Embrace Wellcare Homes Limited

Greenheys Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection was unannounced and took place on 21, 26 and 28 February 2018. At our last inspection on the 3 and 9 May 2016, the service was rated overall as Good, the responsive domain was rated as requires improvement to improve the person centred care for activities and stimulus provided to the people living at Greenheys Lodge.

Following the last inspection we asked the provider to complete an action plan to show what they would do and by when to improve the key question of responsive to at least 'good'. At this inspection, we found that they had met this requirement and implemented a member of staff to provide activities and stimulus to meet the needs of the people living at the home.

Greenheys Lodge is a purpose built residential care home that provides care for up to 33 older people and forms part of the 'Sefton Park Care Village' situated near Sefton Park in Liverpool. Bedrooms are all single occupancy with ensuite facilities and there are several lounges, a dining room and accessible bathroom facilities throughout the home. Greenheys Lodge has ample parking and large gardens to the front and rear of the building. 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.

The home required a registered manager to be in place however the registered manager had left the service in November 2017. A new manager had been appointed in November 2017 and had applied to become the registered manager in January 2018. 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.

We found breaches in relation to Regulations 9, 12, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities). Regulations 2014. These breaches related to person centred care, safe care and treatment in relation particularly to staffing levels and medication administration, nutrition and hydration, good governance, and staff support.

Staffing levels at the home were observed to be insufficient at times to meet the care and support needs of the people living there. Records of staff duty rotas looked at and talking to people, staff and visitors evidenced this. Information looked at and talking to staff about their support and training and development showed us this had not been sufficiently kept up date. This had an impact on staff morale.

The medication rounds were not completed in a timely way due to the senior staff member administering medication being frequently interrupted. The medication procedures were not correctly adhered to as there were incorrect recordings, missed medication and the safe storage of administration was not adequate.

We saw that although the care documentation was designed to be person centred, it had not been correctly or comprehensively completed and there were omissions and contradictions in the care records. We saw that care records were incomplete, were contradictory or missing important information. Monitoring was not done or recorded appropriately. Monitoring records including food and fluid charts, repositioning charts and pain scale records had not been completed by staff to inform that the care and support had been provided as required in the care plans.

Not all risk assessments accurately reflected the risks people faced.

Peoples' nutritional needs were met by the service. The chef told us that they provided meals based on people's dietary needs and we saw that they had detailed information regarding the nutritional needs for people with varying religious, medical or cultural requirements.

Although the management had completed audits initially at the home the scores did not reflect the findings of this inspection. On the final day of the site visit on the 28 February 2018 the managing director had initiated a quality assurance team to complete all audits again including staffing levels, training and development, medication, care plans and monitoring records and the environment. This was to address the issues raised from this inspection.

There was not good partnership working with external health professionals visiting the home. The records indicated that communication was an issue that required staff to ensure safe treatment practices shared, were followed by staff.

The provider was following the Mental Capacity Act 2005 and its guidance although records showed that some people's records required up dating.

We found that overall through observation and talking to people living at the home and their relatives that the care was generally good. Staff treated people with kindness and respect although at times the staffing levels had an impact.

There was a good range of activities available and some innovative practices were being followed by the activity coordinator.

Staff had not completed training to enable them to provide effective end of life care to people.

A system was in place to ensure people knew how to complain if they needed to and we found that complaints had been dealt with appropriately.

A range of policies and procedures were in place however staff told us that they were locked in the office and they could not always be accessed by them.

The management team were open and transparent during our inspection and worked with us proactively.

Ratings from the last inspection were displayed within the home and on the provider's website as required.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There were insufficient staff at times to meet people's care and support needs.

The medication administration procedure was not followed appropriately, records of signatures omitted, incorrect counts and medicines were not safely stored.

Care records did not have the relevant up to date details in place to ensure that staff were providing the relevant care and support.

Staff were recruited safely. People told us they felt safe living in the home.

Staff were knowledgeable regarding safeguarding procedures.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff support and training and development were not being provided effectively.

Treatment plans implemented by external health professionals were not adhered to effectively by staff.

People's nutrition and hydration records were not completed or used effectively by staff.

