Kirkley Limited

Greenways Care Home

Inspection report

Greenways Care Home
Marton Road
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Warwickshire
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29 June 2017
27 July 2017

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 28 & 29 June 2017 and 27 July 2017. The inspection visit was unannounced on 28 June 2017; we then announced our return on the 29 June 2017 to continue our inspection. We returned unannounced on 27 July 2017 because the provider and registered manager had not sent sufficient information following the inspection feedback to us, that explained how they would respond promptly to the issues we found.

Greenways Care Home is a residential home which provides care to older people including some people who are living with dementia. Greenways Care Home is registered to provide care for up to 27 people. At the time of our inspection there were 22 people living at the home.

The inspection was a comprehensive inspection to follow up on issues we found at our previous two inspections. We had also been given information that the local authority, had agreed that no further people would be admitted to Greenways following their most recent inspection due to concerns they had identified at the home. They had also issued the provider with an action plan to make improvements.

When we inspected the home in January 2017 and March 2016 we found continued breaches in the governance of the home and in medicines management. At the January 2017 inspection visit we also found there were not enough staff on duty to respond to people's health needs and to keep people safe. Because of our concerns, we rated the service as 'Inadequate.' This meant the legal requirements and regulations associated with the Health and Social Care Act 2014 were not being met. Requirement notices were issued to the provider to tell us what action they would take to make improvements following our inspection in January 2017. We also met with the provider who gave us assurances improvement actions would be made and reviewed to improve the quality of care people received. Greenways Care Home was placed in special measures in January 2017 with continued breaches of Regulation 12 (medicines), Regulations17 (good governance) and a new Regulation 18 breach (staffing). Requirement notices were issued to the provider which required them to send us action plans of how they would meet the regulations.

At this inspection we looked to see if the provider and registered manager had responded to make the required improvements to meet the regulations. Whilst we found some areas of improvement had been made, we found more improvements needed to be made and we also identified other areas of concern.

There was a registered manager 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.

We found the registered manager and provider did not have safe and effective procedures and processes in place to ensure medicines were stored and managed safely. We could not be sure people received their prescribed medicines when they should and in line with manufacturers guidelines.

At our previous inspection we had identified there was not always enough staff at Greenways to ensure people's safety, and staff training was not up to date. We continued to find staff training was not always sufficient to ensure people received safe and effective care and a lack of effective management of staff meant people were not always supported or had time to spend with staff when needed.

Relatives told us they felt their family members were safe and were satisfied with the service their family member received.

Some fire safety checks had not been completed following our inspection in January 2017, People did not have emergency evacuation plans in place and staff were uncertain about what actions to take in the event of an emergency. The fire authority visited the service in July 2017 and issued the provider with a number of recommendations that required action to keep people safe.

Care plans provided information for staff that identified people's support needs and associated risks. However, some care plans and risk assessments contained important health information and advice which was not followed, other care records lacked the information staff needed to ensure people received safe care.

The registered manager and provider had not consistently notified the CQC and the relevant authorities of accidents and incidents that occurred at the home, and safeguarding concerns had not been investigated or referred to other agencies. There was a lack of analysis following accidents and incidents to identify how these could be prevented in the future.

There was a lack of management oversight by the provider to check delegated duties had been carried out effectively. The quality monitoring systems included reviews of people's care plans, health and safety checks and checks on medicines management. These checks were not regularly reviewed by the provider so it was difficult for them to be confident people received the quality of service they deserved. Quality assurance procedures had not been evaluated and improved following the concerns we identified during this and previous inspection visits.

At the last inspection we found people were not supported in line with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). We continued to find this, and further improvements were still required.

Some people felt their physical and mental stimulation was limited because they were not proactively supported to pursue their own hobbies and interests. Some people told us there were limited things to do. These concerns were also raised with us at our previous inspection.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, two were continued breaches. The overall rating for this service is 'Inadequate' and the service therefore continues to be in 'Special Measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will consider the action we need to take in line with our enforcement procedures, to bring about improvement. This could include action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their

registration and, if needed, could be escalated to urgent enforcement action.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risk assessments for the environment were not up to date and put people at risk of harm. Medicines management continued to be unsafe and medicine storage required significant improvement to ensure people were not placed at risk. Where people were identified at risk of harm, measures were not taken to keep people safe. Safeguarding procedures were not always followed to investigate issues where these were identified. Staffing levels continued to not always be at a level that supported people safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People did not have up to date mental capacity assessments in place to determine where they lacked capacity to make their own decisions, where these were relevant. There were no DoLS assessments conducted by the registered manager at the home, however, we saw some people had restrictions placed on their care.
We were unable to assure ourselves that staff had the relevant training, skills and support to provide people with effective care. People were provided with nutrition that met their needs. People were supported to maintain their health and referred to external healthcare professionals when a need was identified.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Some staff were kind and caring, and knew people well. However, some people told us they did not always consider staff to be sensitive to their individual preferences. People were unable to make choices about how they lived their daily lives. Documents about people's care and medicines were not stored securely and did not always protect people's privacy.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People and their families were not always involved in planning how they were cared for and supported. Records did not show people's life histories and what was important to them. However, some staff knew and understood people's preferences, likes and dislikes and how they wanted to spend their time. There continued to be minimal physical and mental stimulation for people, which did not always meet their needs.

Is the service well-led?

Inadequate

The service was not well led.

The provider and registered manager's management systems continued to be ineffective. Actions identified as requiring improvement at our last visit had mostly not been addressed by the provider. There were a number of continued shortfalls in relation to the service people received and a lack of effective checks meant people continued to receive a service that fell below their expectations.

Greenways Care Home

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 28, 29 June 2017 and 27 July 2017. The first and third day of our inspection visit was unannounced. On the first day of our inspection visit two inspectors and an inspection manager visited Greenways. On the second day of our inspection visit two inspectors and a specialist pharmacy inspector visited the home. On the third day, one inspector visited.

Before the inspection visit we looked at our own systems to see if we had received any concerns or compliments about Greenways Care Home. We analysed information on statutory notifications we had received from the provider. A statutory notification is information about important events which the provider is required to send us by law. We considered this information when planning our inspection of the home.

This inspection was a follow up visit to check improvements had been made in the management of the service and management of medicines. During this inspection, we asked the registered manager to supply us with information that showed how they managed the service, and the improvements they had made. We considered this information along with the action plan they had submitted to us following their inspection in January 2017.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We observed care and support being delivered in communal areas of the home.

To gain people's experiences of living at Greenways Care Home, we spoke with six people and two relatives of people who used the service. We spoke with the registered manager, the provider, four care staff, the cook and a house keeper.

