National Society For Epilepsy(The)

Greene House

Inspection report

The National Society for Epilepsy
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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?	**Good**

Summary of findings

Overall summary

Greene House is a care home which provides accommodation and personal care for up to fourteen people with epilepsy and other associated conditions. It is a listed building. People who used the service lived on the ground floor. The registered manager's office and the administration office was situated on the first floor.

At the time of our inspection there were thirteen people living in the home. 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 inspection took place on the 6, 7 and 8 January 2016 and was carried out as part of our schedule of comprehensive inspections.

Risks to people were generally identified and managed. However in two files viewed risk assessments did not identify all risks and one risk assessment was not up date to reflect change in practice. We have made a recommendation to address this. There was also good practice in this area, one person with capacity to make choices and decisions made choices which potentially placed them at risk. The relevant professionals were involved and provided advice and guidance to support staff to minimise the risks.

Systems were in place to promote safe administration of medicines. Some staff practice was not in line with guidance which was addressed by the registered manager on the day.

People told us they felt safe. Relatives were confident people were safe. Staff were trained in how to recognise potential abuse and keep people safe. Policies and procedures were in place to support safe practice to safeguard people.

People were happy with their care. Staff were generally kind and caring. We observed some practices that did not promote people's dignity and we have made a recommendation for the registered manager to address this. Staff offered people choices and engaged with them. However we saw aids such as objects of reference and pictures were not used to communicate with people who had limited communication. We have made a recommendation to address this.

The minimum staffing levels were maintained to meet people's needs. This was under review to meet people's changing needs. Staff were suitably recruited. They completed induction and training. We have made a recommendation to improve induction and training. This is to ensure all staff receive the same level of induction and that the training meets their needs to give them the required knowledge and skills to do their job. Staff felt supported and supervision took place although not in line with the organisations policy on supervision which the registered manager was addressing.

Systems were in place to promote good communication within the team. We have made a recommendation to look at ways of improving communication to ensure key information on people is handed over to staff. People had access to a range of health professionals. Their health and nutritional needs were identified and met. People had mixed views on the meals that were provided. Some people liked them but others told us they would prefer proper home cooking. The provider agreed to look into what options were available to enable that to happen.

People had care plans in place which provided guidance for staff on how to support people. Staff were knowledgeable about people's needs. People had a programme of activities in place. The registered manager was reviewing this, in line with staffing levels to see how they could provide more community based and person centred activities for people.

The home was clean, maintained and systems were in place to ensure it was suitably maintained and fit for purpose. Equipment was cleaned and regularly serviced.

People, staff and relatives told us the home was well managed. They told us they found the registered manager to be accessible and approachable. The registered manager acted as a positive role model to staff and was committed and motivated to providing good care to people.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People were put at potential risk as risks to people were not always identified and managed.

People receiving medicines would benefit from improvements to some aspects of medicine administration.

People were safeguarded from potential abuse. Accident/ incidents involving people were audited to identify trends and prevent reoccurrence.

The required staffing levels were maintained and were being reviewed to meet people's changing needs.

Is the service effective?

Requires Improvement

The service was not always effective

Systems were in place to ensure staff were inducted, trained and supervised. The level of induction and training provided varied and did not provide all staff with the required skills and knowledge to do their job.

Systems were in place to promote good communication within the team. However this was not always effective in ensuring key information on people was handed over from shift to shift.

People's health and nutritional needs were met and monitored.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff were kind, caring and generally supportive of people. Some staff practice did not promote people's dignity.

People were not provided with aids and prompts to promote their involvement in making choices and decisions.

Is the service responsive?

Good

The service was responsive.

People had care plans in place which provided clear guidance on how they liked to be supported.

People had access to activities but the registered manager recognised staffing levels needed to improve to enable them to provide more person centred and community based activities.

People were provided with opportunities and the information to enable them to raise concerns about their care.

Is the service well-led?

Good

The service was well led

The management team were approachable and accessible.

Effective audits were in place which enabled the provider to identify and make improvements to the service.

Records were generally well maintained.

Care Quality Commission

Greene 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 6, 7 and 8 January 2016 and was unannounced. This meant staff and the provider did not know we would be visiting. The inspection was carried out by one inspector and a specialist advisor. A specialist advisor is a professional who has specialist knowledge in a chosen area. In this case they were a specialist advisor in learning disabilities and epilepsy.

