Buckland Rest Homes Limited

Greenbanks Care Home

Inspection report

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Hampshire
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09 February 2023
10 February 2023
21 February 2023

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Greenbanks Care Home is a residential care home providing personal care and accommodation for up to 30 people. The service provides support to older people, some of whom were living with dementia. At the time of our inspection there were 24 people using the service. The home provides care for people in one building across two floors.

People's experience of using this service and what we found
On our inspection we found systems to oversee the quality and safety of the service were not effective throughout all levels of management.

Medicines were not being properly and safely managed. There were omissions and errors, a lack of stock control and monitoring, lack of training and effective auditing. Systems to identify and mitigate risk were not effective. People were at increased risk of harm due to poor infection control procedures. Risks related to the premises were not safely managed.

We found the principles of the Mental Capacity Act 2005 (MCA) were not always followed, for example in relation to the use of bed rails, sensor mats and CCTV. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible, and in their best interests; the policies and systems in the service did not support this practice.

The provider did not ensure that recruitment checks were carried out in line with the law. People were at increased risk of being cared for by staff without the knowledge and skills to fulfil the requirements of their role. People's assessments and care plans were not always accurate or complete.

Staff did not always receive and complete all training in line with their role during their induction . There were staff who required or were overdue updates in key areas relevant to their role, such as medicines; mental capacity and DOLs; moving and handling; fire drills; safeguarding adults; food hygiene; dementia; falls and health and safety.

People told us "the staff are very good." and "there's always [staff] about. [staff] are very nice."

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

Rating at last inspection and update
The last rating for this service was good (17 July 2019). We carried out a targeted inspection on the key questions of safe and well-led, where we inspected but did not give the service a rating (9 February 2021).

Why we inspected
This inspection was prompted by a review of the information we held about this service. We also received

concerns in relation to staffing, training and risks. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

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.

The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement
We have identified breaches in relation to consent, safe care and treatment, good governance, staffing and fit and proper persons employed at this inspection.

Please see the action we have told the provider to take at the end of this report.

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

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service well-led? The service was not always well-led. Details are in our well-led findings below.	**Requires Improvement**

Greenbanks Care Home

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 Health and Social Care Act 2008.

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
This inspection was undertaken by 2 inspectors on-site, assisted remotely by 1 medicines inspector and an Expert by Experience on-site. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Greenbanks 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. Greenbanks is a care home without nursing care. 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 a registered manager in post.

Notice of inspection

This inspection was unannounced.

Inspection activity started on 9 February 2023 and ended on 23 February 2023. We visited the service on 9, 10 and 21 February 2023.

What we did before the inspection
We used information gathered as part of monitoring activity that took place on 19 January 2023 to help us plan the inspection and inform our judgements. 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. We used all this information to plan our inspection.

During the inspection
We spoke with the owner and nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We spoke with 5 members of staff, including the registered manager. We spoke with 8 people using the service, 1 person's relative and 1 visiting health and social care professional.

We reviewed sections of 9 people's care plans, a number of medicines records and other care records. We reviewed policies and procedures, training records, staff recruitment files, audits and other records in relation to the running of the service.

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 good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

● The provider did not keep accurate records of medicines administration. There were entries on the provider's electronic medicines administration record (EMAR) which were completed by staff members who were not at the service at the time of administration. It was later found that untrained staff had been using the log in details of trained staff to record medicines administration. Therefore, these records were not accurate and untrained staff had been administering people's medicines. This placed people at risk of harm.

● Controlled drugs (CDs) are medicines that come under strict legal controls. We found CD stock balances were incorrect and did not reflect accurate totals within the building. The CD register contained errors, lacked essential information and CDs had not been accurately signed into the building by the 2 staff as required. Therefore, the provider was not meeting the legal requirements for the management of these medicines.

● Additional cautionary instructions for certain medicines were not being followed. For example, one person's EMAR documented that a medicine needed to be administered 30 - 60 minutes before food and other medicines. However, this was being given at the same time as their other medicines. Some people who had medicines prescribed for night-time administration were receiving these up to 4.5 hours early, this type of medicine can make you drowsy and by not following the prescribed instructions this had increased the risk of harm to people.

● The provider did not always ensure there were adequate supplies of people's medicines in place. For example, one person did not have their Parkinson's medication as prescribed for a period of 7 days, this meant they may have experienced increased symptoms. 4 people's records showed that there were 120 missed doses of a medicine over a 63 day period due to a lack of supply at the service.

