Flintvale Limited

The Green Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

This unannounced comprehensive inspection took place on 16 and 17 May 2017. We last inspected this service in December 2016 when we looked specifically at the three key questions of safe, caring and well led.

We undertook the inspection in December 2016 to ensure that shortfalls we had identified in our last comprehensive inspection had been fully addressed. In December 2016 we found that the registered manager and registered provider were ensuring people received support that was safe and caring. However we found further improvements were required to ensure the home was well led. At this inspection in May 2017 we found that people could no longer be confident they would receive safe care and that the improvements that had started to increase the effectiveness of monitoring systems had not been sustained.

The Green Nursing Home is registered to provide nursing care to up to 59 older people who may also be living with dementia. At the time of our inspection there were 56 people living at the home. The home has a registered manager and they were present throughout our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Feedback from people living at The Green and their relatives was that they felt safe at the home. People went on to describe the kind and caring interactions they experienced from staff. We saw individual staff supporting people with kindness and compassion. However we had concerns about the management of people's medicines, staff were not always available at the times people needed them, action had not been taken to protect people from injuries and incidents of a safeguarding nature had not always been reported.

People were offered and supported to eat a wide range of nutritious and tasty meals. People told us they enjoyed the food. The food we saw looked and smelt tasty. Adjustments people needed to their food and drinks to ensure they could eat and drink safely had been made. However we could not always be sure that people were supported to eat and drink enough to maintain their health.

Staff had received training in the specific needs of the people they were supporting, as well as safe working practices. Some of this knowledge had been applied to staff practice, however we observed staff working in ways that were not always consistent with good practice guidelines, or which would keep people safe.

People were offered the opportunity to make a wide range of every day choices. We saw and heard people being asked about what they would like to wear, to do, to eat and drink for example. Processes to help people make bigger decisions were not all established, and there was a risk people would not get the support they required.

Some aspects of people's healthcare were well met, and we saw staff providing people with equipment and special cushions for example that would reduce the chance of them getting sore skin. There were good

relationships between the staff working at the home and local health care professionals. Changes in people's healthcare were noted and the relevant support was sought for people. We looked in detail at some people's care and found that other parts of their healthcare were not as well planned, and the staff responsible for planning and providing this care were not all fully informed about people's needs. We observed that this placed people at risk of receiving unsuitable or unsafe care and treatment.

Individual staff demonstrated kindness and compassion in their interactions with people. We saw some staff offer people a hug or reassurance when they were anxious or confused. We saw this brought the person comfort. On other occasions we observed that there were no staff in the areas where people required support. In these instances people did not receive comfort or reassurance. People's privacy and dignity was not consistently protected.

Permanent staff that we met knew people well, and we saw they often used this knowledge to provide care and support in line with people's preferences and wishes. This knowledge about people had not all been documented, or used to personalise people's plans of care. Some people's preferences had been recorded however we observed the care and support provided was not always consistent with this.

People and their relatives told us the manager was approachable and that they could share concerns or complaints at any time. This had resulted in positive changes happening quickly for people, once the manager had been made aware. No record had been made about complaints, which meant that the number, type or any themes could not be tracked. Doing this would enable wider improvements to be made across the service.

Most people, staff and relatives we spoke with described the home manager as being approachable and involved in the day to day running of the home. We found that the governance systems (Processes to ensure the safety and quality of the service) had not been effective, and had not ensured that people would receive a consistently safe service that met their needs and the requirements of the legal regulations.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.You can see what action we 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.

People could not be confident that their medicines would always be managed or administered safely.

People could not be confident that the risks associated with their care and support would be consistently managed.

People could not be confident they would always be protected from the risk of abuse. People could not be confident that if they experienced harm this would be identified, reported and people given the support they required.

There were not always adequate numbers of staff on duty to meet people's needs at the time they required support.

Is the service effective?

Requires Improvement

The service was not always effective.

Systems to support people make more complex decisions were not well established. People had the opportunity to make a range of day to day choices.

People received tasty and nutritious food, which they enjoyed and met their nutritional needs.

Changes in people's health were identified and action taken to liaise with the relevant professionals. Some health needs were not well understood within the staff team and this placed people at risk of receiving unsafe care.

Staff received the training and support they required to understand people's care needs. However this was not always applied in practice.

Is the service caring?