We previously inspected the service on the 23 September 2014. At that time the service was not meeting the regulation in relation to records. The progress was reviewed at this inspection.

Before the inspection the provider completed a Provider Information Return (PIR) The PIR is a form that the provider submits to the Commission which gives us key information about the service, what it does well and what improvements they plan to make. We reviewed the previous inspection reports of the home and notifications made to us by the home. We made contact with health professionals involved with the home to get their feedback on the service.

Some people who used the service were unable to communicate verbally with us. Therefore we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

During the inspection we walked around the home to review the environment people lived in. We spoke with the registered manager, deputy manager, team leader and five support staff. We also spoke with two relatives by telephone after the inspection and obtained written feedback from another three relatives. We looked at a number of records relating to individuals care and the running of the home. These included six care plans, medicine records for three people, staff duty rosters, shift planners, three staff recruitment files and five staff supervision records.

Requires Improvement

Is the service safe?

Our findings

People told us staff helped them and made sure they took their medicines. We looked at medicine records for three people. One person was self-medicating and others required some level of support and observations. Care plans identified the level of support people required. Risk assessments were in place to manage risks associated with self-medicating. One person took their medicines with yogurt. The person's care plan outlined how this was managed. The person told us they took their medicines with yogurt as it enabled them to swallow the tablets easier. We observed the persons medicine being administered. This was in line with the guidance provided in the person's care plan.

We saw medicines were stored appropriately and given as prescribed. Protocols were in place for the use of as required medicines and emergency medicines for managing seizures. Records were maintained of medicines received and disposed of. The home had a high number of medicine errors. As a result they had logged the errors and audited them to identify trends and possible causes. A daily stock check and audit of medicine records was introduced. We saw these were completed and helped identify missed signatures and any other discrepancies with medicines. The registered manager confirmed the organisation was in the process of introducing printed medicine records and this would further reduce the potential risk for error.

Staff responsible for medicine administration were trained and deemed competent to administer medicines. There was a list to confirm who those staff members were. We observed medicines being safely administered throughout the three days of the inspection, except on one occasion where the staff member administering medicine did not take the medicine record with them to the person whose medicine they were administering. This was feedback to the registered manager who addressed it with the staff member. We received feedback from the pharmacist involved with the home. They told us the home had excellent policies and procedures in place for staff. They felt staff were suitably trained to administer medicines and resources were provided to enable staff to look up information on the medicines they administered.

Risks to people were identified and systems were in place to manage them. People's care plans contained a range of risk assessments in relation to individual risks. These included risk assessments in relation to finances, medicine administration, falls, bed rails, lap belts, behaviours, medical conditions and pressure sores. We saw where people were considered at risk of choking professional advice had been sought to provide guidance to staff on how they reduce the risks. We saw the guidance was adhered to and individual's food was cut up and thickeners were used in drinks to minimise the risk. In one file we saw the person was at risk of developing pressure sores. The risk assessment outlined what measures were in place to reduce the risk when the person was in bed or sitting in their wheelchair. We saw the person spent a lot of time sitting in an armchair. The person's risk assessment made no reference to the potential risk of sitting in the armchair and whether measures were in place to manage that risk. The registered manager confirmed the armchair had a pressure reliving cushion. Records were provided which confirmed this. The registered manager agreed to update the risk assessment to reflect that.

We saw guidance was sought to support staff to move and handle people safely. In one person's moving and handling risk assessment it indicated they required a handling belt and two staff to support them to

mobilise. During the inspection a handling belt and one staff member was used to support the person to mobilise. The registered manager told us this was because the person had been reviewed and now only required one staff member. The risk assessment was not updated to reflect that. We saw one staff member started to mobilise the person with the handling belt not secured. The registered manager intervened and made the handling belt safe and secure. This practice had the potential to put the person at risk of injury.

One person was not complying with their care and refused support and intervention to ensure their needs were meet. Risk assessments and management plans were in place to minimise the risks. These had been discussed with the person and professionals involved in the person's care. The records showed a mental capacity assessment had been completed and the person had capacity to make decisions on their care. However they choose to take the risks which compromised their safety. The registered manager confirmed the person was regularly reviewed by their funding authority and health professionals were aware of the potential risks. A review of the persons care was imminent. After the inspection the registered manager confirmed they had contacted the Local Authority's safeguarding team to discuss any potential safeguarding issues for that person. The Local Authority confirmed they were happy with the action and support being provided and did not deem it a safeguarding issue.

