Community Integrated Care

Griffin Lodge

Inspection report

4-5 Griffin Lane
Heald Green
Cheadle
Cheshire
SK8 3PZ

Tel: 01614371235
Website: www.c-i-c.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The current inspection took place on 27 January 2016 and was unannounced. The inspector returned to complete the inspection on 4 February 2016. Griffin Lodge was last inspected in May 2014 when it was found to be meeting the regulatory requirements which applied to a home of this kind.

Griffin Lodge is part of the Community Integrated Care (the "registered provider") group of services. The home accommodates 12 younger adults in single rooms arranged in two bungalows. The home is situated in a quiet cul-de-sac in a rural part of Greater Manchester and has car parking on site.

There is a registered manager at the home. 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 that the care provided at Griffin Lodge was safe and that the registered manager and her staff were keen to provide people with a standard of care that was personalised to their individual needs. Staff were well trained both in providing general care but also in providing the specific care that the people who lived in the home required.

Griffin Lodge is a modern building which is suitable for people with mobility difficulties. During our inspection we found that the home was clean and was being redecorated and refurbished. There was a range of facilities in the home including gym and sensory equipment. People who lived in Griffin Lodge were able to take part in activities both within the home and in the local community.

The people who lived in the home were able to enjoy a higher degree of personal care because the staffing levels were sufficient to support this. We found that people who lived in the home were encouraged to develop and maintain their independence. The relatives of people who lived in the home felt able to complain on their behalf about anything they were unhappy about. The registered manager had access to systems which allowed her to monitor the quality of care provided to the people who lived in the home.

We found that arrangements for making decisions for people who could not do so for themselves were not adequate. You can see what action we told the provider to take at the back of the full version of the report.

We have recommended that the provider reviews its care planning documentation to make sure it is easy to use and that quality assurance systems are extended to cover more areas of activity within the home.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The home was safe. Staff had a good understanding of the need to safeguard people who lived in the home and knew what to do if they suspected abuse. There were sufficient staff employed to provide the care required by people living in the home and the provider took steps to make sure that they were suitable to work there.

Medicines were stored correctly and administered only by trained staff and in accordance with best practice guidelines. Fire precaution routines had been undertaken and were up to date.

Is the service effective?

Requires Improvement

The home was not always effective because decisions made in connection with the Mental Capacity Act 2005 were not always recorded clearly enough. However staff understood the provisions of this legislation and the registered manager had made appropriate applications within the provisions of the Act.

Staff were well-trained so that they could provide the care required by the people who lived in the home and new staff received induction in accordance with current recommendations. The home was clean, well equipped and adapted for the needs of the people who lived in it.

Is the service caring?

Requires Improvement

The home was not always caring. Care documentation was not easy to use and in one instance was not complete. However where it was complete it was often person-centred so that staff could easily see how to provide care in a way that the person really wanted.

Staff worked hard to treat people with dignity and respect and most understood what this meant in practice. However on two occasions we heard staff referring to people in a way that was not consistent with their age or status as an adult.

Is the service responsive?

Good

The home was responsive. People who lived there had lots of

variety in the way they might spend their days. People could make choices about their care. Staff communicated with each other about care so as to ensure there was continuity.

The home used specialised means of communication where people did not do so verbally. Staff were competent in doing this. The home also used appropriate techniques to intervene where someone exhibited unusual or unexpected behaviour. The home had introduced reviewing arrangements to ensure people's care was kept up to date with their current needs.

Is the service well-led?

Requires Improvement

The home was not always well-led because a statutory notification to the Care Quality Commission had not been made as required. However the registered manager had otherwise dealt with the matter appropriately.

The registered manager had a number of systems of audit and other ways in which she could check on the quality of service being provider to people who lived in the home. This included regular checks made on the home by the registered provider. However we found that the quality assurance system needed extension to include some of the areas for improvement recommended in this report.

Griffin 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 provider was 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 home was last inspected in May 2014 when it was found to be meeting the regulatory requirements which applied to a home of this kind.

This inspection took place on 27 January 2016 and was unannounced. It was undertaken by an adult social care inspector together with an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service in this instance services for people whose behaviour can be unusual or unexpected. The adult social care inspector returned to complete the inspection on 4 February 2016.

Prior to the inspection information was requested from the local authority which commissions services and is responsible for safeguarding adults in the area in which the home is located. We reviewed this along with information already held by the Care Quality Commission (CQC) such as previous inspections, registration information and notifications made by the provider to the CQC.

During the inspection we met nine people who used the service. People were not always able to communicate verbally with us but expressed themselves in other ways such as by gesture or expression. The expert by experience subsequently contacted the relatives of five of the people who lived in the home. During the inspection we spoke with six members of staff as well as the registered manager of the home.

We looked around different areas of the home at various times. We looked at six care plans and two staff files as well as other records used by staff in connection with the care of people in the home. We also looked at audits and other quality assurance documents as well as the home's policies and procedures.

Good

Is the service safe?

Our findings

We saw that some of the people living at the home could behave in a way that might be unpredictable or unexpected. This could lead to unintentional injuries. Some relatives talked to us about this and we also asked them if they were satisfied that the home safeguarded their relatives against abuse.