We looked at five people's care records to see how they were cared for and supported. We looked at other records related to people's care such as medicine records, daily logs and risk assessments. We also looked at a range of documents produced by the manager which demonstrated how quality assurance was undertaken at the home.

Inadequate

Is the service safe?

Our findings

At our last inspection 'Safe' was rated as 'Inadequate.' The provider had breached Regulation 18 as there was insufficient numbers of suitably qualified, competent and skilled staff to meet people's care and welfare needs. The last inspection also identified a continued breach of Regulation 12. This was because care and treatment was not being provided in a safe way because risks were not managed and action was not taken to minimise the risks to people's health and wellbeing. Medicine management was not effective to protect people from potential harm. We found the provider's policy for managing risk was not consistently followed and actions were not taken to keep people safe. Some people were placed at increased risk because staff did not know important information that protected people from risk.

On this inspection we looked at how risks were being managed at the home and we continued to have concerns that medicines were not being managed safely. Staff told us staffing levels had improved at the home and staff numbers on certain shifts had increased, however the deployment and management of staff at times had potential to put people at risk.

Some care plans documented where risks were identified to people's health and wellbeing, and described the equipment needed and the actions staff should take to support people safely. However, staff were not always managing the risks to people's health where risks had been previously identified. For example, we found one person whose risk assessments and care plans were not up to date regarding their mobility. The person required the use of a hoist when staff assisted them to move around. The risk assessments and care plans did not show the person required hoisting, or how staff should use the appropriate equipment to assist them. This put the person at risk, as all staff may not be aware of the need to use the hoist or have the knowledge or experience to do this safely. We asked the registered manager during and post inspection to provide us with the person's records but they failed to send them to us.

Special equipment was in place for some people, such as specialist pressure relieving mattresses to reduce the risks of people's skin developing pressure sores. To ensure the optimum benefit for people, the mattresses should be set to a specific airflow, according to the person's weight. We found people using this type of equipment did not have the safe mattress settings for their weight recorded for staff to follow. We saw that some people's mattresses were set at an inappropriate level for their weight. For example, one person who told us they were underweight and were trying to increase their weight had their mattress set for 150kg, which is the equivalent to 23 stones in weight. This incorrect setting of the mattress put the person at risk of developing skin damage. We also found that mattress settings had been highlighted as an area of concern at our previous inspection and action had not been taken to improve this. There were not sufficient safety checks in place to ensure mattresses were set at the correct level. However, on the third inspection day we found mattresses were set to correct pressures, staff knew how to set them and information was recorded in the persons room for staff to refer when needed.

We found some safety checks were not always effective to ensure people remained protected in the event of an emergency. There was not an up to date risk assessment in place regarding fire procedures. No-one had a personal evacuation plan drawn up to inform staff and emergency services how they should be evacuated

in the event of an emergency. The registered manager told us at our last inspection time constraints meant they had not had an emergency fire drill for 13 months and were not confident staff knew what to do in an emergency situation. On this inspection we found a fire drill had still not taken place. We asked one member of staff how they would evacuate people in the event of a fire, they were unclear of the procedure to do this, and were not trained in the use of fire evacuation equipment. On the third inspection visit staff told us they had still not completed a fire drill or evacuation.

We observed the fire alarm being tested, and the registered manager was able to tell us about staff being trained in emergency fire procedures the week before our inspection visit. They told us an up to date risk assessment was in the process of being updated by mid July 2017 by a specialist consultant, who had already visited the home. This was because the Fire Authority completed a visit in July 2017 and found a number of concerns that required attention.

We checked the home's environment and some of the equipment used to ensure the home was safe was not always effective. We found a number of radiators in the communal areas of the home were not protected by radiator covers. Radiator covers are commonly used in residential homes to protect people from the risk of burns. We asked the registered manager and provider about the lack of radiator covers in communal areas of the home, they told us they had not previously identified this as a concern. There was no risk assessment in place for the use of radiators without covers at the home. There was no regular audit completed inside the home to identify environmental issues such as the temperature of radiators or the installation of radiator covers, which meant there was no clear process in place to monitor and improve environmental concerns. The provider told us they would organise an audit of the internal environment of the home following our inspection visit.

During the first and second day of our visit we found the lift in the home was 'out of order'. There was only one lift in the premises, and no stair lift was available in the home. The registered manager told us the lift had only been out of order for a few days, and they were waiting for a part to fix the lift. As the home was split over two floors, and some people on the top floor of the home required support to move around, it meant some people were unable to come downstairs without the aid of staff. We asked the registered manager how people were being supported to come downstairs or go out whilst the lift was 'out of order'. They told us people were not able to leave their room, and no provision had been made to support people to come downstairs. One person told us they wanted to go downstairs but had not been offered the support to do so. Seven people were on the top floor during our inspection visit. No extra staff had been brought in to offer support to people on the top floor of the home, however, the registered manager told us, "I have asked staff to regularly check on the people upstairs." We asked to see a risk assessment and risk mitigation plan to assess how staff and the registered manager should act in the event of an equipment failure, such as the lift being 'out of order'. The registered manager told us there was no contingency plan in place for these types of events. On the third inspection visit the lift was working.

Where incidents and accidents resulted in people requiring treatment from other healthcare professionals, it is the registered manager's and providers legal responsibility to notify us. Prior to our inspection in January 2017, we found they had not notified us of some serious injuries which resulted from people falling. We were concerned that positive action had not been taken to assess why some people who were identified at risk of falls, continued falling, and what interventions could be taken, to minimise the risk of further falls and potential injuries. Since our inspection in January 2017 the registered manager introduced a system to monitor the number of accidents and incidents that occurred at the home, to see whether any areas for improvement could be identified, or any patterns and trends to incidents could be identified. However, we found the registered manager had not yet reviewed the falls and incidents at the home, as the system had just been implemented. We found numbers of incidents were recorded but the analysis did not record what

preventative measures were and could be taken to prevent similar incidents from happening again.

Prior to this inspection visit we asked for the provider to send to us all of the accidents and incidents for a specific period. We analysed this information as part of our inspection planning. We found on more than one occasion a person had fallen in their room, and their pressure mat which was placed next to their bed, had not 'sounded' as it should, to alert staff that the person was out of bed and needed to be assisted. We found the person had fallen onto the floor, and staff had not been alerted to their fall. This was because their pressure mat had been unplugged by staff, as it was not functional. The person was taken to hospital following their fall. We asked the registered manager what investigation they had done to determine whether any lessons could be learned from the incident. We also asked them if a pressure mat audit was now in place at the home and we were told they were. However, we asked for copies of the audit to be sent to us but we have not been sent them. On the third visit, the registered manager was not present so we could not see what systems were implemented to ensure all mats remained effective and fit for use. We found one person had a fall on the night before our third inspection visit. The person had suffered bruising and required a wound to be stitched. We checked the falls record, daily diaries and incident record for this fall and found a staff member had recorded the incident but stated an incorrect date. We highlighted this to both senior staff members on duty about the importance of keeping accurate records.