● Systems to ensure time specific medicines were given appropriately, such as medicines for Parkinson's disease and diabetes, were not suitably robust. For example, 2 people had received their Parkinson's medicine more than 1.5 hours late on 100 occasions over a 63 day period.

● Some people were prescribed 'as needed' (PRN) medicines, which require clear protocols for their use. Guidance in the form of protocols or care plans were not always in place or person centred. This meant the provider could not be assured PRN medicines were always administered consistently. Where a person was prescribed the use of a transdermal patch the area of the body the patch was applied too was not always being alternated. This could lead to an increase in adverse reactions or potential overdose of a medicine.

People's medicines were not being properly and safely managed. This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Due to the level of concerns around medicines we raised a safeguarding concern to the local authority,

who have now visited the service and are providing support.

Assessing risk, safety monitoring and management
● An external fire risk assessment completed in October 2021, identified several significant findings. The provider had documented when required actions had been completed. However, some of the issues found on this inspection were the same as the concerns raised in the external report. Therefore, actions taken had not been effective in reducing risks related to fire safety.
● Storeroom doors were not fire rated doors, some had holes in them, missing intumescent strip, and doors which had fire signs on them stating 'Fire Door Keep Locked' were unlocked. Some did not have fire detection; this meant the fire alarm system would not have detected a fire in those areas.
● Risks related to the premises were not always safely managed. For example, there were no window restrictors in place for 2 windows on the first floor including a bedroom, these areas were accessible to people who are living with dementia. This was raised with the registered manager on day 1 and 2 of our inspection, on day 3 these were still not in place nor were measures taken to ensure safety of people for example, to lock the windows until the restrictors were fitted.
● There were no emollient risk assessments in place for people who were prescribed topical creams. The use of these creams can pose an increased fire risk. People were at increased risk of burns and scalds due to the provider not ensuring bath water temperature checks were completed. Oil filled radiators were found in bedrooms that were not covered. Radiators throughout the building were not covered and there was no evidence of recorded mitigation to risk.
● Risks related to people's health and medical conditions were not always managed safely. For example, one person's diabetes care plan contained conflicting information which meant it was not clear how staff should monitor the person's condition and escalate concerns. This meant the person was increased risk of harm.

Failure to manage risks to people's health and safety was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider responded after the inspection. They confirmed the window restrictors were now in place.
● Due to the level of concerns around fire safety, we raised a referral to Hampshire and Isle of Wight fire and rescue service, who have now visited the service.
● The provider was signposted to the Health and Safety Executive for further guidance on hot surfaces control and mitigation.

Preventing and controlling infection
● There were concerns around the infection control within the home. The home was currently experiencing an outbreak of Covid, we were not made aware of the outbreak straight away on our arrival. Covid positive people were in their bedrooms with the doors wide open, there were no signs on bedroom doors informing of infection and PPE requirements.
● Staff were not donning and doffing in the correct way when going into and coming out of the bedrooms where people were Covid positive. We observed staff going into Covid positive bedrooms without the required PPE, then coming out and going to areas were non Covid people were, this increased the risk to people who were not Covid positive becoming infected.
● We observed staff wearing false nails, nail varnish, rings and bracelets. The chef was serving food wearing a woolly hat and no mask. Staff were observed wearing their masks under their noses and chins, some other staff in the building were seen not wearing masks.
● Cleaning schedules showed gaps and multiple entries on one page. There were no cleaning schedules for high touch point areas. Clinical waste bins containing infected waste were in corridors, which other people

used to access areas of the home.
● Infection control within the building was poor considering the home was in outbreak. Staff were not wearing the correct PPE or donning and doffing in the correct way. The registered manager had not informed UK Health Security Agency (UKHSA) regarding the Covid outbreak and no risk assessment was in place in line with government guidance.

The provider had failed to ensure that systems to prevent and control infection were implemented effectively. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Due to the concerns around infection control we made a referral to the Hampshire and Isle of Wight Integrated Care Board.
● The provider was signposted to resources to develop their approach in relation to preventing and controlling infection.