A health professional involved with the home commented that balances have been struck and continue to need to be struck, around safe empowerment, skill mix to deal with the vulnerabilities, but also abilities of the people who live there.

Another health professional told us they get the general impression the home is safe. They have been made aware of a behaviour demonstrated by one person that compromised their safety. They told us the registered manager struggled to manage this behaviour and moderate its impact on the safety of the environment. However they felt the registered manager had some success in the past and was addressing the issue, once again. They commented" The registered manager must balance respecting the person's desires with finding a solution to the problem".

The organisation had environmental risk assessments in place. This outlined risks to staff, people who used the service and visitors and how they were to be managed. This was reviewed and up to date.

The home had systems in place for recording accidents and incidents. Staff were clear of their responsibility for dealing with an accident and or incident. Body charts were completed to record injuries. Accident forms were signed off by the registered manager. A log of accidents/ incidents was maintained for each individual. This enabled the registered manager to pick up trends in accidents/incidents and take action to manage risks and prevent reoccurrence.

People told us staff were available to support them. Relatives told they felt there was enough staff available when they visited. One relative told us they know they are always actively trying to recruit staff but the management do their best to ensure there are enough staff on duty. On day one of the inspection we pulled the call bell and there was a delay in responding to it. We were told this was because the deputy manager had both receivers and was caught up in a specific task that they could not leave. Later on in the day we pulled the call bell again and it was responded to immediately. Staff told us they did not think there was always enough staff and this impacted on the amount of time they were able to give people. They said some people required a lot of time to support and encourage them to do things but they did not get that time due to other demands of the shift such as medicines administration, supporting people with personal care, cleaning and cooking tasks. Staff also told us there were occasions where there was only one female staff member on shift which meant they had to support all of the females with their personal care. Staff felt there was delay in individuals getting this care. The deputy manager was responsible for the rota. They told us

they tried to make sure the rota had an even mix of male and female staff per shift. They advised a 9-5 shift had recently been introduced and they had a female carer in that role which would address some of those issues.

The registered manager was not included in the staffing numbers. However they actively supported and got involved in shifts as required such as accompanying people for appointments. The deputy manager worked on shift and had two delegated administration days each week. The home had two team leaders who had one delegated administration day each week. There was always a designated shift leader on duty who took responsibility for managing the shift. The rota showed there was a minimum of four staff on each day time shift. Two staff members were rostered on duty at night.

We discussed people's dependency levels. Two people required two staff for moving and handling support, one person was funded for one to one support care for when they were awake, one person required staff support with their meals, some people displayed behaviours that challenged and required staff intervention to prevent incidents and de-escalate them. Staff were responsible for heating and serving the meals also. The home had a mix of people with high personal care needs and people who were less dependent but required staff intervention and support to enable them to develop life skills and get the opportunity for more community involvement. We saw less time was spent with those individuals. The registered manager had already recognised the staffing levels were not sufficient to meet people's needs. They told us they were applying to local authorities to get more funding for some individuals to enable them to get the input they required. The home had two full time staff vacancies. They were actively trying to recruit into those positions. We saw bank and agency staff were used to cover shortfalls in the rota to ensure the minimum staffing levels were maintained.

A health professional involved with the home told us they thought staffing levels and managing staff absences could be improved to ensure there is a key worker co-working for when a person's key worker has been on long leave of 3 – 4 weeks on more than one occasion.

People told us they felt safe living at the home. One person commented "Yes I do feel safe, staff are always available and that is reassuring." Relatives told us they felt their relatives were safe. One relative commented "Staff know people really well and they know when something is wrong and act to put it right."

We saw safeguarding was included as an agenda item on residents meetings and people were reminded what they could do if they had any concerns. Staff were trained in safeguarding and were aware of their responsibilities to safeguard people. They were clear of the procedure to follow if they observed practice that put people at risk. Policies and procedures were in place to support staff practice and provided guidance for staff on how to respond to any allegations of abuse.

A professional involved with the home told us the person they were involved with stated that they felt safe living at the home and their family had no concerns with the care and support provided.

