MGB Care Services Limited

# Greenwood Lodge

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

We inspected Greenwood Lodge on 22 and 23 February 2017. The inspection was unannounced.

Greenwood Lodge is a situated in the village of Bunny in Nottinghamshire and is operated by MGB Care Services Limited. The service is registered to provide accommodation for up to 19 people who have a learning disability, some of whom also have physical disabilities. The accommodation comprises of sixteen bedrooms on two floors in the main building, in addition, an annexe to the side has two further bedrooms. At the time of our inspection 16 people lived at the service.

We inspected this service in March 2015 and the service was rated as good. During this inspection we found that there had been deterioration in both the quality and safety of the service. This resulted in us finding multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches were in relation to safe care and treatment, the premises and equipment, staffing, person centred care and good governance

We were informed prior to our visit that the registered manager was no longer in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. There was an acting manager in place during our visit who had recently taken over responsibility for the day to day running of the service, they informed us that they would be submitting an application to register as manager for the service.

We found that people were put at risk of unsafe support as systems in place to reduce the risks associated with people's care and support were not always effective. People were not protected from risks associated with the environment. The environment was not maintained to a safe standard and was not clean and hygienic.

People did not always receive appropriate care and support as staff were not always deployed effectively.

People received their medicines as prescribed, however where people required their medicines to be administered covertly (without their knowledge), the proper procedures were not in place.

People were supported by staff who had not received adequate training to enable them to carry out their role effectively.

People's rights under the Mental Capacity Act (2005) were not always respected. Where people had capacity to make decisions they were not consistently asked for their consent before staff provided support or assistance.

People had their day to day healthcare needs met and were provided with enough to eat and drink.

Some staff were kind and compassionate and treated people with respect, however other staff were focused on tasks and had limited interaction with people who used the service. People were not always provided with information in a way that was accessible to them.

People were at risk of receiving inconsistent and unsafe support as care plans were not always accurate and staff did not follow the guidance in these plans. People and their families were not involved in planning their care and support. People were not consistently provided with the opportunity for meaningful activity.

People were supported to maintain relationships with family and friends and visitors were welcomed into the home and their right to privacy was respected. People were supported to raise issues and concerns and there were systems in place to respond to complaints.

Systems in place to monitor and improve the quality of the service were not effective. There was a lack of effective governance which put people at risk of receiving poor care. People and their families were not meaningfully involved in giving their views on how the service was run.

The management team were passionate about improving the quality of the service. People and staff felt able to share ideas or concerns with the management.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not safe.

Systems in place to reduce the risks associated with people's care and support were not always effective and this exposed people to the risk of harm.

People were not protected from risks associated with the environment. The environment was not maintained to a safe standard and was not clean and hygienic.

People did not always receive appropriate care and support as staff were not always deployed effectively.

People received their medicines as prescribed, however where people required their medicines to be administered covertly (without their knowledge), the proper procedures were not in place.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

People's rights under the Mental Capacity Act (2005) were not always respected. Where people had capacity to make decisions they were not consistently asked for their consent before staff provided support or assistance.

People were supported by staff who had not received adequate training. Staff were provided with regular supervision and support.

People had their day to day healthcare needs met and were provided with enough to eat and drink.

### Is the service caring?

**Requires Improvement**

The service was not consistently caring.

Some staff were kind and compassionate and treated people with respect, however other staff were focused on tasks and had limited interaction with people who used the service.

People were not provided with information in a way that was accessible to them.

People's right to privacy was respected.

## Is the service responsive?

**Requires Improvement**

The service was not always responsive.

People were at risk of receiving inconsistent and unsafe support as care plans were not always accurate and staff did not follow the guidance in these plans.

People and their families were not involved in planning their care and support. People were not consistently provided with the opportunity for meaningful activity.

People were supported to maintain relationships with family and friends and visitors were welcomed into the home. People were supported to raise issues and concerns and there were systems in place to respond to complaints.

## Is the service well-led?

**Requires Improvement**

The service was not consistently well led.

Systems in place to monitor and improve the quality of the service were not effective. There was a lack of effective governance which put people at risk of receiving poor care.

People and their families were not meaningfully involved in giving their views on how the service was run.

The management team were passionate about improving the quality of the service. People and staff felt able to share ideas or concerns with the management.

# Greenwood Lodge

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the 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.

We inspected the service on 22 and 23 February 2017. The inspection was unannounced. The inspection team consisted of two inspectors and 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.

Prior to our inspection we reviewed information we held about the service. This included previous inspection reports, information received and statutory notifications. A notification is information about important events which the provider is required to send us by law. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the visit we spoke with four people who used the service, we also received feedback from the relatives of three people. We spoke with three care staff, a nurse, housekeeping and catering staff, the deputy manager and the acting manager.

