Horizon Care (Greenacres) Limited

Greenacres Grange

Inspection report

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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 well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Greenacres Grange is a care home which provides personal and nursing care for up to 80 people. At the time of the inspection, the home had 38 people living there.
Greenacres Grange is a purpose-built care home which accommodates people across four separate wings, each of which has separate facilities. One of the wings specialises in providing care to people living with dementia.

People's experience of using this service and what we found
People had not always received their prescribed medicines on time because the care home sometimes ran out. People were not always protected from the risk of developing pressure wounds, because the staff did not always help them to reposition at the required intervals.

People had not always received the individual continence aids they required, because the care home sometimes ran out. People, who wore continence pads, had not always had them regularly checked and changed.

Staff preparing and administering medicines to people did not have easy access to hand washing facilities, because the provider had not installed hand washing sinks into the nursing stations/clinical rooms. The care home was generally clean, and there were no unpleasant odours.

People were not always supported by enough staff to meet their care needs. The provider's quality monitoring systems had not always led to effective action being taken to improve things.

People did not always have suitable care plans in place to guide staff and had not always received the 1:1 support they needed. People's diet and nutrition was not always well supported, and the availability of preferred drinks and snacks had sometimes been limited, in the evenings, when the main kitchen was closed.

The design and decoration, of some parts of the care home, was not homely and was not in line with best practice guidance on living environments for people who have dementia.

The provider had not worked in effective partnership with the local authority and had not shared requested information with safeguarding social workers in a timely manner. The provider had not always been open, honest and transparent with people's relatives when serious injuries had occurred.

Staff morale at the service was low and there had been a succession of temporary managers recently appointed which had unsettled the staff team and had raised the anxieties of some people's relatives.

People were supported to have maximum choice and control of their lives and staff supported them in the

least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

People's individual equality and diversity characteristics were recognised in their care plans, and staff understood how to meet those needs. People had their mental capacity assessment needs met, and where restrictions were in place, they had been appropriately authorised.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was Requires Improvement (published 26 April 2019).

Why we inspected
We received concerns in relation to the management of medicines, staffing, person centred care, infection control and the management of the service. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from Requires Improvement to Inadequate. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe, effective and well-led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Greenacres Grange on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment, person-centred care, governance processes, staffing, and the duty of candour, at this inspection. Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe, and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of the registration.

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.

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.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Greenacres Grange

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection team included an inspector, an assistant inspector, a nurse specialist advisor 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. The Expert by Experience supported the inspection by telephoning a sample of people's relatives to obtain their feedback on the care home.

Service and service type
Greenacres Grange is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The registered manager was on long term absence from the care home at the time of the inspection, and the provider had arranged for an interim manager to support the service.

Notice of inspection
This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with seven people who used the service, as well as nine staff members including, healthcare assistants, nurse assistants, registered nurse, quality compliance manager, manager, regional manager, and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also observed interactions between staff and people at mealtimes. We reviewed a range of records. This included 19 people's care records (in whole or in part), risk assessments and multiple medication records. We looked at three staff files in relation to recruitment and pre-employment checks.

After the inspection
The Expert by Experience spoke on the telephone with 12 relatives of people who used the service, and we received feedback from two other relatives by email. We received feedback on the service, by email, from nine members of Greenacres staff. We received feedback on the care home from local authority social care commissioners, social workers, district nurse team, GP practice, community pharmacist, clinical commissioning group (CCG), community chiropodist and the CCG infection prevention and control team. A variety of records relating to the management of the service, including policies and procedures, were also reviewed. We looked at training and quality assurance data and continued to seek clarification from the provider to validate evidence found.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

● People did not always receive their prescribed medicine. Records showed the provider sometimes ran out. This meant people were not always protected from risks associated with medicines that were not administered as prescribed. This was raised with the provider during the inspection, who made immediate arrangements for any missing medicines to be obtained for people.

● Staff were not always suitably trained to use the provider's electronic medicine administration record (eMAR) system. The lack of training increased the risk of the care home running out of people's medicines.