Relatives told us they thought their family members were safe living in the home. One told us "(My relative) seems safe and at ease there. We've not had any problems though once they got hurt by another client and they let us know straight away….A cup hit their head. They have had no other injuries".

Another told us "It's generally very good. The way (my relative) is cared for is good and they seem very happy and settled and they are OK ….Yes, they are safe and at ease". Another relative echoed this view saying 'Yes, I think (my relative) is safe and at ease there. My relative needs high quality care and they have found ways to stop him coming to harm. They have strategies to avoid this. It has reduced a self-injury problem (my relative) has had for many years. They review their medication regularly and change it to reflect (my relative's) situation and they seem to have reached a good balance….and they have kept us informed."

One relative told us "They (my relative) have had a few bumps and scrapes over the years but I was always informed straight away" whilst another told us "There have been very few incidents in that time. One incident was reported to us when it happened. Treated seriously and we were told about it …. I have no worries of abuse. I hear about it if these issues come up".

All the staff we spoke with were very clear about their responsibilities in respect of safeguarding the people who lived in the home. They told us "If something was not right I would raise it with my team leader. I am happy to challenge it and I would take it higher if I needed to – there is a confidential number we can call. If necessary I would go outside (e.g. to the local authority or the Care Quality Commission (CQC))". Staff had access to their own accounts on the provider's intranet where we saw that they could find further information on safeguarding and whistleblowing. Photographs of staff helped people who lived in the home to know who to approach if they were concerned and we saw that the provider made a programme called "Speak Out" available which included the facility for hearing or speech-impaired people to use text formats to report concerns.

Staff therefore understood the local arrangements for safeguarding, knew what to look out for and what to do if they encountered anything of this kind. They each told us that they had undertaken safeguarding training within the last eighteen months and in some instances were due to attend again for this in the next month. Their later comments above showed that they were aware that they could "whistle blow" if they thought something was wrong and nothing was being done about it. The CQC is authorised by law to receive such concerns. None of the staff expressed any concerns about the current safety of the people living in the home or about the staff group working there.

We asked staff to explain the staffing arrangements for the home. They told us that there were two case managers who reported to the registered manager. Each case manager had line responsibility for three

team leaders each of whom managed a group of around nine support workers.

We checked this against the staff who we saw working in each of the bungalows. At any one time there were usually six support workers for the twelve people who lived in the home. We saw that given the layout of the home that this was ample to ensure that people received appropriate levels of attention including some one-to-one time with a member of staff.

At night time we were told that there were usually four waking carers together with a waking supervisor. However on the night of the first day of our inspection there were some staff shortages and so a member of the day staff was going to remain on the premises in a "sleeping in" capacity. They would be available if any of the four waking carers required them. We were told that the home did not use agency staff but instead relied on the existing staff group to work additional shifts to fill vacancies. This avoided people being cared for by staff who might be unfamiliar with them and the routines needed to provide care for them properly. When we asked if they thought they would be able to arrange cover this way one supervisor told us "Yes. We have a good staff team here".

We checked that the provider took steps to make sure that people recruited to work in the home were suitable to do so. We looked at staff recruitment files and saw that these were ordered in such a way that they could easily be checked for completeness. The files included application forms from which the provider could check each applicant's background and employment history together with references which the provider used to verify this. Proof of identity was included as well as confirmation that a Disclosure and Barring Service (DBS) check had been obtained. DBS checks allow a provider to check any criminal records for an applicant to help to determine if they are suitable to work in the home. We saw that where required confirmation of permission to work in the UK was obtained.

We saw that the home took steps to assess and manage risk in relation to the care provided to people who lived in the home. We saw that care documentation included risk assessments. Three-monthly key team meetings considered risk and whether any changes were needed to respond to changes. Specific risk assessments were completed in relation to certain activities such as trips out. Certain staff were trained in in specific techniques which would help them to deal with unexpected care situations as safely as possible.

We saw records that showed that as part of the appointment process prospective employees were asked questions and asked to respond to scenarios about the work for which they were applying. These included safeguarding situations. We saw that the provider published a detailed checklist of its requirements for local staff to follow prior to accepting a new employee and that these conformed with the appropriate regulations which apply to people who work in a home such as Griffin Lodge.

We looked at the arrangements for storing and administering medicines in the home. Only designated members of staff who had received the appropriate training were allowed to administer medicines. We saw that supplies of medicines were stored in a locked cupboard in the home. Most of the medicines in current use were kept in two locked medicines trolleys in the team leader's office which were attached securely to the walls. Creams were kept in a locked filing cabinet and there was a medicines refrigerator. We saw that the temperature of the refrigerator was regularly checked to ensure that it was in the correct range for storing medicines since their efficacy can be affected otherwise. The thermometer was a single-reading analogue type. Guidance from the Royal Pharmaceutical Society recommends that a maximum/minimum thermometer is used for this so as to provide more continuous monitoring of medicines refrigerator temperatures.

We saw that staff sent orders for repeat medicines into the local chemist. Any variations over the previous

month were recorded by email so that they would be reflected in the reorder. Having received the new prescriptions from the general practitioners the pharmacy would then deliver the completed order to the home together with medicines administration sheets. Where possible medicines were delivered in blister packs as part of a monitored dosage system (MDS). An MDS helps to eliminate mistakes in medicines administration because the drugs are prepacked into the correct doses by the pharmacist.