The service followed safe recruitment practices. Staff told us they had completed an application form, attended for interview and completed a written exercise. People who used the service told us they were involved in staff interviews and asked for feedback on potential candidates. Staff files included application forms, records of interviews and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to work with vulnerable adults. We saw one staff member's criminal records check had been requested but not obtained. A risk assessment had been completed which addressed the potential risks of this. The staff member was clear what tasks they could perform unsupervised and what aspects of their role had to be supervised. We

saw they worked in a supernumerary capacity and was not included on the rota. Records seen confirmed that staff members were entitled to work in the UK. On day one of the inspection an agency staff member was on duty. We saw the required recruitment checks had been completed for them.

The home had a nominated infection control lead. Staff were aware who that was. Staff were trained in infection control and were aware of their responsibilities for preventing cross infection. Risk assessments were in place for people who posed an infection control risk. The home had an infection control risk assessment and audit in place which was up to date and reviewed. The home was clean. Cleaning schedules were in place to ensure all areas of the home were kept suitably cleaned. Areas of the home had been updated as a result of the previous inspections. The kitchen was due to be replaced and the provider was considering the long term plans for the home as there was limited space to meet the changing needs of people.

Water legionella checks took place. The gas, lighting, fire equipment and moving and handling equipment was serviced and safe to use. Records were maintained to demonstrate equipment such as wheelchairs and hoists were cleaned. Fire safety checks were carried out in line with the provider's policy. Health and safety checks were completed of communal areas and bedrooms and action taken to address any shortcomings. A maintenance log was in place which indicated when work was reported and completed. People were kept safe from the risk of emergencies in the home. The home had a contingency plan in place which provided guidance for staff on what to do in the event of a major disaster at the home. They had an emergency bag which contained a floor plan of the home, emergency contact details and key information on the people they supported. This was easily accessible to staff.

It is recommended risk assessments reflect all areas of risk and are updated promptly as needs change.

Requires Improvement

Is the service effective?

Our findings

New staff told us they had received a week's induction training and had worked in a shadowing capacity alongside more experienced staff in getting to know people and their needs. Alongside this new staff were given an induction booklet to work through. We reviewed one of the induction booklets which was available to us. The bulk of the induction checklist was signed off over two dates. Other aspects of the induction booklet were incomplete. Some staff felt the induction provided them with what they needed to know to do their job. One staff member told us they did not know what they were meant to do with the induction booklet. They felt the training and induction was not comprehensive enough to enable them to do their job. They gave an example where they had received a half days training in epilepsy which they felt was not sufficient to enable them to support people with complex epilepsy. During discussion with another staff member they felt the induction and training was sufficient but they were unable to describe to us the difference between different seizure types. There was no evidence the induction and induction training provided was consolidated through supervision to ensure staff were suitably inducted and trained. The nominated individual told us they were looking to develop and enrol new staff on the care certificate training. The Care Certificate is an identified set of 15 standards introduced in April 2015 that health and social care workers must adhere to in their daily working life.

Experienced staff told us they were clear of their roles, responsibilities and what was expected from them. They said they got regular updates in training and had access to specialist training if they required it. They felt they developed skills in recognising and managing epilepsy through knowledge of people, epilepsy protocols and training in emergency administration of buccal medicine. A health professional involved with the home commented "Staff are very skilled and attentive regarding epilepsy".

Staff were in the process of completing Non-Abusive Psychological and Physical Intervention training to support them in managing behaviours that challenged. Some staff had specific roles that they were responsible for such as infection control, health and safety, rotas and medicines management. They told us they were trained to take on those roles. We looked at the training records. Staff had training in subjects the provider considered to be mandatory for the service such as first aid, fire safety, safeguarding of vulnerable adults, moving and handling, food hygiene and epilepsy awareness training. We saw updates in training were booked for staff when required. A number of people at the home presented with mental health issues. Four out of eighteen staff had completed mental health awareness training and a further three staff were booked to go on this training. A medical professional involved with the home told us they reviewed people who lived at the home with mental health needs. They said occasionally they were asked to give over view training about mental health, mental health aspects of making best interests decisions where capacity is limited, and also do some de briefing, if there was an unfortunate event or set of circumstances. They told us they found that staff, people who used the service, management and families where involved, worked very harmoniously and supportively for each other. We saw they had facilitated a mental health awareness training in August 2015 for a number of staff.

