Greenroyd Residential Home Limited

Greenroyd Residential Home

Inspection report

27 Hest Bank Lane
Hest Bank
Lancaster
Lancashire
LA2 6DG

Tel: 01524824050

Date of inspection visit:
21 August 2017
25 August 2017
05 September 2017

Date of publication:
30 October 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This unannounced inspection took place on 21, 28 August and 5 September 2017.

Greenroyd Residential Home is a detached property situated in Hest Bank, close to Morecambe and Lancaster. The home is registered for up to twenty three people living with dementia and has three floors, a lift and stair lift. There are three lounges and two dining rooms on the ground floor. All rooms are single and have en suite facilities. At the time of the inspection visit twenty people were receiving care and support at the home.

There was a registered manager in place. 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.

The service was last inspected on 09, 16, and 22 March 2017 and was rated as Inadequate. We identified breaches to Regulation 12, 13, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014 and a breach to CQQ Registration Regulations 2009. Following this inspection visit the service was placed in special measures.

At this inspection visit carried out between August and September 2017, we found the management team had worked hard to make improvements however further work is required to ensure the fundamental standards are understood and embedded within the service. Breaches were identified to Regulations, 9, 10, 12, 13, 15, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Deployment of staffing was poor. Measures put in place to review staffing levels and staff deployment were ineffective. Training for staff was out of date and incomplete.

Whilst some improvements had been made to manage risk we found not all risks had been considered. Care records did not consistently identify risk and ways to reduce risk. Good practice guidelines were not always considered and implemented.

Infection control processes were inconsistent and did not always follow regulatory guidance. During the first day of the inspection visit we found areas of the home which were not to a required standard and conflicted with information held within the infection prevention and control audit.

Whilst improvements had been made in relation to the recording of falls we found records continued to be inaccurate and up to date. Care plans and documentation did not always identify people's risk and did not always reflect people's health needs. Care records were not consistently updated when people's care needs had changed.

The registered provider had formalised an auditing system to ensure people who lived at the home were provided with safe and effective care. Whilst improvements had been made to the auditing of falls we found other auditing systems were ineffective and had failed to identify the concerns we noted during our inspection visit.

Whilst improvements were noted in the way safeguarding concerns were reported and responded to, we continued to find people were not always protected from the risk of abuse and harm. Processes in place for managing safeguarding incidents were not always clear and comprehensive.

We noted a lack of disparity between service policies and staff practice. Staff roles and responsibilities were unclear.

Visions and values at the home were not person centred. Dignity and respect were not consistently addressed and considered by staff.

Improvements had been made to mitigate risk within the environment. However, we found recommendations had not been acted upon to ensure premises were inclusive for people living with dementia. We found equipment required to meet people's needs was not always provided and fully functional at the home.

Organised activities did not always take into consideration people's individual needs and abilities. We have made a recommendation about this.

Relatives said the food provided at the home was satisfactory. Deployment of staffing at meal times was variable and had a bearing upon the meal time experience for people.

We looked at how medicines were managed by the service. Good practice guidelines were not always consistently followed. We have made a recommendation about this.

The registered provider had a system for managing complaints. Relatives told us they had previously raised concerns with the registered manager. These however had not been formally documented by the registered manager. We have made a recommendation about this.

We received mixed feedback about the caring nature of staff. Observations made during the inspection process showed that staff interactions were variable. Staffing levels and staff deployment meant there was a focus on completing tasks as opposed to spending quality time with people.

Recruitment procedures were implemented by the registered provider which meant staff were correctly checked before starting employment.

The registered provider was aware of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards. (DoLS.) We saw evidence of processes being followed to ensure people were only deprived of their liberty lawfully.

Relatives of people who lived at the home told us they were consulted with and involved in the management of the home. They told us they were able to make suggestions as to how improvements could be made. We saw evidence of this occurring.

Staff were positive about ways in which the service was managed and the support received from the

management team. They described a positive working environment.

The overall rating for this service is 'Inadequate' and the service therefore remains in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

You can see what action we have asked the registered 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 always safe.

Appropriate numbers of suitably qualified staff were not deployed to meet the needs of people who lived at the home.

Procedures were not consistently established and followed to ensure safeguarding concerns were suitably managed.

Risk was not consistently addressed and managed within the home.

Arrangements were in place for management of all medicines. We have made a recommendation about this.

The service had recruitment procedures to assess the suitability of staff.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always have suitable and sufficient access to ongoing up to date training to meet the individual needs of people they supported.

Nutritional and health needs were met by the service. However, good practice guidelines were not consistently followed to enhance the dining experience for people.

People's health needs were monitored and advice was sought from other health professionals, where appropriate.

Staff had an understanding of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and the relevance to their work. However we identified one situation where due process had not been followed.

Is the service caring?

Requires Improvement

The service was not always caring.

People and relatives told us staff were not always caring.

People were not always treated with dignity and respect.

There was an emphasis on task focussed care. Personalised care was not always delivered. Staff did not always know people's needs and preferences.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans focussed upon task orientated care and did not always incorporate people's preferred needs and wishes.

People's care records were kept under review and staff sometimes responded when people's needs changed.

The service had a complaints system in place. We have made a recommendation about this.

Is the service well-led?

Inadequate

The service was not well led.

