Independence Matters C.I.C.

Church Green Lodge

Inspection report

Aslake Close
Norwich
Norfolk
NR7 8ET

Tel: 01603411855
Website: www.independencematters.org.uk

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection was carried out on the 17 April 2018. This was an unannounced inspection, which meant the staff and provider did not know we would be visiting.

This service 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.

Church Green Lodge is a care home providing short respite accommodation, personal care and support for people who have a learning disability, sensory impairment or mental health conditions. The care home is a ground floor building and is registered to provide care for up to six people. Nobody resides at the care home on a permanent basis. There were six people staying at the home at the time of our inspection.

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

The 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.

We last inspected the service in August 2015 and rated the service as 'Good' in all areas and 'Good' overall. At this inspection we found the service remains 'Good' overall, although the rating for the key question of 'is this service effective?' has changed to 'Requires Improvement.' Improvements were required to ensure people's capacity was assessed, best interest decisions were recorded and consents were obtained in accordance with the Mental Capacity Act (MCA).

We observed people receiving care that was personalised to their individual needs. However care plans did not always reflect people's needs, preferences and ambitions. The registered manager had identified the need to improve the personalisation of care planning within the service. The registered manager was in the process of updating the care plans and the target for completion was December 2018. This process had been started before our visit and we were able to sample what the care plans would look like once completed. These were more personalised to peoples needs.

Staff understood their responsibilities in safeguarding people from abuse and knew how to report any concerns they had.

Care records contained guidance and information to staff on how to support people safely and mitigate

risks. Risk assessments were in place and reviewed monthly. Where someone was identified as being at risk, actions were identified on how to reduce the risk and referrals were made to health professionals as required. People received their medicines safely and as prescribed.

People were supported by sufficient numbers of staff to meet their needs. Robust recruitment procedures were followed to ensure only suitable staff were employed.

People's needs had been assessed before they moved into the home to ensure staff could provide the support they required. Staff received training considered as mandatory by the provider. All staff attended an induction when they started work and had access to ongoing training. Specific training was provided if people developed needs that required it. The provider supported staff to achieve further qualifications relevant to their roles.

People lived in an environment that was homely and adapted for their needs. The service was clean and hygienic and people had access to communal areas, a garden and their own bedrooms which were individualised. People had been encouraged to choose the décor. Equipment and adaptations were in place to meet people's mobility needs.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People were able to make choices about the food they ate and were supported to maintain a healthy diet. Staff ensured that individual support guidelines around diet and nutrition were followed.

People were supported to maintain good health and to obtain treatment when they needed it. Staff were observant of any changes in people's healthcare needs and responded promptly if they became unwell.

Staff were kind, caring and compassionate. People had positive relationships with the staff who supported them and there was a homely, caring atmosphere in the home. Staff treated people with respect and maintained their dignity. They respected people's individual rights and promoted their independence.

People were supported to make choices about their care and to maintain relationships with their friends and families. People had opportunities to take part in activities that reflected their interests and preferences. People were supported to access the local community and had developed relationships within their community.

There were appropriate procedures for managing complaints. Records demonstrated complaints had been listened to and acted upon.

People, relatives and staff benefited from good leadership. Staff told us the management team supported them well and valued them for the work they did. They told us their suggestions for improvements were encouraged. There was a strong team ethos and staff said they received good support from their colleagues.

People who lived at the home, their relatives and other stakeholders had opportunities to give their views and the provider responded positively to feedback. People's care records were stored accessibly yet securely. The provider had notified CQC and other relevant incidents of notifiable events when necessary.

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 remains 'Good.'

Is the service effective?

Requires Improvement

The service was not consistently good.

The service has deteriorated to 'Requires Improvement' as improvements were required to ensure people's capacity was assessed, best interest decisions were recorded and consents were obtained in accordance with the MCA.

Staff had access to the support, supervision and training they needed to support people effectively.

People's needs had been assessed before they moved into the home to ensure their needs could be met.

People's dietary and health care needs were assessed and met.

The physical environment of the home met people's needs and equipment and adaptations were in place where necessary.

Is the service caring?

Good

The service remains 'Good.'

Is the service responsive?

Good

The service remains 'Good.'

Is the service well-led?

Good

The service remains 'Good.'

Church Green Lodge

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 checked 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.

The inspection took place on 17 April 2018 and was unannounced. This was a comprehensive inspection carried out by one inspector.

Before the inspection, we reviewed information we held about the service including statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. Statutory notifications include information about important events, which the provider is required to send us by law. We used this information to plan the inspection. We did not request a Provider Information Return (PIR) form. A PIR is a document that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We gave the provider an opportunity to provide us with information that was relevant to our inspection.