The provider followed the requirements the Mental Capacity Act 2005.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff we observed interacting with people treated them with kindness and respect. Staff were however rushed at times and this impacted on the care and support provided.

There were insufficient staff on duty at times to adequately meet people's care needs.

Staff communicated well with the people they were supporting and showed patience and understanding and gave them information and explanations about what they were about to do.

Peoples' friends and family were able to visit the home at any time.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Although the care plan documents were designed to be person-centred, they were not completed properly. Records were not up to date and staff were not always following the wishes of people including bathing and showering frequencies, repositioning for comfort and treatment plans so records did not achieve the aim of being person-centred.

People were offered choice about their food and were able to experience activities they preferred and enjoyed.

A system was in place to ensure people knew how to complain if they needed to and we found that complaints had been dealt with appropriately.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The service was not always well-led.

The manager was not registered with the CQC and the governance of the home was not being monitored effectively. The provider did not have over-sight of the service and its issues found at this inspection.

The issues of staffing levels and poor record keeping had not been identified by the home's audits.

Greenheys 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 was prompted in part by information of concern from an anonymous source and by the receipt of statutory notifications from the provider and correspondence to and from the CQC. This informed us about inadequate staffing levels at the home. There had been allegations that staff did not have the appropriate time to attend to people's care and support needs. This inspection examined those risks.

This inspection took place on 21, 26 and 28 February 2018 and was unannounced. It was carried out by two adult social care inspectors.

We checked with the local authority and also looked at our own records to see if there was any information we should consider during this inspection. We looked at the information the service had sent to us as statutory notifications. We also looked at the local Healthwatch website to see if they had recorded any concerns about the home.

We used the short observational framework for inspection (SOFI). SOFI is a tool developed and used by CQC inspectors to capture the experiences of people who use services who may not be able to express their views for themselves.

We used pathway tracking to follow five people's care through from its planning to its delivery. We looked at four staff recruitment files, training records for all staff, five medication records and other records relating to the running of the service.

We spoke with six people, with four relatives and fifteen staff including the managing director, regional manager, the manager, a quality assurance officer, the activities co-ordinator a senior carer, two care staff, four domestic staff, the chef, the maintenance person and the administration officer. We toured the home and observed some care, checked a medication round and observed lunch and other social activities.

Inadequate

Is the service safe?

Our findings

We saw that risk assessments were in place in areas such as falls, moving and handling and skin integrity. However, we found that not all risk assessments had been accurately completed or updated to reflect the care being provided. For example, one person's care file showed that they had difficulty repositioning themselves and staff were required to support them two hourly, but this was not reflected appropriately within their risk assessment. Another person was in an old nursing bed with bed rails, this was observed to be a high risk. The risk assessment recorded that the person had requested the bed, this information was incorrect. Another person's risk assessments included incorrect information and was out of date as they had moved to another bedroom. Risks identified were regarding falls and a sensory mat that did not work and we received conflicting information from staff and the manager. This meant safe care and treatment was not being provided.

We found that appropriate actions had not been taken for one person when health professionals had identified risks to their health and implemented a plan and records to support the staff to ensure safe care was provided. Records were not completed by staff in areas of repositioning, pain management and food and fluid intakes. This made it difficult to ensure that the provider was reasonably doing all that was practicable to mitigate risks to people.

We identified another person who we observed to be in their bedroom when a room alarm triggered their bedroom door to automatically close. This was dangerous as the person was at risk of falls and records showed they had fallen three times, the last fall recorded as being on the 19 January 2018. We requested that the management team deal with this immediately as we were informed the alarm acoustics had triggered their door and another bedroom door to close.

Records for six people that we looked at had a risk assessment and care plan for monitoring food and fluid intakes, these records were not completed appropriately by staff. This made it difficult to ascertain what staff had provided. This meant that risk was not always accurately assessed.

These are breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

We looked at how the home was staffed. The manager told us that staffing levels had been a difficult area to address due to staff vacancies. We had received information in relation to staffing levels being insufficient to meet the care needs of people. We requested rotas of staffing levels on each shift from December 2017 up to the 28 February 2018. We requested a dependency record off the manager and the managing director, they provided the information informing us of the care each person required in their care agreements.