At our last inspection we found the service had breached Regulation 12 because they had not administered medicines to people safely. In response we issued the provider with a requirement notice to improve medicines management. The provider sent us their action plan and detailed what measures they would take to make the necessary improvements. The action plan explained staff would be re-trained and two staff would assess people on admission to the home to check any incoming medicines and relevant records.

On arrival on the first day of our inspection visit three people were out of bed and eating their breakfast when we arrived. In the communal lounge area of the home there was a medicines trolley, which contained the stocks of people's current medicines. We found the medicines trolley had been left unattended by staff, the door to the trolley was open and keys were hanging from the lock. This posed a significant risk to people, as they could access the contents of the medicines trolley. In addition two medicines (eye drops) had been left on the top of the medicines trolley. We were concerned that the medicines trolley had been left open for several hours, since people had been given their previous dose of medicine during the evening of the previous day. One staff member told us, "[Name] wanders about at night. It's a worry as they pick things up."

We immediately brought this to the attention of a member of care staff. The member of care staff was asked to make the medicines secure. On returning to the medicines trolley after around 20 minutes we found the medicines trolley had been locked and the medicines on the top of the trolley had been placed inside, however, the key to the trolley had been left on top of the trolley and was still not secure. We brought this to the attention of the registered manager; we later saw the key had been removed from the trolley. Following both inspection visits the provider assured us the medicines trolley was secured. On the third inspection visit we arrived and saw the keys were still in the lock of the medicines trolley with no staff present and people present in the lounge close by. We found a senior member of staff and showed them what we found, seven minutes later and the keys were still in the lock. The senior staff member said, "[Registered manager name] will be unhappy." The senior administering medicines said they left the key in as they were only close by, but they said this was not normal practice for them. This demonstrated lessons had not been learnt from our previous inspection visits.

A member of the CQC medicines team visited the home on the second day of our inspection visit, as part of the inspection team. We reviewed Medicines Administration Records (MAR) for fourteen people and saw that medicines were not managed safely in accordance with the prescriber's instructions. At our previous

inspection some medicines which needed to be kept in a fridge, were kept in a food fridge in the kitchen. Safe practice is to have a designated medicines fridge away from possible contamination. We found at this inspection the provider had bought a new medicines fridge which was in use. This was situated in the kitchen area of the home and accessible to all staff. On the first day of our inspection visit we observed that the fridge was unlocked, this however was rectified on the second day of the inspection visit. There was no procedure in place to monitor the temperature of the fridge to be sure medicines were being stored safely in accordance with manufacturer's guidance to maintain their effectiveness. We checked on the third day and found medicine fridge temperatures were being recorded. Some medicines were stored in a locked cupboard in the hallway of the building; the temperature of the cupboard was monitored by staff to ensure that temperatures were below 25 degrees centigrade. This was to ensure medicines were kept below the manufacturer's recommended temperature to ensure they continued to be effective. Some of the medicines in current use were held in a lockable medicines trolley in a communal area. Despite recent high temperatures, the provider was unable to provide assurance that the temperature of the trolley was checked to ensure medicines remained suitable for use.

The home held controlled drugs (medicines that require extra records and special storage arrangements because of their potential for misuse) for people in a lockable cabinet. We saw that access to this was not monitored and keys were left in the lock of the cabinet door. We identified that one liquid medicine within the cabinet had not been dated on opening, and on reviewing the person's records we were able to see that it was held beyond its expiry date. This medicine had not been administered to the person for some time, but remained on the MAR charts as an 'as necessary' medicine, so could have been administered despite being out of date. We found that a significant amount of this controlled drug was not accounted for. The stock level held did not match the stock count in the controlled medicines register, the provider was unable to account for the discrepancy. The registered manager and provider confirmed that the service did not conduct regular stock checks of controlled drugs, in line with national guidance. We asked the provider and registered manager to report the loss of the controlled drugs to the appropriate authorities immediately following our inspection visit and to notify us when this was completed. The provider and registered manager failed to notify us. We checked on the third inspection day and found this medicine was still in the home, even though the person was no longer taking this medicine.

We saw that when prescriptions were altered during the month or when new people came into the home, the MAR charts were handwritten. These handwritten charts did not contain the full information from the labelled medicines including maximum doses or standard warning labelling. This put people at risk of receiving an incorrect dose. We saw that for one person on respite care in the home the MAR chart had been handwritten twice. We noted that the dose of one of the medicines appeared to have changed from one chart to the next. The provider was unable to tell us, and we were unable to establish, whether this was an intentional change or a mistake. This meant the person was at risk of being given the wrong dose of the medicine.

Some people were prescribed medicines on a when required/as needed basis. The home's medicine policy required that plans to describe the use of these medicines should be included with people's MAR charts. We did not see any plans or protocols in place with MAR charts to guide staff on when to administer 'as necessary' medicines'. The registered manager confirmed that there were none in place. Some medicines were prescribed with a variable dose e.g. 5-10ml to be taken twice a day. The charts did not detail how much had been given on each occasion with the risk that a dose greater than the maximum may be given in a 24 hour period. We checked on the third inspection visit to see if this was addressed and found variable doses were still not being recorded accurately.

At our previous two inspections, where people required pain relief in the form of patches on their skin, we

found staff had not completed body maps or patch position records to make sure the correct amount of patches had been applied in the right places. At this inspection we found staff were keeping a record of where some skin patches had been applied to people. However, for two of the people whose MAR charts we examined there was no record to show where a patch had been applied. In addition staff were unable to describe adequate rotation of sites of the patches to reduce the risk of skin irritation to people.

We saw medicines were left in people's rooms to be taken when they preferred. Whilst this supported people's independence, the care staff then signed the MAR as having administered the medicines, even though they could not be sure the person had taken the medicine. When we returned on the third day, we checked one person's records and found staff no longer completed the MAR, however there was no system to check the person was exceeding the required dose. Before our inspection visit we had received information that tablets and medicines had been found on the floor in some people's rooms. Daily records also indicated medicines had been found where one person usually sat in a communal area of the home. The procedure meant people were at risk of not taking their prescribed medicines, when records showed they had done so.