Requires Improvement

The service was not always caring.

Overall, individual staff supported people with compassion and

kindness. On some occasions, staff did not always work in ways that promoted people's dignity and demonstrated respect.

Is the service responsive?

Requires Improvement

The service was not always responsive

People could be confident concerns would be responded to quickly, however there was no process to ensure wider service development or learning took place as a result of complaints.

Some people enjoyed watching and participating in a wide range of activities. People with more complex needs did not always have activities or opportunities suited to their needs.

Some aspects of the service people received were tailored to their individual needs and wishes. People could not be confident that all staff would know their needs or preferences.

Is the service well-led?

Requires Improvement

The service was not always well led.

Systems to monitor and improve on the safety and quality of the service had not been effective, and had not ensured on-going continuous improvement.

There was an established registered manager in post, who was committed to improve the service.

Some aspects of the culture of the home were open, and enabled people, staff and relatives to speak up and contribute to the running of the service.

The Green Nursing 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.

The inspection took place on 16 and 17 May 2017 and was unannounced.

The inspection was undertaken over two days. On the first day there were two inspectors, a Specialist Advisor and an Expert by Experience. An expert-by-experience is a person who has personal experience of caring for someone who uses a care service for older people. The specialist advisor was a nurse with current experience of the care and support needs of people living with dementia. On the second day there was one inspector.

As part of the inspection we looked at information we already had about the provider. Providers are required to notify the Care Quality Commission about specific events and incidents that occur including serious injuries to people receiving care. We refer to these as notifications. We received feedback from the local clinical commissioning group, and the local authority that monitors the quality of the service. Before the inspection, the provider had completed a Provider Information Return (PIR) and returned this to us within the timescale requested. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information from commissioners, notifications and the PIR to plan the areas we wanted to focus our inspection on.

We visited the home and spoke with 13 people. We met all the other people who lived at the home. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.
We spoke with the registered manager, the nominated individual, two registered nurses, a senior support worker and nine staff. These included staff that had responsibility for providing care and support to people and staff responsible for undertaking housekeeping duties. We spoke with eleven relatives. We had feedback from three healthcare professionals. We looked at records including parts of five care plans and the records kept to show the care and support people had received. We looked at medication administration records.

We looked at three staff files including a review of the provider's recruitment process. We sampled records from training plans, incident and accident reports and quality assurance records to see how the provider monitored the quality of the service.

Inadequate

Is the service safe?

Our findings

People were not consistently protected from avoidable harm. The registered manager had identified that during March 2017, 16 people had obtained skin tears related to poor manual handling practice. The registered manager had identified that the injuries had been caused by staff wearing unsuitable jewellery and long finger nails. The action taken to reduce the likelihood of this happening again had not been effective as we observed staff continuing to wear unsuitable jewellery and long nails throughout our inspection. This was unchallenged by the registered manager or nurses on duty. Other incidents included unexplained bruising to a person's hands, and some episodes of unsettled behaviour in which a person caused physical harm to others. None of these incidents had been identified or reported as safeguarding. Action to reduce or minimise the risk of this happening again had not taken place. In discussions the registered manager told us she was aware of her responsibility to report safeguarding concerns that may arise. Notifications for some incidents had been sent to the local authority and CQC as is required, although other incidents we identified had not been referred to the local authority. Subsequently we had not been notified of these.

Staff told us they had received safeguarding training in their induction and on-going refresher training. This should ensure they were aware of current processes to follow and the signs of abuse to be aware of. Staff we spoke with who were responsible for providing both direct care and housekeeping demonstrated a good knowledge of the different types of abuse and described incidents that they would report and confirmed they felt confident and supported to do this. One member of staff told us, "I would feel confident to raise any concerns." Despite this staff had failed to always work safely, or identify and report injuries they had observed.