On receipt into the home the blister packs were checked by staff against the MAR sheets to ensure that they were correct. None of the people in the home administered their own medicines and so this was undertaken by a senior member of staff. Each person's medicines were dispensed and a mark made on the MAR sheet after which they were taken to them. We saw that staff took care to make sure that the remaining stocks were locked away whilst they were doing this. When they returned they completed the MAR sheet with a signature to confirm that administration had been completed.

We noticed that there were no photographs of the people who lived in the home with the medicines though because of the relatively small number of people living in the home and staff familiarity with them, recognition was unlikely to be a problem. We were told that the home was in the process of changing pharmacy and were shown samples of the way medicines would be presented under the new arrangements. We saw that photographs of the people who used the service were shown alongside their medicines in the new arrangements.

We saw that there were written reminders to staff about good practice in relation to medicines administration including those of the National Institute for Care and Health Excellence. Detailed step by step instructions about medicines administration were displayed and we saw that there were arrangements for a second member of staff to check that the actions of the member of staff administering the medicines had been correct and that the record keeping was accurate and reflected the actual stocks remaining. A sign was displayed on the office door during medicines administration to warn visitors that staff must not be disturbed or distracted when completing this task so that errors would be eliminated as far as possible.

We found that the home was clean. We looked in each of the toilets and saw that there were hand washing facilities, including liquid soap hand towels and pedal bins. A cleaning schedule was pinned on the wall. However on the first day of our inspection we noticed that the schedule had not been completed since the day before and there was no soap in one toilet. This had been corrected by the second day of our inspection. We brought this to the attention of the registered manager. We saw that the different kinds of waste in the home were identified and separated by the use of different coloured bags. This meant that the risk of cross-contamination was minimised.

The home had installed video cameras to assist with security on the site. These monitored the car park and certain vulnerable parts of the home. The provider had informed the Care Quality Commission of its intentions in installing these. The cameras did not directly monitor the communal areas of the home or the people who lived there and there was appropriate warning signage on the team leader's office concerning its use. This meant that people living in the home could feel safe that measures had been taken to protect them from intruders or vandalism.

Current government guidance suggests that where people have special needs individual "personal emergency evacuation plans" (PEEPS) in the event of fire should be developed and should be discussed with the people to whom they apply. We saw that there were PEEPS on the care files. We saw that copies of these were made readily accessible to staff in a master file in the team leader's office and that these had been reviewed.

We checked other fire precautions records for the home. We saw that items such as fire alarm tests undertaken at different alarm points were up to date, records of fire drills identified staff participation and had been undertaken quarterly, and the functioning of the fire door closures had been checked monthly. We saw that a fire risk assessment had been completed within the last twelve months and were told that a new one had just been undertaken

Requires Improvement

Is the service effective?

Our findings

One relative told us "They don't seem to have a high turnover (of staff). It's been mostly the same people. (My relative) has been there for some time. They can give him a lifestyle that we wanted to give them. To me they are outstanding.....To me, it's the staff who are very consistent. They've mostly been there a long time". Another said "They have retained some staff and clients for many years. There is a lot of continuity. Some staff who still know (my relative) very well". A third relative told us "Staff have been there a good while. It's a good sign that they stay. They are just very good. Not seen anything bad".

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 procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

We were told that all the people living in the home had been assessed under the MCA and had been determined as not having the capacity to make certain decision for themselves. We found it difficult to locate these capacity assessments because they were stored on a computer system to which we did not have access. We looked at a number of DoLS applications and found that according to the copies retained on the files these had been completed correctly however only one had so far been returned by the supervisory bodies (local authorities). Usually this would be the local authority where the care home is located but because the people living at Griffin Lodge were funded by a wide range of places across England the appropriate supervising body was often the local authority area from which they came and this meant that the home had to deal with a number of different locations.

Staff told us that they had received training in the MCA and although they were not completely familiar with the detail of the DoLS arrangements, understood that where decisions were taken on behalf of a person who did not have mental capacity these should be taken using best interest principles. Care staff who provide personal care using these principles will be protected by law and we saw that there were flow charts displayed in the office showing the correct pathways for best interests and decision-making using the principles of the MCA.

We asked to see copies of some recent best interest decisions. We could not find these on the care or medical files but were shown one relating to the use of a personal vehicle. This had been incorporated into an annual review meeting relating to continuing care. We saw that some or all of the relevant people who might contribute to a best interest meeting were present although the person themselves was not recorded as being there nor was any reason given for their absence. The meeting also discussed the nature of this person's diet but this was not recorded as included in the best interest decision.

In another instance we were shown a plan which covered a number of the aspects of a person's life where a best interest decision might be required. This was shown as having been reviewed within the last six months but was unsigned. We also saw some notes preparing for a best interest decision to be made for another person but there was no record of the actual decision or when it was made. It was difficult to follow all of this paperwork and none of it included a discussion of the person's current mental capacity or the arrangements for reviewing any decision.