To help us assess how people's care needs were being met we reviewed five people's care records and other information, for example their risk assessments. We also looked at medicines records, staff recruitment and training records, as well as a range of records relating to the running of the service including audits carried out by the management team.

Some people who used the service had limited verbal communication so we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

# Is the service safe?

## Our findings

People were not protected from risks associated with their care and support. Although we saw that care plans contained detailed, individualised risk assessments these were not always followed by staff to ensure people's safety. One person who used the service had a health condition which meant they were at risk of causing harm to themselves by ingesting non-food items. Their risk assessment specified a number of items that posed a significant risk, one of which was gloves. We looked in this person's room and found a box of latex gloves in an unsecured chest. In addition to this we found dry wipes and toiletries which would pose a risk if ingested. Although this person received one to one support they did spend time in their room alone so this placed the person at risk of harm by ingesting dangerous non-food items. We informed the acting manager of this risk during our visit and on the second day of our visit we found that these items had been removed, however this did not address the potential gap in staff knowledge of how to support the person safely.

Another person who used the service had been assessed by a speech and language therapist as being at risk of choking. Their care plan contained clear details of how to support the person to eat and drink safety including constant supervision whilst eating and drinking, hand over hand assistance to eat using a tea spoon and reminders to drink slowly. During the first day of our visit we sat with this person at lunchtime and saw that they were not offered assistance to eat, they were given a knife and fork to use and struggled to eat unaided, they then coughed and choked on their food. When this happened staff responded quickly, however this could potentially have been prevented had the correct support been in place. We raised this with the team leader and saw that the person was given assistance to eat at tea time, however they were then left unsupervised with their drink which again put them at risk of choking.

People were not adequately protected from risks to their health. We checked the records relating to measures taken to reduce the risk of legionella developing in the water supply. Legionella is a bacteria that can develop in stagnant water and can lead to a fatal form of pneumonia. Although annual bacteria tests were conducted on the water supply there was not an adequately detailed legionella risk assessment in place and checks on the water system were very limited. Water storage systems were not being treated regularly to control the growth of legionella and the provider did not have a system in place to flush infrequently used taps, this is one way of reducing the risk of legionella. We saw one room had an ensuite bathroom which had been permanently locked, this posed a risk that stagnant water could build up in this part of the water supply but there was no evidence that the risk of this had been considered. This meant that steps had not been taken to reduce the risk of legionella developing in the water supply and this was a potential risk to people's health.

People were not adequately protected from the risk of infectious disease. One person who used the service had a highly contagious infectious disease which was spread through skin to skin contact. We reviewed their care plan and found that, although there was information printed from the internet about the condition, there was not a clear person specific protocol for preventing the spread of the infection. Not all staff we spoke with were aware that the person had this condition and those who were aware were not able to describe procedures to avoid the spread of infection, such as handwashing. We observed staff supporting

this person throughout our visits, they had frequent close physical contact with the person and did not wash their hands prior to supporting other people who used the service. This placed people who used the service at risk of contracting an infectious disease.

People were at risk of scalding themselves due to hot water temperatures in some bathrooms being above the recommended safe level. Although hot water temperatures were being regularly tested this was not effective in identifying where water temperatures were too high. We measured water temperatures on the first day of our visit and found that temperatures in some sinks and showers were above the recommended level of 44°C, in some cases as high as 60°C. People who used the service were reliant upon staff to ensure their safety. Although the acting manager told us that everyone who used the service required supervision to bathe and shower, we observed people unsupervised in areas of the service where they had access to the taps and showers that were above the recommended temperatures. This placed people at risk of scalding. We shared this feedback with the acting manager who informed us that a plumber would be visiting the service to address this, however this had not yet been completed.

People were not protected from risks associated with the environment. We saw large heavy items in rooms, such as wardrobes, were unstable and had not been secured to the walls. This put people at risk of sustaining injury from falling objects. This risk was exacerbated by the fact that some people who used the service communicated using their behaviour and could become physically forceful at times. We informed the acting manager about these risks and they took decisive action to secure large items and safeguard people from these risks, however this work had not been fully completed.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our visit the acting manager informed us of a number of actions planned or already taken to reduce some of the above risks. They took swift action to complete a thorough legionella risk assessment, implemented new maintenance checks and informed us that they would be ensuring that staff were familiar with the content of care plans and risk assessments. However, it remained of concern that these risks were not identified and acted upon prior to our visit.