The knowledge provided to staff about keeping people safe had not consistently impacted on staff practice and this combined with the management systems in place to identify and report potential safeguarding incidents would not ensure people were always protected from harm. The registered manager and registered provider had failed to protect people from abuse and improper treatment. The systems and processes in place had failed to effectively prevent abuse of people living at the home. This is a breach of regulation 13(1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's health conditions and older age placed some of the people we met at greater risk of developing sore skin, not eating or drinking enough to maintain good health, of choking and of falling. These risks had all been identified, assessed and reviewed using professionally recognised tools. In some instances we found good practice and these risks were well managed. However we also found that these assessments and the actions identified as being required to help reduce the risks to people were not always taking place in practice. We saw that people were seated and had on their beds cushions and mattresses that helped to reduce the risk of developing sore skin. However we observed one person who was not given the pressure relief that a healthcare professional had identified as being required. This person already had a wound which increased the impact of poor pressure care. The failure to provide pressure care in the ways directed by expert health professionals was not identified by staff working at or managing the home, and inspection staff had to request appropriate pressure relief for this person. Staff we spoke with told us, "We have no

special instructions about elevating [name of person] feet" and another member of staff said to the person, "What's wrong with your foot?"

Throughout the day people were regularly offered both hot and cold drinks and snacks. A record had been made of the food and drinks each person had been offered. We looked in detail at the records for two people who were at risk of not eating and drinking enough. We observed that they were sleeping throughout the lunchtime and had not eaten. The records showed that this was the third day both people had missed meals or refused to eat. We saw people were offered additional snacks and drinks between meals, some of which had been eaten. One person had taken a very limited amount of fluid that could result in them becoming dehydrated. There was a significant risk to their health if this pattern continued. A system to alert or 'handover' information about the person's needs or to seek advice from a health professional was not in place. Staff we spoke with were not aware that this reduced diet and fluids had continued for three days. Two staff we spoke with told us this was not raised in the staff handover. This could result in people at risk of not eating or drinking enough failing to receive the support they require to remain well-nourished and hydrated. Failing to assess the risks people face, and taking all reasonable action to mitigate these risks is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People living at the home required support to receive their medicines safely. The management and administration of medicines did not always follow good practice guidelines. The systems in place to monitor the administration of boxed medicines had not been effective, and records and stocks of medicines held did not always balance. This suggested people had not always been given the medicines prescribed. Nurses did not always sign to confirm they had administered medicines. This had not always been identified by other nurses or in audits. This practice had not always been challenged, or action taken to ensure the person had received the medicines and that the missing signature was a recording error.

Some people had medicine prescribed that was to be taken "when required". There was not always information available to staff on why the medicine would be needed, how much to give, and when. This meant there was a risk that the nurses did not have enough information about what these medicines were prescribed for and how to safely give them consistently and appropriately.

When people needed their medicines to be prepared to enable them to have it administered directly into their stomach through a tube or hidden in food [covert administration] the necessary safeguards were not in place to administer these medicines safely. There were no written protocols in place to inform staff on how to prepare and administer these medicines and therefore there was a risk that people's health and welfare could be affected. Care staff applied prescribed creams to people's skin. A record of the application had been made, showing these had been used however, body maps had not been completed or instructions available to show staff where the creams should be applied. This meant that there was a risk the creams would not be applied to the correct part of the person's body. Members of staff that were applying creams had not been trained or completed competency checks to administer medicines or apply creams.

We did not find evidence that showed these issues had caused harm to people, but they all had the potential to do so. Improvements were needed to reduce the risk of medicines errors and ensure nurses were working consistently in line with professional good practice. Failing to properly and safely manage medicines is a breach of regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We observed people being supported with their medicines on three occasions. We saw that staff approached people kindly and explained that it was time to take their medicines. People were asked if they needed any medicines for pain relief. This was a person centred approach and in line with good practice.

People told us, "The nurse brings my medicines." A relative told us, "The nurses see to the medicines. I've never known of a problem." Controlled drugs, which are medicines that require extra records and special storage arrangements because of their potential for misuse were stored securely and had been recorded correctly.

People told us that they felt safe at the home and that staff treated them with kindness. Comments we received from people included, "The care is good, they look after you." A relative we spoke with told us, "I am really over the moon with the place; I have never had any concerns about [name of person] safety. I can just come and enjoy the visit, not have to check-up he is okay." However, six of the eleven relatives we spoke with raised concerns about people's safety in relation to the number of staff on duty to provide support. Our observations supported this feedback as we found that staff were not always available at the times people needed them. For example, we observed a person ask to be supported with personal care. They waited over 30 minutes for the required number of staff to be available. We saw other people make requests for help with personal care, to access meals and drinks and having to wait for staff to be available.