● The administration of people's prescribed topical skin cream medicines was not always recorded. Recording was not consistent, and it was not always possible to check whether people had received their skin creams as prescribed.

Assessing risk, safety monitoring and management

● People were not always protected from the risk of developing pressure wounds. People were not always repositioned at the intervals they required. That meant people were at increased risk of developing pressure wounds.

● People did not always have access to the continence equipment they required. Staff also told us the care home often ran out of people's individual continence pads and had to borrow pads from other people. That was discussed with the manager who told us they would review their reordering system.

● People's continence care needs were not always met. For example, a person known to be at high risk of skin integrity breakdown did not always have their continence pads checked and changed at regular intervals. That meant they were at increased risk of harm.

Preventing and controlling infection

● People and staff were not always protected from the risk of health infections. There were no handwashing facilities in the clinical rooms/nursing stations. The provider stated installation of those facilities had been delayed by the COVID-19 pandemic. However, handwashing facilities should always have been in place.

● Recognised infection control guidance was not always followed. The provider had not ensured the hot water temperature at the non-handwashing sinks in the sluice rooms, commercial kitchen and laundry were in accordance with recognised safety guidance. That meant there was an increased potential for the spread of health infection in, and from, those areas of the care home.

● Clinical waste storage arrangements were not always hygienic. During the inspection the external clinical waste bins were overfull, with lids unable to be closed; creating a potential infection hazard. This was raised with the manager and the waste removed that day. The nominated individual subsequently told us the issue had been addressed and would not be repeated.

The provider failed to ensure that safe care and treatment was adequately assessed and that they were doing all that was reasonably practicable to mitigate any risks to people using the service. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had implemented measures in response to the COVID-19 pandemic and we were assured that staff were using personal protective equipment effectively, that people and staff were being tested for COVID-19 appropriately, and that the provider was meeting shielding and social distancing rules.
● People lived in a care home which was generally clean and tidy and there were no unpleasant odours.

Staffing and recruitment
● People were not always supported by enough staff to meet their assessed care needs. The provider used a dependency assessment tool to determine the number of staff required to support people. However, rota records showed that, between 1 October 2020 and 18 November 2020, there were 11 days when there were less staff on shift than the minimum identified as being required by the provider.
● People's care and well-being was affected negatively when the care home was understaffed. A staff member told us, "A lot of our residents lost weight because we were short of staff and they didn't have time to monitor every ones diet intake, and encourage diet and give snacks."
● People's relatives gave us similar feedback. Some relatives told us staff levels were a concern and that many experienced staff had left. For example, a relative told us, "(My family member) says there were loads of staff initially but now we have the impression staffing levels have gone down over the past months. On many occasions they tell me there are only two members of staff on duty on their wing." This meant people were at increased risk of not receiving the care they required.
● Some people received support from staff who did not understand how to meet their specific needs. For example, the provider had failed to ensure staff had received training necessary for them to effectively support a person who had specific support needs. A relative told us the staff didn't understand their family member's needs, that they were not getting their specific support needs met, and that it was affecting their well being.

The provider failed to ensure that enough suitably qualified, competent, skilled, and experienced staff were deployed to meet people's care support needs. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were supported by staff who were safely recruited. The provider had an effective recruitment policy and procedure, and pre-employment checks were routinely carried out.

Systems and processes to safeguard people from the risk of abuse
● The provider had arrangements in place to provide safeguarding training to staff, and copies of the provider's safeguarding policies and procedures were available for staff to refer to. This helped to ensure staff were aware of their individual responsibilities to report safeguarding issues.
● The staff team did not always receive feedback on how incident reports were dealt with by the provider, and opportunities to share learning from safeguarding incidents or accidents, with the staff team, were missed.
● The provider's safeguarding policy and procedure document contained incorrect guidance for staff, in that it directed them to contact the wrong local authority about any safeguarding concerns. This meant the provider's safeguarding policy and procedure document did not support staff appropriately and had not been effectively reviewed by the provider. This was raised with the provider who subsequently told us they had amended the policy and procedure document, so the correct local authority details were shown.