Incorporated into the rotas were the usage of agency staff that was seen to be high on certain shifts and we were told and saw details when only agency staff were on duty on a night shift. We were told by the manager and staff that agency staff at times did not turn up or were not competent to fulfil the role required. This was discussed with the management team and we were told that there should always be an in-house senior on

duty who was competent in the running of the home and knew the people living there however, this had not always been in place.

When we asked people about staffing levels within the home, we received the same feedback from all. One person told us, "They don't have enough staff they are always running around" and another person said, "There seems never to be enough staff although there are plenty today". Another person told us, "No, not really, [staff] have so much to do". When asked if they had to wait for care people told us, "It depends, most of the time though I do" and another person said, "[Staff] try their best but not enough of them".

Feedback from staff was also mixed, although most staff told us there were not enough staff. Relatives we spoke with all told us they felt there were not sufficient numbers of staff on duty. During the inspection we observed that call bells were answered, however two people who we visited in their bedrooms did not have their alarm close to them and were unable to request support. We spent time talking to a person who had been shouting from their room for help. We went onto the floor and were unable to find any care staff, after five minutes we supported the person to activate their alarm as it had been placed at the side of the bed and couldn't be reached. This meant that there were not sufficient numbers of staff deployed to meet the care and treatment needs of the people and people did not always have access to call on the staff for help.

We looked at staff training records for all staff and were provided with an up to date training matrix. We were told by the manager and staff that training was not up-to-date specifically in induction training and refresher training for example moving and handling, fire safety at work and safeguarding vulnerable adults. We requested the competency records for agency staff working at the home and were provided with a profiles summary sheet that had their training recorded. Agency staff spoken told us they had not received any information prior to arriving at the home, on arrival they had been shown the fire panel by a member of staff and the direction of the lounge and dining room. They had not been shown around the home, told about people's needs or how the call bells worked. This meant that the staff deployed were not provided with appropriate support and training necessary to effectively carry out their duties.

These are breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

During the inspection we looked at how medicines were managed within the home. Medicines were stored within a trolley in a locked clinic room. The temperature of both the clinic room and the medicines fridge were not monitored and recorded each day as required to ensure medicines were safely stored within safe ranges. If medicines are not stored at the correct temperature it can affect the way they work.

We reviewed the medicine administration records (MARs), we found that not all peoples' MAR had a photograph on and two people with the same first name were next door to each other. One of these people did not have a photograph, which could increase the risk of an error, especially for staff who did not know people well, such as agency staff.

There were other omissions on MAR sheets we looked at, for example one person prescribed a weekly Butrans patch had two gaps in administration on 13 and 20 Feb 2018. The MAR was last signed for by staff on the 7 February 2018. No patches were in stock and staff told us they were not sure why this had not been administered. There was no system in place to record rotation of topical patches. We requested the GP be contacted immediately to ensure the person was provided with their prescribed medication.

Another person's MAR for liquid antibiotics Amoxicillin had incorrect information and staff had not followed

the administration instructions. The medication was to be administered for 5 days however, it had been given three times per day for seven days. There were 22 signed administrations, which would total 220 mls, but only 200mls was booked into the home. This meant that records regarding medicines were not always maintained accurately by staff.

Another person prescribed Dipyridamole each day had an unsigned gap on their MAR record.. We checked the stock balance and 60 tablets had been booked in, 28 staff had signed to state they had administered and a balance should have been 32 left. There were 38 left; meaning 6 tablets had been signed for and not given. This meant that the person had not received their prescribed medication.

We looked at the different prescribed amounts of 'Thick and easy', a thickening agent for people with swallowing difficulties. The MAR's had no evidence that this had been administered effectively to the people at the correct consistency. A record in the servery by the dining room had a list of people and amounts to be administered. The record was out of date and had incorrect information that staff were to follow. This could impact on the health of the people receiving it as they could choke.