During the inspection we met five people who lived at the home and four members of care staff, the registered manager and two team managers. If people were unable to tell us directly about their experience, we observed the care they received and the interactions they had with staff.

We looked at three people's care records, including their assessments, care plans and risk assessments. We checked recruitment and training records and how medicines were managed. We also looked at health and safety checks, quality monitoring checks and the results of the provider's latest satisfaction surveys.

Good

Is the service safe?

Our findings

People who were staying at Church Green Lodge had complex needs which meant they sometimes found it difficult to fully express their views about the service. During the time we spent with people we saw they appeared comfortable in staff's presence.

People were protected from the risk of abuse as staff were aware of their responsibilities in this area. Staff had completed training in how to safeguard people from abuse. They demonstrated a good awareness of the types of abuse people may experience and their role in reporting any concerns. Guidance regarding reporting procedures were available to staff. One staff member told us, "The management here have always ensured we know the procedures relating to safeguarding. We are trained annually in safeguarding. If I was concerned by anything untoward, I would immediately report it to my manager. If I was not satisfied it was being reported to safeguarding, I would do this myself. I know I can share the information with the police and yourselves if needed as well." We noted that the service had worked with the local authority in relation to a recent safeguarding concern and in turn had submitted a notification to CQC.

Risks to peoples safety were assessed and action taken to minimise them. These included accessing the community, road safety, manual handling, eating and drinking and management of medicines. They were completed in a way that gave people as much freedom as possible, and promoted people's independence. Staff understood any risks involved in people's care and followed the guidance in their care plans to ensure people were safe. Some people were at risk due to their individual needs, for example one person had diabetes and another person was at risk of choking due to swallowing difficulties. Staff had taken appropriate action to protect people from these risks. Staff supported the person who had diabetes to manage this condition through medicines and regular monitoring. The person at risk of choking was protected because staff followed guidance from a healthcare professional to minimise this risk.

The premises were safely managed and suitable for its intended purpose. Key safety checks took place to help keep the building in a safe condition which included to the gas, electric, water and fire systems. A fire risk assessment had been carried out and personal evacuation plans were in place for each person stating the support they needed to evacuate in the event of a fire. Equipment used in the delivery of care, such as toilet supportive aids, were checked regularly. The provider had developed plans to ensure that people's care would not be interrupted in the event of an emergency, such as loss of utilities or severe weather. A missing person profile had been created for each person which would be shared with the police in the event of a person going missing.

Sufficient staff were deployed to meet people's needs. We observed that staff were available to support people both at home and when going out. The team manager told us that there were some agency staff used at the service although these were regular agency staff who knew people well. Some people were independent so needed less staff support when going out. There was one person who required one to one support and staff told us this always happened.

People were protected by the provider's recruitment procedures. Prospective staff were required to submit

an application form detailing their qualifications and experience and to attend a face-to-face interview. The provider obtained references, proof of identity, proof of address and a Disclosure and Barring Service (DBS) certificate before staff started work. DBS checks identify if prospective staff have a criminal record or are barred from working with people who use care and support services.

People received their medicines in line with prescription guidelines. There were reliable arrangements for ordering, administering and disposing of medicines. There was a sufficient supply of medicines and all care staff who administered medicines had received training. Records demonstrated arrangements had been made for all trained staff to be assessed annually to ensure their competence to undertake this. This is an observation of how staff safely handle and administer medicines, which is recommended in the Royal Pharmaceutical Society guidance, 'The Handling of Medicines in Social Care.' We saw them correctly following the provider's written guidance to make sure that people were given the right medicines at the right times.

We observed that unused medicines were discarded safely and in accordance with the administration of medicines policy. Stocks of medicines showed people received them as the prescriber intended. When people had their medicines administered on an 'as required' basis there was a protocol for this which described the circumstances and symptoms when the person needed this medicine. The temperature of the medicines storage room was monitored as was the temperature of the fridge used to store medicines. These were within the recommended safe limits.

People lived in an environment that was suitable for their needs. The premises were uncluttered and fully accessible for people. We noted everywhere was clean, tidy and hygienic and staff were aware of their role in meeting infection control standards.

Accidents and incidents were acted on appropriately and analysed to see if lessons could be learned to improve people's safety. For example, following one incident staff received additional training and additional control measures were put in place to increase a person's safety.

Requires Improvement

Is the service effective?