Although mental capacity can fluctuate and must always be assessed in the context of the decision being taken, there was no record of a relevant capacity assessment which had been completed in respect of these decisions and hence whether consideration had been given as to whether the degree of mental capacity which the person may have had was sufficient for them to contribute to them. We also saw care plans which included the use of restraint but we were told there were no best interest decisions recorded relating to this and it had not been used for some time. However we found in at least one up to date risk assessment a reference to the use of restraint which meant that it was still a possibility for that person. We also did not see any best interest decisions relating to nutrition such as might be appropriate if a person was to be made subject to a soft diet on a prolonged basis.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Where a person is unable to give consent to care and treatment because they lack capacity to do so, the registered person must act in accordance with the Mental Capacity Act 2005.

There is a Code of Practice associated with the MCA which provides guidance for providers as to how best interest decisions should be made. The principles contained in this guidance do not preclude best interest decisions being incorporated into other meetings such as reviews provided they are explicitly recorded as part of the decision reached.

The relatives we spoke with told us that they felt confident in the ability of the staff in the home to care for the people who lived there. There was both praise and appreciation for the way staff assisted people with very complex needs.

We checked the records of staff training and saw that the provider maintained a corporate system covering such areas as infection control, fire safety, emergency aid, and moving and handling. The matrix allowed the registered manager to identify when refresher training was required and we saw that most staff were up to date with this. There were also records relating to training specific to the requirements of the people living in the home such as relating to epilepsy and Management of Actual or Potential Aggression (MAPA®). We saw that other training such as in medicines administration or in the Mental Capacity Act 2005 were completed by staff according to their role and were up to date.

We saw that there were also records of induction for new staff. The induction programme followed the structure of the care certificate which was recommended by the recent Cavendish Review which made recommendations about the training and support of care workers. Staff we spoke with confirmed that they had been provided with this induction on commencing their employment with the provider.

Staff confirmed that they received supervision but the registered manager told us that she was aware that this had fallen behind the approved frequency of every six to eight weeks. We checked supervision records and found that the interval for some staff had increased to every six months. However the records of supervision we saw were comprehensive and allowed for an exchange of information to be recorded between staff and their supervisor.

Although Griffin Lodge is a registered care home it seeks to help the young adults living there to be as independently as possible and where appropriate to develop the skills that they might require if they moved to a community setting. We saw from activity programmes that people undertook household chores including those associated with the preparation of food and drink. Relatives confirmed that they felt that people who lived in the home had enough or more than enough to eat or drink and that they enjoyed the food available and any choices of what or where to eat.

We saw that there was a menu posted on the noticeboard in each of the two bungalows. The menu did not offer choices but we were told that it had been constructed in consultation with the people who lived in the home and reflected their preferences. The menu currently rotated on a six-weekly basis but we were told that a seventh week was to be added so as to increase the variety across this rotation. Menus needed to be fixed in advance so as to coordinate the supplies of centrally-ordered provision with food for which we were told people went shopping on two nights of the week.

The menu was similar in both bungalows but on both days of our inspection people were served nearly identical meals at lunchtime. People were accommodated for meals in sittings with three people attending each sitting in each kitchen/dining area. We saw that this allowed staff to give more individualised attention to people and to provide any supervision which might be needed.

We saw that care staff prepared the meals and in one instance we saw that people living in the home were involved in this preparation. Sharp implements used were stored separately, brought out whilst the meal was prepared and then stored securely again so that people would not injure themselves which might be the case if they had been left lying around.

Although there was no choice on the menu, we were assured that there was a plentiful supply of alternative foods for people from which people could choose. For example one of the people we saw did not like the soup that was being prepared at lunchtime, and we were told that they would probably choose macaroni cheese instead. However they were actually served food which had been left over from the previous evening's meal. On the second day of our inspection we saw staff preparing alternatives such as macaroni cheese. The registered manager told us that this was a firm favourite with the people who lived in the home.

Each kitchen/dining area had appropriately facilities. We checked the food storage area and found that there were fridges and freezers and saw that the temperatures of these were correct and were meant to be checked on a regular basis. However on the chart we looked at these checks had only been completed about every other day rather than daily. This meant that the home could not be certain that the right temperature had been maintained throughout and therefore that the food had been stored correctly. We brought this to the attention of the registered manager who said that she would correct this in future. Foods were divided between the fridge and freezers and in order to keep meats separate from other foodstuffs such as bread and desserts.

We were told that one distinction between the food served in either bungalow was its consistency and that one group required soft diets. Soft diets are often recommended where people suffer from swallowing difficulties (dysphagia). However when we visited the other bungalow we saw food and nutrition plans which recommended similar diets for people who did not suffer from this condition.

The reasons given for such diets where there was no dysphagia was that people who lived in the home sometimes showed behavioural difficulties and might on occasion gulp their food or otherwise eat or drink in a way that would present a risk of choking or other risk. We saw guidance in the form of a notice to staff which identified some of these difficulties and advised them on how to support people. The notice stated

that these dietary arrangements were required in order to manage risk and that this overrode considerations of people's choice.

Nutrition plans which had been reviewed within the last three months were displayed inside the kitchen cupboards in each unit although when we asked some staff if we could see them not all of them were aware of this. We noted from these that the consequence of these recommendations was that most of the people in the home were effectively being served a soft diet of some description. We saw guidance posted on noticeboards advising staff on how to prepare food to the correct consistency. This was usually achieved by staff preparing the food so that it was softer than usual and then cutting it into small pieces which would be more easily swallowed.