We also found that protocols were not always followed by staff for medicines that were prescribed 'as and when required' (PRN). Other professionals told us they had concerns about the health care practice for PRN pain scale monitoring and administration. For example we looked at the MAR for one person and records that had been implemented for staff to follow how to recognise signs of pain. The records were not completed appropriately and did not inform if the person had the specific PRN pain relief. This meant that records regarding medicines were not always maintained accurately.

The Medicines procedure for staff countersigning was not being followed appropriately. We observed staff signing to inform they had observed medicines being administered. This was not the case as we observed the staff had signed when shown medication but had not witnessed the administration as required.

These are breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

We saw that a medicine policy was in place in the clinic room on the notice board which provided guidance to staff on the safe administration of medicines. We requested the training information on medication training and the manager said that only senior care staff administered medication. There was only two seniors' currently employed one of them who had been working at the home from January 2018 all other shifts were covered by agency staff.

We looked at how staff were recruited to the home and found that recruitment files contained two references, a full employment history and a Disclosure and Barring Service (DBS) checks. DBS checks consist of a check on people's criminal record and a check to see if they have been placed on a list for people who are barred from working with vulnerable adults. This assists employers to make safer decisions about the recruitment of staff.

All people we spoke with told us they felt safe living in Greenheys Lodge. When we asked people why they felt safe, comments included, "I am safe, I think and staff are really good", "The [staff] make sure I'm safe", "Yes, because it's secure and people can't get in unless they come through the main doors that are always closed" Relatives we spoke with also agreed that the home was safe. Their comment's included, "Yes, we have no worries, the door is safe and we sign in and out", "Yes, our experience of other homes is not great but we are happy [family member] is here".

Staff we spoke with understood local safeguarding procedures and were able to clearly explain how they would report any concerns they had. A safeguarding policy was available to guide staff in their practice and contact details for local safeguarding teams were on display within the home. Records showed that not all staff had completed safeguarding training, however we were told by staff that they would inform the senior in charge. We saw that appropriate referrals had been made to the Local Authority when required.

The provider had a whistleblowing policy in place which encouraged staff to raise any concerns without fear of repercussions. An equality and diversity policy was also in place. This helped to raise staff awareness and ensure that people were not discriminated against regardless of their age, sex, disability, gender reassignment, marital status, race, religion or belief or pregnancy, as required under the Equality Act 2010. The manager told us there was nobody living in the home at the time of the inspection that required personalised support in relation to any of the protected characteristics.

Systems were in place to help maintain the safety of the environment. For instance, external contracts were in place to check the safety of the gas, electric, fire alarm, lifting equipment and water safety and these were in date. Records showed that regular internal checks were also completed in areas such as water temperatures, fire alarms, emergency lighting, call bells, first aid boxes, fire doors and closures, bed rails, air mattresses and fire-fighting equipment.

The home appeared clean and people we spoke with told us they had no concerns regarding the cleanliness of the home. One person told us, "It's very clean they do my room every day" and another person said, "Yes, it's always nice and clean here". We observed a downstairs bathroom by the clinic room where a laundry trolley was placed without any laundry sacks in. Dirty laundry had been left on the frame of the laundry trolley and on the floor below it. A red sack of soiled clothes was also left on top. Although we observed paper towels and liquid soap in the bathrooms we observed, there were no paper towels at the sink in the clinic room that meant when staff washed their hands they had no effective way to dry them.

Accidents and incidents that had occurred within the home had been recorded and reported appropriately however, the provider did not have systems in place to ensure that lessons could be learnt from incidents. We asked the manager what systems they had to analyse peoples' falls and any incidents, to look at ways of preventing future accidents. We were not provided with a record.

Requires Improvement

Is the service effective?

Our findings

Care files we viewed included care plans in relation to people's mental, physical and social health needs. This showed that people's needs had been originally assessed holistically. We saw that staff were required to record outcomes monthly or more frequently if required due to ill health and malnutrition universal screening tool (MUST) records had been implemented. However, we looked at people's MUST records and saw one person's showed that there were gaps where staff had not recorded anything. We were made aware by staff that close monitoring of the individual was required due to their diminishing health and to ensure staff provided effective outcomes in the support. This made it difficult to ascertain if the person had received the support required and staff had acted on any changes.