A person we spoke with told us, "I do have a call bell but the time you have to wait for a carer to come you could be dead and buried. Sometimes it feels like a very long time to wait." Another person told us, "Sometimes you have to wait when they are short staffed." We asked how often they felt the home was short staffed and they told us, "They're short staffed at least once a week." A relative we spoke with said their main concern was the shortage of staff at weekends. Another relative told us that their relative required the support of two staff for personal care. When two staff could not be located they provided the support required to meet the person's care needs. A staff member we spoke with told us, "The only bad thing about here [The Green] is that we are sometimes short of staff." They told us that at least one of the shifts they worked each week would be short staffed. We asked them what the impact of this was on people, they told us, "They [people] still get washed but it is later, I feel like you have to rush people, and you can't always help them when they want to get up." Another member of staff told us, "When we are busy we don't have the time to spend with people, to cheer them up or settle them down."

We spoke with the registered manager about staffing and looked at staff records and a sample of call bell response times collected electronically by the call bell system. The manager showed us how they had assessed and kept under review the dependency of the people living at the home, and how they had adjusted the staff numbers to reflect this. The records of staff on duty showed that the number of staff required as determined by the dependency tool was usually provided. The records of call bell monitoring showed that staff responded to people promptly, if only to provide assurance and check on the person's safety, and then to return to meet the person's needs at a later time. The registered manager had not used the experience and needs of people in addition to the dependency tool to determine the correct number of staff required. Our observations and feedback we received showed that the number of staff and delegation of staff was not adequate to support people promptly and safely. Failing to have adequate numbers of suitably skilled and qualified staff is a breach of regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We looked at the system in place to recruit new staff. Recruitment files we looked at showed that a robust process was in place. In two of the three files we checked this had resulted in thorough checks being made before offering new staff a position within the home. The process involved checking the suitability of staff to work with people prior to them commencing work at the home. These checks included obtaining Disclosure and Barring Service Checks. (DBS) Although all documents had been collected, in one case checks had not been made to verify the validity of the reference. This could not give the registered manager full assurance that the staff member was of good character, and had the skills and experiences they had given. Staff we spoke with described the recruitment process. One newly recruited member of staff told us, "I had an

interview, gave two references, they checked my DBS, then I did training and an induction." Routine checks had been carried out on the registration of nurses working at the service to ensure that their registration was current. Completing these checks is a way of ensuring people are supported by staff suitable to work in Adult Social Care.

Requires Improvement

Is the service effective?

Our findings

We looked at some of the health needs people living at the Green experienced. Staff we spoke with were aware of some of these needs, however they could not consistently tell us the support and action they took to help people maintain good health in these areas. Not all of these needs were well known within the care and nursing team.

We spoke with nursing staff about tissue viability needs [The risks relating to people getting sore skin if they are unable to change position]. They were unaware of the management plan regarding people we spoke with them about. We looked at the care given to one person who required all food and fluids to be administered by a tube directly into their stomach. The records and feedback from staff about this person's care was inconsistent. The person's care plan had not been updated following recent advice from a healthcare professional. These inconsistencies placed people at risk of receiving unsafe care or treatment.

People told us they were happy with the health care they received. Comments from people included, "I can see the Doctor if I'm poorly." A visitor we spoke with told us their relative had frequently developed infections throughout their life. They told us, "They [staff] pick up changes as quickly as I would and call out the GP." Another relative told us, "My [name of person] wasn't well and they called the doctor and informed me. I was so glad to hear that the staff had already noticed and booked a doctor." One health professional we spoke with told us that staff called them appropriately and followed the guidance they provided.

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 people lack mental capacity to take particular decisions, any decision made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA. Staff consistently offered people day to day choices such as what they would like to wear, to eat and drink, where they would like to sit and what they would like to do. More formal decisions had not always been agreed using the correct process, and we observed records that had been signed by relatives, who we could not confirm had the legal authority to do this. These decisions included relatives signing to say that people could be woken early, and consent to staff of a different gender to the person providing personal care. The process for holding and recording Best Interest Decision meetings was not established within the home, and there was a risk that people might not receive the correct support to help them make complex decisions.

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 are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service had applied for DoLS appropriately and whether any conditions on authorisations to deprive someone of their liberty were being met. Not all of the staff we spoke with were aware of who had a DoLS, or what the impact of this was on the person's care. There were systems in place to review and if necessary re-apply for DoLS before they expired to ensure the person continued to receive the support they required.