The environment was not always well maintained. For example, window restrictors were in place in people's rooms to prevent accident or injury, however we found that these had not been adequately maintained and were therefore not functioning effectively. For example, in one person's room who lived on the first floor the window restrictor was broken on a large window, this put the person at risk of falling from the window. This risk was exacerbated by the fact that this person frequently communicated with their behaviour when anxious or agitated. We shared our concerns with the acting manager during our visit and they took swift action to rectify this to ensure people's safety.

Fire doors had not been maintained to a safe standard. Records of regular fire alarm tests showed that a number of fire doors had failed to close as intended to protect people in the event of a fire. This had been recorded an issue for a number of weeks and no action had been taken to rectify this. Fire drills were infrequent and it had been over a year since the last drill. Records of fire drills showed that some people 'refused' to leave the building when the drill took place, however this information was not clearly reflected in their personal emergency evacuation plans and these did not contain information about how to safely evacuate people should they refuse to leave. This posed a risk that people may not be adequately protected in the event of a fire.

People could not be assured that the service was clean and hygienic. We found that effective cleaning

procedures were not in place. Areas of the service including people's bedrooms were not cleaned to an adequate standard, for instance, some bathrooms had an unpleasant odour and walls and grouting were stained. Some bedrooms and communal areas were dusty and had sticky marks on the walls. We also found that areas of the service that were in a poor state of repair and this did not facilitate effective cleaning. For example, we found two shower chairs which were heavily rusted and in need of replacement and furniture which was soiled and damaged. We observed a member of housekeeping staff cleaning the home and saw that the equipment they used to clean was not hygienic, they were using the same water between rooms which was very dirty. This did not promote good hygiene or infection prevention and control.

This was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The acting manager informed us after our visit that additional resources would be allocated to ensure the effective cleaning of the home, including a deep clean and an additional domestic assistant post. They also informed us that they had put systems in place to ensure regular maintenance of the building and new equipment had been ordered.

People who used the service were not able to provide feedback about staffing levels but the relatives we spoke with were positive about staffing. The relative of one person told us, "I am confident my relative is safe because there are always staff around." Another relative said, "There are plenty of staff."

The acting manager told us that they felt that there were enough staff employed to provide support to people and told us that they could utilise extra staff if needed to support things such as holidays and trips. Feedback from staff about staffing levels was variable, whilst one staff member said, "Yes there are normally enough staff." Another member of staff told us, "There are times when it is chaos and we ask for more staff."

Staff were not always deployed effectively to ensure the safe running of the service. We spoke with a member of staff who told us that there were generally enough staff but that certain times of the day were more challenging, such as mealtimes as a number of people required one to one assistance. We observed one person at lunch time who required assistance and supervision to eat safely. The staff team were not well organised during this period and this resulted in the person being left without the required support. Despite the person's attempts to request support no staff were available to assist. The person continued to eat unaided and this resulted in them coughing and choking at which point staff intervened. We spoke to the acting manager about this and they informed us that they would take action to reorganise mealtimes.

It was not clear if people received the support that was funded for them. The acting manager explained that, as they had only recently taken over management of the service, they did not have clear information about how many hours of one to one support people were funded for or what this should be used for. This meant that staffing rotas were not designed to reflect people's individual support needs. A concern had recently been raised in relation to one person not receiving the support that was funded for them in order to keep them and others safe and to enable them to safely access the community. Records showed that action had been taken to address this, however due to the lack of information about other people's one to one support requirements it was not clear whether or not people were receiving the support they required.

The lack of clarity in relation to one to one support put people who used the service at risk. We spoke with a nurse who told us that one person who lived at the home was at risk of falls. They told us, "[Person] has good and bad days, they fall a lot when they are tired so they have to have one to one support. They don't always have it just on bad days." There was a lack of clarity within the staff team about whether or not the person required one to one support, another member of staff we spoke with said, "No, [person] is not one to

one." We reviewed incident records which showed that this person had fallen a number of times and had sustained a serious injury on one occasion. During our visit we saw that the person was active throughout the day and for some periods of time had a staff member by their side. At other times they were left to mobilise independently with staff observing from a distance. This lack of clarity in about one to one staffing requirements put the person at risk of further falls and potential harm.

This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People could not always be assured that safe recruitment practices were followed. We found that staff had been employed without disclosing their full employment history or reason for leaving their previous employment which meant that the provider was not able to take all information into account when making a decision about recruitment. We also found that there was not always evidence that criminal records checks had been undertaken through the Disclosure and Barring Service (DBS) were in all staff files. These checks are used to assist employers to make safer recruitment decisions. References had been sought from previous employers. However, where previous employers had provided a very basic reference which only included confirmation of the dates the person was employed, further character references had not been sought. This put people at risk of being supported by unsuitable staff. Following our visit the acting manager provided us with an action plan which stated that a full audit of staff files would be completed to ensure these contained the required documentation.