Another person's assessment records regarding their assessed needs and choice for care was out of date in most areas and was for a short stay at Greenheys Lodge. The records and monitoring plans had not been updated to reflect the changes for example they had been relocated to a new bedroom and a sensory mat was in place to monitor their movement due to falls, the sensory mat did not work and we were told by staff that it was broken. This meant that the care was not being provided to the person effectively as they were not receiving the care and support they were originally assessed to receive.

We saw that referrals for healthcare advice for people were made. However we looked at how people's nutritional needs were met within the home and monitoring records implemented for staff to complete when concerns regarding their health were raised. The food and fluid charts for eight people had not been completed by staff there were gaps and information on quantity of food and fluid intake. This made it difficult to know if the relevant plans had been followed and if the people had been provided with the relevant support by staff.

These are breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

People living in Greenheys Lodge were supported by staff and other healthcare professionals in order to maintain their health and wellbeing. All people we spoke with told us they could see a doctor when they needed to. Care files showed that advice was also sought from other professionals such as the dietician, dentist, optician, chiropodist and the speech and language therapist.

Newly recruited staff should have received an induction with the provider's mandatory training programme and go on to complete other training, as necessary. We saw that there were gaps in the training matrix that indicated induction training and refresher training in some areas, such as safeguarding and Mental Capacity Act 2005 had been provided. One staff member us that the training was predominantly e-learning and they felt they were not learning and that it was an "Exercise by them [the provider] to tick boxes". Another staff member said about e-learning, "I do not rate it; who monitors our learning and we don't get any feedback".

Staff told us and records looked at informed that supervision meetings were not taking place as frequently as required by the providers supervision guidelines and policy . The manager told us that the meetings were

not up to date due to him concentrating on other areas to be actioned by him. A staff member said that they did not feel supported by the management and had not received an appraisal in over a year. They told us, "The management don't' listen". However, another staff member told us that they felt supported in their role and had regular supervision meetings with one of the management team.

We spent time talking to agency staff working at the home who informed us that they had not felt supported in the role they were required to do. Comments were "There is a lack of communication" and "No systems in place to ensure information is shared and the orientation into the home was none existent".

These are breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

We discussed the food provided with people living at the home and comments included, "Good food, I like it", and "We enjoy sitting together at meal times, the food it's nice but not like my cooking". Relatives spoken with told us "The food always appears to be appetising when I visit" and "my [relative] has put weight on here as they were not eating at home, this is a good thing".

The chef told us that they provided meals based on people's dietary needs and we saw that they had detailed information regarding the nutritional needs for people with varying religious, medical or cultural requirements. They were currently providing meals to meet people's individual needs, such as a diabetic diet, pureed and fortified diets. We were provided with copies of the new menus that were being provided. The meals included breakfast, mid-morning tea and coffees, lunch that consisted of sandwiches and fresh soups, afternoon teas and a cooked evening meal. We observed people having breakfast and lunch on two days of this inspection, staff were seen to be respectful and supported people in a dignified manner.

During this inspection we looked to see if the service was working within the legal framework of the Mental Capacity Act 2005 (MCA). The 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 make 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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Applications to deprive people of their liberty lawfully had been made, 12 DoLS applications had been made to the Local Authority. The manager maintained a record which reflected when applications had been made, this helped to ensure that applications and authorisations were managed appropriately.

When people were able to provide consent to their care and treatment, this was recorded within their care file. For instance, one person's care file contained signed consent forms for the use of bed rails and agreement for their photograph to be taken. Another person's file reflected that the use of bed rails had been assessed and discussed with the person and that they had provided verbal consent, but were unable to sign the form. However one person was in a bed that was unsafe and the assessments and care plans informed this was the person's choice. In discussion with the person who had capacity it was clear that this was not accurate information.

When people were unable to provide their consent due to memory difficulties, decisions were made and recorded in their best interest. For instance, one person's file included a mental capacity assessment to decide whether the person was able to make a decision regarding cardiopulmonary resuscitation. It

reflected that the person lacked capacity to make this decision, so family members had been consulted along with the person's GP and a decision was made and recorded in their best interest. This showed that consent was sought in line with the principles of the MCA.