During our previous visit we found staff's ability to administer medicines safely had not been checked by the registered manager, and staff had not received training to refresh their understanding and skills in relation to the safe administration of medicines. On this inspection we found the registered manager had been on a refresher course regarding the safe administration of medicine, as had some members of care staff. Those care staff who had received updated medicines training had been signed off by the registered manager as being competent to administer people's medicines. Four staff at the home in addition to the registered manager were able to administer medicines.

However, we found some care staff who had not received medicines training or competency assessments were applying medicated creams. The registered manager explained care staff who applied creams would inform the medicines trained staff that treatment had been applied, and then trained staff would sign the MAR to confirm the medicine had been applied. Greenways medicines policy was not being followed as it stated that 'medication is always administered by a registered first level nurse or by a designated appropriately trained and competent member of staff'. For most of the creams we looked at there was no information recorded to describe where they must be applied or the quantities to use so it was not clear that they were being applied as intended by the prescriber. On our third inspection visit we checked to ensure MARs were now updated following our feedback. We found cream records were not updated; furthermore some creams did not record 'opened dates'. This meant staff could not be confident the creams remained effective and used within the specified time period. The registered manager said they completed regular audits on medicines however, medicines audits had not identified the areas of concern we found during our inspection visit so were not effective.

We found this was a continued breach from our inspection in March 2016 and January 2017 of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 .

During our preparation for our inspection visit in June 2017 we looked at the statutory notifications that had been sent to us by the registered manager and provider. A statutory notification is information about important events which the provider is required to send us by law. At our previous inspection we had found that the registered manager and provider did not always notify us of important events as they should and without delay. For example, we received a notification for a fall which happened on 25 May 2017, yet the notification was sent to us on 4 July 2017.

We found that we had received no statutory notifications regarding safeguarding concerns in the previous

three years. As we had noted a number of safeguarding concerns during our inspection visit, we raised this with the registered manager and provider. For example, one person's relative had made an allegation of abuse against a member of staff. This had only been investigated internally and not referred to us or other agencies. The registered manager told us they were unsure of the safeguarding procedure they should follow to refer concerns to the local authority safeguarding team and CQC. We asked them to review their procedures in this area and to submit to us statutory notifications for safeguarding concerns.

All staff were clear about the different kinds of potential abuse, and told us they had received training on how to protect people from abuse or harm. Each staff member was aware of their role and responsibilities in relation to protecting people and what action they should take if they suspected abuse. All staff said if they saw anything of concern, they would tell the registered manager. We found staff had alerted the registered manager to some instances that could be considered 'safeguarding'. For example, one member of staff had raised an issue with the registered manager about a potential theft at the home. However, we found the registered manager had not reported this incident to the safeguarding team for investigation.

It was clear staff had received training in how to 'whistle-blow' and raise their concerns with the CQC, as prior to our inspection visit we had received concerns from a member of staff. We spoke to the provider about some of the concerns that had been raised with us, as this impacted on people's safety at the home. The provider told us they were disappointed staff had contacted the registered manager and CQC about their concerns, but had not contacted the provider directly. They explained they would circulate their contact details to the staff team to ensure they had this information.

We found this was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 .

At the last inspection we found there were not always enough staff to keep people safe and the provider breached this regulation. The provider had been asked to submit an action plan to us to tell us how they would ensure staffing levels were adequate to meet people's needs at the home. They had submitted an action plan to us stating they had recruited three new care staff to increase staff availability. They had also agreed an arrangement with a local staffing agency to provide temporary care staff.

We found staffing levels in the morning at the home had been increased since our previous inspection. The registered manager told us they now employed three to four members of care staff to support people. This was an increase of one member of staff in the morning. We found later in the day staffing levels dropped to two to three members of care staff, with two care staff members working during the night shift. The registered manager told us that sometimes staffing levels dropped, due to staff availability.

At this inspection we continued to have concerns about staffing despite the increase in staffing levels. Our concerns related to a lack of effective management of the shift. For example, during the morning at 7am staff coming into the home for the day shift, and staff leaving the home from the night shift, sat together to handover any relevant information about people's care. However, as all staff attended this meeting, there were no staff to support people in the home. The meeting on the first day of our inspection visit lasted for approximately 15 minutes which had potential to place people at unnecessary risk. On our third inspection visit, when we arrived we saw most of the ancillary and care staff sat in the dining room area having a break at the same time, yet they were not able to observe people in the room because of where they were seated. Effective staff management would have prevented this from happening and more staff would have been able to observe people.

We saw throughout our inspection, staff were not always in place to keep people safe and meet their health

and support needs. For example, there were periods throughout the morning where the lounge and communal areas of the home, where people sat, were left unattended. Several people in the lounge area required support to mobilise, and were not near a call bell to easily request staff to assist them. Other people at the home had limited understanding or communication, and could become confused. At the time of our inspection visit six people required two members of staff to assist them with personal care and getting into bed. Staff said that at certain times of the day such as mornings, they were busy and it was difficult to spend time observing people to ensure they remained safe. We saw during the morning of our inspection visits four members of care staff were on duty. Our observations showed us staff were 'task focussed' and did not always have time or take the opportunity to sit with people and engage them in conversation. We spoke with staff on the third inspection day who said following our last visit, staffing was better. One staff member said, "We use agency now." When we arrived we found there were four care staff on duty, as well as a cook and housekeeping staff. Staff said this worked well and the use of agency staff meant people were supported and encouraged to be more involved.

Prior to this inspection we received information that suggested people were being woken up and dressed which was not in line with their preferred choices. Because of this, we arrived at 6.00am on the first day of our inspection visit. We saw three people were out of bed, dressed and sat in the lounge. We asked one member of staff why three people were out of bed when we arrived, they told us, "It's to help the day staff." Another member of staff told us, "We are forced to do this; we have to get three people up to help the day shift. It makes me feel awful." We raised this with the provider who said they were appalled with this and did not know about this. We discussed this with the registered manager and showed them examples of the handover sheets where they wrote, 'Any three to be got up'. The registered manager said this had been a misunderstanding. Following our inspection visits we spoke with a staff member who shared similar concerns with us about this practice. They said they had to get people up and knew it was in some cases, against their wishes. They said, "I'm disgusted but have to do it."