Staff told us they received regular supervision and felt supported. The provider had a staff supervision policy in place which outlined staff would have a formal one to one supervision every 8 weeks. A supervision matrix

was in place which outlined when one to one supervisions were planned and had taken place. For two staff this contradicted what was recorded and available on their files. One of the new staff members in post since October 2015 had no recorded supervision on file. Another new staff member in post since November 2015 had one recorded supervision on file and the third staff member in post since March 2015 had two recorded one to one supervision sessions and a probation review on file. The other two staff files showed they had one to one supervisions every other month. The registered manager had identified supervisions were not taking place when scheduled. We saw they were addressing that with their senior team. New staff completed probationary reviews prior to being confirmed in post and all staff had annual reviews of their performance. Some annual appraisals were completed, others were scheduled.

Systems were in place to promote good communication within the team. A communication book, daily shift planner, daily handover report was in use as well as daily handovers, weekly clinical review meetings and staff meetings. We sat in on one handover meeting. The shift leader on the morning shift handed over to the afternoon shift. We noted there was two incidences concerning people who used the service that they were not aware of and therefore did not hand over. These incidences were dealt with by the registered manager and deputy manager. However they failed to inform the shift leader or record it on the handover record. The omission in handover of key information on people and their well- being had the potential to put people and staff members at risk.

A relative told us of occasions regarding their relative's holiday when communication was not satisfactory. They said this is resulted in unnecessary distress and anxiety for them and their relative. This was feedback to the registered manager to follow up on to ensure effective processes were put in place to prevent reoccurrence.

A health professional involved with the home commented "The team still appeared pressured and very busy, and the communication of staff who have just come off holiday suggests they do not take full responsibility for handovers before therapy sessions". They said there were improved language skills in the new staff cohort. . Another health professional told us an area for improvement would be clearer understanding and communication of regular session times to assist with attendance and an awareness of people unable to attend sessions. They also told us better communication was required to appropriate external staff who worked with people when a challenging incident has occurred with a person from the home.

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 procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found related assessments and decisions had been properly taken. The MCA DoLS require providers to submit applications to a 'Supervisory Body' for authority to restrict people. We saw applications had been made and one had been authorised. People's care plans outlined if they had capacity or not. Staff were trained in MCA and DoLS. They demonstrated a good understanding of those. However not all staff were aware who had a deprivation of

liberty safeguard in place or why. This had the potential for conditions on the DoLS authorisation not to be upheld by staff.

People had access to health professionals to meet their specific needs. We saw records were maintained of appointments with professionals and the outcome of those visits. Care plans included guidance from professionals such as physiotherapists, occupational therapists and speech and language therapists. Protocols were in place for the management of people's epilepsy. These outlined the seizure type, treatment and subsequent actions if the seizures were not responding to the protocol. The protocols were signed and dated by the medical team responsible for overseeing people's epilepsy care. People were registered with a GP. Recent changes meant people had to attend for appointments at the GP surgery as opposed to seeing the GP on site. Some people expressed dissatisfaction with this. During the inspection people were supported to attend appointments at the surgery. There was no evidence people were offered the required health screening checks and this was feedback to the registered manager to address with the GP practice. People had access to dentists, opticians and podiatrists. A health passport was in place which staff took with them when they took people out on activities and went with the person if they required hospital treatment. These were updated and reviewed as people's needs and medicines changed. Relatives told us staff kept them informed of changes in people's health and seek medical input if required. One relative told us they were not informed of Doctor's appointments and the outcome of any changes to treatment plans. This was feedback to the registered manager to follow up on.

A health professional involved with the home told us the registered manager took the advice from the Therapy Service seriously and was able to have open and informed discussions with them regarding individual people's needs. They said the registered manager had the challenge of supporting a very varied group of people, some with very unpredictable and very variable support needs to live together in a house with few communal areas. They commented "The new staff in the team had definitely enhanced the service to people".

Another health professional commented "They thought follow up of therapy guidelines had improved a little".

Staff were aware of people's dietary needs and preferences. They told us they had all the information they needed and were aware of people's individual needs and risks around mealtimes. People's needs and preferences were recorded in their care plans. The home used an external company to provide prepared meals. Staff were responsible for supporting people to make meal choices, ordering the meals, storing them in date order, cooking and serving them. We saw a menu plan was in place. This showed the meals were varied. Other food provisions such as bread, milk, cereals, eggs, fruit and tinned foods were purchased at local supermarkets. People who did not like what was on the menu were offered various options such as omelettes or sandwiches to encourage them to eat. Some people told us they liked the meals that were provided. Other people said they did not like the ready prepared meals which were supplied to the home. One person commented "They were not proper home cooked meals". We saw feedback from people in November 2015 highlighted that there was a need to make the meals and meal times more attractive. During feedback the nominated individual agreed to review the current meal arrangements.