People and their relatives gave us positive feedback about the ability of the staff to support people effectively. Comments from relatives included, "Mum's needs are met really well here. I'm very happy with how things are." A person living at the Green told us, "They seem to know what they are doing I think they do get relevant training." We observed some occasions when staff supporting people used good practice techniques but we also saw instances where staff failed to recognise or respond to people's needs. We observed some very responsive and compassionate support from staff to help people when they were unsettled and when they were supporting people with their mobility. On other occasions we observed people's anxiety escalate and staff were not in the room and able to intervene appropriately to support people. Staff we spoke with were able to describe people well, were aware of many but not all of their care needs and were aware of the things that were important or which could be unsettling to people.

Staff starting work at The Green had received an induction that covered safe working practices and some of the specific needs and conditions of the people they would support. Recently recruited members of staff that we spoke with told us they had received an induction and the opportunity to 'shadow' (work alongside) more experienced members of staff. We were informed that the Care Certificate was available for any new staff that required this. The Care Certificate is a nationally approved set of induction standards that ensure staff have the knowledge they need to provide good, safe care. We were informed no staff had required this training; however our discussions with staff identified two care staff that should have received this training as part of their induction. While they informed us that the induction provided was adequate this did not show the home was following best practice in relation to staff induction training.

Staff told us they had received sufficient training to carry out their role effectively. We were provided with a copy of the registered provider's training plan. This showed that all new and existing staff were being supported to develop and refresh their knowledge in both the specific needs of the people they were supporting and safe working practices. Staff confirmed that they felt supported in their role.

Staff we spoke with confirmed that individual supervisions were currently not being offered frequently however there were regular staff meetings, and staff felt supported by their peers, senior colleagues and the registered manager. Registered nurses are required to undertake continuous professional development to meet the requirements of the Nursing and Midwifery Council (NMC) and to ensure that they maintain current, best practice knowledge. Nurses we spoke with confirmed training that would help them meet this requirement as well as support with their revalidation was provided.

People's feedback about the food provided at The Green was entirely positive. One of the people we spoke with told us, "The food is okay, pretty good. I get what I like." Another person told us, "The food is very good, always a lot. I like it." Relatives we spoke with told us, "The food is lovely," and "I was here at lunch time today and was amazed at the food. I thought it was fabulous." The meals we observed looked and smelt tasty. Adjustments had been made to the content and texture of the food to meet people's individual nutritional needs. We looked in detail at the support some people received to eat and drink. People had the opportunity to sit at a table or to eat from a tray that pulled up to their chair. People received support from staff to eat, and plate guards were available to support people to be as independent as possible. Throughout the day people were regularly offered both hot and cold drinks and snacks. A record had been made of the food and drinks each person had been offered.

Requires Improvement

Is the service caring?

Our findings

People did not consistently have the support they required to maintain their dignity. Staff we spoke with described the actions they took to ensure people's dignity was maintained. These actions included closing doors and curtains for example when providing personal care, taking care when hoisting people and where possible offering people staff of the same gender to support them. One of the people we spoke with told us, "They help me as well as they can with my care. They cover me up in my private parts, and they are very good with my privacy really." A relative we spoke with told us, "[Name of relative] was lifting her blouse in front of other people and she was not wearing a vest underneath. I requested the staff to make sure they put a vest on, they listened and now this respects her dignity." Whilst it was positive that staff acted on this, it was of concern that the relative had to bring this to the attention of staff.

People could not be certain they would always have the support they required to maintain their privacy and dignity. Some people we met had dirty, long and misshapen finger nails. A visitor we spoke with also brought this to our attention and described the action they took to support their relative to keep their hands clean as this was not always undertaken by staff. We looked in three people's care plans, and nail care was an activity listed of specific importance to the person. The personal care provided had not always met people's wishes or ensured people's hands were effectively cleansed. We observed a health professional examine a person in the communal area of the home. Staff in the area did not prompt the professional to do this in a more private area, and had not made arrangements to move the person to a more private area in readiness for the examination.