There were systems and processes in place to minimise the risk of abuse. Staff we spoke with had an understanding of how to recognise allegations or incidents of abuse and understood their role in reporting any concerns to the management team and escalating concerns to external agencies if needed. Staff were confident that any concerns they raised with the management team would be dealt with appropriately. Records showed information had been shared with the local authority safeguarding adults team when needed.

Where people required their medicines to be administered covertly, the proper procedures were not in place. Covert medicine is the administration of any medical treatment in a disguised form. This usually involves disguising medicine by administering it in food and drink. The deputy manager told us that one person who used the service sometimes received their medicines covertly in food. Advice and authorisation had not been sought from the person's GP this meant that proper consideration had not been given to whether it was safe to administer the medicines in this manner.

Apart from the above person medicines were stored and administered safely. People we spoke with told us they received their medicines as required. Medicines systems were organised and records were completed accurately to show when people had been given their medicines. Each person had a medication sheet which included a photo of the person, allergies and the person's preferences for taking medicines. Staff had been trained in the safe handling and administration of medicines and had their competency assessed annually to make sure they were keeping up to date with good practice. When people were prescribed medicines to be taken as and when they required them (known as 'PRN') there were written protocols in place detailing what these medicines had been prescribed for or when they should be taken.

Frequent audits of medicines systems were not in place and, although we did not find any major issues with the storage or administration of medicines, this absence of an audit meant there was a risk that future issues or errors may not be identified.

Requires Improvement

# Is the service effective?

## Our findings

People received care and support from staff who did not all have the skills and qualifications necessary to support them safely. Training records showed that there were a high number of staff who had either not received any training or their training was out of date in areas such as safeguarding, equality and diversity and moving and handling. Since being in post the acting manager had reviewed the training records and booked staff on to training as required.

Not all staff received role specific training to enable them to undertake their job effectively. We spoke with a member of housekeeping staff who told us that when they had started they had not had any specific training related to the role. We asked how they learnt how to effectively clean the service and they told us, "The staff told me what to clean." We found issues in relation to the cleanliness of the service which may have been avoidable had proper training been provided.

Despite the above shortfalls in training people and their relatives told us that they thought the staff team had the skills and knowledge to provide good support. One person's relative told us, "The staff seem to be well trained and seem to know what they are doing." The relative of another person commented, "The staff are trained and sympathetic."

The acting manager told us that the provider had a process in place to ensure that new staff had an induction to the role when starting work at Greenwood Lodge. However, they had identified that recently recruited staff had not been provided with all aspects of this induction. This was confirmed by a recently recruited member of staff who told us that when they started they spent time reading care plans and then were expected to start supporting people. They told us, "It was okay because they gave me the people who were easy to work with to start with."

The acting manager told us that staff did not currently complete the Care Certificate but added that they had plans to introduce this in the near future. The Care Certificate is a recently introduced nationally recognised qualification designed to provide health and social care staff with the knowledge and skills they need to provide safe, compassionate care.

People were supported by staff who had regular supervision and support. Although we were not provided with records of supervision, most staff we spoke with confirmed that they were offered supervision regularly. Following our visit the acting manager provided us with a plan for staff supervision.

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. We checked whether the service was working within the principles of the MCA.

People's rights under the MCA were not protected as the principles of the Act were not always correctly

applied. Whilst we found that in most cases clear assessments of people's mental capacity had been conducted and best interests decisions had been recorded, this was not always the case. For example, one person sometimes received their medicines covertly. Although there was a mental capacity assessment in place in relation to decisions about medicines for this person it stated that the person was 'compliant' with taking medicines and did not mention the fact that medicines were sometimes administered covertly without the person's knowledge. This did not respect the person's rights under the MCA.

We found that staff had a basic knowledge of the MCA. Staff were able to explain the basic purpose of the MCA and had an understanding of how to support people who may lack capacity. One member of staff told us, "We always give people a choice, but sometimes we have to make decisions for people, it can change day to day."

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 in relation to DoLS, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The acting manager had a good understanding of DoLS and applications for DoLS had been made by the previous manager where appropriate to ensure that people were not being deprived of their liberty unlawfully. Where DoLS had been granted authorisations were in place and the conditions on the DoLS were being complied with. However, we saw that action had not been taken to ensure that DoLS were up to date. For example, one DoLS authorisation expired on the second day of our visit and timely action had not been taken to apply for the DoLS to be extended. We discussed with the acting manager who told us they would make an application to extend the DoLS to ensure the person's rights were respected.