People's care plans outlined if they required their food and fluid monitored and why. We saw a number of people had fluid and food charts in place. In two of the care plans viewed guidance was provided on the minimum and maximum fluid intake required. The guidance in the care plan was clear on what action to take if the minimum fluid intake was not reached but there was no guidance on what action to take if the maximum fluid intake was exceeded. The food and fluid monitoring charts were well completed, totalled daily and a daily shift handover report was completed for the registered manager which outlined each

individual's total fluid intake recorded. Where the fluid intake fell below the minimum level the registered manager emailed the deputy manager, team leaders and shift leaders to remind them to reinforce to the staff team the need to encourage more fluids. We saw occasions where the maximum fluid intake was exceeded. This was recorded and reported but no action was taken. During discussion with staff they were clear on what action to take if the minimum fluid intake was not reached. However they were not aware what action to take if it was exceeded and if there was any consequences associated with this. After the inspection the provider contacted a medical professional for advice. They confirmed that exceeding the maximum fluid amount on occasions would have no clinical significance for the person. They confirmed the person was not placed at risk.

It is recommended that the provider introduces a system to assess staffs work practices following training received. This will ensure staff have understood and implemented what they have learnt.

It is recommended the provider considers any improvements that can be made to ensure effective communication within the team to ensure key information on people is made known and handed over to staff and others involve

Requires Improvement

Is the service caring?

Our findings

People told us staff were kind and caring and they felt cared for. Relatives told us staff were caring. A relative gave an example where they had to break bad news to their relative. They commented "Staff were so kind, caring and helpful in supporting their relative." Another relative told us staff do a difficult job well. They commented "Staff are selfless, happy and make the extra effort to support and encourage people." Another relative told us they believed staff were caring. They commented "Staff appeared to have a patient manner, they listened to what is being said and showed sympathy for people's concerns". One relative told us they have had to raise concerns that their relative's personal care was not maintained to an acceptable standard. Staff at the home were aware of this and had support plans in place to support the person to maintain their personal care whilst promoting the person's choices and decisions.

A health professional involved with the home told us the example of allowing the person to take risks is an excellent example of the level of care and respect afforded people by staff, both carers and management staff. They said there are several people living at the home with possible mental health issues and the entire team all demonstrate respect and care for those individuals.

Another health professional told us they observed people being spoken to respectfully and kindly, including offering help for feeding. Another person was given time to mobilise safely and encouraged to stand square to their chair properly before sitting down.

We observed staff engaging with people. Staff were kind, caring, gentle, supportive and provided people with reassurance. Staff provided people with good eye contact and were seen laughing and joking with people. They had a good understanding of people's needs and were aware when people were unhappy and becoming distressed. We observed negative staff interactions at lunch time. One person required staff support with their meal. Throughout the meal time three different staff members were involved in supporting the person. One staff member demonstrated positive interactions. They encouraged the person to eat whilst promoting their involvement and allowed the person the time they required to eat their meal .The other two staff had little or no engagement with the person they were supporting. One staff member sat next to them and did not speak to them. The other staff member sat next to them and proceeded to have a conversation with the person sat opposite and another person in the lounge. They then got up and stood behind the person's chair and engaged with a staff member. That practice did not promote the person's dignity. This was feedback to the registered manager. They agreed to review how staff are allocated to support people with their meals and to address the poor practice observed.

People were encouraged to have involvement in the running of the home. Residents meetings took place. We saw people were informed of proposed staff changes, planned trips out and anything else that was happening in the home. One of the people who used the service was also on a committee meeting and acted as a representative for the home.

The home had people with a wide range of needs. People were supported by staff to clean their bedroom and do their laundry. We saw some people did their own shopping and some cooking. Their independence

and development of their life skills was promoted. However the staffing levels did not allow people to have the required support to further develop life skills and their independence. The registered manager confirmed they were in the process of reviewing this with funding authorities.

A professional involved with the home told us they had attended an annual review of a person's care and from their observations the home provided the adequate support needed to enable the person to remain independent and in control of their own life.