We looked in detail at the needs of three people who regularly became anxious. We observed one person received prompt, appropriate care that helped relieve their anxiety but for a further two people they did not receive effective support. One person had been prescribed a specific medicine to help reduce their anxiety. It was positive that the medicine prescribed to the person in relation to these needs was reviewed regularly by a doctor, this is recognised as good practice. However there was no written plan of care, detailing how staff should support the person when they became anxious, and there were no monitoring charts to record the frequency or any circumstances relating to the incident that might help plan better future care. Staff we spoke with all described appropriate but inconsistent ways they would support the person. Another person whose care we looked at in detail had been prescribed medicines to help them when they felt anxious. We observed the person experience anxiety throughout our inspection. We observed staff offer the person comfort and reassurance. This did not help the person. Nursing staff we spoke with were unaware that medicines to help the person in times of anxiety were available.

We observed another person who was very anxious. Staff supported the person and were aware that contact with the person's family would bring them comfort. We saw staff support the person to speak with their family on the phone, and then to look at some photo albums. This intervention did bring the person comfort.

People we spoke with shared many positive examples of the compassion they had experienced from staff. Comments from people included, "The care is good, and they do look after you." A relative we spoke with

told us, "The staff are nice here. Really nice." Relatives we spoke with told us they were made to feel welcome at the home. There were facilities for them to make a drink. Compliments had been received from relatives in response to a special birthday party that had been held for a person celebrating a significant birthday. We saw two people celebrated their birthdays during our inspection and both received a cake and a balloon and were made to feel special. People we met were wearing clean clothes, had fresh bedding and attention had been paid to ensure people were comfortable. People we met told us that they were helped to stay clean. One person told us, "I'm clean and comfy. I have had a wash and a clean nightie. I feel fine."

Staff told us they enjoyed working with the people who lived at the home. Comments from staff included, "The best part of the job is the people. I love them." We observed numerous kind, caring interactions between people and staff and saw occasions when staff took the time to sit and talk with people about topics that interested them. There were four activities co-ordinators. They were aware of people's interests and had made efforts to plan and organise activities that would bring people pleasure or comfort. Staff were aware of the risk to people who were cared for in bed of becoming socially isolated, however we found people being cared for in bed needed further opportunities to enjoy the company of staff. Many of the staff had a relaxed and friendly manner, and we saw people enjoying their company when possible.

Requires Improvement

Is the service responsive?

Our findings

There was a complaints procedure in place; however the registered manager informed us that people usually spoke informally with her so that she was able to address these concerns. Relatives told us that the manager had an open door policy and twice a week made herself available to people who wished to speak with her in the homes lounges. Relatives told us, "We've not really had any problems, but if we have any niggles we can talk to the manager at any time, she's a very good manager." People living at the Green also told us they felt able to raise any concerns. The lack of records detailing the number and type of concerns that the manager had dealt with meant there was no means to review or analyse the feedback and complaints being received to look for themes or trends. We noted in one staff meeting record that the manager informed staff there had been, "Nothing but complaints from residents families" It wasn't possible to see what action had been taken to respond to this, or to be able to track that the circumstances had improved.

We observed a range of activities and opportunities being provided each day. Some of the activities we observed were tailored to meet the person's needs and preferences. One relative we spoke with told us, "Before living here [Name of person] used to go the social club all the time. The bar here is great for him, and sometimes the staff will take him over the road to the pub." Around the home we saw photos of previous activities and events people had been able to enjoy. Posters advertising events coming soon, including a visit from some exotic animals, a garden party, and a pub quiz and pie night were all on display in the home.

There were four dedicated activity staff and during our inspection we observed then offering people the opportunity to be involved directly in activities such as bingo, dominoes and table tennis. We saw that other people enjoyed the atmosphere and being close to the activities although they did not wish to or were unable to join in. We looked at the opportunities for people who were cared for in bed, or who chose to spend the majority of the day in their bedroom. While we could see that some activities had been provided these were far less and there was a greater risk of people becoming socially isolated. One person whose care we looked at in detail liked to listen to the radio. Although a radio was present in their bedroom, we found this did not work. Action had not been taken to order a replacement or arrange a repair. We met people waiting in bed for their personal care. One person whose care we looked at in detail had records that showed they had been awake for several hours, however we found them lying in bed, facing the wall. They had not been provided with anything to listen to or look at. One of the people we met who spent a lot of time in their room told us, "I sometimes feel isolated, I only occasionally speak with one or two people. I like to watch TV in my room, like reading and doing cross words etc. I like to keep myself to myself. I don't think they do many activities here." Relatives we spoke with told us, "I am happy that my relative is safe, however I wish there was more of a life them," and "There is a lack of activities for people with more advanced dementia." We were informed by the registered manager that further training would be delivered to staff to help them understand and meet the needs of people with more complex dementia.