Where people had capacity to make decisions they were not always asked for their consent before staff provided support or assistance. We observed staff did not always interact with the person they were supporting to let them know what they were going to do or to gain their consent. For example, at lunch time we saw staff put clothes protectors on people without asking them or explaining what they were doing. However, we also saw other occasions where people were consulted about their care.

People told us they enjoyed the food at Greenwood Lodge. One person told us, "The food is alright." We asked another person if they enjoyed the food and they responded saying "yes." People's relatives were positive about the quality and quantity of the food available at Greenwood Lodge. The relative of one person told us, "There are choices given and the food is very nice. [Relation] never complains about the food." Another person's relative told us, "The food is very good and I am very impressed because [relation] had a very restricted diet before living here." We observed that people had access to drinks and snacks throughout the day and that staff were aware of any dietary requirements such as people who required a low sugar diet.

People's weight and BMI were assessed regularly to determine whether they were at risk of weight loss. However, there was no evidence of analysis of this information which meant that there was a risk that changes and patterns may not be identified. Although we saw that some people were provided with fortified drinks to help maintain their weight this lack of analysis placed the people at risk of changes in their weight not being identified which could have an impact on their health.

People were supported with their day to day health needs. The relatives of people who used the service spoke positively about access to health care and the support provided by staff at Greenwood Lodge. A

relative we spoke with told us, "[Relation] has good health and sees the GP for check-ups. They have just had some new handmade boots. They struggle with blood tests but they (staff) always manage this." Another person's relative commented, "[Relation] sees all the health professionals they need to see."

Records showed people were supported to attend health appointments and staff were arranging for health professionals to visit people as needed. We saw evidence of the involvement of a range of health professionals in people's care records including a speech and language therapist, GP, dentist and optician. People had health action plans in place which detailed information about their general health and contact with health professionals.

Where people had specific health care conditions, care plans contained information about the condition and guidance for staff about how to respond to any changes. However this information was variable in quality. Some care plans had detailed information about health conditions whereas other care plans lacked important information about people's health needs. For example, one person had a condition which caused them to have seizures. There was basic information about this in their care plan but there was a lack detail about how often the person had seizures, and how staff should support the person during and after a seizure. This put the person at risk of receiving inconsistent support in relation to their health.

Requires Improvement

# Is the service caring?

## Our findings

Although we observed some instances of kind and compassionate care and support, we found that some staff were task focused and had limited interaction with the people they were supporting. We observed that staff spent more time with those people who were able to verbally communicate or those who posed a risk to others, compared to people who did not or were not able to initiate interaction. While staff were not being outwardly unkind to people, they sometimes overlooked people who, due to their disabilities, were not able to seek staff company and interaction. For example, one person who used the service spent the majority of the time we were at the home playing with a box of bricks. Although we saw some brief positive interactions with staff, which gave the person obvious pleasure, other interactions were task focused and they spent the majority of their time sitting alone. We reviewed activity records for this person which showed that 'playing with Lego' had been recorded as their activity every day for the past three weeks.

Staff did not always communicate clearly with people or explain their actions when providing support. We saw a staff member approach a person and wipe their face without communicating with the person or explaining what they were doing. We also saw that some people were assisted to eat with minimal interaction from staff.

People did not always receive support that was based upon their individual needs. For example, we observed everyone being given a clothes protector at lunchtime, even though some people did not appear to need them. People did not seem to be given a choice over whether they would like a clothes protector, there was an expectation that they would wear them.

Mealtime experiences were not always dignified, personalised or sociable experiences for some people. We observed two meal times and saw whilst one meal time was organised and calm the other meal time was disorganised and chaotic. Some people who required assistance to eat safely were not provided with this support, three people had to wait a long time for their meal to be served and a number of people became agitated which resulted in loud vocalisations, objects being thrown and people being startled by the behaviour of others.

Staff did not always respond quickly to people who were showing signs of anxiety and distress. On the first day of our visit we observed one person making increasingly loud vocalisations and wringing their hands. We checked the person's care plan which stated that these behaviours normally indicated that the person was in distress. This escalated for a period of 30 minutes until a staff member intervened. This was not a timely response to the person's distress. On the second day of our visit we observed the person behaving in the same way with little intervention from staff. An external professional who worked with this person was visiting the service, they observed this person's behaviour and commented, "[Name] you are very anxious today." The visitor spent around ten minutes reassuring and calming the person and this appeared to reduce their anxiety.