Our findings

At our inspection in August 2015 we rated this domain as 'Good.' At this inspection improvements were required in how people's capacity was assessed, how people were supported to make decisions in their best interests and how their consent was obtained. Therefore the rating has changed since our previous inspection, from Good to Requires Improvement.

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 an assessment shows a person lacks 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 told us because most people who used the service lacked the capacity to make decisions; staff worked within the MCA and made decisions on their behalf in their best interests. For example, staff supported people with everyday choices about what to wear. We found staff made decisions for people in their best interests, for example, referring people to health professionals when they were ill. Staff told us most people had parents who they involved when making best interest decisions. Records confirmed staff had contacted relatives for advice when making certain decisions, for example referring people to the GP. However, we found best interest decisions were not consistently recorded, so it was not clear on people's care plans why the decisions had been made and who had been involved in making the decisions.

We found the registered manager had not established if people had legally appointed representatives who could make decisions about their welfare on their behalf. Records showed people's relatives had signed people's consent forms for decisions such as agreeing to have photos taken. However, there was no information recorded to show if relatives had the legal authority to make decisions on behalf of people, so there was a risk peoples legal rights may not be upheld. We discussed this issue with the registered manager who advised us they would clarify if people had legal representatives as soon as possible, in order to ensure people's rights were protected.

The registered manager acknowledged the current care plan format did not fully consider peoples capacity and how decisions were being made and was able to show us the new care plan format that had been introduced in April 2018, prior to our visit, which did fully explore these areas. They assured us they would take action straight away to ensure everyone who used the service was assessed for their levels of understanding. Care plans would be updated to provide staff with guidance on how to support people to make more complex decisions. They said the provider's process for obtaining consent would be reviewed to ensure it was obtained in accordance with the MCA.

Staff followed appropriate procedures to ensure that people's rights under the MCA were protected. We did

find some examples of where people's capacity assessments had been carried out where necessary to determine whether people needed support when decisions that affected them were being made. Staff presented information to people in ways they best understood, which helped their decision-making.

Staff received the training they required to ensure they were effective in their roles. Training records showed staff had completed training in areas including moving and handling, infection control, MCA and DoLS, first aid, fire safety, data protection, Equality Awareness, Dignity Awareness, death and dying matters, food safety and health & safety. In addition, training specific to the needs of the people living at the service was provided which included epilepsy, diabetes, autism, sexual identity and express yourself. Staff told us the training they received gave them the competence and confidence to do their job.

All new staff attended an induction and completed the Care Certificate if they had not already done so. The Care Certificate is a set of nationally agreed standards that health and social care workers should demonstrate in their daily working lives. Staff were encouraged to work towards relevant qualifications in health and social care. The provider supported staff to achieve these qualifications by arranging an assessor who observed staff and provided them with feedback and advice about their practice.

Staff received regular supervisions and appraisal to monitor their performance and support them in their job role. This gave them the opportunity to discuss any concerns, training needs or general aspects of their role.

People were supported to have a varied diet in line with their preferences. Menus were discussed with people on a weekly basis and people were involved in the shopping and meal preparation. Everyone told us they enjoyed the food. Menus were varied and the food was home cooked.

People were able to make choices about what they ate. We observed staff planning the next few days menu with people. They used a recipe book and supported people to choose from the book, people were supported to plan what ingredients were needed and then were supported to the shop to purchase items.

People's nutritional needs had been assessed before they moved into the home and in an ongoing way. Any support they required was outlined in their care plans. For example one person had diabetes and there was detailed guidance for staff to follow in regards to healthy eating. Staff were reminded about always checking sugar contents in food items and making sure sugar free options were available. Healthcare professionals such as speech and language therapists had been consulted when people developed needs related to their eating and drinking. Any guidelines put in place by healthcare professionals had been incorporated in people's care plans and was followed by staff.

Staff sat down to support people when they were eating and drinking and made it a social occasion. They supported people to eat at their own pace. A member of staff smiled at the person they were supporting, making sure they had eye contact while they were helping them. Staff made sure people were safe when they were eating and drinking. A person was eating their meal independently, a staff member made sure they did not eat too much food each time, so they could swallow safely.

People were supported to access healthcare professionals when required. Records indicated staff were observant of any changes in people's healthcare needs and responded promptly if they became unwell. We observed multiple professionals contacting the service and talking to people about their upcoming appointments. Record demonstrated that people's healthcare needs were monitored by staff and that relevant healthcare professionals were consulted about people's care where necessary.

People told us the home provided suitable, comfortable accommodation. The home provided bright

communal and private rooms. A well maintained garden was available for people to use. People were able to personalise their bedrooms as they wished. Equipment and adaptations were in place where necessary to meet people's mobility needs including shower chairs and toilet handrails. There was evidence that these were checked and serviced regularly.