Documentation did not always reflect people's assessed needs and risks. Records reviewed were sometimes inaccurate and incomplete.

The service had implemented an auditing system but this was not fully operational or effective.

Procedures implemented since the last inspection were ineffective as they were inconsistently followed and staff had not been trained within the procedures. There was disparity between staff practice and protocols in place.

Improvements had been made to ensure processes for reporting statutory notifications were consistently followed.

Greenroyd Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place over three days on 21 and 25 August 2017 and 5 September 2017. The first and second day of the inspection visit were unannounced.

On the first day the inspection team consisted of two adult social care inspectors, an assistant inspector, a specialist advisor and an expert by experience. The specialist advisor was a paramedic with experience in management of falls. The expert by experience was a person with experience of caring for older people. On the second day one adult social care inspector was supported by an inspection manager. The adult social care inspector returned alone on the third day to complete the inspection.

Prior to the inspection taking place, information from a variety of sources was gathered and analysed. We spoke with the Local Authority contracts and safeguarding teams as well as the Clinical Commissioning Groups responsible for commissioning care. At the time of the inspection visit the registered provider was working with the local authority quality improvement team to make the required changes. The local authority were able to update us on the progress being made upon the action plan.

We reviewed information held upon our database in regards to the service. This included notifications submitted by the registered provider relating to incidents, accidents, health and safety and safeguarding concerns which affect the health and wellbeing of people.

Throughout the inspection process we gathered information from a variety of sources. We spoke with six people who lived at the home to seek their views on how the service was managed. We found not all of

those who lived at Greenroyd Residential Home were able to communicate fully with us. Therefore, during our inspection, we used a method called Short Observational Framework for Inspection (SOFI). This involved observing staff interactions with people in their care. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with six relatives who were visiting the home and ten members of staff. This included the registered manager, manager, a cleaner and seven members of staff who provided direct care.

To gather information, we looked at a variety of records. This included care plan files related to eight people who lived at the home. We also looked at medicine administration records related to people who received support from staff to administer their medicines.

We viewed recruitment files relating to four staff members and other documentation which was relevant to the management of the service. This included health and safety certification, training records, team meeting minutes, policies and procedures, accidents and incidents records, call bell logs, the business continuity plan and findings from monthly audits.

As part of the inspection process we looked around the home in both communal and private areas to assess the environment and to see if the required improvements had been made.

Following the inspection visits we liaised with the local authority safeguarding team, the local authority environmental health services and the fire and rescue service.

Inadequate

Is the service safe?

Our findings

At the inspection carried out in March 2017, we found people who lived at Greenroyd Residential home were not always safe. Deployment of staffing was not always consistent to meet people's needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008, (Regulated Activities) 2014.

Following the inspection visit we asked the registered manager to undertake a review of staffing levels at the home to demonstrate they had analysed and considered staffing arrangements.

We used the inspection carried out in August and September 2017 to check what improvements had been made. We did this to ensure staffing levels had been reviewed to ensure people were safe.

We spoke with relatives about staffing levels. Feedback included, "There are not enough staff. They obviously need help." And, "There are times when residents have to wait because they (the staff) are doing other things." Also, "The carers obviously need more help; they are doing three different things at once."

We asked three staff their opinion of staffing levels. All three staff described staffing levels as adequate. Two of the three staff however said there were times when staffing levels did not always meet need. They said, "There are some times when we are busier than normal, like the mornings. It depends on people's needs." And, "It can be quite difficult in the evenings; a lot of people wander and are unsettled. It can be quite difficult."

We reviewed the staff rota and noted there had not been an increase in the number of staff deployed since the last inspection. The registered manager said they had carried out observations at the home to see if staffing levels met need. They said they had consulted with relatives and staff and had found staffing levels were sufficient. No evidence was available to support this. The registered manager said they had designed and implemented a staffing dependency tool in July 2017. They said this had evidenced that staffing levels at the home were correct. We reviewed the staffing dependency tool and found there was no evidenced based research to show how the calculations had been determined. We discussed our concerns about the accuracy of the tool with the registered manager. They told us the staffing dependency tool still required amending and reviewing.

The registered manager said they had developed a staffing deployment schedule to address how staff were to be deployed to ensure consistent staffing arrangements within the home. They told us the senior member of staff was to deploy the three care staff between the dining area and the two communal lounges. This was to allow oversight. During the inspection process we found communal areas were not consistently monitored as described by the registered manager. On three occasions we had to seek help on behalf of people who lived at the home as there were no staff present when people required assistance. In addition, the deployment schedule failed to take into account the layout of the home and the areas which required oversight. Nor did it take into consideration additional tasks staff were expected to carry out during the day, such as cooking, cleaning and laundry. We raised these concerns with the registered manager; they acknowledged the deployment schedule did not take into consideration the extra factors and needed

reviewing.

We reviewed the number of accidents that had occurred at the home. Thirty four accidents had been reported since the last inspection visit. Twenty five of these had occurred within communal areas between 8am and 10pm at night. Of the thirty four accidents, twenty seven accidents had occurred when no staff were present to witness what had happened.