The above information was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our visit the acting manager informed us in an action plan that a staff meeting would be held to address the approach of the staff team and encourage staff to work in a person centred way. There were also actions related to the improvement of the environment to make mealtimes a more pleasurable experience

A number of people who used the service had limited verbal communication and their care plans contained information about this and how staff should communicate with them. However, we did not see any evidence that alternative methods of communication, such as Makaton or the use of signs and symbols had been considered to encourage and support people's communication. Some notices around the service used signs and symbols but this was not consistent and it was not clear if any consideration had been given to if this information was actually accessible to people.

Despite the above, people's relatives told us they felt staff were caring. The relative of one person told us, "They are very kind and caring." People's relatives also commented that their loved ones had developed positive relationships with members of the staff team and felt staff knew them well. One relative commented, "The staff know [relation] well. They have a lot of fun, especially the staff who have been there a long time." Another relative said, "The staff listen to [relation] and they understand them probably better than I do."

We observed some positive interactions throughout our visit. Some staff demonstrated an understanding of how to encourage and support people to make or be involved in some day-to-day decisions that affected them. This included supporting people to make choices in what they ate or how they spent their time.

People had access to an advocate if they wished to use one. Advocates are trained professionals who support, enable and empower people to speak up. Two people were using an advocate at the time of our visit. There was information displayed in the service so that people knew how to contact an advocate if they wished to and the acting manager told us that they would ensure that people had access to an advocate should they need to.

People's right to privacy was respected and this was confirmed by feedback from people's relatives. The relative of one person told us, "I think they respect my relative's privacy and dignity as there has been nothing to the contrary." Staff understood how to respect people's right to privacy and we observed that this was put into practice for the duration of our visit. We observed staff knocking on bedroom doors and waiting for an answer prior to entering. People also had the opportunity to have undisturbed private time in their bedrooms. Visitors were able to come to the home at any time.

Requires Improvement

# Is the service responsive?

## Our findings

We observed a lack of meaningful activity for a number of people who used the service and this was supported by records. Prior to our inspection we received concerns about the level of activity and stimulation for one person who used the service. We spoke with the acting manager about this who had taken action to ensure that this person was enabled to take part in meaningful activity. However, they told us that they had not yet had opportunity to review activities for other people who used the service.

The acting manager told us that team leaders were responsible for allocating roles to staff, including activities. Records showed that some people went out to day centres and other trips and we observed that a small number of people were engaged in activities such as colouring and doing a jigsaw for parts of our visit. However, other people spent much of their time unoccupied. Meaningful activities within the home were not planned for in a way which would prevent people from becoming bored. For many people their daily routines were dominated by meal times and personal care tasks. We reviewed the activity records of five people which showed that a number of people left the service infrequently. Two people had not been out of the service at all in the past three weeks and another two people had only been out on one occasion in the past three weeks. These records also evidenced a lack of meaningful activity within the home., For example, one person's activity records recorded 'relaxing in lounge' as the person's main occupation.

We spoke with staff about how people spent their time and they explained that the lack of activity was often down to the 'choice' of the person. However we saw no evidence that staff had explored what other more meaningful choices could be offered or explored for these people. One member of staff we spoke with talked about a specific person and said, "I think [person] could go out more, they are always crying to go out." They went on to say, "I feel like if we had more staff people could go out more."

People and their relatives were not always involved in the planning of care. A number of people living at the Greenwood Lodge were unable to give their views about the care and support they received, or to be actively involved in the planning of their care. The acting manager, who had only been at the service for a short period, explained that where people were unable to be meaningfully involved in planning their care their relatives would be consulted where possible. However, people's relatives told us that although staff communicated with them about the care of their loved ones they had not recently been involved in decisions relating to people's care. The relative of one person told us, "I am not asked about any decisions and I presume the home knows what's best." Another person's relative told us, "There used to be a care plan but I am not sure now. They always ring me if they need to tell me anything."

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not consistently receive the support they required as staff did not always follow guidance in care plans. Although staff told us that they routinely read people's care plans we observed multiple occasions where support had not been provided as detailed in people's care plans. For example, one person was not assisted to eat as detailed in their plan, another person was not provided with reassurance and support in

relation to their anxiety as detailed in their care plan and staff had not followed guidance in a third person's plan to remove dangerous items from their room.

People were at risk of receiving inconsistent and unsafe support as guidance in care plans was not consistently detailed or accurate. We looked at one person's care plan who had a catheter. Although the care plan contained information for nurses about the catheter there was no information for care staff about how to support the person with their personal care in this area. This lack of information placed the person at risk of not receiving the correct support which could potentially have an impact upon their health. Another person's care plan stated that they must be encouraged and reminded to wear a splint on their hand to prevent their hand from contracting. The person did not wear a splint throughout our visit and we spoke with a nurse who told us that they had not been wearing the splint for some time. The reason for this was not clear and we could not find any record that this decision had been made based upon expert professional advice. The same person's care plan contained advice from a speech and language therapist on how to reduce the risk of choking which stated the person should not be given bread. However, the care plan stated that the person could have brown bread. The failure to follow care plans and inaccuracies in care plans put people at risk of unsafe and inconsistent support.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The acting manager told us that they were aware that some care plans were out of date and had already identified this as an area for improvement. Following our visit they submitted an action plan which provided timescales by which all care plans would be updated, this action plan also included measures to ensure that all staff had read care plans.