Good

Is the service caring?

Our findings

People told us they were happy staying at Church Green Lodge. One person said, "I treat this as a holiday. I have my home. This is where I come to rest."

We observed staff working and speaking with the people present at the time of the inspection. They spoke in a respectful tone, did not rush their speech and gave people time to respond. Staff had good rapport with people and demonstrated they knew all about their likes and dislikes when speaking with them.

Staff we spoke with demonstrated a caring approach to people and expressed that they wanted to provide care that met people's needs to improve their quality of life. Staff told us they had sufficient time to listen to people and spend time with them. Staff we spoke with knew about people's care needs and were able to explain people's preferences and daily routines.

One staff said, "It's essential we know the people we are supporting. They come from one family into another. It is a family here it's really important people are treated as individuals. Respected and well cared for." We saw that staff responded to people in a proactive way that enabled them to predict people's mood and behaviours and reduce the likelihood of any behaviour that may challenge the service.

People were supported to maintain relationships with those important to them. One person was supported by staff to send emails to their family member. Another person was enabled to maintain their own personal relationship with someone who lived locally.

Staff knew people's individual communication skills, abilities and preferences. For example, one person used sound to communicate. Staff understood what each sound meant and what the person was trying to communicate. Staff told us this was based on working with the person over a period of years. One person was unable to communicate verbally and staff told us they used Makaton (a form of sign language) to communicate with them. A staff member told us, "[Person] uses Makaton but they also have their own signs which we have got to know over time. I know just by looking at them what they want." Our observations supported this statement.

People and their relatives were also able to comment about the care and the support they received through regular reviews, informal discussions, meetings and feedback questionnaires sent out by the provider.

People were encouraged to be independent and participate in the daily routines of the home. We observed people being encouraged to participate in the cleaning and tidying of their bedrooms and the communal areas and participate in meal preparations. Care plans identified that people should be encouraged to do as much as possible for themselves, in relation to their personal care.

Staff we spoke with understood about confidentiality. They told us they would never discuss anything about a person with others and when they have handovers or meetings, they do so in a private area so they would not be overheard. Files were kept in the office, which was accessible to staff only.

People's dignity and privacy was respected. We heard staff call people using their preferred name and speaking to them in a respectful manner. Staff acknowledged people when they came into the service and took time to show an interest in them, asking them about their plans for the day or how the previous day had been for them. Prior to going out we saw staff make sure people were appropriately dressed and one staff member adjusted one person's trousers to ensure their dignity was preserved. We also saw care staff knocking and waiting for permission before going into bedrooms, toilets and bathrooms.

Good

Is the service responsive?

Our findings

Without exception, staff demonstrated thorough knowledge of people's needs. Each person had a current assessment of their needs and their preferences were documented. However, we found that care plans contained unclear and minimal information. The management team informed us that they were in the process of reviewing and updating all care plans. We have expanded on this in the 'well led' domain. We found although the care plans lacked personalised detail, this had not impacted the delivery of care being provided.

One person's care plan had been completed on the new format, this contained detailed information and clear directions about all aspects of their health, social and personal care needs to enable staff to care for them. There was guidance about the person's daily routine, communication, well-being and activities they enjoyed.

People's needs were assessed before they moved into the service. Where a person's care was funded by the local authority, an assessment was obtained from the funding authority so that a joint decision could be made about how people's individual needs could be met. These assessments formed the basis of each person's care plan. Each person had a one page profile so staff could see at a glance what was important to the person and how best to support them.

Detailed guidance was in place for staff to support people who presented behaviours that could result in harming themselves or other people. The specific behaviours that the person may exhibit were clearly listed, together with the appropriate response that staff should take and information about what could trigger the behaviour.

People's moods and behaviours were observed and recorded together with any lessons learnt from any incident that could inform future ways of positively supporting the person. People's well-being was discussed at staff meetings, reviewed by the team managers and health professionals were involved as appropriate.

People's appearance was clean and tidy. Each person we observed had clean hair and nails, their clothes were in good condition and they generally looked well cared for. This indicated people's personal care needs were met by the service.

People had access to a good range of activities and maintained good strong links with the local community. People told us they had enough to do and said they undertook many activities every week. Everyone who was currently staying at Church Green Lodge attended a day centre each day, leaving evenings and weekends to socialise and access the community. This was confirmed by records we reviewed and staff we spoke with. The service worked with other organisations that ran activities to ensure people regularly attended these projects and events to give people meaningful activity, and develop friendships with people who used other services.

