Mrs Touran Watts

Garden Lodge

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Garden Lodge is a 'care home'. People in care homes receive accommodation and personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

Garden Lodge accommodates 10 people in one adapted building. At the time of our unannounced inspection there were 9 older people, some of whom were living with dementia, living at the service.

This inspection took place on the 8 January 2018 and was unannounced. At the last comprehensive inspection on 11 December 2015 we rated the service as good. At this inspection the service remains rated as good.

Why the service is rated good.

The Care Quality Commission (CQC) records showed that the service had a registered manager. However, they were unavailable during this inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Staff demonstrated to us an understanding of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible.

Staff demonstrated their knowledge about how to report poor care practice and suspicions of harm. However, not all staff could demonstrate their understanding of what would be a safeguarding concern. Information and guidance about how to report concerns, together with relevant contact telephone numbers were displayed as a prompt for staff to refer to. Pre-employment checks were in place to ensure that new staff were considered suitable to work with the people they were supporting.

People were assisted to take their medication as prescribed. Processes were in place and followed by staff to make sure that infection control was maintained and the risk of cross contamination was reduced as far as practicable.

The service had building adaptations in place to help people with limited mobility. This meant that people could access all of the communal areas and garden.

Staff supported people's individual needs in a kind, patient and respectful way. People's privacy and dignity was promoted and maintained by the staff members assisting them.

People and their relatives were given the opportunity to be involved in the setting up and review of their individual support and care plans. Staff encouraged people to take part in activities and maintain their interests. People's friends and family were encouraged by staff to visit the service and were made to feel very welcome.

People were supported by staff and external health care professionals, when required, at the end of their life to have a comfortable and as dignified a death as possible.

People had individualised care and support plans in place which recorded their needs. These plans informed and prompted staff on how a person would like their care and support to be given, in line with external health care professional advice. Individual risks to people were identified and monitored by staff. Plans were put into place to minimise people's risks as far as practicable to allow them to live as independent and safe a life as possible.

People were supported by staff to have enough to eat and drink. People were assisted to access a range of external health care professionals and were supported by staff to maintain their health and well-being.

Staff were trained to be able to provide care which met people's individual needs. The standard of staff members' work performance was reviewed by the registered manager through supervisions, spot checks and appraisals. This meant that the registered manager monitored and supported staff through regular meetings and checks.

Compliments about the care provided had been received and the positive feedback shared with staff. Complaints were investigated and action taken to make any necessary improvements and to resolve to the complainants satisfaction wherever possible.

The registered manager sought feedback about the quality of the service provided from people, their relatives, visiting health and social care professionals, and staff. There was an on-going quality monitoring process in place to identify areas of improvement needed within the service. Where improvements had been identified, actions were taken. Learning from incidents took place to reduce the risk of recurrence.

Records showed that the CQC was informed of incidents that the provider was legally obliged to notify us of.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains good.	**Good**
Is the service effective? The service remains good.	**Good**
Is the service caring? The service remains good.	**Good**
Is the service responsive? The service remains good.	**Good**
Is the service well-led? The service remains good.	**Good**

Garden 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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 8 January 2018 and was unannounced. The inspection was carried out by an inspection manager and one inspector.

Before the inspection we looked at all the information we held about the service. This included the provider information return (PIR) which was submitted to the Care Quality Commission on 31 January 2017. This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make.

We also looked at information we held about the service and the provider. This included information from notifications received by us. A notification is information about important events which the provider is required to send to us by law. Before the inspection we asked for information from a fire safety officer; representatives of a local authority commissioning team and quality improvement team; and Health watch. This helped us with planning this inspection.

During the inspection we spoke with two people who used the service and a relative. We also spoke with the deputy care manager, four care workers and a visiting heath care professional.

We observed staff who were supporting people to help us understand the experience of people who could not talk with us. We looked at two people's care records and records in relation to the management of the service; management of staff; management of utilities; and the management of people's medicines. We also looked at compliments and complaints received; staff training records; and three staff recruitment files. After the inspection, on the 9 January 2018, the deputy care manager sent us information about what the service does well and what challenges the service faces. This information included information on how they were going to tackle these challenges.

Good

Is the service safe?