People's care plans outlined their communication needs and how people with limited communication expressed their needs and were understood. In one person's file it indicated they used visual prompts, aids and objects of reference to enable them to make choices, decisions and communicate effectively with staff. During the course of the inspection staff engaged verbally with people and gave them choices but did not give people the opportunity to make an informed choice or decision and promote their involvement.

A health professional involved with the home told us there had been an increase in requests from the Speech Language Therapy services to help staff implement communication strategies for people to help them express themselves and understand others. They commented "I'm very pleased about that improvement".

At the time of our inspection the home had no advocate involvement. Advocates are independent and represents the persons interests, supporting them to speak or speaks on their behalf to ensure their needs and wishes are taken into account. The registered manager was aware how to contact them if one was required.

The majority of bedrooms were single. We viewed a sample of bedrooms. People's bedrooms were personalised and reflected their interests and hobbies.

It is recommended the provider reviews mealtimes. This is to ensure better continuity of care for individuals and positive staff engagement to promote people's dignity.

It is recommended the provider considers how aids are better utilised to promote communication with people who have limited communication.

Good

Is the service responsive?

Our findings

Relatives told us staff were responsive to people's needs. One relative told us staff know when someone needs a bit extra support due to increase in seizures or effects of medicines and it is provided. They said they also support people who are able to, to be as independent as possible. They commented "Staff offer their relative really tailored and personalised care."

A health professional involved with the home told us Greene House provided a highly personalised model of care, responsive to individual needs, based on the long term knowledge of the people who have been living there for many years. They said this has been achieved through continuity, in particular from the current house manager who has been involved with Greene House in different roles for many years. They said problems usually arise, if bank or in experienced staff are confronted with people who can be rather rigid in their thinking and behaviour. They said protocols for seizure and behavioural management were in place, but this did not replace the personal experience and knowledge. They commented "This problem had become more relevant and prominent with the cessation of the first-line nurse services which had provided continuity and knowledge, combined with specialist expertise in epilepsy and behavioural management to the homes". The provider was aware of this and addressing it.

Another health professional told us the house team had improved their overall approach in communicating understanding and reacting to challenging situations involving the people they supported. They said the house staff they had experienced worked appropriately and sensitively dealing with potential conflicting situations. They commented "Very challenging complex needs appear to be met and worked with on a daily basis with thought and care".

A third health professional told us they got the impression that staff were responsive to people's needs. They commented "This responsiveness is apparent in the way they manage behaviours which challenge safety and is reflected in the friendly and trusting relationships between staff members and the people they support. It is also reflected by the amount of information staff are able to share about the personalities and preferences of people".

People had care plans in place. Care plans were detailed and specific as to the support people required. They provided clear guidance for staff on how all aspects of the persons care was to be met. Some people had signed their care plans and were aware they existed. Others were unable to sign or chose not to. People told us they had a keyworker. A key worker is a named member of staff that was responsible for ensuring people's care needs were met. This included supporting them with activities and spending one to one time with them. People were aware who their keyworker was and the key workers were clear of what was expected from them. Each individual had a number of folders. These were bulky and information was not easily accessible as it was recorded in a number of different places.

People had regular reviews of their care and progress. Some relatives told us they were invited to and included in their relative's review. Other relatives felt they were not given sufficient notice to enable them to travel to the home for the review. The registered manager provided evidence that the Local Authority did not

always give the home sufficient notice of reviews to enable them to give families sufficient notice. Where this had happened the registered manager informed families as soon as they could and apologised for the short notice.

People had an individual programme of activities. Some activities took place in the home, on site or in the community. The home had a designated activities coordinator who divided their time between doing activities at the home and other administration tasks as part of a central activities team. During the course of the inspection we saw a game of scrabble took place a discussion group was held and a group of people went bowling. We saw two people liked to go to church. Their activity programme indicated they went every other week. We reviewed the records and saw that they had not gone to church throughout December 2015. Staff had recorded that on one occasion this was because there was not enough staff on duty and on another occasion there was no driver. The registered manager confirmed the staffing levels were under review to enable them to provide more community based person centred activities for people. A professional involved with the home told us that during their visits there they saw a number of people sitting in the lounge area and there was not much activities that were being provided.