We observed staff going about their duties. Interaction with people who lived at the home was minimal and was task focussed. On the morning of the first inspection visit we observed staff rushing around. We observed a staff member pushing a person in their wheelchair with one hand and carrying a box of dirty laundry with the other hand. This placed the person at risk of harm as the staff member did not have full control of the wheelchair. We observed one person in a restless manner at lunch time repeatedly asking for help to leave the dining area. Staff supported other people around this person and did not respond. After being left alone in the dining area the person tried to mobilise themselves. We had to seek assistance from staff as there were no staff present and this person was at risk of falls.

We discussed our observations with the registered manager on the first day. They said they were unsure as to why the deployment of staffing had been inconsistent. They said they had some concerns about the skill mix of staff on duty that day. We asked the registered manager if they ever reviewed staff mix on each shift to ensure that suitably experienced members of staff were on each shift. They said they had not done but would consider this.

The above matters show the provider was not meeting legal requirements in relating to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because they had failed to ensure staff were effectively deployed at all times.

At the inspection in March 2017 we found risks were not suitably managed to ensure safety was considered at all times. We identified risk in relation to management of accidents, incidents and falls and safe use of bed rails. Following the inspection visit we asked the registered manager to consult with appropriate professionals and review all risk assessments in place to ensure risks were identified and addressed. In addition we asked them to provide a weekly report to the Care Quality Commission in regards to the number of falls occurring at the home and action taken following a fall.

We used this inspection visit carried out in August and September 2017, to see if risk had been identified, assessed and mitigated. We found not all required improvements had been made. Improvements had been made within the environment to manage the risk of people falling on stairs. Doors onto fire escapes had been alarmed and a gate had been fitted on the main staircase. The registered provider had liaised with the Environmental Health Office to review environmental risk. In addition they had consulted with the steady on team for advice and guidance to help them manage and reduce falls at the home. The steady on team are a group of health professionals who provide advice and guidance on the management and prevention of falls.

We reviewed six care records related to people who were deemed at risk of falling. We found improvements had been made to mitigate the risk of people falling. Of the files we viewed we found falls diaries were accurately maintained for each person at risk of falls. We saw evidence of the registered provider consulting with health professionals following a person falling. In order to mitigate risk audits of falls regularly took place. The manager said the new systems had resulted in a decrease in falls.

Although processes had been implemented to manage falls, systems were reactive rather than proactive.

For example, there were no references within care plans or risk assessments which addressed individual mobility, sight, medicines and muscle tone. All these factors had a bearing upon a person's ability to mobilise safely. We discussed this with the manager; they told us staff were encouraged to check these factors with people on a daily basis. These checks were not however documented. We found these checks did not consistently take place. On one occasion we observed one person mobilising in their slippers. We noted the slippers were too big for the person. Another person's care record stated the person required glasses. The person wasn't wearing these. We noted from care records and accident reports this person had recently tripped in their bedroom and had sustained an injury as a result.

Following the inspection visit carried out in March 2017, the registered manager had adopted a new policy for the management of slips, trips and falls. We reviewed the policy and found that processes were not consistently followed to meet the requirements of the policy. For example, the policy stated that in the event of a fall and in the event of an injury a full assessment must be performed by a medically trained individual. This was defined as a nurse, first aider, general practitioner (GP) or ambulance professional. This was not always put into practice as records demonstrated full assessments were not consistently carried out by a medically trained professional following a person falling. In addition, we reviewed the staff training records and noted twelve staff had not received any first aid training to provide them with the skills required to assess people as stated in the policy.

The above matters show the provider was not meeting legal requirements in relating to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because they had not ensured sufficient processes were consistently implemented to ensure that risk was managed and mitigated in relation to the management of falls.

At the inspection visit in March 2017, we found no bedrail risk assessments were in place for two people who lived at the home who used bed rails. Bed rail risk assessments are important to assess and mitigate the risks identified with the usage of bed rails as stated within the guidance, 'Safe use of bed rails.' (Medicines and Healthcare Products Regulatory Agency, 2013.)

We reviewed the bed rail policy implemented after the March 2017 inspection. We looked at bed rail risk assessments completed by the registered provider. Risk assessments acknowledged that bed rails were to be used and indicated monthly checks of bed rails were to take place. There was no separate risk assessment however to indicate the format of what to check for when reviewing the bed rail, nor was there any reference to daily visual checks which should be carried out each time the bed rail was in use. Daily visual checks are important to ensure that equipment is in full working order and there are no defects which may contribute to people being entrapped between bed rails.

The above matters show the provider was not meeting legal requirements in relating to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because they had not ensured sufficient processes were consistently implemented to ensure that risk was managed and mitigated in relation to the safe use of bed rails.

We looked at how other risks were managed within the service. On the first day of the inspection a visiting health professional told us one person had an ongoing health condition relating to skin breakdown. We reviewed care records and found there was no reference within the person's care record or risk assessment relating to the skin breakdown. We noted a pressure sore calculator for the person had not been reviewed as stated within records. A body map within the person's care record did not indicate there were any skin breakdowns. This placed the person at risk of harm as there was no information for staff to consult with in regards to management and oversight of this condition.

We looked at the moving and handling plans in place for two people who required support to transfer. We found these did not accurately reflect people's needs. For example, we observed one person being transferred from a wheelchair to a chair. The person could not weight bear. The moving and handling plan stated the person could weight bear and required a stand aid hoist. This demonstrated that moving and handling assessments did not always accurately reflect people's needs. We observed staff moving and handling techniques and found inappropriate moving and handling practice took place. We raised concerns immediately with the registered manager who told us this practice was not acceptable. Following the inspection visit we consulted with the safeguarding team in relation to this. On the third day of the inspection visit, we noted two people had been reassessed and staff were now using the hoist to manoeuvre them.

