M G B Care Services Limited

Greenwood Lodge

Inspection report

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Ratings

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

Overall summary

The inspection took place on 17 March 2015 and was unannounced.

The last inspection took place on 19 September 2013 when we found that the provider was not meeting the standards of care we expected. We found that people were not protected against the risks associated with infections and staff were not supported to have appropriate skills to care for people. After the inspection the provider wrote to us to say what they would do to meet the legal requirements. At this inspection we found the provider had made many improvements to the care people received and was meeting all of the legal requirements.

Greenwood Lodge is a home for adults with learning disabilities, some of whom also have physical disabilities. The home can support a maximum of 19 people. Accommodation is provided in sixteen bedrooms on two floors in the main building, in addition an annexe to the side has two further bedrooms which have wheelchair access.

Summary of findings

There was a registered manager, however, they were no longer working at the service. A new manager was in place and the inspection took place on their second day in post. The new manager told us they were going to register and following our inspection we received an application for the manager to be registered. 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 Quality Commission is required by law to monitor how a provider applies the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way. The new manager was aware of their responsibilities under the MCA and appropriate assessments were being completed to ensure people's rights were protected.

The home was clean and tidy. The infection control policy did not always reflect the procedures in place in the home. However, there was no impact on people as appropriate infection control procedures were in place. Protective equipment such as aprons and gloves were available in places where people received care.

The registered provider used safe systems when new staff were recruited. The manager continually reviewed staffing levels to ensure there were enough staff available to meet people's needs. People received care from staff who had the skills needed to meet their needs. This was because staff were supported with appropriate training and regular meetings with their manager to review their working practices. New staff completed and induction within the home and were observed providing care to ensure they were safe to work with people.

There was a warm and kind relationship between people and staff. Staff ensured people's dignity was respected at all times. People's care plans contained appropriate information to enable staff to meet people's individual needs, including risk assessments. For example, we saw risk assessments were in place to ensure appropriate equipment was used to prevent people from developing pressure sores. Staff ensured that people received their medication safely and at appropriate times. Systems were in place to obtain, store and dispose of medicines safely.

The registered provider had a mission statement and aims for the staff to work to and all the staff we spoke with were aware of the aims and how they impacted on the care they provided. People and their relatives told us they trusted the staff and could raise any issues about their care. Systems were in place to monitor the quality of care people received and any concerns were identified and rectified.

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 service was safe.

Staff knew how to raise concerns if people were at risk of harm.

There were enough staff to care for people and risks to people were identified and care was planned to keep people safe.

Medicines were obtained, stored and disposed of safely and medicine was administered to people in the way they preferred.

Good

Is the service effective?
The service was effective.

Staff received training and support to ensure they cared for people safely and had the skills to meet people's needs.

The registered provider had complied with the law to ensure people's rights were protected.

People's nutritional needs were identified and any special diets were provided in line with people's care plan.

People were supported to have their healthcare needs met in a way which reduced its impact on their daily lives.

Good

Is the service caring?
The service was caring.

There was a warm and caring relationship between people living at the home and the staff who supported them.

People were offered choice in all areas of their lives and staff ensured they recognised non-verbal communication to help people be involved in their care.

Good

Is the service responsive?
The service was responsive.

Care plans recorded people's care needs and were personalised to meet people's individual needs. Staff were aware of people's needs and how they liked to be supported.

People were supported to engage in activities, hobbies and interests. People's individual interests were supported in daily life and in their holiday choices.

The registered provider had a complaints policy and people living at the home and their relatives knew how to raise concerns.

Good

Is the service well-led?
The service was well led.

Good

Summary of findings

The registered provider had a mission statement and set of aims for the service and staff worked to ensure the aims were embedding the care they provided.

Relatives told us they trusted the care staff and were supported to input into the development of the care and environment.

The registered provider had systems in place to monitor the care provided and to act when issues were identified.

Greenwood 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 was planned to check whether the registered 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 the 17 March 2015 and was unannounced. The inspection was completed by a single inspector.

Before the inspection we reviewed the information we held about the home. This included any incidents the registered provider was required to tell us about by law and concerns that had been raised with us by the public or health professionals who visited the service.

During the inspection we spoke with two people living at the home and a relative who was visiting. Following the inspection contacted two more relatives to gather their views of the service. Some people living at the home were unable to tell us about their care so we spent some time observing care and what it was like to live at the home. We also spoke with a cook, a housekeeper, a nurse, two care workers and the new manager.