Learning lessons when things go wrong

● Opportunities to learn lessons when things had gone wrong had been missed. Previous audit reports from the CCG infection prevention and control team had identified issues which required improvement, but the provider had not taken all the necessary action.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People did not always have appropriate care plans in place. This meant care staff were not always effectively guided on how to support people to prevent the recurrence of prior medical conditions; or were unaware of important information about the person.
- People did not always receive the support they required. For example, a person was assessed as needing regular 1:1 support from staff who were familiar to them. The person's relatives told us the person did not always receive the amount of 1:1 support they needed and that negatively affected the person's wellbeing; which had also then had an impact on the wellbeing of other residents.

Supporting people to live healthier lives, access healthcare services and support; Supporting people to eat and drink enough to maintain a balanced diet

- People did not always receive consistent support to manage their diet and nutrition. Referrals to a Dietician for specialist nutritional support were not always made when people had significant unplanned weight loss. Advice from the District Nurse team was not always followed. This meant people were at increased risk of their diet and nutrition needs not being met.
- Staff told us that during the night, people did not always have access to their preferred drinks and snacks, which may help them to maintain their weight. This was raised with the interim manager who confirmed that the main kitchen pantry was locked at night. The interim regional manager told us they would arrange for preferred snack/drink items to always be available for people at night.

The provider failed to ensure the care and treatment provided to service users was appropriate, met their needs and reflected their preferences. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs

- The design and decoration of the living environment was not always in line with best practice for people who have dementia support needs. The nominated individual told us they believed the decoration of the living spaces was appropriate. However, the communal areas of the upper floor of the care home were blandly decorated, with little personalisation, or objects of interest, for people to engage with. A staff member told us, "It just isn't homely here. There are some parts of the units that feel like you are sat in a doctor's waiting room."
- The design of the building did not always support people to have a restful night's sleep. A staff member told us the building was noisy at night and that it was not possible to dim the lighting sufficiently to support

people, who may have dementia, to recognise that it was night time.
● Some people were not happy living in the unit they had been placed in. A person, told us, "I am the only one in [this part of the care home] who is compos mentis. I've got no one to talk to. It's really depressing in here." This was raised with the manager who agreed the person would benefit from being placed in a different unit within the care home. The nominated individual subsequently told us the person had declined the opportunity to have their meals in a different part of the care home.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● People had appropriate mental capacity assessments in place within their care notes. They covered various aspects of their care support needs and demonstrated whether the person had the capacity to make decisions about those areas. People were supported to make their own decisions where they were able to.
● The provider had made the necessary applications to the local authority when it had been determined it was in a person's best interests to be deprived of some aspects of their liberty. For example, where it had been identified a person would not be safe if they left the building without being supported.

Staff support: induction, training, skills and experience
● Not all staff had received appropriate supervision. The provider had a supervision process in place, but it was not being consistently used with staff. A staff member told us they had never had a probationary meeting, or a supervision meeting, since they started work at the care home. However, some staff told us they recognised the recent changes in managers, and senior staff, had reduced the opportunities for regular supervisions.
● With the exception of training about people's specific support needs, and eMAR training (as mentioned in Safe above) the provider's training
records showed that staff had received the necessary training to safely support people.

Staff working with other agencies to provide consistent, effective, timely care
● Staff did not always work in effective partnership with other agencies to ensure people received the care they needed. For example, there had been delays in obtaining Dietician advice and in obtaining people's prescribed medicines from the community pharmacist. That meant people's care needs were not always met.
● Some people in the care home wanted to move into another type of accommodation. A person told us they wanted to move back to the area they originated from, and to live more independently. The nominated individual told us they would work with the individual, and their social worker, to support that move.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The provider's governance systems had not led to effective action to mitigate identified risks to the health and safety of people. The provider's medicines audits had identified problems with the reordering of people's prescribed medicines but had not led to the necessary improvements. We found missed medicine incidents still occurring when we inspected, which placed people at increased risk of harm.
- Opportunities to learn from mistakes were missed. The provider reviewed an incident in which people had not received their prescribed medicine. The provider determined the problem lay with the GP's and community pharmacy's prescription ordering processes. The provider did not initially identify problems in their medicine re-ordering processes and that staff did not fully understand how to use the eMAR system correctly. That meant incidents of people missing doses of their medicines had continued to occur.
- The provider's quality governance systems had not identified when poor care was being provided. Care records, such as repositioning and continence care records, had not been regularly reviewed. This meant people had continued to be at risk of receiving poor care.