We looked at how naturally occurring risk was managed. On one occasion a person slipped down a recliner chair and the chair tipped forward. The person fell forward and required assistance from staff to put the chair back in the upright position and to help the person reposition in the chair. We discussed this incident with the registered manager and they said they would ensure this incident would be investigated and documented. On the third day of the inspection visit this had still not been completed. The manager who was responsible for over-seeing accidents at the home had not been aware of the incident. There was no documentation to acknowledge the incident had taken place.

The above matters show the provider was not meeting legal requirements in relating to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because they had not suitably assessed the risks to people who lived at the home and done all that was reasonably practicable to mitigate the risk.

During this inspection visit we reviewed fire safety procedures at the home. We noted two fire doors routinely wedged open with equipment. We checked the door closures on one door and noted this did not work. This meant staff had to prop the door open should the person wish to have the door ajar. This contravened fire safety regulations.

We noted each person who lived at the home had a personal evacuation plan (PEEP) in place. Personal evacuation plans detail the support people require to be evacuated from a building in the event of an emergency. People's evacuation plans made reference to accessing the nearest fire exit and stairs. We asked the manager what equipment was available to support people down stairs should the stair lift and lift not be available. They confirmed no evacuation equipment was available at the home. They said, "[Registered Manager] is thinking about buying these."

We spoke with staff about evacuation procedures. Staff told us the policy was to laterally evacuate a building. This means moving people from one side of a building to another using fire doors as protection. We explored this further with two senior members of staff responsible for coordinating a fire evacuation. They told us they would laterally evacuate people and leave people in a safe place within the building until further assistance arrived. This conflicted with information held within the evacuation plans for people which did not refer to lateral evacuation and simply stated that people should be escorted through the nearest fire exit and down the stairs. Following the inspection visit, we spoke with the Fire and Rescue Service to inform them of our concerns.

We found equipment to assist people to summon help was not appropriately maintained. We observed one person trying to seek assistance from staff. Their call bell did not work and we had to seek help on their behalf. Upon inspection we were told the batteries in the system had expired. The manager confirmed no checks were in place to ensure all batteries were fully functioning in call bell alarms.

The above matters show the provider was not meeting legal requirements in relating to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had failed to ensure equipment was available and suitably maintained to meet the needs and safety of people who lived at the home.

We looked at infection prevention and control procedures in place at the home. The registered manager told us they had reviewed policy and had referred to 'The Health and Social Care Act 2008, code of practice on the prevention and control of infections' and the associated guidance so improvements could be made. We found some improvements had been made. Records demonstrated hand hygiene; mattress and commode audits had taken place and had been documented. Hand hygiene facilities had been introduced into each person's bedroom and within bathrooms. This meant there was ready access to hand wash and paper towels. A hand hygiene dispenser had been installed at the entrance hall for visitors and non-touch bins were now in use throughout the home.

Although improvements had been made we found infection prevention and control procedures had not been consistently carried out. On the first day of the inspection we found four bathrooms were in an unclean state. Toilets were stained with faeces and we found a blood stained cloth in one toilet. The communal entrance hall and lounge area had a malodour. Two chairs were wet and smelled of urine. We saw communal towels were being stored in bathrooms despite the infection control audit stating they should be removed. In addition, when spare toilet rolls were present in bathrooms they were left exposed to contamination. We observed staff taking dirty laundry to the laundry room. Staff informed us both clean and dirty laundry was transferred within the same box. A staff member said boxes were sprayed and disinfected after each use but we were unable to see any processes in place to show this occurred. We observed a staff member supporting a person in the bathroom. The staff member was not wearing any personal protective equipment. This meant that infection control processes were not being followed as set out in the services own infection control policy.

We reviewed the registered provider's policy in relation to infection prevention and control. There was no reference within the services' policy to 'The Health and Social Care Act 2008, code of practice on the prevention and control of infections' and actions staff should take to improve infection control processes at the home.

The above matters show the provider was not meeting legal requirements in relating to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because they had not ensured processes were consistently implemented to assess the risk of and preventing and controlling the spread of infections.

We asked people who lived at the home and relatives whether or not people were safe at the home. Feedback from people who lived at the home included, "I don't feel safe." And, "I don't know if I am safe." Relatives we spoke with told us they considered people safe. Feedback included, "I think [relative] is safe." And, "I am satisfied with it being safe."

At the last inspection visit carried out in March 2017, we found safeguarding procedures at the registered location were weak and inconsistent. Systems for investigating unexplained injuries were unsuitable and safeguarding concerns were not always reported as per protocol to the local authority safeguarding team. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Following the inspection visit carried out in March 2017, we were informed the manager was now overseeing all falls and unexplained injuries. We saw evidence of safeguarding referrals being made to the local

authority when required. Staff told us they had received safeguarding training and were confident they could identify and report abuse. They were aware of the need to report any safeguarding concerns in a timely manner.