During the inspection we looked at the care records of two people who lived at the home and other records related to their care such as daily notes and food and fluid charts. We also looked at staff training, complaints and the quality assurance records.

Good

Is the service safe?

Our findings

At our last inspection on 19 September 2013 we identified that the infection control processes in the home did not fully protect people from the risk of infection. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 cleanliness and infection control. The provider sent us an action plan which set out how they planned to address the areas highlighted.

At this inspection we found the infection control policy had been updated. However, it did not fully reflect the infection control processes that were in place in the home. We discussed this with the manager as the infection control processes were followed by staff however; they were just not accurately recorded.

The home was clean and tidy and a relative told us they were happy with the level of cleanliness. The housekeeper had a schedule of cleaning which needed to be done. They told us they did a deep clean of each room on a two weekly basis. The housekeeper was able to describe how they worked to ensure the risk of infection was minimised. This included having different coloured cloths and mops for each area, which were routinely disposed of.

Care workers were able to tell us how they worked to prevent the risk of infection. Staff said that there were always enough gloves and aprons available and antibacterial gel was available in people's bedrooms. This helped to reduce the risk of cross infection. Clinical waste bins were available in bathrooms and appropriate products were available for cleaning commodes.

The chef told us how they worked in the kitchen to reduce the risk of infection. Records showed the temperature of all hot food was checked before service to ensure it was hot enough to have killed any bacteria. Food was stored appropriately in fridges and freezers and was labelled with the date it was opened.

At the inspection on 19 September 2013 we identified that the bathrooms did not support good infection control processes. For example, taps could not be operated without touching them with your hands. At this inspection the registered provider had started work on a project to refurbish all the bathrooms in the home and to ensure they met infection control standards.

The registered provider was now meeting this regulation.

The registered provider had policies and procedures in place to keep people safe from harm. Staff were familiarised with the policies and received training in how to keep people safe at their induction and through regular refresher training. Staff were able to describe the different types of harm people may be exposed to and how that may affect them. Risk assessments were in place to identify if people were at risk of being harmed when accessing the community and actions taken to reduce this risk. Staff were clear on how to raise concerns both to their line managers and to external organisations. Phone numbers for raising concerns externally were available for staff in the office.

Risks to people whilst receiving care had been identified and risk assessments were in place. Care plans contained information on how to keep people safe from these risks. For example, we saw one person had a call sensor mat in place so that staff were alerted when they got out of bed.

Environmental risks were also identified and personal emergency evacuation plans were in place if the home needed to be evacuated. Plans included information on people's mobility and how they may respond in an emergency. This meant emergency personal would have access to information to help them manage any situation.

Incidents and accidents were reviewed and used to identify if people's care needed to be reviewed and if there were other ways of keeping them safe. The information was also used to identify if staff required further training in specific areas.

Staffing levels were based on people's needs and reviewed when new people moved into the home. One relative told us, "There are always plenty of staff." Staff told us they were happy that they could meet people's needs. The nurse was not included in the staffing levels and so was available if more support was needed. In addition, the rotas were organised so that a number of people were on duty from morning to evening. This ensured that people had continuity of care each day.

The registered provider had systems in place which ensured the staff they employed were suitable and safe to work with the people living at the home.

Medicines were obtained, stored, administered and disposed of safely. We saw that each person's Medication Administration Record (MAR) had been completed

Good

Is the service safe?

appropriately. MAR charts also contained information about how people liked to take their medicine. For example, one person liked their medicine offered to them on a spoon with a drink with a straw to drink from. The nurse followed the information in the care plans and also showed an awareness of when people liked to take their medicines. For example, they looked to see who needed to take medicine and then they looked at what people were doing. If a person was eating they left the medicine until after the person had finished.

One person refused to take their medicine; we saw that the nurse continued to support this person to get them to take their medicine. They asked another member of staff to help whilst they retreated to a distance and watched while the person took their medicine.

MAR charts contained information about when medicines were prescribed to be taken as required should be given. They also contained a list of homely remedies, like cough mixture, which each person could take.

Good

Is the service effective?

Our findings

At our last inspection on 19 September 2013 we identified that the staff had not received refresher training, supervision or appraisals in line with the registered provider's policies. This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Supporting workers. The registered provider sent us an action plan which set out how they planned to address the areas highlighted.