We saw meals being prepared in this way. In one instance we saw that once cut into pieces, thick sauce was added to the food so that the small pieces were bound together. Although the ingredients were prepared separately at this stage they were then all mixed together in the sauce. This appeared to make the meal less appetising than if the ingredients had been kept separate.

Griffin House is made up of two modern bungalows which are connected. We saw that the accommodation was all provided at one level which assisted people with mobility difficulties and also meant that staff could provide more effective supervision. The building was being redecorated and refurbished during our inspection and the registered manager explained that because of this it was not as personalised as she would wish. New floor covering was being laid throughout the communal areas in response to recommendations by the local infection control service. The building was therefore suitable for providing the level and type of care required by the people who used the service.

Requires Improvement

Is the service caring?

Our findings

Relatives told us "I admire (the home's) honesty with me. We have realistic conversations and when I'm at the home I'm treated with respect and I demand things as well as just have some good banter with the staff". Another relative told us "I can turn up any time for a chat and they take me seriously. They are honest and realistic if I'm taking (my relative) out….for example, they will say if they (my relative) are not very cheerful or if they are a little agitated".

A third relative said '(My relative) looks well looked after. They love a bath and they give (my relative) a bath very often. I would just love them to do a diary of their week to send me. They do an occasional letter as if (my relative) had written it. And in signs which is lovely….but we know it's made up though it's still nice".

All the relatives we spoke with said they felt the staff treated their relatives with care, kindness and respect. Relatives described a high degree of involvement in either setting up the original care plans or, in reviewing and developing them for the people who lived in the home.

We asked staff how they made sure that people were treated with dignity and respect. They told us that one way they did this was to "Treat everybody as you'd like to be treated yourself". It was clear to us from what we saw that staff had a detailed knowledge of each person and their preferences and so were able to adjust their approach to match the person's current mood and avoid any unnecessary distress. They spoke calmly with people and were courteous and kind in their approach. Consequently we did not see any instances of unpredictable or unexpected behaviour during our visits. People who lived in the home appeared to appreciate and reciprocate this kindness and respect.

There were exceptions to this however. On two occasions we heard staff referring to people (who were often equal in age or older) in terms that were more appropriate to younger people or even children. These included referring to people as "sweetheart" or telling them "that's a good lad". This did not acknowledge these people's status as adults. We brought this to the attention of the registered manager who told us that she was aware of this and had reminded staff to address people in a way that was age appropriate.

We looked at the care documentation used in the home and were shown a master file which detailed the locations of a number of other documents in an "index of forms". These forms were then held in a series of other files which were colour-coded for ease of location. These included one for reviews and key meetings as well as a file dedicated to health and medication.

We saw that there was a green care file and that much of the material held in this file was person-centred, which meant that it was written from the point of view of the person receiving the service. This made it more likely that service would be organised around people's needs and preferences rather than around the needs of the service. We saw that where appropriate pictorial charts were used to help a person understand their care plan where they might not be able to read this for themselves. We noted that care had been taken to include positive comments on people's abilities, positive attributes and qualities.

The files included a photograph of the person together with other key documents. There was an "all about me" profile which recorded personal preferences such as in relation to daily activities, food choices, personal strengths and important people. The file included an information passport which recorded key information that would be of use to any other agency with whom the person might come into contact. This detailed next of kin, primary support needs, communication requirements, and risks.

There was a key relationship circle which identified all the people who were important to the person, ranking them in terms of how close they were to them. There was a "one page profile" which would enable any member of staff to quickly build a picture of the person around the questions "what people like about me", "what is important to me", "my communication", and "how best to support me".

We saw a detailed behaviour support plan with descriptions of how that person might behave if they were upset, or were unable to control a situation and the way that staff should respond when this occurred. This document also detailed the daily activities the person would be engaged in such as receiving personal care, meal times, going out into the community and following various activities in the home together with the risks which might be associated with that activity and the measures staff should take to reduce these risks. The document was very detailed and had been completed a little over twelve months before the date of our inspection and was signed by the registered manager. It included a formula for calculating the date of the next review but this had not been utilised on one of the plans we saw. A form inviting staff to sign to acknowledge that they had read the support plan had also not been completed.

We also saw another equally detailed behaviour support plan for the same person. This had been drawn up some years beforehand and had been reviewed within the last six months. This document was also person-centred and written from the point of view of the person who it was about including headings such as "the good things going for me", "some things about me you should know" and detailing the sorts of situations which presented high risk situations for the person. Detailed information was included about restraint techniques although the document emphasised that these were only to be used by trained (and therefore authorised) staff.

The two plans were complementary but we were unsure why there were two plans for the same period and could not understand which one staff would follow. Staff were not able to satisfactorily explain this. They told us that there had been a number of different styles of paperwork in use in the home at different times but that these were about to be replaced by the provider by a new single system.

The main care files were all kept in a locked room so that they remained confidential. On three of the files we looked at we saw that the two key documents relating to care planning and risk had been reviewed within the last six months. However we were unable to locate these documents at all on the fourth file we looked at. We brought this to the attention of the registered manager.