Although improvement had been made, we noted there was a lack of clarity from the registered manager about when safeguarding concerns had been raised and systems followed. Since the last inspection visit the local authority had implemented new guidance in regards to when to raise a safeguarding alert. Changes had been implemented which placed responsibility on the registered provider as to whether or not to raise a safeguarding concern. The registered provider would be expected to use a decision making tool to evidence why or why not a decision to make a safeguarding alert should be made. On the first day the registered manager told us they were now working within the new guidelines and had followed process. This conflicted with the manager's feedback who said they had not been working within the new guidelines and had not used the new document template. We reviewed two safeguarding incidents that had occurred at the home. We asked the registered manager if they had been safeguarded and they said they had. We reviewed the documentation and noted the decision had been made by the manager to not safeguard these incidents. This demonstrated there was lack of clarity about what procedures were being followed and a lack of communication between the manager and registered manager.

We reviewed an incident which had occurred at the home which had resulted in a person having an unexplained injury. Care documentation stated that staff were alerted due to a sensor mat within the person's bedroom sounding. We looked at the electronic recording system which was linked to the sensor mat for the date and time in question. We could see no evidence of the sensor mat being triggered at the time of the incident. We asked the manager why the sensor mat was not showing as being activated when staff had claimed it had. The manager was unable to say why this was so but agreed they should have investigated the incident further for clarity.

Whilst reviewing care records and through discussions with staff and management we were made aware that one person who lived at the home required some equipment to enable them to remain safe at the home. We noted this equipment was not available for the person. We discussed this with the registered manager who told us they had been unable to access this equipment due to family's wishes. The registered manager was aware of this potential to cause harm. They had failed in their duties and not reported it as per their own policy which stated, 'Greenroyd will protect all residents from abuse and will support them seeking treatment and redress in the event they have been abused.'

The above matters show the provider was not meeting legal requirements in relating to Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because systems were not consistently implemented and followed to ensure people were protected from abuse and harm.

At this inspection we looked at the arrangements for the management and storage of medicines.
We observed a senior member of staff administering medicines and noted the staff member followed good practice guidelines. We reviewed four medicines administration records (MAR'S) maintained by the registered provider. Each MAR sheet had the person's photograph and a list of any allergies. The MAR sheet was consistently signed after medicines had been given. Whilst reviewing the MAR sheets we found that not all hand written MAR sheets had been checked and double signed by another staff member to show they were correct. We discussed this with the registered manager who agreed to take immediate action.

Whilst reviewing processes in place for administering medicines we were made aware there was no senior member of staff on duty at night time. We noted some people who lived at the home were prescribed as and when medicines to manage their pain relief. We reviewed one MAR record for a person who was prescribed

pain relief and noted this was last administered by day staff before they finished their evening shift. We received mixed feedback about the protocol in place for prescribing medicines during the night. The registered manager said in the event of a person being in pain, night staff were advised to either call the person's doctor or request help from the person on call. They said if assistance was required the person on call would attend to prescribe medicines. We spoke with a senior member of staff who had on call responsibility. They told us that people who lived at the home had homely remedies written into their care plan. They said on these occasions untrained night staff could respond and administer these medicines. This conflicted with information provided by the registered manager.

We recommend the registered provider reviews their medicines policy to ensure good practice guidelines are reviewed, consistently implemented and person centred.

We looked at recruitment procedures to ensure people were supported by suitably qualified and experienced staff. We found suitable processes were in place. The registered provider sought references for candidates, checked personal identification and reviewed their employment history prior to offering employment. We looked at processes in place to ensure that staff were not able to work without a valid Disclosure and Barring Service check (DBS). A valid DBS check is a statutory requirement for staff providing a personal care service supporting vulnerable people.

We also looked at documentation relating to the health and safety of the home. We noted all required certification was up to date, regular maintenance checks took place and comprehensive records were maintained.

Requires Improvement

Is the service effective?

Our findings

At the inspection visit carried out in March 2017, we found the environment was not wholly inclusive and did not fully cater for the needs of people living with dementia. Greenroyd Residential Home is registered to provide a service for people living dementia and therefore we recommended the service consulted with and implemented good practice guidelines in relation to dementia friendly environments.

At this inspection carried out in August and September 2017, we undertook a visual inspection of the home. We noted the environment still did not meet the needs of people living with dementia. For example, carpets in communal areas had large patterns. Large patterned carpets can confuse people living with dementia and can contribute to falls as they can affect spatial awareness. Universal, non-personal signage was still in use on bedroom doors. High contrasting equipment had not been introduced to promote people's independence. There was no equipment or signage around the home to assist people with time and date orientation. On two occasions we observed people who lived at the home looking confused and asking for direction. People told us, "I have no idea where I am going." And, "We don't know where we should be."

We spoke with the registered manager about promoting a dementia friendly environment; they said they were in the process of starting to make bedroom doors personal but this had not yet been completed.

This was a breach of Regulation 15 of the Health and Social Care Act 2008, (Regulated Activities) 2014 as the registered provider had failed to ensure premises and equipment were suitably maintained and intended for purpose.

We looked at staff training to check staff were given the opportunity to develop skills to enable them to give effective care. Staff told us they had no concerns and felt training was appropriate to their need. We spoke with the manager about the service's training and development plan for staff. They told us staff training was planned every year following staff appraisals. They told us the services policy was that safeguarding of vulnerable adults, infection control and first aid training should be refreshed every three years.