At this inspection we found the registered provider had made significant improvements in how they supported staff and ensured they had the skills needed to care for people. Staff told us and records showed they had completed training to update their skills. The registered provider had a training co-ordinator who monitored staff training needs and prompted the manager when a member of staff required refresher training. Alongside the mandatory training staffs' skills were also reviewed when new people moved into the home to ensure extra training was not needed to meet their needs.

New members of staff completed a comprehensive induction which included time at the registered provider's head office to go through administration and policies. This was followed by an induction in the home. Records showed that during the induction a senior member of staff would observe the new member of staff working ensure they were competent to complete required tasks.

Staff told us and records showed they were supported by having meetings with their manager every eight weeks. This was an opportunity for them to raise any concerns they had about the home. Records also showed staff had received an appraisal in the last year to preview they performance and to discuss their career aspiration and training needs.

The provider was meeting this requirement.

Staff had received training in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DOLS). These are laws which protect people's rights when they are unable to make decisions for themselves. The nurse had completed assessments for people living at the home to see if they were at risk of having their liberty deprived. One more review was needed before paperwork for the entire organisation could be submitted to the local authority.

People's capacity to make certain decisions had been assessed and the least restrictive options needed to keep people safe were in place. For example, one care plan recorded the person could understand money and had the capacity to spend money on small things but needed support when spending large amounts of money.

People were involved in making choices about their safety. Where people became upset and displayed a behaviour which may injure themselves or others care plans recorded the actions staff should take. These started with the least restrictive methods such as distraction and trying to calm the situation. We saw where medication was used to calm people down this was done in co-operation with the person. For example, we saw one member of staff sit with a person and discuss their escalating behaviour and ask them if they felt they needed any medication to help them remain calm.

We saw that there was a daily menu with choices for people at mealtimes. However, we saw that people were supported to choose food that was not on the menu. The cook told us that on some days a person may only want a sandwich, They added, "It's their home, it's their choice." Staff told us about one person who had a limited list of food they would consent to eat. We saw that this was supported by staff who always ensured there was food in the home the person would eat but encouraged them to try other foods.

Where people needed special diets this was supported. For example, the cook had a list on the wall of people's dietary needs and if they needed thickener and how much they needed in their drinks. One relative told us how the staff had worked hard to get their family member to eat food that would support their medical condition. They said "It has made an enormous difference to his health."

Where people had been unable to maintain a healthy weight they had been referred to the doctor for advice. We saw that food and fluid chart had been completed, however, information on fluids given with medicines had not consistently been recorded.

There were lead roles in place to help support people as they moved between services to have their health needs supported. For example, lead nurses supported people's health and learning disabilities.

Records showed people had been assessed should they require admission to hospital and appropriate support was

Good

Is the service effective?

identified for each person. A relative told us, "[Name] is attached to the staff and when she was in hospital one carer stayed in all night with her." Staff also tried to make hospital appointments easier for people. For example, a relative told us how staff had worked with the hospital to re-arrange appointments times for a person who had to attend frequently. The change in times allowed the person to have more free time to spend doing things they wanted

People's other health needs had been supported and we saw people had accessed dental services, chiropody services and the optician.

Good

Is the service caring?

Our findings

There were kind caring relationships between staff and people living at the home. People were keen to tell staff how they had spent their day and staff took the time to listen to people For example, we saw one person had a new hat on and staff took the time to compliment them and ask who had given it to them. People living at the home and relatives told us they were happy with the care they received. One relative told us, "[My relative] is always happy, always clean and happy." Another relative said, "We are very pleased with the care."

Staff told us how they had held a family day last summer so that people could invite their family and friends to their home for a party. This allowed people to return the hospitality they received from friends and family.

When people were required to complete forms about their health and welfare when needed, staff supported them to access the information needed and fill in the form correctly. This meant that other agencies involved in the care and welfare of people living at the home had correct information to be able to support them appropriately.

People were supported to make everyday choices about the care they received and staff ensured people could understand the choices available to them. For example, we saw staff had access to pictures of food to help people make a choice about what they wanted to eat. Staff were also aware of how people communicated their needs. For example, one person was making a low groaning noise and staff knew this meant they were hungry and so they were offered food outside a of a set meal time.

One person chose to go home to their parents' house for lunch every day. They were supported to do this by a member of staff. This person was protective of their personal space and had a key to their room so they were able to lock the door when they left the home. People's individual preferences were supported. For example, we saw one person did not like to have a duvet on their bed and had sheets instead.

When people's rooms were decorated they were encouraged to be involved in the process and choose the paint colour and curtains and duvet. A relative told us, "[My relative] has just had their room decorated and she loves it."