We asked people and their relatives if they had the opportunity to plan and review their care. Some relatives were aware that reviews took place, and recalled having meetings with staff from the home and a social worker. Records we viewed did not show the regular involvement of people or their relatives. Throughout

the inspection we saw examples of staff using their knowledge of people as individuals to provide reassurance, orientation and comfort to people. Good practice for people living with Dementia is to record some of this information in life history books. These had not been completed. The records we looked at did not show that this valuable information about people had captured and was available in a format for staff to share which would promote good and consistent practice. We found that much of the person centred good practice we observed was initiated by individual staff, and their knowledge of the person.

Requires Improvement

Is the service well-led?

Our findings

Systems in place for monitoring the quality and safety of service provided had not been entirely effective at identifying issues for improvement. When issues had been identified the action taken to address the shortfall and drive forward improvements had not always been adequate. Many of the issues that were identified during the inspection had not been identified by the quality assurance processes in use at the home. Our experience of this service shows that in recent years improvements had been made but not sustained. Our inspection identified that this pattern had occurred again, and that the systems in place and management support had not been effective to ensure the continuous improvement of the service over time.

We viewed audits and checks that had been completed by the registered manager. These included regular walks around the home, and completing of a variety of audits including falls, people at a low body weight, medicines, infections and equipment. The information collected had not been analysed to look at what this meant for people, or what changes and improvements it identified needed to take place. Some of the audits had identified issues similar to those we identified. In these instances it was not always clear what action had been taken, or we could see that the action taken had been ineffective. There had been no checks made to ensure that changes made following the audits had been effective and become embedded.

In the past month a relative's survey had been sent out, to seek the feedback of relatives and provide the opportunity for suggestions about how the home could be improved. We were informed that the information received was still being analysed, but that the majority of feedback was positive. We were informed that 27% of relatives had returned this survey, but plans to obtain the views of other relatives that had not returned the survey were not in place. People living at The Green had been supported to complete a 'Residents listening form' in November 2016. Nine of these had been returned, but no evidence of the action taken in response to the completed forms was available. It was evident that some systems were in place to seek feedback however these required further development to ensure they were fully effective at driving changes and developments within the home.

Failing to have effective systems to review and improve the quality of the service offered is a breach of Regulation 17 of the Health and Social Care Act 2008. (Regulated Activities.) 2014

The provider had recently secured the support of a professional with experience of governance and service improvement. This person had become the Nominated Individual and was present throughout our inspection. They told us about the preliminary work they had undertaken to assess the service, to prioritise and action plan the work that was required to ensure people received consistently safe, good quality care. The registered manager and nominated individual showed a strong commitment to improving and developing the service further. Meetings had been scheduled and some had taken place with the staff team to explain and gain support for the improvements and change process. Staff we spoke with described feeling positive and hopeful about the future, and were keen to embrace change.

People we met spoke favourably about the registered manager. They were aware of who she was, and how

to contact her. One health professional described the manager as being involved and approachable. Staff we spoke with described the manager as, "Approachable" and "Supportive." One of the relatives we spoke told us, "She is a really good manager."

The registered manager had ensured that the current rating of the home was on display within the home and on the provider's website. This is required by law, but also demonstrates transparency and an open culture. Staff we spoke with shared the view that the culture within the home was open. They told us, "I found the home to be very welcoming, close, like a family, we do genuinely help each other out," and "I do feel well supported, and if there are any concerns we are always encouraged to speak up."

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Action had not been taken to fully assess the risks people faced. All reasonable action to mitigate these risks and protect people had not been taken. People could not be confident their medicines would be administered or managed safely or in line with professional good practice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People had not been protected from abuse and improper treatment. Systems and processes had not been established and operated effectively to prevent, investigate and report all potential abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance There were ineffective systems in place to review and improve the quality and safety of the service offered.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People were not supported by adequate

Diagnostic and screening procedures

Treatment of disease, disorder or injury

numbers of well delegated staff to ensure they would be supported promptly and safely.