Lifeways Community Care Limited

Greenlands View

Inspection report

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Date of inspection visit:
10 October 2022
11 October 2022

Date of publication:
09 February 2023

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Greenlands View is a residential care home providing personal care for up to 9 people. The service provides support to people with learning disabilities and autistic people.

Greenlands View is a purpose – built bungalow, with self-contained accommodation for 1 person attached to the main building. At the time of our inspection there was 4 people using the service.

People's experience of using this service and what we found
We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

Right Support
Risks to people were not always well managed which meant people were placed at risk of harm. People had identified goals in relation to things they wanted to do and skills they wanted to develop. There was limited evidence to monitor what steps people had taken to achieve these goals and how staff could support them further. This meant opportunities for developing people's individual skills and independence could be lost. Improvements were needed to some aspects of medicine management. Repairs and general maintenance were not always dealt with promptly, which increased risks to people.

People lived in a spacious purpose-built house with a safe outside space. The home was situated in a residential area with facilities close by. People accessed local facilities and were supported to do things they liked to do. There were adequate numbers of staff to support people.

Right Care
People's care plans and risk assessments did not always reflect their current needs or promote their wellbeing and enjoyment of life. People were not always supported and encouraged to become more independent. There was a core team of staff who knew people's needs and were kind and caring.

Right Culture
Since our last inspection the management and staff had not stabilised and there were continued changes and a high turnover of staff. A lot of agency staff were supporting the service. Regular agency staff were in place, which helped ensure some consistency. There was further deterioration in the quality and oversight of the service. Where it had been identified that improvements were needed, these had not been completed in a timely manner. The systems for reporting, recording and monitoring of incidents were poor. The provider's governance systems were not always effective. Governance systems did not ensure people were kept safe and received a high quality of care and support in line with their personal needs.

Please see the Safe and Well-led sections of this full report

Rating at last inspection
The last rating for this service was requires improvement (published 31 August 2022).

Why we inspected
We undertook this inspection to monitor progress on the Warning Notice we issued in June 2022. It was also prompted by a review of the information we held about this service. This included an increase in information received about concerns with people's care.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection. Please see the Safe 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.

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 monitor the service and will take further action if needed.
Breaches of legal requirements were found in relation to providing safe care to people, safeguarding people and good governance.
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 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 provider's oversight of the service had not identified some of the shortfalls we found during the inspection process as part of their audits and checks.

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 well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Greenlands View

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.

Two inspectors carried out the inspection.

Service and service type
Greenland's View is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection, there was not a registered manager in post. There was a deputy manager who lead part of the inspection and the area manager and regional manager were also present during the inspection.

The service did not have a manager registered with the Care Quality Commission. There was a deputy manager who lead part of the inspection and the area manager and regional manager were also present during the inspection. This means the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced on 10 October 2022 and we told the provider we would be returning to complete the site visit on 11 October 2022.

What we did before 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. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all this information to plan our inspection.

During the inspection
We met with 4 people who used the service. We spoke with 9 members of staff including support workers, deputy manager, area manager, regional operations director. We spoke with 3 relatives. We reviewed a range of records. This included people's care records and medication records. We looked at 2 staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Preventing and controlling infection

At the last inspection the provider was in breach of regulation 12. Risks to people were not effectively managed. At this inspection we found the required improvements to the management of risk, had not been made. The provider remained in breach of Regulation 12.

● At our last inspection we found risks to people were not well managed. The provider took action on risks to people in the environment during our last inspection, that we brought to their attention. They told us measures were in place to ensure people would be provided with safe care. At this inspection, however, we found repeated environmental concerns that placed people at risk of harm.
● People were at risk of drinking or eating harmful substances that should be safely stored, in accordance with their care plan and risk assessment, because they were not aware of the danger. These care plans and risk assessments were not being consistently followed. Cleaning products and harmful substances were left unsecured, placing people at increased risk of harm.
● Staff failed to follow a person's care plan and risk assessment that stated staff should provide supervision at all times. Staff left the person unattended, and they sustained an injury that may have been avoided, had their risk assessment and care plans been followed. Staff not following the person's care plan was a repeated concern from our last inspection.
● Incidents and accidents were not consistently reported, recorded and acted on to minimise the risk of reoccurrence. For example, a person was showing distressed behaviour and staff had recorded the person may have been experiencing pain. The incident record was incomplete, and potential reasons for the incident had not been explored further. Action to identify any triggers or trends, to minimise the risk of reoccurrence were not taking place.
● People were not always protected from hazards around the home. A person's bedroom window had a blind with a looped chain. This potential hazard had not been risk assessed, in line with Department of Health guidance. In the sensory room, items including five crash mats and toy items were stored in a manner that posed a risk of the items falling on people or staff and causing injury. The access to laundry room had been risk assessed, and a notice on the door stated 'keep locked' at all times. The door had been left open with no staff nearby, and there were unsecured cleaning items in this room.
● We were not assured the provider was promoting safety through the layout of, and hygiene practices at, the premises. There were broken floor tiles in the kitchen where the bin was situated, and cleaning of this area was compromised. In the lounge area we saw a sofa with dirt and food items under the cushions and dust and dirt behind the sofa. In a person's bedroom we saw thick dust and dirt behind the door to their ensuite bathroom. We observed food items and dirt under the cushions of the sofa in the hallway. We observed a shower stool in the sensory bathroom with dried faeces on the seat. There was a build-up of