Our findings

Staff received training on how to safeguard people from avoidable harm and poor care. They confirmed to us that they would be confident to whistle-blow. (This is a process where staff can report any poor standards of care if they ever became aware of this). Staff told us how they would report concerns in line with their training. A staff member said, "I would report [safeguarding concerns] to the [registered] manager." However, not all staff were able to demonstrate to us an understanding of how they would identify a safeguarding concern. We fed this back to the deputy care manager during this visit. They told us that they would make the necessary improvement.

Staff explained to us that they would report poor care and suspicions of harm both internally to management and to external agencies. A staff member told us that they knew they could report concerns to, "Social services, Care Quality Commission [and the] police." Information and guidance about how to report concerns, together with relevant contact telephone numbers were displayed in communal areas for staff to refer to if needed. This showed that there was a process in place to reduce the risk of poor care practice.

People's care and support plans were stored securely and contained enough information for staff to deliver safe care. Risks to people had been identified when they first arrived at the service and as staff got to know them and their individual requirements. These risks were assessed to provide guidance and prompts for staff to assist people and reduce the risk of harm. In general, the majority of people living at the service were unable to tell us how they had been involved in the management of their care records, risk assessments, and review of these. However, a relative confirmed that, "Communication [with staff] is good. The family feels involved in any care decisions [made]."

Technology was used to support people to receive safe, care and support. We saw that there were call bells in place for people to summon staff when needed. We also noted that sensory mat technology was used to inform staff when a person, assessed to be at risk of falls, was up and attempting to walk. This showed us that technology was used in the service to support people where needed.

Records relating to checks on the service's utility systems and building maintenance showed that checks were in place to make sure people were, as far as possible, cared for in a place that was safe to live in, visit and work in. The service had had an inspection by the local fire safety team on 22 December 2017 which was found to be satisfactory. People also had emergency evacuation plans in place to assist them to evacuate safely in the event of an emergency such as a fire.

Staffing numbers were established based on people's care and support needs. Staff told us that when they needed extra assistance the registered manager and deputy care manager would step in to help out. A staff member said, "If something crops up, the residents always come first. The management [team] will always support [staff]." People had positive opinions over the number of staff available. One person told us, "I ring [my] bell and staff come when I call them." Observations during this inspection showed that there was enough staff to meet people's needs. This meant that staff were busy, but assisted people in an unhurried way.

Checks were carried out on new staff by the management team to confirm that they were appropriate to work with people and of good character. Staff told us that these checks were in place before they could start work at the service. A staff member said, "I couldn't start until everything [checks] came through." This showed us that there was a process in place to make sure that staff were deemed suitable to work with the people they supported.

Staff who administered medication received training to do this and their competency was assessed by the management team. We saw that staff explained to people what their prescribed medication was for and did not sign to say that the medication had been given until people were seen taking it. Medication was stored securely, at the correct temperature and disposed of safely. Medication administration records showed that medication had been administered as prescribed. This meant that the provider had systems in place to ensure that people's medication was managed safely.

We saw that the service was visibly clean and free from malodours and we saw that soap and hot water was available for staff, people and their visitors to use to wash their hands. A relative confirmed to us that they thought the service "Was kept clean and tidy." A member of staff told us that they had enough cleaning equipment and personal protective equipment (PPE) available to use. They talked us through how they cleaned different areas of the service using different cloths, and different colour mops and buckets to maintain good infection control practices. This demonstrated to us that processes were in place to reduce the risk of infection and cross contamination.

Records showed that there was monitoring of any falls people may have had, and any accident and/or incidents that had occurred. Actions taken by the management team as a result of this monitoring, included a referral to the GP being made by staff for a person following a fall. The deputy care manager said that any learning to come out of these investigations was discussed with staff either during handovers and staff meetings. This showed us that any learning as a result of investigations and actions were taken to reduce the risk of recurrence.

Good

Is the service effective?

Our findings

External health and social care professionals visited the service. They worked with staff to help them support and promote people's well-being in line with legislation and guidance. A visiting health and social care professional confirmed to us that staff were receptive and accommodating to their visits. This showed us that staff worked with external health and social care professionals to try to make sure people's needs were met.

To maintain people's well-being staff told us, and we saw, that they encouraged people to use appropriately assessed equipment to assist with people's poor skin integrity or mobility requirements. This included pressure relieving equipment being in place and hoists to manoeuvre people when needed and equipment to assist a person when walking. Staff offered reassurance and encouragement to people when they were assisting them to walk.