In spite of the above, other parts of the care plans that we reviewed contained clear information about each person's individual needs. Care plans included information about where people needed support and areas where they were independent. The support people required with communication and information about how to respond to behaviours that may put the person and others at risk was also included.

People were supported to maintain relationships with friends and family. People's friends and relations were welcome to visit and we saw visitors during our visit. People were also enabled to visit family in the local community, one person made daily trips to their family home supported by staff. People's relations spoke positively about the atmosphere and told us they were welcomed by the staff team. One person's relative told us, "I am always welcomed when I visit with the offer of tea."

People could be assured that complaints would be taken seriously and acted upon. People and their relatives told us they did not currently have any concerns and said that they would feel comfortable and confident in raising an issue or complaint with the staff team or acting manager. One relative we spoke with told us, "I would know how to complain but have never needed to." Staff we spoke with knew how to respond to complaints if they arose and were aware of their responsibility to report concerns to the manager. Staff told us they were confident that the management team would act upon any concerns appropriately. There was a complaints procedure on display in the service informing people how they should make a complaint, although this was not presented in a format that people who used the service would be able to understand we saw that complaints had been discussed in residents meetings.

We reviewed records of complaints made during the last twelve months and these had been processed and concluded to people's satisfaction. However, we found there was no overall analysis of complaints and no learning had been highlighted in response to the complaints received. This meant that although the

provider responded to complaints, there was no evidence to demonstrate that this was used to improve overall practice or the quality of care for people.

Requires Improvement

# Is the service well-led?

## Our findings

Systems in place to ensure the safe and effective running of the home were not robust or comprehensive and this resulted in negative outcomes for people who used the service and put people at risk of harm.

The provider did not have effective systems in place to observe and review the day to day support provided by staff. At times this resulted in people not receiving the support they required as staff did not always follow care plans. For example, we observed that staff did not follow guidance around supporting one person to eat and drink safely and this placed the person at risk of choking. This lack of effective oversight placed people at risk of unsafe and inconsistent support.

There was a lack of audits within the service which meant that issues in some areas were not identified. For instance, the health and safety issues we found related to poorly maintained, unsafe furniture and equipment in people's rooms and communal areas were not covered by any audit. Consequently these potential hazards had not been identified nor acted upon. There was no medicines audit in place and although we did not find any issues related to the storage and administration of medicines this lack of audit made it unlikely that any issues or errors would be picked up should they occur.

During our visit we found multiple concerns related to the cleanliness of the environment and the management of infection control and prevention. There were no audits in place related to the cleanliness of the environment or infection control and no checks were done to ensure that the cleaning had been completed effectively. In addition to this the cleaning schedule did not contain adequate detail of what should be cleaned which resulted in areas of the home and equipment such as walking frames being missed.

The provider had not ensured that a competent person was in place to manage the risks associated with Legionella. This meant that the required checks and controls had not been put in place to reduce the risks. The lack of quality assurance systems meant that risks associated with legionella had not been identified and acted upon.

Staff did not always have a clear understanding of their role and this put people who used the service at risk. For example, records of fire alarm checks showed repeated faults with the fire doors causing them not to close when the fire alarm sounded and putting people at risk should there be a fire. The member of staff completing the fire alarm checks had not shared details of these defects with the manager and consequently no action had been taken to rectify this issue.

There was no system in place for analysing patterns of accidents and incidents across the service. Whilst we saw that action was taken in response to incidents, such as falls, on an individual level, overall trends of accidents and incidents across the home, such as the location or timing, were not analysed. This meant that opportunities may have been missed to identify ways of preventing future incidents.

The provider had systems in place to audit the quality of the service provided, however these had not been

used effectively at Greenwood Lodge. The acting manager told us that the provider had a peer audit system in place where registered managers conducted in-depth audits of other services run by the provider. We saw a record of one of these audits from 2015 and found that it was effective in identifying issues. However, no action plan had been developed as a result of this audit so it was not clear if any action had been taken to rectify the issues. The acting manager told us they had conducted a more recent audit of Greenwood Lodge, however records of this could not be located during our visit. Following our visit the acting manager provided us with a copy of an audit completed in November 2016. This audit had been effective in picking up a wide range of issues including some of those that we identified during this inspection such as staff training, out of date care plans, failure to analyse incidents and management and record keeping issues. Again no action plan had been developed by the previous registered manager in response to this audit, this meant that opportunities to make improvements had been missed. The acting manager told us that they had raised their concerns about a failure to act upon known issues with the provider but it was unclear what action had been taken by the provider to resolve this.