The registered provider had a set of rules around dignity which they required staff to be aware of and implement when caring for people. These included that staff respect people, ensured they have access to the community, that their dignity is promoted at all times and that they treat people as they would want to be treated. Staff were able to tell us how they supported people in line with these rules to maintain their dignity. For example, by supporting people to be dressed appropriately when going out and by being polite to people living at the home.

Good

Is the service responsive?

Our findings

We looked at two people's care plans and could see that they had been written to support people as individuals. For example, care plans recorded if people had the capacity to be involved in making decisions about their care and family members who should be consulted. Staff respected the rights of family members to be involved with a person's care and worked in partnership with families to ensure care met people's needs. Care plans also contained a profile so that staff knew what was important to people.

Staff were able to describe people's individual needs and how they supported them. For example, one person did not like water to be poured over their head while having a bath. A relative told us, "[Name] is happy and settled. They [Staff] let me know if anything is wrong. He's happy and goes out when he wants to go out. He goes to the pub." They told us they sometimes attended reviews but if they were unable to attend then they would be sent a copy of the updated care plan.

Staff were reactive to people's needs on a daily basis. When people became restless in the home, staff raised this with the manager and action was taken. For example, we saw one person was taken out or a drive and a walk to an area where they liked to spend time. Another person was asleep at lunch time as they had been unwell in the morning. Staff left them to wake up in their own time and they had a late lunch. Staff told us how this was better for the person as they would be happier in the afternoon and eat better than if they had been woken up for lunch.

There were a range of activities scheduled for people dependent upon their hobbies and interests. For example, going bowling or going for a meal out. Most people living at the home had a holiday booked and had been involved in making a choice about where they wanted to go dependent upon their interests. Staff told us how one person who liked to walk was going to the lake district.

One relative told us, "[My relative] loves it here. They take her out a lot and take her on holiday."

When people did not have a planned activity in place they spent time in the craft room or watching television in the living room. Outside of structured hobbies people's individual interests were supported. For example, one person had a magazine every week to keep up to date in their chosen subject.

People living at the home told us if they were not happy they would talk to the staff about any concerns they had.

The registered provider had a complaints policy in place but had received no formal complaints since our last inspection. Relatives said they did not need to make formal complaints. "The carers are wonderful with him and we can talk to them about anything. We can point out issues and they are fine with us. But we don't have to do so very often."

Good

Is the service well-led?

Our findings

There was a registered manager, however, they were no longer working at the service. A new manager was in place and the inspection took place on their second day in post. The new manager told us they were going to register and following our inspection we received an application for the manager to be registered.

The registered provider ensured the company and the home had clear aims and had a mission statement. This promoted individual rights, to enable people to take advantage of opportunities presented to them and to promote people's independence and quality of care. Staff were aware of the aims and were clear how they supported people to ensure they met the aims. For example, by ensuring people were offered opportunities to go on holiday.

During the day we saw the manager and the area manager were visible about the home. We saw people living at the home were relaxed and happy with them and knew who they were. For example, one person was really happy to see the area manager and spent time telling him what they had been doing. Staff told us the management were approachable and they were happy to raise concerns and ideas.

Relatives told us they were happy with the care people received. One relative said, "I don't think you can fault it." They also told us staff and management were approachable and would listen to what people wanted. A relative told us they had no concerns about the care provided by the home and that they got on well with the staff and felt they could talk to them about anything. They told us they trusted the staff at the home.

We saw the registered provider reviewed how well they were meeting people's needs with the environment. They had recognised that the building did not always meet people's needs and had started a programme of modernisation and refurbishment to provide better facilities for people. The home was being reconfigured to increase the number of rooms with en-suites available.

People's rooms were being decorated and people were given a choice of how they wanted to decorate.

The registered provider held regular staff and residents meetings. Records showed at staff meetings they discussed things like how they could help people maintain their dignity and the other aims of the organisation. People living at the home and their relatives had completed quality assurance surveys at the end of 2014. However, there had been no feedback to the home if any areas needed improving.

Within the registered provider's organisation, managers visited different homes to review the environment and the care provided to people. Their review was based on the legal requirements the registered provider needed to meet. Records showed these visits were being completed on a routine basis and action was taken to resolve any issues identified.

There was a systems of audits in place to monitor the home was meeting the latest requirements. This included environmental audits, vehicle audits and health and safety. We saw the audits identified concerns and action was taken to resolve these concerns.