Following the inspection carried out in March 2017 the manager had reviewed the training matrix and had revised this to show actual dates staff had completed training. A training matrix is a document which records all staff training and allows the service to identify where gaps in training lie so training can be planned. We looked at the training matrix and noted staff had not received all the training required as set out by senior management. For example, twelve staff had no up to date first aid training, one person had not received safeguarding refresher training for seven years and eighteen staff had no up to date infection control training.

We looked to see what training had been provided in relation to new policies and procedures introduced at the home. We found no evidence to show additional training had been provided in relation to the new policies implemented at the home. For example, requirements set out in the slips, trips and falls including having staff trained in first aid and neurological observations. There was no evidence of this occurring. We spoke with the registered manager about this policy. They confirmed no additional training had been

provided to staff in order for them to be able to carry out these tasks.

The above matters show the provider was not meeting legal requirements in relating to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the registered provider had failed to ensure staff had received the appropriate training and professional development necessary for them to carry out their roles.

We spoke with two members of staff who had been recently employed. We noted one staff member had just started their induction and were shadowing staff on shift that day. We observed staff giving the new employee support and guidance whilst carrying out tasks. Another staff member told us they had been at the home for approximately six months. They confirmed they undertook an induction period at the commencement of their employment.

We spoke with staff about supervision. Supervision is a one to one meeting between the staff member and a senior member of the staff team to discuss any concerns and training needs. Staff confirmed they received regular supervision. They said managers were approachable and they were not afraid to discuss any concerns they may have in between supervisions.

At the inspection carried out in March 2017, we recommended the registered provider reviewed and implemented good practice guidelines to enhance the experience of meal times for people who live at the home.

At this inspection visit carried out in August 2017 we asked people who lived at the home and relatives about their views on the quality and availability of food at the home. Feedback included, "The food is okay, lunch is twelve o clock regular." And, "We think the food is good."

The registered manager told us that following the March 2017 inspection they had introduced a deployment schedule which meant that at least one member of staff would be deployed to each dining area at all times. They would be supported by another member of staff. They said they had also introduced drinks over meal time.

On the first day of the inspection visit we observed lunch being served. We found organisation and deployment of staffing was poor. We observed people being taken into the dining area forty minutes before lunch was due to be served. Deployment of staffing did not reflect information directed within the staff deployment schedule. We observed staff worked alone in dining areas and had to multi-task to meet people's needs. For example, we observed one staff member supported one person to eat their meal. In addition, they were also clearing people's plates away and bringing meals from the kitchen area. Drinks were placed in dining areas but these were left on the side and not routinely offered to people.

There was a choice of meals available however one person was not offered any choice and was served egg and chips. The person did not eat this meal and was not offered any alternative despite telling staff they did not want it and did not like it. We discussed this with the person's relative. They told us the person did not have their teeth in at lunch and the meal provided would have been difficult for the person to eat. We highlighted this to the registered manager. They told us the person had refused to wear their teeth before lunch was served. Staff had failed to take this into account when providing the person with a suitable meal.

When providing feedback the registered manager could offer no explanation for our observations of people's experience.

On the third day of the inspection visit, the registered manager asked us to observe lunch once again to see if there was any difference. We noted the lunch time experience was much more positive. We observed staff being suitably deployed to ensure people's needs were met. People were offered drinks during their meal and staff appropriately engaged with people. For example, we observed a staff member motivated a person to eat and offered them praise when they had eaten their food.

We looked to see how people received appropriate levels of fluid. We observed drinks being served during the morning and afternoon. We noted however people were not offered choices as to what they wanted to drink and no cold drinks were offered to people. On the first day of inspection no accompanying snacks were made available with drinks.

We looked at how people's health care needs were met to ensure people received effective care. Relatives told us health needs were monitored and action taken when people required support with health care. Feedback included, "I was contacted after my [relative] had fallen. They told me they were going to call the doctor." And, "The home has got the doctor and the district nurse to [family member.]" One relative told us their family member had been hospitalised with a health condition. They said they were now fit and well.

We looked at care records for people who lived at the home. We saw evidence of health professionals being consulted with in a timely manner. This included people's doctors, dietitians and opticians. Records were maintained to show the outcome of each health professional's visit. This enabled staff to understand what action was to be taken so health could be monitored and enabled them to be able to communicate with other health professionals.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Greenroyd Residential Home had a locked door policy to ensure people who lived at the home were safe. This had been considered and DoLS applications had been made to the Local Authority to ensure all restrictions placed upon people were lawful. We saw evidence these applications were routinely followed up to check on their progress. In addition, when new restrictions were identified these were communicated with the local authority.

We looked at care records and found the service acted lawfully when supporting people to make decisions. We noted when people did not have capacity and decisions were to be made good practice guidance was followed. During our discussions with the registered manager and manager we were made aware of one situation when a decision had been made on a person's behalf which had not been made following the best interests process. We highlighted this to the manager who agreed to review this.

Requires Improvement

Is the service caring?

Our findings

We received mixed feedback from people who lived at the home about the caring nature of staff. Feedback included, "I like some staff." And, "Staff say I make too much of a fuss." Also, "I am happy with the care." And, "Staff only just look after me."

Relatives we spoke with also provided us with mixed feedback. This included, "I am happy with the care." Also, "[Relative] is happy here. They smile when they see staff." And, "Some of the staff aren't nice to [my relative.] I can understand if staff get frustrated or annoyed but I find it difficult to take."