Other information included in the files included detailed risk assessments for activities such as personal shopping, driving out in the community, cooking and baking, and riding a bicycle around the grounds of Griffin Lodge or at the local cycling club. There were a number of other documents in the care files but although some of them were very detailed they were not always dated and/or signed. We saw that these were documents which supported the key information around care planning and risk.

There were also a number of risk assessments relating to activities such as going to the pub, personal shopping, swimming and riding a bike. These were grouped at the back of the care file and had not been reviewed for some years. We were told they were probably archive documents but this was not clear from their inclusion on the care file. We found that the retention of documents that were either not verified by

date and signature or which were out of date to be confusing and made it difficult for us to follow the care plans.

Given that all of the people living in the home were deemed not to have mental capacity we asked the registered manager about arrangements for advocacy. Where possible the home relied on families many of whom remained actively involved with the care of their relatives. The registered manager had a good awareness of local paid advocacy services and had used Independent Mental Capacity Advocates in the past. However she told us that she now found it difficult to secure paid advocates and that where available they had proved to be prohibitively costly given that this would have to be borne by the people who lived in the home.

We noted that an application had been made for Deprivation of Liberty Safeguards (DoLS) for each person living in the home. Where a DoLS authorisation is granted the supervising (local) authority must appoint either a relevant person's representative (who might be a friend or family member) or if this is not possible a paid relevant person's representative either of whom might ensure that the rights of a person being deprived of their liberty are protected. This meant that where the DoLS authorisation was granted people who lived in the home would be allocated a relevant person's representative who might advocate on their behalf.

We recommend that care documentation is reviewed to ensure that key information can be located easily and that it provides the most up to date information about each person.

Good

Is the service responsive?

Our findings

One relative told us "(My relative) needs to be doing things. They want to do things all the time. We can see they are always with the staff and loves them and does not trust other people easily. They (the staff) get (my relative) doing jobs. They do seem to involve people and I think (people) are given choices and I thing they get to know what's what. (My relative) does what they want. I can see how they have choices which will help as (my relative) is being prepared to be able to be more independent."

They added 'Yes I have complained at times. A couple of years ago (my relative) put on a lot of weight. They needed to do something….. I'm passionate about (my relative) being healthy and they took me seriously, and they measured their weight and they have lost some now. (My relative) loves the outdoors, so now, they will walk miles with them, and (my relative) loves this rather than feeling hungry. They've dealt with this well".

Another said "We used to have annual reviews but have not had one for two years and the social worker (from the local authority) has not contacted us but we've had no complaints". A third commented "(The home) has not taken (my relative) on a holiday for a while but they will take them this year….. I cannot take them myself easily now. They are keeping up (my relative's) quality of life and they have plenty to do….they now have a better quality of life. (My relative) is absolutely fine. (The home) does the reviews with us there as well as the social (services). Yes, there's plenty of scrutiny. The service meets (my relative's) specific needs. It's very personal. I can't think of anywhere better for them. It's excellent". A fourth relative told us "There's a lot more going on there (in Griffin Lodge). It can be boring at home for (my relative)".

We were not able to ask people who lived in the home about the contents of their care plan and their involvement in them but all of the relatives we spoke with were able to say how the care being delivered met people's short and long term care and support needs. Not all the people we met required high levels of personal care, but they all benefited from the close support which we saw was always at hand. Relatives we spoke with knew their own family members well and so were aware which high level care needs were priorities. They were very complimentary of how the service could identify and meet some very complex needs. They said this enabled the service to deliver a caring and safe environment for people who lived in the home.

Some relatives said that they had had to complain about the service, and all confirmed that they would be confident in doing so and would know who to address this to. Those who had complained said these matters were all dealt with properly and although they were often sensitive matters they were handled well. However they told us that they felt that most things they did not like could be dealt with less formally by discussing them with the staff whom they knew and whom they described in positive or very positive terms.

We asked staff how they made sure that people could exercise choice over the care provided for them. They told us that staff had a good idea of people's choices because they knew the people well and therefore knew of their preferences for how they liked personal care to be completed. One member of staff told us "If a person doesn't want something like a bath one day then I'll try and offer them a shower instead". Another

told us "If they refused I would try and encourage them. I would give them time, leave them for a while, and then ask them again". A third member of staff said "If a person refuses something important then I would try my hardest to encourage them to accept it". Each of the staff were clear that they could not force people to receive care they did not want. One summed it up saying "At the end of the day it is their (people's) choice".

We saw that staff used a variety of methods to communicate with people who used the service. Most communication was non-verbal and staff used British Sign Language as well as pictures and symbols. Staff carried "flash" cards with pictures of commonplace items on them so that they would be able to communicate readily with people. Preferred methods of communication were noted in the care plans.

Because the main care files for people were kept in a locked cupboard we saw that staff kept a separate file in which they recorded key information about people as they were provided with care. This file contained a number of records such as a staff signing sheet to show who had been on duty at different times, records of personal care, nutrition and fluid intake, and an up-to-date mood chart.