Staffing and recruitment
● Recruitment checks were not always carried out in line with the law. Not all staff had the appropriate checks before being employed in the service. This included obtaining a full employment history and evidence of conduct in all relevant previous employment.
● Staff files also indicated that not all staff had received their DBS checks prior to working within the home. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● People were asked if there was enough staff to get the care they needed when they wanted it. There was mixed feedback which included, "No, not all the time, you have to wait for it,", "I wish there were more staff so when I ring my bell, they come a bit quicker and very often at night time, there is only 2" and, "I have to ring my bell and wait for them to come. It depends if they're attending to someone else or not but they're usually really quick."
● During our inspection there were enough staff in place to meet people's needs. We raised the feedback from people regarding 2 staff at night and the registered manager told us that at night they will have an additional staff member as a sleep in however, this was not recorded on the rota.
● The registered manager assessed people's needs using a dependency tool to determine appropriate staffing levels.

The failure to ensure appropriate staff recruitment processes were in place was a breach of Regulation 19(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● There was an appropriate safeguarding policy in place to safeguard concerns promptly, using local safeguarding procedures. Issues had been reported appropriately and investigated. Staff understood signs of abuse or neglect and they felt confident to report any concerns.
● People stated they felt safe and that they were happy.

Learning lessons when things go wrong
● During inspection there were no effective system to monitor and analyse trends and patterns to ensure that lessons were learnt.
● The falls incident log did not correspond with the amount of falls that occurred during the month of February. For example, on reviewing one person's care plan it was documented that they had a fall and

needed support to stand from 4 care staff. However this was not recorded on the falls incident log nor was there any evidence of a falls protocol form or follow up.
● The registered manager confirmed that a member of staff is preparing to introduce a new auditing system focusing on falls and root cause analysis to identify trends.

Visiting in care homes
● Visiting arrangements at the home were in line with current guidance.
● Feedback included, "I go out a lot with my family. I can see them any time I like." One relative told us "I can come in whenever I want as long as I don't come before 9, but that suits me down to the ground any way."
● During our inspection we saw visitors arriving and visiting their relatives in the home.

Requires Improvement

Is the service effective?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The 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 MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● The provider did not always ensure that decision specific mental capacity assessments (MCA's) and best interest decisions were carried out in relation to bed rails. We did not find that bed rails were used to restrain people, however the provider was not following the principles of the MCA.
● We found other examples where the provider was not following the principles of the MCA when supporting people to make specific decisions. For example, there were no MCA's or best interest decisions for some people who required sensor alarms to reduce the risk around falls. In other examples, there were no MCA's or best interest decisions for some people regarding CCTV in the building. There were also no consent forms from people who had capacity regarding CCTV.
● We found that a deprivation of liberty safeguards (DoLS) had been applied for a person, however the mental capacity assessment that had been completed stated the person had capacity. This showed a lack of staff knowledge around the principles of the Mental Capacity Act (2005).

Failure to obtain consent from the relevant person for care or treatment decisions is a breach of Regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● Some staff had been administering medicines without receiving training and having their competency assessed. Some staff had issues identified in competency assessments that were not followed up. This

meant that staff were not always suitably trained or skilled to carry out these tasks. This put people at risk of medicine errors.
● There were staff who had worked in the home for several months who had not received all the required training in line with the provider's induction policy, competencies in moving and handling and infection control were not always in place for all staff. Some staff were overdue updates in key areas relevant to their roles, such as medicines; mental capacity and DOLs; moving and handling; fire drills; safeguarding adults; food hygiene; dementia; falls and health and safety. This meant people were at risk of being cared for by staff without the knowledge and skills to fulfil the requirements of their role
● Staff had not received training around specific conditions, for example, Parkinson's. Staff had not received training in oral health care and some staff were showing as 'NA' in privacy and dignity.
● Fire evacuation drills were not robust. Fire drills were taking place, however there was limited information on the scope and whether drills included simulation of evacuation of the largest fire compartment with the fewest staff that would be available. There were no actions or learning identified from drills. Fire evacuation equipment had not been used in drills to ensure staff were familiar and confident in its use.

The failure to ensure staff received appropriate training was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Supporting people to eat and drink enough to maintain a balanced diet
● People were supported to eat and drink enough to maintain a balanced diet. People told us they enjoyed their meals and were given a good variety of options. The home had a 4-week menu which was devised with the input of people.
● Feedback from people about the meals was positive, for example, "Reasonable choice, it's usually good. Portion size is adequate." and "food is good, we have two choices. They come round and ask us what we want in the morning." and "There is plenty of it and it's free, that's even better."