mold in the shower rooms. The lack of cleanliness placed people at an increased risk of infection.

People were not fully protected from the risk of harm. This was a repeated breach of regulation 12 (Safe Care and Treatment) Health and Social Care Act 2008 (Regulated Activities).

The provider took action during the inspection on a number of concerns we brought to their attention. This included; securing items of risk, locking the laundry door, and arranging repair of the broken flooring in the kitchen

●We were assured that the provider was preventing visitors from catching and spreading infections.
●We were assured that the provider was meeting shielding and social distancing rules.
●We were assured that the provider was admitting people safely to the service.
●We were assured that the provider was using PPE effectively and safely.
●We were assured that the provider was accessing testing for people using the service and staff.
●We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
●We were assured that the provider's infection prevention and control policy was up to date.

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

Systems and processes to safeguard people from the risk of abuse
● Prior to our inspection, we received an increase in concerns about the service, relating to poor care and unsafe staffing levels. We shared information about the concerns with the local authority and the provider. At the time of writing this report safeguarding investigations were still taking place.
● An incident record detailed an incident between 2 people living at the service. One person caused an injury to another person. The provider had not recognised this as a safeguarding incident and therefore did not make a required referral to the local authority in line with the providers own policy.
● The local authority requested the provider investigated and reported back on a number of incidents reported to them regarding one person. This had not been completed within the timescales set by the local authority and was still outstanding when our inspection took place. The delay in the investigation outcome meant preventive measures and actions were not taken in a timely way.

The provider had failed to implement robust procedures to protect people from abuse. This was a breach of regulation 13 (Safeguarding from abuse and improper treatment) Health and Social Care Act 2008 (Regulated Activities).

Using medicines safely

● Some people's protocol's for medication taken on an 'as required' (PRN) basis lacked information about the circumstances in which the medication should be given. For 1 medicine taken on an as required basis, there was no protocol in place, and this had been recently administered to the person. The provider took action on this immediately.
● There was no protocol in place for the safe administration of topical creams to ensure the cream was applied safely. The provider took action on this at the time of the inspection and following our inspection they sent us the protocol.
●The provider told us reviews of people's medicines were due and would be arranged. We asked for information about this, but this was not provided at the time of writing this report. This would ensure any medicines people were taking remained necessary and were at the appropriate dose in line with national guidance on the prescribing of medication for people with a learning disability. STOMP (stopping the over medication of people with a learning disability) NHS England 2016.

Staffing and recruitment
● There was enough staff to support people. However, the provider continued to face challenges in relation to staff recruitment and retention, and was taking steps to address these.
● There was a number of vacant posts being recruited to. Agency staff were used to support the rota. The provider told us regular agency staff were supporting the service, to ensure some consistency for people.
● The provider told us the staffing levels they were commissioned for including where people were on one to one or two to one staff support. Records confirmed the required staffing numbers were in place.
● Relatives told us there were enough staff to support people, but were concerned about the number of staff changes. A relative told us, "A lot of staff have left, fortunately, there are a few good care staff who know [person's name] well."
● Staff told us there were enough staff to meet people's needs, but they needed more permanent staff, and were reliant on agency staff. A staff member told us, "We use a lot of agency staff, mainly the same staff. We need to have consistent staffing for people, they [people living at the service] notice, and its unsettling for them."
● The provider carried out checks on new staff before they were employed to work in the home. New staff were checked against records held by the Disclosure and Barring Service. This checked they had not been barred from working in a care service and did not have criminal convictions which had the potential to make them unsuitable to work in the home. The provider also requested references to confirm applicants' good character and conduct in previous employment in a care setting.
● Staff knew people and were able to tell us about people's individual needs and risks.

Learning lessons when things go wrong
● The system in place for monitoring and learning from accidents and incidents had not been implemented effectively. This meant people were at an increased risk of avoidable harm.