During the planning of our inspection visit we identified there was a high rate of people developing infections at the home, compared to other homes of a similar size in the area. We brought this to the attention of the registered manager and provider and asked them if they had also identified this. The high rates of infection had not previously been identified as a concern by the registered manager or provider. However, they explained a recent infection control audit conducted by the local clinical care authority had highlighted a number of areas of improvement around the home. Action plans to improve infection control at the home had been drawn up in response to the audit. We asked to see a copy of the audit and the actions that had been taken since its completion in May 2017. The action plan showing which items had been completed was not available on the day of our visit and following a second request, was not provided.

The provider and registered manager had not conducted their own infection control audit at Greenways. We identified a number of infection control concerns when we walked around the home. For example, a downstairs bathroom was dirty, mould was present on the ceiling and floor area, light pulls were dirty, and shower equipment was dirty and laid on the floor. A radiator in this room was rusty. Some furniture at the home required cleaning, as it was soiled and we found one person who was sitting on a dirty pressure cushion, told us, "It does get cleaned, but not often."

The registered manager told us they had not attended recent refresher training on infection control procedures, although they planned to attend a course. We saw from the staff training matrix that staff had last received training in infection control in early 2016.

However, most people and their relatives told us they felt safe at Greenways. One relative said, "[Name] is 100% safe here."

The provider's recruitment process ensured risks to people's safety were minimised, as they took measures to try and ensure new staff were of 'good character.' Two recently recruited members of staff told us they had a DBS check which the home completed and they had to wait for their references to be returned before they were offered employment. The Disclosure and Barring Service (DBS) is a national agency that keeps records of criminal convictions.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection, 'Effective' was rated as 'Requires Improvement' as we found the provider did not always have up to date and accurate assessments of people's capacity so that they could be supported with making decisions, where appropriate. At this visit 'Effective' continued to be rated 'Requires Improvement'.

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. Where people have capacity, a mental capacity assessment is not required. However, we found some people appeared to lack the capacity to make all their own decisions. Mental capacity assessments had not been conducted to establish which decisions they could make themselves, and which decisions needed to be made in their 'best interests.'

We identified one person who had been assessed as having capacity to make their own decisions. However, we spoke with this person on several occasions and some of their statements indicated a level of confusion. We had previously raised concerns about this person's level of capacity with the registered manager at our inspection visit in January 2017 but no assessment had been completed.

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). At our last inspection, the registered manager had limited understanding about restrictions on people's freedoms and liberties. At this inspection the registered manager had not submitted or identified any applications that were required to restrict people's freedoms. As people did not have up to date mental capacity assessments in place to establish their level of capacity, it was unclear whether anyone at the home required a DoLS.

We saw some people were having their movements restricted at the home. For example, some people were unable to move around the home or go out due to the lift being 'out of order' on the day of our inspection visit. Other people told us they needed to seek permission from staff to go out for a walk, and always needed to be accompanied. We saw people had bed rails to prevent them from falling out of bed, other people's movements were monitored by staff as they had pressure mats in place, which alerted staff to when the person moved around their room. We also saw some people had small tables placed in front of their legs when they were seated. This prevented people from standing up without the assistance of care staff. One person we spoke with indicated with hand gestures that they disliked the table being placed in front of their legs, they showed us marks on their legs that had been made by the table, and asked us to move it. We were concerned people may be restricted in their movements by the placements of tables in front of them.

People's consent to some aspects of their care was not being obtained, and people's right to make some decisions for themselves was not being respected. For example, on the first day of our inspection visit we found one person who had been 'got up' by staff against their consent.

Care plans showed that where people had the capacity to consent to their care and treatment they had signed to do so. The registered manager was aware that people's capacity to make some decisions could fluctuate, because of a change in people's health. For example, they explained people's capacity to make decisions could be different if they had a urinary tract infection, as this could cause the person confusion. However, where people had the capacity to sign consent to their care, we found people's relatives had sometimes been asked to consent instead. We brought this to the attention of the registered manager, we explained that family member were unable to 'consent' to care and support unless formal arrangements were made through power of attorney for them to do so. The registered manager agreed to change care records to reflect that family members were 'consulted' about certain decisions.

At our previous inspection we had identified the registered manager did not hold copies of power of attorney documentation where these were in place. We found during this inspection the registered manager had requested copies of these types of documents from relatives, and some were available for review in people's care records. The registered manager now recognised the importance of ensuring relatives had the legal right to make health and financial decisions on behalf of people living in the home.

We found this was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 .

People had mixed opinions about the quality and choice of food provided. One person told us, "We are happy with the food" and, "The food was good today, I have poached eggs on toast for breakfast." Other comments people said about the food were, "The food can be a bit repetitive," and "If you wanted fish and chips, or an alternative, you wouldn't get it."

The atmosphere in the dining rooms was calm. Tables were laid with cutlery and table mats and provided a pleasant environment where people could enjoy their meal. The mealtimes were a sociable experience for people in the dining room, people sat and chatted together. People were offered a range of drinks when they sat down to eat their meal, including hot drinks and wine.

The cook told us, and we saw, they had informed people of the choices on the menu that morning by asking people at breakfast what they would like to eat. We saw the cook ask two people for their meal choice, one person chose an omelette, another person chose to eat chicken. The person who chose omelette then realised the chicken was a chicken roast dinner and changed their mind. The cook promptly changed their order. However, food orders were taken at breakfast time, and by lunchtime some people said they could not remember being offered a choice. We noted there was no menu on display at the home for people to refer to. During the first two inspection visits people were not shown visually what food choice was available to them, before they made their 'main meal' decision although they were later shown a choice of dessert. It is important that people with short term memory loss or dementia are shown visual choices of food to be able to make an informed choice and to understand the options available to them. During the third inspection visit, plated meal options were shown to people.

The cook knew people well and knew what people liked or disliked. They demonstrated this when serving food to people, saying to one person, "You don't like custard do you?" and the person agreed. We observed two mealtimes during our inspection visit. We spoke to some people about their experience of breakfast at the home. One person told us, "We have to come down to breakfast in the morning about 8-8.30am. They [staff] like us to be dressed and breakfasted by a certain time." They added, "We can't have breakfast in our room because we are able to get dressed ourselves, they expect us to eat in the dining room." However, we saw some people who were cared for in bed had breakfast in their room. The registered manager told us people could choose where to eat their breakfast.

One person told us their preference was to eat in the dining room, but they were not regularly supported by staff to do this. On the day of our inspection visit the lift to take them downstairs to the dining room was out of order, so they were unable to go downstairs. They told us "I did not know the lift was out of order." They showed us how they ate their meal saying, "I don't like trying to eat from a tray on your lap, you move and everything slides around." We were unsure why the person had not been offered the use of a table to eat their meal.