We looked around the home and saw that the environment was in need of redecoration specifically the bathrooms and communal rooms. We were told by the manager that there was a plan to redecorate the home. We observed numerous windows could not close properly and reported this to the managing director. On day three of this inspection all of the windows had been assessed and work was taking place to fix all. The corridors in the home were suitable to help maintain people's safety and were seen to be clear of any obstacles such as equipment. However orientation for people would be difficult as the corridors although they had pictures, looked the same. For example, not all bedroom doors contained numbers and people's names to help them identify their room if needed.

Requires Improvement

Is the service caring?

Our findings

It was clear through observations and discussions with in house staff, that they knew the people they were caring for well. For instance, a staff member told us how they observed a person for specific facial gestures which indicated they were in pain, as they were unable to verbally communicate this to staff. However when we had looked at the persons records this information was not recorded in the 'Abbey pain scale' monitoring care plan. This meant that the person was at risk of staff not realising that they were in pain as many staff were not familiar with the people who lived in the home.

The staffing levels had an impact on the care provided as written in the other domains. There was a high use of agency staff that were not at all times orientated into the role and aware of what care to provide. We were told and observed agency staff were not familiar with the people, one agency staff member told us "I don't know what I'm supposed to be doing".

During the inspection we observed some positive interactions between the home's permanent staff and people living in the home. We saw that support was provided in a friendly, familiar and respectful manner. We heard staff ask for people's consent to provide care and explain what support they were going to assist them with.

We observed people's dignity and privacy being respected by staff in a number of ways during the inspection. For example, all staff knocked on people's bedroom doors before entering and support was provided in a discreet way. During discussions, staff were able to clearly explain how they ensured they protected people's dignity and privacy when providing personal care. Examples included ensuring the door was closed, asking for consent, ensuring the person was covered as much as possible and closing curtains/blinds.

People living in Greenheys Lodge told us that staff were usually kind and caring and that they were treated with respect by staff. Their comments included, "Most staff are lovely", "[Staff] are really kind, I can't fault them", "Lovely, they are so busy" and "They are lovely and do a good job".

All of the relatives we spoke with agreed that staff were caring. Their comments included, "We get on really well with the staff, very caring", "[Staff] are always helpful", "[Staff] respectful and I couldn't say I have seen any poor care here" and "[Staff] are kind and patient, they take time to talk to us".

We looked at the service user guide and the statement of purpose for the service, which were available in the entrance of the home. They contained information about the service and what people could expect when they moved into the home. It also included information regarding the complaints and safeguarding processes. The aims of the service and a resident's charter were also included within the service user guide. This showed that people were given information and explanations regarding the service.

People we spoke with were happy with their care and told us that their family members were kept involved. Relatives we spoke with agreed that they were involved in the care planning process and that staff mainly

informed them of any changes. One relative told us, "I know about them [care plans] and I feel informed".

We saw that care files were stored securely within staff offices that were locked when nobody was in them. This helped to ensure that private and personal information was stored confidentially and only people who needed to know people's confidential information had access to it.

We saw people's friends and family visiting throughout the inspection and all those we spoke with told us they could visit at any time and were always made welcome. The manager told us that there were no restrictions as to when people could visit and this encouraged people to maintain relationships they had built in the community before moving into the home. There was a notice in the lift requesting that when people visited in the evening they were quiet and respectful to other people who had gone to their bedrooms early.

For people that did not have any family or friends to support them, details of advocacy services were available within the home. The operations manager told us that they had arranged for a local advocacy services when required. We observed records in peoples' files where advocacy services had been sought, for example supporting a person who did not have capacity to consent to the care and support being provided.

Requires Improvement

Is the service responsive?

Our findings

The last inspection in May 2016 the provider was found to be in breach of regulations regarding person centred care in the responsive domain that was rated as requires improvement. The provider did not provide care that achieved and reflected peoples' preferences. There was a lack of activities and stimulus that ensured person centred care was being provided.