We found dignity and respect were not always considered when staff delivered care and support. For example, we observed a member of staff administering a pain relieving patch applying to a person's skin. We watched the staff member adjust the persons clothing and place the patch on the person's body. This was done in front of other people and visitors sitting in the communal lounge and compromised the person's dignity and privacy. We spoke to the registered manager about this. They told us they did not move the person from the communal area as moving the person would cause additional pain and discomfort for this person. They said this had been discussed and agreed with the person's relative. Although this had been agreed, no further controls were put in place to respect and promote privacy for the person. In addition, we observed a staff member placing a person in an incontinence pad. When the relative told the staff member the person did not wear continence pads the staff member tried to reassure them saying, "It was a spare one we had." We looked within the person's care record. This recorded the person did not wear incontinence pads. The manager confirmed this was accurate. This action from the staff compromised the person's dignity and restricted their autonomy.

This was a breach of Regulation 10 of the Health and Social Care Act 2008, (Regulated Activities) 2014 as the registered provider had failed to ensure people were treated with dignity and respect at all times.

We looked to see if person centred care was delivered to people. We found staff did not always have the knowledge to deliver person centred care. We asked an established member of staff about people's individual needs and requirements. They were unable to give us basic information about people who lived at the home including people's names. We raised these concerns with the registered manager. They told us they were unsure why this staff member did not know this information as they had received an induction at the start of their employment.

On the first day of the inspection visit, we were informed by a relative that staff on duty had been unable to locate their family member's teeth. These were located later in the day by another member of staff. The staff member told us they were hidden in a specific place where the person always stores them. This information was not documented within the person's care record so person centred care could be delivered. In addition, the relative told us the person's favourite meal was carrots. Carrots had been served at lunch but not offered to this person in a consistency they could enjoy.

One person had been seated in a chair in the dining room for lunch. Following lunch we observed the

person struggled to get out of the chair. The chair had no arm rests upon it. This meant the person could not use the arm rests to push themselves up. It took the person three attempts to stand up with assistance from two staff members. One of the staff members commented, "They have sat you in the wrong type of chair."

The above matters show the provider was not meeting legal requirements in relating to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had failed to ensure person centred care was consistently delivered.

On the first day of the inspection visit we observed mixed interactions taking place between staff and people who lived at the home. At times staff were rushed and had minimal interactions with people who lived at the home. Interactions during busy times were task focussed and tended to be directive. For example telling people to "Eat up," and "Stand up." On another occasion however, we observed one staff member supported a person who lived at the home to have a drink. The interaction was good and there was a light banter between staff and person receiving support.

On the third day of inspection we noted some improvements in interactions between people who lived at the home and staff. We observed the manager sat with one person who was anxious. The manager offered reassurance and acted to improve the person's self-worth and confidence. The person responded well to this and embraced the manager. We observed interactions between a new member of staff and people. They made small talk at lunch time whilst people ate their lunch. For example, they enquired with people asking them how their lunch was. On another occasion the staff member praised a person saying, "You have done smashing."

During the inspection we observed staff knocked on doors before entering. They did this to seek permission to enter rooms whilst people were in their own private space. This showed us privacy was considered.

Requires Improvement

Is the service responsive?

Our findings

Relatives told us they were consulted with during the care planning process. Feedback included, "I was consulted about the care plan, and [staff member] came to our house before [family member] came here. Times of getting up and going to bed were discussed. I wasn't asked about bath or showers." And, "We had a care plan review with [staff member] and other family members."

At the last inspection visit carried out in March 2017, we recommended the service referred to and implemented good practice guidelines to ensure person centred care was implemented within care planning records and care delivery. We used this inspection process to see what improvements had been made.

We looked at care records related to eight people who lived at the home. Care plans addressed a number of topics including personal care, diet and nutrition needs and personal safety. Although reviews of care records had taken place they were still not person centred. For example, one person's care record stated the person required full assistance with personal care but did not detail the person's likes and preferences. In addition within one person's care plan it stated the person had been bereaved. There was no information to state what the bereavement was, when it occurred and how staff could adequately support the person with this.

We spoke with the registered manager about their plans for making records more person centred. They told us the manager had started liaising with the local authority to develop a new care plan record and risk assessment template which would enable them to make the care records more person centred. They showed us the first care record completed and said they hoped to roll this out so that all care records were in the new format.

We looked at activities provided for people who lived at the home. One relative told us they had seen people playing ball games and skittles when they had visited. Another relative told us their family member liked to play the piano. They said however they didn't think they had played it for a long time.

There was an activities schedule placed outside the lounge area which had pictorial information about activities on offer. This stated that activities took place each day between 14:00 and 16:00. We reviewed the activities on offer and noted activities did not always reflect the needs of people who lived at the home as they failed to take into consideration people were living with dementia.

On the first day of the inspection visit we watched the activity taking place. The activity for the day was ball games. We observed a staff member throwing a ball to people who lived at the home. The member of staff tried to include all people sat in the lounge, including those who could not join in independently. We saw this activity was interrupted as the staff responsible for providing the activity had to go and assist other people as no other staff were available. It was noted the activity only lasted for fifteen minutes. We observed no other activities taking place during the day.