New staff completed an induction when they started work at the home. This induction included new staff working alongside more experienced staff to gain the practical skills they needed to support people. A training programme was in place that included courses that were relevant to the needs of people using the service.

Staff told us they had regular training to ensure their skills were maintained. At our last inspection the system to improve training records was discussed with the registered manager who assured us they would update their training records, so they knew when refresher training was due. We asked to look at training records to help us determine what training staff had received. We found the registered manager had set up a staff training database showing the training staff had completed, and when refresher training was due although this was not accurate. The database had last been updated in April 2017.

We found there were some areas where staff needed to complete refresher training at the home, which had not yet been organised by the provider. For example, no first aid training had been provided to staff since 2010, health and safety refresher training had not been provided since 2010 for some staff. The registered manager had not updated their infection control training, although a recent infection control audit had shown a number of improvements that needed to be made in this area. In addition we saw from the training matrix not all staff had attended certain essential training such as manual handling, and safeguarding training. One member of staff told us they did not think their safeguarding training was useful, as they continued to do things the way it had always been done, regardless of what the trainer said on the courses they attended. Therefore, we had limited confidence staff had received essential training when required, or their practices were being monitored and assessed by the provider to ensure staff put into practice what they learned.

People were referred to other healthcare professional if there was a change in their health. Care records included a section to record when people were visited, or attended visits, with healthcare professionals. For example, people were able to see their GP, dietician, chiropodist and dentist when required. Details of GP visits were recorded, together with the outcome of the visit, medicine prescribed and whether the family had been informed. However, some staff raised concerns with us that one person requested a GP numerous times and they had asked on behalf of this person, for a GP to be contacted. We were unable to speak with this person so checked records and found written requests were made for a GP to be contacted, but GP visits did not correspond with those requests. The person subsequently saw a GP and was referred to a hospital for tests.

Requires Improvement

Is the service caring?

Our findings

At our last inspection, 'Caring' was rated 'Requires Improvement' because people's privacy was not always protected. At this visit it continued to be rated 'Requires Improvement'.

We arrived at the home at 6.00am on the first day of our inspection visit because of concerns we received. This was because we had received information that staff were instructed by the registered manager to get 'any three people up' and dressed before the daytime staff arrived at 7.00am. A staff member told us this was to ensure daytime staff had less people to get up each morning before breakfast. During our visit we found information written by the registered manager at the handover staff meeting on the 6 June 2017 which stated 'any three residents up in the morning now please'. Other handover records seen also recorded this information.

We found three people out of bed, dressed, and eating their breakfast at 6.00am. Two of the people were unable to speak with us to tell us whether they had asked to get up, but one person told us, "I don't want to be up, it's too early." The person started crying. A member of staff told us about another person saying, "[Name] has been upset when we got them up early, I have apologised." We found that the person the member of staff had referred to was also one of the three people who were having their breakfast when we arrived. All three people went to sleep in their arm chairs after their breakfast. One of the people was asleep until after lunchtime. None of the staff assisted any of the three people to get back into bed, although they were obviously tired.

We brought this to the attention of the registered manager and provider during our inspection visit. The registered manager apologised and said this had been a misunderstanding with staff, they had only intended that people should be got out of bed if the person wanted to. They stated they were clear, to offer a person centred service, people should be given choices about when they went to bed and when they got up in the morning.

At the previous inspection visit, we had concerns people's privacy was not always maintained. For example, a chalk board displayed people's names with dates when their medicines were due for change. We found on this inspection we continued to have concerns about people's privacy. We found care records and medicine administration records were open and left out in the communal areas of the home. This meant visitors and people who used the service could read personal information about people at the home.
Some people told us they felt staff were caring and kind. One person told us, "It's a little community. Staff showed real compassion to me recently when I lost a family member." They added, "I would not want to go anywhere else, definitely not." One relative commented, "I think the home is amazing, think the team are amazing, friendly, welcoming and amiable."

However, other people told us they would like staff to act differently around them. One person told us, "I don't like the staff being noisy, they say it's because people are deaf. 'Let's be having you' is what they say; I'm not sure about that." Another person said, "Some staff are rude. For example they have said to me "You stupid woman." One person told us, "They [staff] don't call me by my preferred name, I would like to be

called by my full Christian name, but they shorten it or call me Mrs." The person later told us, "I am not given the choices I want, like when to get up." One person told us they were concerned to ring their bell, dependent who was on duty but said most of the staff were considerate.

During our visits we saw staff spoke to people in a kind way when they assisted them with a task. However; we noticed opportunities for social stimulation were not always recognised or responded to by staff meaning that people sat for long periods of time with little or no interactions. On a number of occasions we saw staff walk through communal areas where people were sat without acknowledging them.

Where possible, people were supported to be as independent as they could. For example, one person was able to walk independently with a walking frame. We saw staff walking by the side of the person, encouraging them to use the frame rather than be assisted by staff.

Relatives and visitors told us they could visit whenever they wanted and said staff always made them feel welcome and offered them a drink. During two days of our inspection visit, relatives and visitors arrived at the service and spent time talking to the people they came to see. We saw when visitors arrived, people became more alert and engaged and were pleased to see them. One person told us their family visited them each week, and they could come when they wished. This helped people maintain relationships that were important to them.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection visit, we rated 'Responsive' as 'Requires Improvement' as people were not always offered the stimulation they required to support their wellbeing and care records were not always up to date to provide staff with information about people's life history and preferences. The home continued to require improvements in these areas.

We received mixed feedback from people about whether staff met their individual needs and preferences. One person told us staff looked after them well. They explained they knew a member of staff before coming to the home, and they felt staff understood their individual needs and preferences because of this. We saw on the first day of our inspection visit staff brought the person some books to read. The person told us, "I read a lot, to keep busy."

We saw when people called out for help, staff responded. One person asked for a cup of tea, after getting staff's attention, the staff member came back with a cup of tea within five minutes. People told us they would like more social interaction, and more activities to be available at the home. One person told us, "There isn't much going on to do." Another person told us, "I would like to go downstairs more often." Other comments included; "I like to go for a walk, but I need to have someone with me, which isn't always possible", "My son takes me out, not staff", "My friends come and take me out. I would like to go out more often." This was also identified as an area for improvement in a recent customer satisfaction survey that had been undertaken at the home.

From speaking with people and our observations on two inspection days, we could not be sure action was taken to ensure people who stayed in their bedrooms were not isolated socially. We found this was a concern on our previous inspection. In the afternoon at the home we found some staff were less busy than in the morning. There was no activities co-ordinator to arrange events and support people with their hobbies and interests at the home. However, we saw staff sat in the communal lounge area with people and chatted, played games and listened to music. On one afternoon staff danced the 'Oaky Coaky', on another day staff helped people take part in exercises. The registered manager had also organised a trip to take people out to a local school for a cake and coffee. On the third inspection visit we found some people and staff mid-morning played 'Play your cards right' in the communal lounge.