Staff completed training to ensure that they had the right skills, experience and knowledge to provide the individual care and support people needed. Training included, safeguarding adults; moving and handling; medication administration; mental capacity act 2005 (MCA) and deprivation of liberty safeguards (DoLS); equality and inclusion and infection control, which included food hygiene. This showed us that staff were given regular training and refresher training to help them provide effective care and support in line with legislation.

Staff were supported through supervisions, competency/ spot checks and appraisals which were undertaken by the registered manager and deputy care manager. When new to the service staff had an induction period. This included training and shadowing a more experienced member of staff until they were deemed competent and confident by the registered manager or deputy care manager to provide care.

People were supported by staff with their meals and drinks when needed and people's individual dietary needs were catered for. Staff told us that currently no one at the service had a special diet due to cultural or religious needs. However, they confirmed that they would adapt the menus to meet people's cultural or religious needs. We observed that snacks and drinks were available to people throughout the day to promote people's hydration and nutritional needs. A relative confirmed to us that, "[Staff] come in [to family member's room] on a regular basis to promote their food and fluid intake."

The service worked with other external organisations to ensure that the best possible quality of service was provided. For example, working with the local authority commissioning team meant that the overall quality of the service was monitored.

People were supported to attend health care appointments both inside and outside of the service, when required. Visits to the service by external health care professionals included; GP visits; district nurses and end-of-life specialist nurses visits. A relative said, "[Staff] will call external healthcare professionals when needed like a GP." Feedback on a survey completed by a visiting health and social care professional stated, "[I was] warmly welcomed and information [from staff] is always readily available."

The service was an adapted building that used to be a family home. Adaptations had been made to the building to enable people to be able to access all areas. The floor was one level and handrails ran the length of the corridors to aid and assist people with limited mobility. Observations showed that people had access to the garden. These again were on one level and paved in areas and with pathways for easy access and people were able to spend time enjoying the views.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The 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 and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff had received training in MCA and DoLS and were able to demonstrate a basic understanding to us. Staff supported people with their decision making and choices .A staff member told us that, "People have choices [for example when supporting a person with their clothes] I would show the person two choices." Applications had been made to the local authority supervisory body for people who had been assessed as lacking mental capacity and needed legal restrictions (for example a person not being allowed to go out on their own as this would put them in danger) in place to aid with their safety. This showed that people would not have their freedom restricted in an unlawful manner.

Good

Is the service caring?

Our findings

People using the service and a relative had positive opinions about the care and support provided by staff. One person said, "Staff are lovely." A relative told us, "Staff are all very friendly and [family member] seems to get on well with the staff."

Staff knew and respected the people they were caring for. A relative said this was, "Because the home is nice and small, [staff] get to know [family member] so well." Staff were able to demonstrate to us that they knew peoples histories, preferences and any wishes they had. This also meant that staff had knew how to promote people's independence. Records documented and prompted staff on what people were able to do for themselves and what staff were to support them with. Staff knowledge also included distraction techniques known to work for people who were at risk of becoming anxious. This included a discussion about how young a person looked, talking to a person about what was worrying them and giving reassurances or giving a person some space. We saw that staff supported people in a kind way that helped reduce the worries for the person who was becoming anxious.

Observations showed that staff respected people's choices and asked permission before supporting them. Advocacy information was available on request for people if they needed to be supported with making decisions. Advocates are people who are independent of the service and who support people to make and communicate their wishes.

People were not able to tell us that they were involved in the setting up, review and agreement of their care and support plans. However, a relative told us, "A pre-assessment [on family member] was undertaken about three years ago so that [staff] could be sure that they could meet [family members] needs. Staff always update [the family] on how family member] is…communication is good and the family feels involved." The deputy care manager told us that people's relatives visited the service on a regular basis and so conversations and updates were held regularly.

People and a relative had positive comments about staff, and said that communication was good. Records showed that feedback was sought from people living at the service, their relatives and visitors and visiting health and social care professionals to express their views. This was captured via surveys or during meetings. The deputy care manager told us that people unable to attend the residents meeting, had a one-to-one chat to update them.

Observations showed that people's privacy and dignity was promoted and maintained by staff. People were seen to be clean and tidy and were dressed in clothes appropriate for the temperature of the service. We saw that conversations about care were held in private and that when a staff member wanted to go into a person room, they knocked on their door and announced themselves before going in. This showed us that staff respected people's privacy and dignity.