Confidential information relating to people's care and support was not stored securely. Daily records including details of people's bowel movements were stored in a cupboard in a communal area which was accessible to other people who used the service and to visitors to the service. At one point we observed a person who used the service access the cupboard and remove records. This meant that people using the service could not be assured that sensitive personal information was stored securely and this did not respect their privacy.

Although people were given the opportunity to provide feedback on the service in residents meetings and annual surveys there was no evidence that this information was used to inform development and improvement. We saw the results of the latest two satisfaction surveys. The surveys we viewed were on the whole positive; however, there was no analysis of responses and no indication of what had been done in response to the surveys. This meant that although there were opportunities to feedback, the provider could not assure us they had analysed and responded to people's feedback adequately.

The relatives of people we spoke with told us that they had not been asked to provide feedback on the service. One person's relative told us, "I don't go to meetings and have not been asked to do a survey." Another relative commented, "I used to get invited to meetings but not now." Although people's relatives told us that they were informed about any changes relating to the care and support of their loved ones they had not been informed about recent changes in the management of the service. One relative told us, "I don't know who the manager is now," another relative commented, "I am not aware that there is a new manager."

The failure to effectively monitor and assess the quality of the service in order to make necessary improvements was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The provider had not always notified us of incidents in the service, which they are required to by law. We saw there had been a police incident and a serious injury sustained by someone who used the service and statutory notifications had not been submitted to us. A failure to notify CQC of incidents has an impact on the ability of the CQC to monitor the safety and quality of the service. We discussed this with the acting manager who informed us that they were aware of their duties to with regards to notifications and assured us the notifications would now be made.

Prior to our inspection we were informed by the provider that the registered manager was no longer in post. On our arrival there was an acting manager in the service who had been in post for approximately six weeks. The acting manager was passionate about improving and developing the service at Greenwood Lodge. They

understood that there were a lot of improvements required and told us, "When I came here it was like leading a brand new home." Since covering the management of the service they had made some improvements to the systems and processes in order to improve the running of the service. For example, they had updated the training records and booked staff onto training where it had expired and had also and had also implemented a system for tracking DoLS applications.

We provided feedback to the acting manager during our visit to Greenwood Lodge and they took swift action to resolve some of the issues during our inspection to lessen the immediate risks to people who used the service. Following our visit the acting manager provided us with an in-depth action plan detailing how other issues would be resolved and how the quality of the service would be improved.

Very few people living at Greenwood Lodge were able to give meaningful feedback on the quality of the service but those who did gave mixed feedback. One person told us, "Nothing changes I don't like it here (main house) but I like my place (residents flat)." Whereas another person told us "Living here is alright." The relatives of people living at Greenwood Lodge were positive about the service. The relative of one person told us, "It's a good quality service." Another relative told us, "I have never had any reason to complain. I would give a score of 9 out of 10."

Staff were positive about working at Greenwood Lodge. They were given an opportunity to have a say about the service in meetings and an annual staff survey. Records of staff meetings showed that these were used to provide feedback to the team, to share information and to address issues within the service. Staff we spoke with told us they felt supported and would feel comfortable in reporting any issues or concerns to the management team.

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>People did not always receive support that met their needs<br><br>People and their families were not involved in planning their care and support.<br><br>Regulation 9 (1) (b) (c) (3) (b) (d) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>People were not protected from risks associated with their care and support<br><br>People were not protected from risks associated with the environment<br><br>Effective systems were not in place to control and prevent the spread of infection<br><br>Regulation 12 (1) (2) (b) (c) (d) (h) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 15 HSCA RA Regulations 2014 Premises and equipment<br><br>The service was not clean and hygienic in all areas.<br><br>The building was not maintained to a safe standard. |

Regulation 15 (1) (a) (e)

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Effective governance systems and processes were not in place to ensure the safe and effective running of the location.<br><br>Sensitive personal information was not stored securely.<br><br>Information resulting from quality assurance systems had not been used to evaluate and improve the service<br><br>People were not meaningfully involved in giving their views on how the service was run.<br><br>Regulation 17 (1) (2) (a) (b) (c) (e) (f) |

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>Staff were not effectively deployed to provide safe and effective support.<br><br>Regulation 18 (1) |