One person told us they would like to see activities and events advertised on a timetable at the home, so that they knew when things were happening. The person told us, "We have people come in and offer us communion, it's not always the same day or time when they come and staff forget to tell you. It would be good to have a noticeboard with what's happening on." We saw there was a monthly timetable displayed in the communal area of the home, however, this was handwritten and did not provide people with times or details of activities and events. The provider recognised this was an area for improvement and wanted to get feedback from people and relatives. The provider's action plan agreed to keep a 'comments book' in the hallway, which was present during our inspection visit. No-one had written in the comments book. We found the registered manager had organised a meeting involving people who lived at the home to discuss activities on offer.

We found people's care records were not always up to date and accurate. For example, we identified people did not always have up to date records of the personal care each person received. Some records of people's care only showed whether care and support had been provided to people during the day or at night, and did not give a time of the support provided (for example when people had a shower or bath). Care records did not provide guidance so that staff could offer a consistent approach to meeting people's needs. We were concerned, for example that people did not always have a choice of the time to get out of bed in the morning or where their meals were served.

People were assessed before they moved to the home to ensure their needs could be met. However, there was inconsistency in the level of personal information obtained about people. People's records did not always have detailed information about their background, formative years, family, work life, interests and hobbies. There was not always consistent information on people's preferences, likes and dislikes so staff knew how to provide care in a way that met the person's individual needs and preferences. This information is vital to provide person centred care based on people's likes, dislikes and taking into account their past experiences.

Staff attended a daily 'handover' meeting at the start of their shift to exchange information about people at the home. Staff told us this assisted them in keeping up to date with people's health and care needs. These handover records were used to communicate important messages. Some staff said they used to reinforce verbal messages which they felt were not responded to quickly enough. For example, we found some staff used these to request GP appointments for people. Handover records in May 2017 stated one person wanted to see a GP three times, yet the persons care records showed this was not done until June 2017. We spoke with staff about this but they were unclear whether GP support was given at the time stated in the handover. We couldn't speak with the person as they had recently passed away. One handover sheet for May 2017 recorded, 'Could [name] have a painkiller left out please?' Staff told us some night staff were not always medicines trained so we could not be certain medicines were given safely or that people's health and welfare was responded to safely.

There was information about how to make a complaint or provide feedback about the service available in the reception area of the home. People and their relatives told us they knew how to raise concerns with staff members or the manager if they needed to. One relative told us, "[Name] would tell me if they were unhappy, I would tell the manager then." We saw a recent complaint had been made regarding staff interaction with a person's relative. The complaint had been recorded and investigated by the registered manager. We asked the registered manager if any learning had been taken from the complaint, they told us they had not reviewed this incident to determine any learning from the issues raised. They told us the family of the person was satisfied with their response. They added this was the only complaint they had received, and therefore no monitoring or analysis systems were in place to monitor complaints for any trends and patterns.

Inadequate

Is the service well-led?

Our findings

At our last two inspections we had found a number of concerns and had asked the provider to take action. We rated the service 'Inadequate' in January 2017, and the service was placed into 'Special Measures'. We had identified a breach under regulation 17 as systems or processes were not robust, established and operated effectively to ensure risks to people were reduced and to provide a good quality service to people. Following the inspection in January 2017 we had also met the provider and registered manager to help them understand why we had rated their service 'Inadequate'. At this meeting they gave us assurances they were committed to make those improvements.

At this inspection visit we continued to find a breach in regulation 17 Good Governance. In addition the local authority who commissioned some peoples services at the home had agreed with the provider following our January 2017 inspection that a voluntary placement stop would be in effect until the service improved. This meant the provider had agreed to take no new people at the home for the time being. When we conducted our inspection in June 2017 we found the provider had admitted self-funding people and another person who was booked to go in August 2017 for respite care. We raised this issue with the provider, they told us this had been a misunderstanding, and assured us no new admissions would be allowed at the home until further improvements had been made. However, in their written response to us post inspection they said this person was already booked in. We have written to the provider and we have asked them for assurance this person will not be able to stay in the home until sufficient improvements have been made.

Following our visit in January 2017, the provider sent us written information about how they would improve the service. This 'action plan' told us they would send out questionnaires seeking feedback from people who used the service and document the feedback they received. From the feedback and other checks on the service they intended to formulate an annual performance plan to review and improve performance, and to hold weekly management meetings with the provider and registered manager. We found the provider and registered manager were meeting weekly.

Following our initial visit to the home on 28 and 29 June 2017, the provider sent us written information about some improvement that had been made following our visit. Because the provider's response lacked detail and timeframes, we returned on 27 July 2017 to see what measures had been implemented following our initial feedback to them on 29 June 2017. We found the service was not well led and systems to monitor the quality and safety of care people received were not effective. The provider's own quality assurance systems failed to identify areas of concern we found during our inspection visit that affected the delivery of care. We continued to find the risks to people's health and well-being had not always been assessed appropriately to ensure people were safe. We continued to find that medicines were not being managed safely.

During our preparation for our inspection visit in June 2017 we looked at the statutory notifications that had been sent to us by the registered manager and provider. A statutory notification is information about important events which the provider is required to send us by law. At our previous inspection we found the registered manager and provider did not always notify us of important events as they should. On this

inspection we continued to find this. For example, the registered manager was required to notify us of the lift not working, as this affected the care and service offered to people. The registered manager told us they were unaware they should notify CQC of these types of events. We were concerned the registered manager was not notifying us or the local safeguarding team about some important events that occurred at the home, especially those which may have required investigation to ensure people were supported safely at Greenways.

We checked food stocks that were in use in the kitchen, because at the last inspection we found food was kept beyond its 'best before' and 'use by' dates. On the first day of our inspection visit we found chicken and bakery products had gone past their 'use by' date and were being prepared for people to eat. The cook assured us that this was because the food had been frozen when purchased, and had been removed from the freezer to defrost the day before. The cook assured us out of date food would not be given to people. We provided feedback to the registered manager and provider regarding the labelling of food during our inspection visit. We were concerned that procedures for the correct labelling of food had not been implemented following our inspection visit in January 2017. We checked food stocks again on the third inspection visit. Some foods were now being labelled, although bread taken out of the freezer was not being labelled. The cook said, "We get through it quickly so we don't label it." We found bacon wrapped in cling film was dated, however the date used was the date it started to be consumed. There was no known expiry date so staff could not be certain it remained in date. The cook agreed to complete this, however it demonstrated to us the lack of oversight and knowledge of staff to take initiative to make sustained improvements.