People's concerns and complaints were encouraged, explored and responded to in good time. Staff said that if a person told them something was upsetting them, they would try to resolve things for the person straight away. If they could not do so, they would report it to the registered manager. Staff told us some people could not verbalise their concerns, but changes in their behaviour would alert them that something was not right that might need further investigation. To help people understand the complaints procedure, it was available in easy read and picture format.

The complaints procedure for visitors and relatives included information about how to contact the local government ombudsman, if they were not satisfied with how the service responded to any complaint. The registered manager made a record of any complaints, together with the action they had taken to resolve them.

No one at Church Green Lodge was receiving end of life care. Senior management at Independence Matters C. I. C were starting to consider how they could begin to gather the views of people and their families regarding the care they received at this stage of their life and afterwards. It is important people are given the opportunity to think about their end of life care before a crisis situation forces hurried decisions in emergency situations.

Good

Is the service well-led?

Our findings

The service requires a registered manager and there was one in post at the time of the inspection. 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.

Quality assurance systems were in place to regularly review the quality of the service that was provided. These audits were carried out by both the team managers and registered manager. There was an audit schedule for aspects of care such as medicines, activities, care plans, finance checks, accident and incidents, health and safety and infection control.

Records demonstrated that information from the audits was used to improve the service. Where issues were found, a clear action plan was implemented to make improvements. For example, care plans were uniform and did not always specify people's choices and preferences regarding how they would like their care delivered. The registered manager informed us that they were in the process of reviewing and updating all care plans. The quality audit tool the registered manager used evidenced that this had been an on-going area of development since September 2017. The registered manager had plans to develop the care plans by December 2018 to ensure they were comprehensive and up to date. We agreed with the registered manager that the care plans needed to be more personalised to ensure peoples care plans reflected their actual needs rather than a uniform approach to care. It was however, clear from our observations that despite the lack of clarity in the care plans, this had minimal impact on the delivery of care being provided.

The senior management team communicated with staff via email. The registered manager submitted monthly manager reports to senior management. These served to highlight any gaps in the delivery of service, both to head office and themselves. Manager meetings were held, these were an opportunity for managers to update each other on any developments and share learning.

We saw the service was committed to continuous improvement. Management meetings were held where areas for improvement were discussed. For example following news articles on care failings, we saw discussions had been held between managers to help ensure similar incidents did not occur within the service.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC) of important events that happen in the service. We read the safeguarding and accident and incident reports and noted that the provider had notified CQC of significant events that happened in the service in a timely way. This meant we were able to check that the provider took appropriate action when necessary.

Staff told us the service was well organised and everyone had clear roles and responsibilities. One commented; "We are really well supported. The staff here are very good and very supportive." Another staff member told us, "It's a great staff team, lovely environment, we are a family. We understand one another

and work well together. The management team are really hands on." Named staff members were assigned specific responsibilities on a daily basis. For example, fire safety checks, medication checks and environment checks.

Staff meetings were held monthly. This ensured that staff had the opportunity to discuss any changes to the running of the service and to give feedback on the care that individual people received. Discussion points were mainly around shift changes, legislation updates, policy, and procedure updates.

Staff said they felt listened too. Staff felt they received support from their colleagues and that there was an open, transparent atmosphere. Staff were aware of the whistleblowing policy and knew how to raise a complaint or concern anonymously.

Staff said they felt valued, that the management team was approachable and they felt able to raise anything, which would be acted upon. There was a stable staff group at the service, that staff knew people well and that people received a good and consistent service.

Staff completed values, equality, and diversity training as part of the induction. This meant they were aware of the organisations visions and values. People and staff were protected from harassment and discrimination. If any employee had specific needs, reasonable adjustments were made to support them to complete training and fulfil their roles and responsibilities.

Records demonstrated that people, their relatives and professionals were contacted to attend reviews and update care plans where needed. Specific incidents were recorded collectively such as falls, medication errors and finance errors so any trends could be identified and appropriate action taken.

People, relatives and professionals were asked for feedback annually through a survey. The last survey was in January 2018. The results of which, were positive. The survey completed by people included their views on the manner of staff, whether they felt listened to, if they had a complaint and if they felt safe.

Two staff explained their understanding of the vision and values of the service. They told us, the ethos of the service was to provide and ensure meaningful trusting relationships were built, that people were respected, all in a homely relaxed environment. Overall staff said their focus was to ensure the quality of care provided and that people and their relatives were happy. We observed these values demonstrated in practice by staff during the provision of care and support to people.