We recommend the registered manager consults with good practice guidelines to ensure activities provided at the home are relevant and take into consideration people's individual needs.

We spoke with people who lived at the home and their relatives to ensure they felt their concerns were responded to in a timely manner. Relatives we spoke with had no complaints on the day in question but told us they had raised some concerns previously with the registered manager which had since been actioned. Concerns included, "I have raised a concern about mid-afternoon snacks not being served on a side plate or napkin." And, "I have spoken with management about clothing not being correctly hung and [family member] looking dishevelled."

The registered manager said they kept a record of complaints made and they reviewed this on a regular basis to ensure action had been taken. We were told by the registered manager no formal complaints had been raised since the last inspection visit. This meant none of the concerns stated above had been formally documented.

We recommend the registered manager consults with good practice and reviews their complaints policy to ensure all concerns and complaints are captured in an appropriate manner.

Inadequate

Is the service well-led?

Our findings

At the inspection carried out in March 2017, we found records were not accurate, contemporaneous and reflective of people's needs. This meant safe and effective care was not consistently delivered. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At this inspection carried out in August and September 2017, we found some improvements had been made. We found staff were now weighing people and recording this consistently. The manager had started to review all accidents and incidents and had started completing descriptive records following each accident. Bed rail risk assessments had been added to peoples care records when people required the use of bed rails.

Although there was improvement, not all records were still consistently completed. For example, we reviewed four turning charts in place for people at risk of acquiring pressure ulcers. Turn charts we viewed did not have people's names on them, nor did they indicate how often the person was to be turned. Two turn charts had been inconsistently completed and there was not consistent evidence to demonstrate people had been turned in accordance with their care plan and risk assessment. We found care plans were amended but were not signed and dated to show who and when they had been updated by. We reviewed an accident report for a person who had sustained a serious injury. The serious injury was not diagnosed for a significant time after the incident had occurred. The accident report had not been updated to reflect the injury sustained.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 (Good governance) as the registered provider had failed to ensure records maintained were accurate.

At the last inspection visit we identified shortfalls within the services' auditing systems. At this inspection visit we found the registered provider had devised a formal auditing system which included auditing accident reports and reviewing falls at the home. In addition they had started auditing care plans on a monthly basis. Although these auditing systems were in place they had been ineffective as they had failed to identify the concerns picked up at this inspection in August 2017. For example, audits of files had taken place but had not identified the inaccuracies in paperwork we identified.

We found systems implemented since the last inspection were unclear and did not always reflect organisational policy. For example, the registered provider had referred to HSCA Regulations and had introduced an infection control process to improve standards of hygiene at the home. Although this had been introduced the service's individual policy had not been amended to reflect the requirements of the Regulation. Consequently, infection control standards had not improved.

The management team had made improvements since the last inspection however further work is required to ensure the fundamental standards are understood and embedded within the home. When protocols had been introduced, there was no oversight to ensure staff were aware of responsibilities and processes were consistently followed. For example, safeguarding protocols at the home continued to be unclear. In addition

the slips, trips and falls policy had not been consistently implemented within the service and staff had not been provided with the appropriate support to follow the process set out.

Risk was not always actively assessed and mitigated. Risks were managed reactively rather than proactively. For example, after a fall had occurred rather than putting measure in place to prevent the fall.

Care and support provided was based upon intuition rather than evidence based practice. For example, the registered manager had failed to consider good practice guidelines to improve the living environment and management of falls.

This was a breach of Regulation 17 of the Health and Social Care Act 2008, (Regulated Activities) 2014 (Good governance) as effective systems were not in place to ensure the safe care and treatment of people who lived at the home.

We found communication between the registered manager and manager to be inconsistent. This resulted in the delay of action being taken. For example, on the first day of inspection we relayed two incidents of significant concern to the registered manager so action could be taken. This information was not acted upon by the registered manager and was not passed on to the manager when they went on leave. This meant there was a delay in action being taken and evidence gathered in regards to the concerns.

The vision and values of staff were inconsistent. Person centred care and the principles of dignity and respect were not routinely considered by staff when delivering care.

At the inspection carried out in March 2017, we identified a breach to Regulation 18 of the Care Quality Commission Registration Regulations 2009. At this inspection visit we found improvements had been made. The manager had reviewed systems in place and provided the CQC with the statutory notifications in a timely manner. We saw evidence of serious injuries and safeguarding notifications being made as required.

We spoke with relatives to see if they were consulted with regarding the ways in which the home was managed. Two relatives' meetings had taken place since the last inspection. Relatives told us the registered manager had discussed the March 2017 inspection report at the meeting. This demonstrated the registered manager was being open and transparent. Relatives were positive about the meetings and said they were able to contribute. Relatives told us they had just received an annual questionnaire to complete. They said this had only just been received but they had been invited to complete it to give formal feedback on the service. This showed us that quality assurance processes were in place and relatives were consulted with.

We spoke with staff who worked at the home. They described a positive working environment and said on the whole teamwork was good. Two staff said however teamwork and outcomes at the home was dependent on which staff team were working. One staff member said there were staff at the home that required additional support and this needed taking into consideration in the future. They said, "Teamwork is good if you have the right team."

As part of the inspection process we looked to ensure the registered provider had their performance assessment on view as set out in the 2008 Health and Social Care Act. We saw the performance assessment was on view as required.