During this inspection we looked to see if improvements had been made and they had. We observed activities taking place over the three days, spent time with the activities coordinator, looked at activity care plans and the activities rolling programme. People were positive about the activities, comments made by people included "Great lady, we have fun and I love the quizzes", and "There is always something happening here, I do join in when I am up to it". A relative told us that it didn't matter what time they visited their relative there was always an activity happening.

We reviewed care plans and saw that most plans were not all up to date. We looked at records relating to the support staff provided for a person to help them reposition in order to prevent pressure ulcers developing. We found however, that these records had not been fully completed. For example, the care file stated that they required support from staff to reposition every two hours and monitor for skin integrity. Records of staff monitoring and supporting were not being completed and we saw gaps of when the support should have been provided. Visiting health professionals advised us the person did have some deterioration to their pressure areas. There were also gaps in other records for this person including food and fluid records and pain monitoring. We discussed this with the management team who agreed to ensure records were completed in a timely way. This meant that the care provided did not accurately reflect the person's needs.

Another person's pressure care was to be monitored and repositioning to take place every two hours as a risk assessment identified a high risk on the 21 January 2018. The monitoring records had gaps in when staff had repositioned. Other monthly evaluations that were required in their care plan had not been updated since 22 October 2017. This meant that the care provided did not accurately reflect the person's needs.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the systems in place to help support people at the end of their life. We saw that care files showed that end of life care had been discussed with people and their preferences had been recorded within their plans. We discussed end of life care with the management team as staff had not had training in this area. Communication with relevant health professionals was not effective at times. For example we were told that access to the home was difficult at times when nurses visited to provide treatment. Another example was there were identified gaps in a person's observational records. We looked at health care plans implemented for staff to follow including repositioning due to pressure ulcers and pain monitoring records 'Abbey pain scale when the person could not verbally communicate discomfort or pain. This made it difficult to inform if personalised care was provided and if staff had been responsive to peoples' needs.

We looked at the personal care plans that had information on how people chose to be supported. This information included having a bath or shower. We discussed with the manager how staff were supporting people and what the frequencies were of baths and showers being provided as there was no information in the files we looked at. We were told that not all people were having a bath or shower as required and there were no records available. The manager devised a record and we were provided with a copy on day two of the inspection to inform when people were supported as required in their care plans.

Other care files we viewed had omissions were staff were required to record how and when they had provided the care as written in the care plans. Reviews regarding people's needs had not been updated regularly. This made it difficult to inform if personalised care was provided and if staff had been responsive to peoples' needs.

These are breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also saw that care files contained documents which detailed people's preferences in relation to their care and treatment as well as their life histories. This included information about where people lived, jobs they had, their family members, preferred activities and any special dates for the person, such as anniversaries and birthdays. Files also included a 'This is me' a profile of the person, which recorded what was important to the individual, likes and dislikes and how they wanted to be supported.

We looked at the social aspects of the home and what activities were available to people. An activity coordinator was employed and provided activities most days. A schedule of activities was available, which included bingo, memory games, chair exercises, cake making and crafts. The activity coordinator told us they also arranged birthday parties and other celebratory events. External entertainers were also arranged and visited the home most weeks. These included folk groups, singers and local choirs. They also told us that local schools and youth groups also visited on occasion. During nice weather the activity coordinator arranged meals in the garden and took people out to a local park for a walk or to a café for lunch. There were also weekly groups for the men that included talking about sports, going to a local pub. Weekly women's groups included beauty and nail treatments. We asked if the men and women were invited to take part in the groups and was told by the activity coordinator "Of course, I call them men and women groups but the men and women will often join in either group".

The activity coordinator told us that peoples' religious needs were met by the service. A priest visited weekly and a vicar from a local Church of England church also visits the home regularly. We discussed other religious denominations and was told that if a person wanted access this would be provided to enable people to practice their beliefs

A complaints policy was available and was on display within the entrance to the home. This provided clear information on how to raise concerns and included contact details for the local authority and the ombudsman. The provider maintained a complaints log and we saw that complaints made had been responded to appropriately. People we spoke with told us they knew how to raise any concerns they had and relatives told us they had not had to make a complaint, but felt confident they would be listened to if they did.

Requires Improvement

Is the service well-led?