These notes provided continuity between the different shifts of staff who provided care in the home and meant that any changes would be communicated easily between them. We were told that this was further supported by handover periods between the different shifts when incoming staff could be briefed about people's care by those staff going off duty. This meant that care could be adjusted in order to respond to people's changing needs.

We saw that there was a key worker system allocating people who lived in the home to specific named workers. We saw photographs of each person alongside a photograph of their key worker so that people would recognise who these were. We saw notes taken at what were termed "Key team meetings" although on one that we saw only the attendance of the key worker was recorded in person. However other staff such as night staff who could not attend in the day had provided notes for inclusion in the discussion.

In the past the home had used the process of annual local authority review in respect of people who lived in the home. Each of the authorities which funded a person's placement in the home would undertake their own review to make sure that the placement still met the person's needs as that authority saw them. We were told however that the frequency of these reviews had now reduced and in one instance a person had not received a visit from the local authority that had placed them there for eight years. This meant that the home had begun to rely increasingly and sometimes solely on its own internal reviews.

We saw that there were key team meetings which reviewed all the major areas of each person's care plan and that these were held at three-monthly intervals. The questions asked included reviews of the main plans such as behavioural, placement and communication relating to people's care, whether risk assessments needed changing and whether the person had any specific needs with regard to personal toiletries or health requirements. We saw that there were also regular meetings held amongst staff at which the night care plans for people were reviewed. This allowed for reflection on whether a person's pattern of behaviour or sleeping at night reflected any other significant issues for their care such as high anxiety levels.

Because some people's behaviour could be unexpected or unfamiliar there was a risk that they might injure themselves or another person. These risks were identified in the care documentation. We saw that the home had adopted the Management of Actual or Potential Aggression (MAPA®) techniques for this. These techniques aim to help staff in dealing with such situations whilst maintaining people's dignity. We checked that the provider had made suitable arrangements for those circumstances in which they used these techniques which are defined as "restraint" by the relevant regulations. One member of staff told us "There is always someone on duty who is MAPA®) trained. If you are new or you have not been trained you don't do

it (MAPA®) – you take a step back". However, as referred to in the "effective" section of this report we did not see any best interest decisions recorded in connection with this practice.

People undertook a variety of activities in the day time. During our inspection we saw staff engaging people in table games and sitting and chatting. We saw that there was a computer workstation in a communal area where one person was working through an education programme. Other activities included games or music either in small groups or on an individual basis. We also saw practical activities such as people helping with cooking, some exercise activity and household chores like cleaning. We saw that there was a fully equipped gym and were told that this was particularly useful as part of the care programme for people who needed to lose weight.

We spent some time with people in one of the lounges and saw that staff were supporting one person as they prepared to go on an outing and engaging with another in their favourite pastime. One person was going to take a long-haul flight to visit family on another continent and staff told us about how they would accompany this person and were planning the details of how they would do so in a way that would support them most effectively.

In the afternoon of the first day of our inspection we saw staff sitting with a group of people who lived in the home. Staff were engaging people in a variety of activities in order to maintain their attention. These included playing dominoes and singing but people were free to come and go from this activity as they wished and did so. One person seemed to enjoy just sitting with the group without participating directly and their choice was respected and supported by staff.

We looked at some of the records of activities which were available on people's files. These showed that people undertook activities outside the home including walks in the park, helping at a local farm, bowling and going out with staff for a drive to local amenities. We saw that there were dedicated risk assessment forms which had to be completed for short journeys by car which helped to make sure that people were kept safe. We were shown medicines bags which staff used to carry essential medicines. These were checked out and checked back in after each trip.

Because the home is on a self-contained site people could use the path around the building for walking or for cycling. People also went out locally to the Wythenshawe Wheelers all ability cycling club as well as to the local swimming pools. We were told that different pools were chosen according to the different abilities and requirements of the people who lived in the home.

We saw that the home kept hens and chickens and saw from photographs displayed around the home that people took part in caring for these and collecting their eggs. We were told that in the summer people undertook other outside tasks in the grounds such as gardening including growing strawberries, working in the poly tunnels and producing garden produce for sale locally.

There was significant building work being completed by contractors on the adjoining land to Griffin Lodge. We saw that the home had developed a sensory room for one of the people who lived there as a diversion because they were sensitive to the noise of these works.

We saw that there were instructions posted to staff at points in the home advising them about various elements of practice. Information about preparation of appropriate diets was displayed in the kitchens and in the office we saw clear information displayed about what action should be taken in an emergency such as an asthma attack.

We were concerned however that a detailed part of a care plan for one person was displayed in the corridor outside the team leader's office, where any visitor would be able to see it. The registered manager explained that she had chosen to display it in this position because it was so important that she needed to assure herself that all staff had seen it. As it was next to staff rota information they would be more likely to sign to confirm that they had seen this. We were concerned that this measure had compromised this person's right to confidentiality. The registered manager assured us that it would be removed immediately.

Requires Improvement

Is the service well-led?

Our findings

Relatives generally spoke favourably about the home and its management and how the staff there could manage the more complex needs of their relatives and seemed well trained to deal with these sometimes in contrast to other services they had sought in the past. The current management was praised by some of them and was described as being very approachable and actively involved in all aspects of the home and their relative's care.