Working in partnership with others

- The provider had failed to share requested relevant information, such as about incidents or risks, and copies of care records, with the local authority safeguarding social workers in a timely manner. This meant the provider had impeded the local authority in the exercise of its duty to safeguard people from potential abuse and harm.

The provider failed to establish effective systems to assess, monitor and improve the service quality and safety of the services provided to people. The provider had also failed to share relevant information about safeguarding incidents with the local authority in a timely manner. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The provider had not been open with relevant people in respect of serious injuries sustained by people. For example, a person fell and sustained a serious injury. Their relative told us, "Despite requests for further details, we received no further information and discovered recently that the Care Home did not log the incident and that, in the words of the Home itself, there is no record and no one left who can remember anything."

● The provider had not been open and transparent with CQC. We requested details of the provider's investigation into an incident where another person sustained a serious injury. The provider sent us a copy of their report and a copy of a letter they stated had been sent to the person's relatives to give details of their investigation findings and lessons learned. However, the relatives told us they had received no letter from the provider and had been requesting information about the incident, from the provider, without success.

The provider failed to act in an open and transparent way with the relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity. This was a breach of Regulation 20 (Duty of candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● The provider had not created a positive culture. One staff member told us, "Some of the management are rude and unapproachable. They show no respect to the workforce and when they are under pressure take it out on them." Another staff member told us, "I will be truthful with you; the staff morale right now is at an all time low."

● Support for staff from managers had been inconsistent. Recent changes in management at the care home had a negative impact on some staff members. One staff member told us, "We have just had so many managers. I never know who I am going to be reporting to, they have changed so often." This potentially increased the risk of poor care being received by people.

● Some staff told us they felt unsupported by the provider. One staff member told us, "It is the owners that seem to block things from being sorted out. The owners do visit sometimes, but they just walk past you in the corridor and never make eye contact or say hello." This was not supportive of an open, inclusive, culture.

● People and their relatives were not always informed about management changes at the service. A relative told us, "I don't know who the manager is – they don't keep us informed". That increased some relatives' anxiety about how the service was operating and the care their family members received.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The provider regularly sent out satisfaction surveys to people living in the service, staff, relatives and external professionals. However, they told us that the response rate was low. The provider had not been successful in finding other effective ways of obtaining feedback from those stakeholders about the service.

● Some relatives told us it was difficult to get through to the care home on the phone, that the phone often diverted to the provider's Head office, and that calls were not always returned. This hindered effective communication with relatives about people's care.

● The provider had an appropriate equality and diversity policy in place and staff received training in how to ensure people's equality characteristics were considered when providing care to them.

● Details of people's individual equality and diversity characteristics were recorded in their care notes and taken into account when care was being planned.

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
Treatment of disease, disorder or injury	The provider failed to ensure the care and treatment provided to service users was appropriate, met their needs and reflected their preferences. That was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider failed to establish effective systems to assess, monitor and improve the service quality and safety of the services provided to people. The provider had also failed to share relevant information about safeguarding incidents with the local authority. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour
Treatment of disease, disorder or injury	The provider failed to act in an open and transparent way with the relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity. This was a breach of Regulation 20 (Duty of candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure that safe care and treatment was adequately assessed and that they were doing all that was reasonably practicable to mitigate any risks to people using the service. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We issued a Warning Notice to the Provider

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure that enough suitably qualified, competent, skilled, and experienced staff were deployed to meet people's care support needs. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We issued a Warning Notice to the Provider