Assessing people's needs and choices, delivering care in line with standards, guidance and the law
● Pre-Admission assessments did not always contain sufficient information to fully reflect people's needs. For example, they did not always contain date of assessment, who completed the assessment, where the assessment took place, medication prescribed, and allergies were not always recorded. The lack of detail was reflected in peoples care plans which did not always contain enough guidance for example, for someone who had a diagnosis of Parkinson's disease.
● The provider utilised a range of nationally recognised tools to ensure people's needs were assessed. For example, the use of the Malnutrition Universal Screening Tool (MUST) to monitor people's risk of malnutrition. There was evidence of people being weighed regularly.

Staff working with other agencies to provide consistent, effective, timely care. Supporting people to live healthier lives, access healthcare services and support.
● There was evidence of working with other agencies such as district nurses and chiropodist.
● People had access to regular healthcare services such as GPs, opticians, chiropodists and were supported to attend regular appointments in relation to their health conditions. People confirmed this and comments included, "I have an optician, that's something I can do." and "Very on the ball there, I can't fault them for anything to be honest."
● Feedback from relatives when asked if staff make sure other services were organised for their relative included, "[Relative] has seen an optician and got new glasses."

Adapting service, design, decoration to meet people's needs
●The home was spacious and light and suitable for people's needs. There was a range of communal areas

which people can use and utilise for different activities throughout the day. Bathrooms could accommodate people who required support with moving and transferring to the bath. People appeared comfortable and happy in their home environment.

● Most of the bedroom doors were personalised with memorabilia that was easily recognisable by the person whom the bedroom belonged to. People were able to personalise their rooms as they wished. We saw rooms were individual to people's tastes and contained items personal to them.

Requires Improvement

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 good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- At this inspection, we found breaches of five regulations. The provider had failed to ensure good governance, safe care and treatment, need for consent, fit and proper persons employed and staffing.
- Audit systems for identifying, capturing and managing organisational risks and issues were ineffective and did not drive improvement. They were not robust and did not provide an effective system to systematically identify the widespread and significant concerns identified on inspection.
- A medicines audit completed by a staff member 4 days prior to our visit showed 100%, with no issues identified. This did not reflect our findings on inspection. A staff member completed a fire door audit 1 day prior to our inspection which showed 97%, with no actions identified. This did not reflect our findings on inspection.
- People's care records were not always consistent or complete. Care plan audits did not pick up on the information that was lacking such as MCA's and consents or the inconsistencies with a diabetic plan.
- The regional manager did not effectively oversee the quality of tasks delegated to the registered manager, including audits of key areas of the service. This meant governance systems were ineffective in identifying and responding to risks.

Failure to ensure systems were in place to monitor and mitigate risks to people and maintain accurate and complete records is a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- We spoke to the regional manager about staff's knowledge and understanding of the electronic auditing system as the governance and oversight of the service was not robust or effective. The regional manager confirmed they would provide additional training around the auditing system to support staff make the improvements required.

Continuous learning and improving care

- The provider, registered manager and regional manager were open to receiving feedback during the inspection about the widespread issues we highlighted and have since taken steps to make improvements. However, improvements made are initial and not fully embedded or sustained.

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

- The registered manager was engaging throughout the inspection process. They were open and

transparent where issues were identified and remained positive and focussed to address these.
● Staff were friendly and seemed motivated in their roles.
● Feedback from people included "They are so lovely. [The registered manager] has always got time for you." And a relative told us, "[Staff] look after people well really, I think. I can't fault any of the staff."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The registered manager understood their responsibilities to be open and honest, and the requirements of duty of candour with people or their loved ones where something went wrong.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● There were records of meetings with people to gain their views and feedback. However, feedback from one person included, "Not very many meetings, occasionally we have them but not many." And "I have been asked once or twice to fill in a questionnaire, so that's no problem."
● Staff meetings took place and were well attended. These were an opportunity to discuss changes within the service and to identify areas for improvement.

Working in partnership with others
● The registered manager worked with other providers and this was evident in care records. They had made referrals to other healthcare professionals and arranged appointments as required. These included district nurses, GP's, and opticians.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Failure to obtain consent from the relevant person for care or treatment decisions is a breach of Regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The failure to ensure appropriate staff recruitment processes were in place was a breach of Regulation 19(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The failure to ensure staff received appropriate training was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's medicines were not being properly and safely managed, failure to manage risks to people's health and safety and failure to ensure that systems to prevent and control infection were implemented effectively. This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Served a warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Failure to ensure systems were in place to monitor and mitigate risks to people and maintain accurate and complete records is a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The enforcement action we took:

Served a warning notice