A resident's survey was completed in November 2015. People feedback then there was a need for more outings, shopping trips and meals out. We were told this was being developed. We saw people spent a lot of time sitting in front of the television, sleeping in armchairs and generally appeared unstimulated and bored. Other people choose not to engage in activities and this was respected. Staff felt there was a need for more community based activities however there was not always enough staff or drivers to enable that to happen. A relative told us they would like to see their relative do more activities and felt the centralising of activities would make this more possible. The nominated individual told us they were looking at recruiting a driver full time as well as putting another two staff through the minibus driving assessment which would address some of those issues.

People told us they would talk to the staff if they had any worries, concerns or complaints. Some relatives knew how to raise concerns and had confidence concerns raised would be dealt with. A relative commented " I do know how to make a complaint as they are very open and transparent with communication, if I had concerns I would be comfortable approaching the manager , I have not had to raise any concerns". Another relative felt they were not informed of the complaints procedure. The registered manager provided evidence that a copy of the complaints procedure had been sent to relatives. People were asked if they had any complaints or concerns they wanted to raise during their residents meetings. The complaints procedure was accessible to people who used the service. Systems were in place to record concerns, complaints and to investigate them.

Good

Is the service well-led?

Our findings

People and staff had confidence the registered manager would listen to their concerns and they would be received openly and dealt with appropriately.

People who used the service were very complimentary of the registered manager. They commented "The registered manager was wonderful, did a great job and always helped them". We saw they had a positive relationship with people and there was a mutual respect between them and people who used the service.

Relatives told us they found the registered manager to be personable, accessible and approachable. One relative said the effort the registered manager and the staff team put in to the care of people was astounding. They described the registered manager as "Superbly Supportive".

A health professional involved with the home told us the registered manager participated in people's reviews and had good knowledge of people's needs and behaviours. Another health professional commented "There has been a very stable staff group there, with kindly, benevolent, thoughtful management for years".

A third health professional told us the registered manager models appropriate care and respect. They said the registered manager is frequently involved in the care of people and they work on the floor and is involved with people and staff. They told us the registered manager was creative with ways to improve people's understanding. They gave an example where the registered manager showed a person who used the service how the food was made and processed for delivery in order to gain the person's consent to the meals. The person ate a large lunch on the premises and said they enjoyed the food. The professional commented "I think this is an example of creativity and 'going the last mile' to help the people using the service, which models respect, care and good leadership".

Staff told us they felt the home was well-led and managed. They told us the registered manager, deputy manager and team leaders were accessible and approachable. The deputy manager and team leaders regularly worked on shift and alongside staff. The registered manager was available to people and assisted on shift and in supporting people when required.

Staff told us they were clear of their roles and responsibilities. They said they worked well as a team. New team members felt they were welcomed and supported by the team. Regular team meeting took place which staff said they contributed to and they felt able to raise any issues. They were confident about using the whistleblowing procedure if they needed to.

The registered manager had notified the Commission (CQC) about significant events, including deprivation of liberty approvals. We used this information to monitor the service and ensure they responded appropriately to keep people safe.

The registered manager told us they felt supported in their role. They had identified areas for improvement

such as meals, activities, environment and staffing levels. These were included as areas for improvement on the homes development plan and were being addressed. The registered manager was committed and motivated to providing a good service to people. They were clear of the vision and values for the service and worked alongside staff in promoting good practice.

Quality assurance systems were in place to monitor the quality of service being delivered and the running of the home. Internal audits such audits of care plans, food and fluid records, medicines, accidents, incidents, health and safety, infection control, supervision of staff had identified shortfalls and action had been taken. Alongside this the provider carried out monthly comprehensive monitoring visits of the service. Actions from all of the audits were added to the homes development plan and signed off by the registered manager and line manager when completed.

People and those important to them had opportunities to feedback their views about the home and quality of the service they received. Family meetings took place. Relatives told us if they were unable to attend the meeting they were provided with minutes of it. Relatives also confirmed they completed a survey at least annually and felt actions were taken as a result of their feedback. The registered manager told us surveys were sent out to relatives in September 2015 and to staff and professionals involved with the home in December 2015. They were still collating the results of those.

At the previous inspection records required for regulation were not accurate and up to date. We saw at this inspection progress had been made in addressing that. Detailed care plans were in place and effective auditing of records such as care plans and food and fluid monitoring charts had been developed which enabled them to pick up gaps in their recording. They also recognised further improvements were required to records and systems to promote safe care.