At our previous inspection in January 2017 we saw a full copy of the previous inspection report was displayed on the 'residents' noticeboard in the lounge area of the home, however, this did not fully comply with the regulations and the provider's legal duty to display their ratings. It is a requirement of the regulations for the provider to display their overall rating in a conspicuous location for visitors and anyone entering the home to see the current rating of the service. We discussed this with the registered manager who told us this was an oversight and assured us they would display the correct ratings poster following our visit. However, at our inspection in June 2017 the provider and registered manager had still not rectified this, and there was no rating poster on display in the home.
However, the ratings poster was displayed in the communal hallway when we returned on 27 July 2017.

The registered manager explained they had been working hard since the last inspection to improve standards at the home. They and the provider said they believed the home had improved. For example, they had arranged more contact with the deputy manager so that some of their working days overlapped, this was to exchange information and work together on improvements. The registered manager explained they had increased their working hours since January 2017, as they previously had not worked on a Wednesday, to concentrate their efforts in improving the service. This contradicted what some staff had told us so when we returned on 27 July 2017 we checked the staffing rota's in the management office for the period from 24 July 2017 to 3 September 2017. These rotas showed at no point did the registered manager and deputy manager share or overlap the same shift and the rotas recorded the registered manager as 'off' every Wednesday. Staff told us the deputy manager completed the rota but we were unable to speak with the registered manager or deputy manager to discuss this further.

The registered manager told us they felt their training and skills had not been kept up to date since they started work at the home several years ago, and they were trying to update themselves about their regulatory responsibilities and their role. We asked whether the registered manager had the authority to make improvements. They told us they did not control the budgets and had no control over purchases at Greenways. They said all identified actions and improvements needed to be agreed by the provider.

At our previous inspection visit we found that staff training had not always been provided to staff, to ensure they supported people safely and effectively. Although some staff training had been updated since our last inspection, and the registered manager had a database in place which recorded when staff attended training, we found some improvements around staff training still needed to be made. Some staff still required training in essential areas such as first aid, health and safety, and infection control procedures.

At our inspection in January 2017 we found some people's care records were not up to date, and did not describe how staff should care for people in the way they preferred. At this inspection we continued to find that care records were not always up to date and consistently completed by staff. We also found that confidential information was not always stored securely at Greenways.

We found the registered manager was not always following the principles of the MCA to obtain people's consent to some aspects of their care. People did not always have up to date mental capacity assessments in place where these were required, and the registered manager was not assessing the restrictions on people's care.

We were concerned at the number of falls people had, and the lack of effective and proactive analysis of those accidents and incidents that placed people at risk. For example, the registered manager had not completed monitoring and analysis into the number of falls people had. From our own analysis we did before this inspection, we found there were more than twenty unwitnessed falls in April 2017 and there were no records to support what action was taken to minimise further incidents or to keep people safe. In June and July 2017 we found all of the recorded falls up to 27 July 2017 were recorded as unwitnessed with no information about what, if any actions were required to prevent further incidents occurring.

The registered manager told us they used an improvement plan to improve the quality and safety of service provided. This was an action plan they had drawn up for the local authority, who had also recently inspected Greenways. The registered manager explained they had an action plan from a recent infection control audit that had been undertaken at the home. We asked the registered manager to see the action plans, these were available for us to review, however the registered manager had not documented which actions had been completed. There were no time frames on the action plan to indicate when all the actions would be complete. We requested the provider and registered manager to submit this information to us following our inspection visit but we had not received them.

We continued to have concerns regarding the management of staff. Staff told us staffing levels had increased however the management of those staff on shift from our observations was not effective. We found staff sat together having a break with some communal areas of the home not being observed. When emergencies happened such as a broken lift, there were no plans in place to redistribute staff or increase checks on people. During one handover we saw all staff discussing how people were which meant for 15 minutes staff were unavailable to support people or be responsive to people's requests for help. We asked the registered manager whether they had introduced a dependency tool to determine how many staff they needed at certain times of the day or on each shift to care for people according to their needs. They told us they did not use a dependency tool to establish staffing numbers; they continued to use their own judgement and experience of the home to determine how many staff were needed.

Speaking with the registered manager and reviewing their audit systems we identified a lack of proactive management and leadership which affected the quality of service. Effective systems to monitor safety checks were not in place. Some fire safety checks were not completed which had potential to place people and staff at risk, in the event of emergency. The registered manager said the provider visited once a week and completed environment audits, however the provider told us environment audits were completed of

the outside of the premises, not the inside. No records of these audits were available for us to review. Medicines audits when completed had not identified where medicine administration required improvement. The registered manager was however completing a fortnightly review of people's care at the home, and reporting risks and actions taken around people's care at the home. This was shared with staff to keep them up to date in a report.

This was a continued breach from our inspections in March 2016 and January 2017 of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most of the staff said they received individual meetings with the registered manager, but these were not frequent although staff said if they had a concern, they would approach the registered manager without delay. Staff said one to one meetings when held, were useful and the registered manager acknowledged they were not always completed at the required intervals. On 27 July 2017 some staff said they were having supervision meetings which supported what the provider had told us.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent (1) The provider had not ensured the care and treatment of service users was provided with the consent of the relevant persons.

The enforcement action we took:

We issued the provider with a condition on their registration, to restrict admissions to Greenways Care Home until further notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment 12(1)(a, b, c, g)The provider did not ensure that care and treatment was always provided in a safe way for service users. Risk assessments were not always in place, and some risks were not mitigated. Staff did not always have the competencies they needed. The provider did not ensure the proper and safe management of medicines.

The enforcement action we took:

We issued the provider with a condition on their registration, to restrict admissions to Greenways Care Home until further notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment 13 (1) The provider had not ensured systems and processes were established and operated effectively to protect people from the risks of potential abuse or poor practice.

The enforcement action we took:

We issued the provider with a condition on their registration, to restrict admissions to Greenways Care Home until further notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance 17(2) (a, b, c, f) The provider had not ensured systems and processes were established and operated effectively to ensure the quality and safety of the service provided was assessed, monitored and where relevant improved. Risks were not always identified and mitigated. Records were not accurate, secure and completed in respect of each service user.

The enforcement action we took:

The registered manager had been issued with a notice that we intended to cancel their registration. They have not appealed against this notice, and we have therefore removed them from our register.