Our findings

We looked at what systems were in place for the provider and manager to be able to monitor the quality and safety of the service provided at Greenheys Lodge. Records showed that senior management staff visited the home to complete audits which looked at a variety of areas, including staff training, supervisions, the appearance of the home, activities and medicines. Regular internal checks had been completed which covered various areas of the service, including infection control, medicine management, care planning and health and safety. When areas of improvement were identified through these checks we did not see actions taken.

We found, that these checks did not identify the concerns highlighted during the inspection, such as those relating to staffing levels, staff training and development, supervision and appraisal meetings, medication and care plans not being up to date. We found room monitoring records implemented due to risk were not completed effectively by staff and not picked up by management.

Monitoring records including repositioning, food and fluid, bed rails, pain relief and waterlow were not completed appropriately by staff and had not been picked up by the audits completed by the provider. Care plan records looked at were out of date and not relevant. Reviews were not taking place as required. There were medication administration records with no photographs of the person on them. Infection control audits did not inform about the concerns we observed in relation to soiled linen left in a bathroom on the floor and not in a bag, soiled incontinent pads in a person's room.

We were provided with audits for care plans, medication, infection control and environmental checks. The audits were all scored really high from 85% up to 100%. We discussed this with the managing director and management team and requested all audits be looked at and action plans implemented to show how the provider will improve the service. As the systems in place to monitor the quality and safety of the service were not always effective.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were told by the management team that an external audit had taken place for medication. We requested a copy of the medication audit, however we never received.

We requested information from the managing director to ascertain what systems were in place to gather feedback from people regarding the service. We were told the last surveys completed could not be located and that new questionnaires would be provided to all of the people living at the home. Questionnaires would also be sent to staff, relatives and other professionals working with the provider at the home. We requested a collation of these surveys be sent to the CQC.

People told us that they were not sure who the manager of Greenheys Lodge was and feedback regarding the manager included "Approachable person", "Who is the manager" and "I'm not sure about the manager

but [staff always helps me]". Through discussions and observations it was clear that the manager was still getting to know people, we did observe him being helpful, polite and supportive to people.

All people we spoke with told us that they were mainly happy with the care and support they received at Greenheys Lodge. Comments included, "It is a good place and people seem happy", "Could be better they need more staff" and "[Staff] are all very good here".

There was also a schedule of meetings for staff, people who lived in the home and their relatives. These were advertised within the home so people were aware of them and we viewed the minutes of previous meetings. People had the opportunity to share their views of the service at these meetings.

A range of policies and procedures were available to help guide staff in their role. Staff did not have access to these policies at all times as we were told the office was locked. Staff we spoke with were aware of the policies and when staff commenced in post they were provided with and signed for, an employee handbook which included information on the essential policies of the organisation.

The manager had notified the Care Quality Commission (CQC) of all incidents that had occurred in the home in accordance with our statutory requirements. This meant that CQC were able to accurately monitor information and risks regarding Greenheys Lodge.

Ratings from the last inspection were displayed within the home and on the provider's website as required. From April 2015 it is a legal requirement for providers to display their CQC rating. The ratings are designed to improve transparency by providing people who use services, and the public, with a clear statement about the quality and safety of care provided. The ratings tell the public whether a service is outstanding, good, requires improvement or inadequate.

We received an action plan from the managing director on the 28 February 2018 that had clear actions and target dates to meet the concerns raised from this inspection. We also spent time discussing how the improvement plan ensured people were receiving the care and support as required in their care plans. The managing director agreed to sending the CQC a monthly update to inform us where the provider was in meeting the plan.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider must ensure that the care and treatment meets the needs of service users and reflects their preferences. 9 (1) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider must ensure that all care and treatment is provided in a safe way for service users. 12 (1) (2) (a) (b) (c) (g) (i)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider must ensure systems are established and operated effectively to assess and monitor and improve the quality and safety of the service provided. The provider must assess and monitor and mitigate the risks relating to the health and safety and welfare of service users. 17 (1) (2) (a) (b) (c) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider must ensure that there are

sufficient numbers of suitable qualified, competent, and experienced staff deployed in order to meet the needs of the service users. 18 (1) (2) (a)