The current manager of Griffin Lodge has been registered there since October 2013. The registered manager was not present on the first day of our inspection but staff were confident that they could manage the inspection without her. We saw that this was consistent with an overall managerial approach that sought to appropriately devolve responsibility amongst the staff team and so provide them with development opportunities. When we met the registered manager on the second day we saw that she knew the people who lived in the home well.

The registered manager told us that she maintained contact with the families of people who lived in the home by a variety of means. These included weekly emails or meeting with relatives when they visited or by responding to telephone enquiries. Twice a year the home held a family meeting the last one of which had been held in October 2015 and which had taken the form of a wine and cheese evening. We saw that there had been a recent questionnaire sent to relatives from which the feedback was overall positive.

The registered manager shared some of the history of the home with us and how it had originally been part of another provider's transitional arrangements for people preparing to live in the community. The registered manager was hoping that the construction of housing adjacent to the home might provide new opportunities to provide similar transition opportunities for some of the people who lived in the home. The registered manager explained to us that changes of ownership of the home had also led to changes in the systems of recording and that the current provider was introducing new care and support plan documentation. We saw some samples of this and saw that it reflected current care practice ("personalisation" which can afford greater choice and control to people) and legislation (the Care Act 2014).

It was clear from our discussions that the staff team was embracing these changes under the leadership of the registered manager and supported the underlying care and practice principles of them. The registered manager described some of the new approach as seeking to reinforce a more positive culture than had been the case at times recently and to reinforce a person-centred (based on the point of view of the person who lived in the home) ethos. One of the consequences of this was that staff were each completing a "one page profile" of themselves similar to that completed with people who lived in the home. This emphasised a desire to "narrow the gap" between the people living in the home and the staff and provide relatives with some similar information about the staff as they themselves had obtained about the people who lived in the home. This approach is becoming more common in other homes similar to Griffin Lodge.

We saw that the registered manager operated an "open door" approach and during our discussions with her

a number of staff visited her office to ask for informal advice. During the second day of our inspection the registered manager took part in epilepsy training alongside the staff group and we saw that she was herself trained by the local authority to deliver safeguarding training. She also held a "licence to recruit" which meant that she had been trained in good recruitment practices.

Staff told us that there were regular staff meetings held for team leaders as well as all other all staff on a monthly basis. We looked at the minutes for three of these meetings. We found that the topics included were extensive and covered both administrative and practice matters. Routines for making sure that people remained active, allocation of tasks such as infection control and menus, and reminders about professional behaviour all featured as well as the proposal to set up a staff consultancy group.

The registered manager had access to a number of audits through which she monitored the quality of care provided in the home. The provider required the registered manager to make an annual return through an annual service quality assessment tool. This was based on a self-assessment of areas such as support planning, risk assessment, nutrition, health care and caring, health and safety, medication management, safeguarding and leadership and staffing and training. The results were then verified by a member of regional staff who was external to the home and an action plan drawn up for the registered manager to follow. We saw that one of the current targets was to find ways of making sure that a record was made where relatives had been involved in care planning.

We saw that the registered manager and staff undertook an annual infection control assessment or audit. This had last been completed in October 2015 and we saw that recommendations such as redecoration and replacement of floor coverings were being progressed during our inspection. This and the action arising from annual service quality assessment tool showed that the registered manager responded to the results of such audits. However the audits themselves had not identified the need for some actions such as in relation to best interest decisions or care planning documentation. The home had also been inspected recently by the local authority quality assurance team who had provided the registered manager with a report of their findings.

The registered manager made a monthly return to the provider on more day to day matters such as clinical governance and finance. We saw that this return would include reports of incidents including any occasions where restraint might be used. This enabled an analysis to be made of trends both locally and at regional level by the provider. Although spot checks of medicines were undertaken by supervisors the registered manager told us she also undertook these.

Throughout our inspection we saw staff making reference to the provider's intranet system. We saw that in addition to providing internal communications and performance management functions that this provided staff with access to a full range of policies and procedures. We looked at a selection of these and found that they were appropriate and readily accessible.

Registered providers such as Griffin Lodge are required to notify the Care Quality Commission (CQC) about certain events which may affect people who live in the home and the service provided to them. This helps the CQC to discharge its statutory responsibilities to protect and promote the health, safety and welfare of people who use health and social care services.

We reviewed the notifications which had been made to the CQC by the provider in the last year and found that appropriate action had been taken to inform us in respect of a number of incidents. However we noted that neither the registered manager or the registered provider had not informed the CQC of a safeguarding matter of which the Commission was not otherwise aware. We pointed out this omission to the registered

manager who told us she had intended to report it and therefore this was an oversight.

The provider had taken other appropriate action both in dealing with the matter internally including initiating an investigation and reporting it to the local safeguarding authority. The registered manager had been transparent with all the relatives of people living in the home some of whom told us about it when we spoke with them. The registered manager undertook to make an immediate retrospective notification to the CQC to correct the matter.

We recommend that the quality assurance system is reviewed so as to provide the registered manager with further information required to manage the home including relating to best interest decision-making, reviewing and the contents of care plans.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Where a person was unable to give consent to care and treatment because they lacked capacity to do so, the registered person did not act in accordance with the Mental Capacity Act 2005.