Visiting in care homes
● The provider had supported people to see their relatives during the pandemic in line with government guidance.
● Visitors to the service had their temperature checked before entering and staff checked visitors did not have symptoms of illness.

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 our last inspection we rated this key question requires improvement. At this inspection the rating has changed 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

At our last inspection the provider was found to be in breach of Regulation 17, as the quality assurance systems in place were not effective. Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 17.

- This is the second consecutive inspection where the provider has failed to meet the regulations. There have been repeated breaches in relation to safe care and treatment and good governance across both inspections.
- The provider had systems in place to assess, monitor and improve the service. We found these systems had not been effectively used. The provider had not sustained all the improvements they told us they had made in their action plan they sent to us, following our last inspection. Many of the environmental concerns were repeated concerns from the May 2022 inspection.
- The provider failed to ensure arrangements were in place for daily walkabout checks to continue, when the manager was away from the service. This meant for 19 days no daily walkabout checks had been completed and their system had failed to identify this. Risks to people's safety in the environment had not been identified. This meant people were placed at an increased risk of accidental harm. Many of the environmental concerns were repeated concerns from our last inspection.
- The provider's systems and processes had not ensured shortfalls in infection prevention and control (IPC) measures were identified, and action taken to address these. This meant people were placed at an increased risk of harm.
- The provider's systems and processes had not enabled them to identify their own policies were not followed, and had failed to set a culture to reduce incidents and risks associated with people expressing distress and agitation. They had also failed to take action when poor staff practice contributed to an incident.
- The provider's systems and processes had not enabled them to recognise the oversight and scrutiny of safeguarding incidents were not always effective. This meant there were missed opportunities to reduce the risk of further potential harm to service users.
- The provider's system and audits had not enabled them to identify all medicines taken on an 'as needed' basis, did not have a protocol in place for staff to follow, to ensure people received these medicines as required.

The provider's quality assurance systems and processes were not effective and had not enabled them to assess, monitor and improve the quality and safety of the service. This was a repeated breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At our last inspection systems in place for the oversight of deprivation of liberty safeguards (DoLS) applications and their outcome, had not been maintained and were ineffective. There was no system in place to record the date an application had been made and its outcome and CQC had not been notified of the outcome, as legally required to do so. At this inspection improvements had been made, and a system was now in place.

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
During the inspection we identified that CQC had not been notified about a serious injury a person had sustained. This had been an oversight by the service. The provider sent a retrospective notification during the inspection.

Continuous learning and improving care
● At our last inspection the provider told us there had been significant management and staff changes at the service. The provider told us in recognition of the need to stabilise the service they brought in a team of support. Since our last inspection they had also employed a new manager and two new deputy managers. However, shortly before this inspection, the manager and one deputy manager left the service. This meant since our last inspection the service had not reached a position of stabilising the staff and management team.
● At our last inspection we identified records relating to people's care required improving and updating to reflect people's current needs. At this inspection some improvements had been made to improving care records. However, further improvements were needed, so staff had up to date information to refer to, so people were supported consistently.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● There had been a number of changes at the service and this had impacted negatively on the culture of the service.
● Relatives expressed concerns regarding the impact of regular changes in management and care staff. A relative told us, " Things were very unsettled, but recently since [deputy manager name] has been there, things have improved. They are sorting things out and they [deputy manager] are really good at keeping me informed about [person's name]." Another relative told us, "There has been so many staff and managers changes, there has been three managers in the last few months. [Person's name] doesn't like change." A third relative told us they were concerned about the number of management changes that had taken place this year.
● The provider had not ensured the service met the values that underpin Right Support, right care, right culture. People were not always supported in an individual and person-centred way and their care plans were still in the process of being updated so they reflected people's strengths, abilities and goals.
● There was a core team of staff who knew people and their needs well. Relatives spoke positively about specific staff members and told us they were kind and caring. A relative told us, "There are three regular care staff and they are lovely and kind and know [person's name] needs well."
● The provider told us work had taken place with families to improve communication since our last inspection, and telephone calls had been made to relatives. However, they were unable to show us evidence

of this. They told us going forward they would be implementing a family monitoring form to capture information about family and friend contact.

● Staff told us the number of staff and management changes had been unsettling for the home and people living there. A staff member told us, " I have been anxious about the service, we have had so many management changes." Another staff member told us, " I think the deputy manager is brilliant, they are approachable if something needs doing, they will get it done. We had previous managers who were not efficient in that way."

Working in partnership with others

● Records showed staff worked with other agencies to improve people's experiences.

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 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way.

The enforcement action we took:

Impose a condition

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 Systems and processes to prevent abuse were not always effective.

The enforcement action we took:

impose a condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not always operated effectively.

The enforcement action we took:

Impose a condition