Visitors were encouraged and made very welcome at the service by staff. A relative said, "I come in on a regular basis." Staff were seen to make people's visitors feel welcome and chatted to them to update them

about their family members' care and well-being.

Good

Is the service responsive?

Our findings

Care and support plans and risk assessments recorded people's daily living needs, care and support requirements and health needs. These had been developed in conjunction with the person, their relatives, legal representative and advocates where appropriate, prior to them moving into the service. This record was in place to ensure that staff could meet the person's individual needs and acted as guidance for staff on how each person wished to be assisted, including their likes and dislikes, interests and any personal preferences. Reviews of these records were then carried out to make sure that these were up-to-date and reflected people's current requirements. A relative told us of the communication they had with staff about their family member's wishes and how these were listened to respected wherever possible. They told us that this made them and their family feel involved.

During our visit we saw activities taking place, this included singing and some dancing to music. People were also supported to maintain their interests by helping look after the pet budgie and spending time with the deputy care manager's dog. One person, with a particular interest in gardening, told us how they helped out with gardening chores when they chose to do so.

We were told that during the summer there had been a fete held to raise money and over the festive period there had been a party held. On another occasion there was a visit from the local school choir to entertain people. A person living at the service continued to attend the activities held outside of the service, as they done prior to moving into the service. However staff told us that they wished they had more time to take people on outings into the local village. We fed this back to the deputy care manager and they told us that they would look at building upon and expanding people's links and visits out to the local community.

We saw that the service received compliments from relatives of people who had used the service. Compliments were used to identify to staff what worked well. One stated, "We just wanted to say thank you to all the staff for the care you gave [named person] over the last three months" and another said, "I would like to thank you and all of your staff for looking after [named person] so well whilst [they] were in your care."

Records showed that the service had received two complaints since the last inspection. We saw that these complaints had been investigated and any action taken to try to reduce the risk of recurrence fed back to the complainant.

A relative told us that they knew how to make a complaint but had not needed to do so. They confirmed to us that they felt that any complaints raised with the management of the service would be listened to, and resolved where possible. A relative said, "If we want anything we would ask the staff…we would complain to the owners if we needed to but we have not needed to."

Garden Lodge is a residential care home that is not registered to provide nursing care. The deputy care manager told us that to support people at the end of their life, they would work with external health care professionals, when it became clear that people's health condition had changed or deteriorated. External health care professionals that staff worked with during this time included doctors and specialist end-of–life

nurses. They also told us that a staff member would be made available to sit with a person, when family was not available, to give the person comfort. This was to enable staff to support people to have the most comfortable, dignified and pain free a death as possible.

Care records documented people's end of life wishes, including a wish to not be resuscitated, cultural and religious wishes and/or funeral arrangements and preferences. This showed us that there were protocols in place for staff at the service to promote and respect people's end of life wishes.

Good

Is the service well-led?

Our findings

The Care Quality Commission (CQC) records showed that there was a registered manager in place. However, they were not in the service during this inspection. The duty care manager told us that they supported the registered manager to oversee the day-to-day running of the service with support from care staff. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The rating from the last CQC inspection that was carried out on 11 December 2015 was displayed in a communal area for people, their visitors and staff to refer to. Records showed that the CQC was informed of incidents that the provider was legally obliged to notify them of. This showed us that the registered manager was aware of their responsibilities in reporting notifiable events to the CQC when required.

Staff told us that there was a clear expectation, by the management team, for them to deliver high quality care and support. Our observations showed that people and their relatives knew the deputy care manager and the staff very well and that communication was good. Staff made very positive comments about the registered manager and deputy care manager. One staff member said, "It's lovely working here, great management, colleagues and residents. We all sort things out together." Another staff member told us, "I love working here, I feel like I belong here. The staff and management appreciate me."

Quality monitoring audits were carried out to ensure organisational oversight was in place. These audits looked at all areas of the service. Areas for improvement were noted and either actioned or on-going. Actions included the identification that a new risk assessment needed to be written for a person living at the service.

Surveys were sent out for people, their visitors/family, staff and visiting health and social care professionals to engage with the service and feedback their views. Records showed that responses were positive. One visiting health and social care professional described the services as, "Very homely." Any areas for improvement were noted and where possible acted upon.

The registered manager and deputy care manager worked in partnership with, took advice from, and shared information with key organisations to provide good care to people living at the service. This included working together with the Marie Curie nurses who specialise in end-of-life care and support.