had the most up to date information about how best to support people. Where possible, people had signed important records relating to their care to show their involvement.

People told us they felt confident in raising issues with staff. One relative of a person living at the home told us, "If I had concerns I would complain to the manager whom I trust would listen to my concerns". One person said, "I don't have anything to complain about but I would speak to staff if there was something wrong". Staff told us how they would support people to make a complaint by ensuring the manager was aware so any matters could be dealt with appropriately and in line with the provider's complaints policy. People had copies of the 'service user's guide' available in their bedrooms. This guide gave advice to people on how they could raise a complaint. People we spoke with told us that they had not had cause to make a complaint.

We saw that people were being encouraged to join in activities. One person we spoke with said, "They keep us busy!" and told us they were never bored. They showed us squares some people were knitting to make blankets for charity. Another person told us, "They try to keep you occupied with the crafts and that". We spoke to the newly appointed activities coordinator. They told us they spoke with people individually and in groups to see what they wanted to do. Records from relatives' and family meetings confirmed that people's opinions on the activities they preferred were gathered.

The activities coordinator told us that they tried to get people involved in external activities. They told us, "We have a religious service that residents like to go to, girl guides come and spend time here and sometimes sing to the residents". People we spoke with confirmed they benefited from these activities, including the regular religious service. One person told us, "Once every two weeks they come from the church in Sedgley". We saw that a summer fayre had been arranged. This meant that people had the opportunity to participate in stimulating activities.

Requires Improvement

Is the service well-led?

Our findings

We asked people if they felt the management of the home was effective. Most people responded positively. One person told us, "The one in charge is very good".

We saw that the management team carried out various audits relating to care and health and safety. For example, we saw that weekly and monthly audits were undertaken which included matters such as staff competency. We also saw that regular medication audits were carried out to check that staff were administering and recording medicines correctly. We found that one of the provider's senior managers undertook audits and feedback any issues to the manager for resolution.

We raised a number of issues with the manager during our visit. The manager sought to address the issues we raised in a timely manner, including making two referrals to the local authority safeguarding team where we identified potential safeguarding issues. However, this meant that the provider's own system of audits and quality assessments were ineffective as these issues had not been previously identified by the manager or the provider, despite audits having been undertaken.

This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider sought feedback from people who lived at the home. We saw surveys which had been filled out by people, sometimes with the assistance of staff. We also saw that themed surveys had been undertaken. For example, one survey looked at people's dining experience. We saw that these surveys were accessible and available in, for example, a pictorial format, so that people would find them easier to complete. The manager told us about a 'wine and cheese evening' being held on the evening of our inspection. People who lived at the home were invited to attend to discuss their views on the home. We saw records of a previous meeting which showed that people had talked about what they would like to happen at the home, such as new activities. We found that the manager had taken action in relation to some suggestions made.

All staff told us, and records confirmed that they had regular staff meetings to discuss matters which affected people who lived at the home. We looked at the meeting minutes for care workers and for senior staff. We saw that issues which had been identified during management audits were discussed so that staff were aware where improvements were required. These included issues which affected individual people who lived at the home to improve their experiences.

Staff told us they felt supported by the management team. There was a clear management structure and staff knew how to escalate matters as required.

We asked the manager about how they sought to work with other agencies to improve their own practices. The manager showed us records that indicated they had implemented advice from the local infection prevention and control team following previous issues in this area. As a result of this an infection and control nurse from this team had commented that there had been a marked improvement in standards after a follow up visit to the home.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The registered person did not take proper steps to ensure each service user received care that was appropriate and safe.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **The registered person did not have effective systems in place to monitor the quality of the service delivery.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **The registered person had not ensured that service users and others, having access to premises, were protected against the risks associated with unsafe premises by means of adequate maintenance and proper operation of the premises.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **The registered person did not have suitable arrangements in place to ensure that people's dignity was maintained as far as practicable.**

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The registered person did not have suitable systems in place to ensure there were sufficient numbers of suitably qualified, skilled and experiences persons employed.