Greenroyd Residential Home Limited

Greenfield House

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
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 03 and 04 March 2016.

Greenfield House is situated in Morecambe and is registered to provide care and accommodation for up to 33 people living with dementia. All accommodation is offered on a single room basis. The home has a variety of communal areas for people to use. There are passenger and stair lifts for ease of access between floors. There were eighteen people living at the home on the days of inspection.

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 registered with the Care Quality Commission in December 2015. This was the first inspection of the home under the management of the new registered provider.

At this inspection, we found people were not always safe. The registered provider had failed to implement suitable systems to ensure risks to people's health and safety were appropriately monitored and managed.

Risks were not consistently identified, monitored and managed in a proactive way. Audits of accidents and incidents and audits of people's weights had not been carried out. This meant the registered manager had failed to identify and manage risks to people who lived at the home. This was a breach of Regulation 12 of the Health and Social Care Act (2008) (Regulated Activities) 2014.

Care plans were not consistently complete and accurate. Care plans had not been reviewed after significant events and had not been audited to ensure they were accurate and reflected people's needs. This was a breach of Regulation 17 of the Health and Social Care Act (2008) Regulated activities 2014.

Deployment of staffing was not conducive to meet people's needs. Staff told us they did not have sufficient time to carry out all their required activities. People who required supervision did not always receive this in a timely manner and in accordance with their care plan.

Eleven staff had left employment since the registered provider had taken over the service and no staff had been recruited to fill the voids. Staff said they were expected to complete extra shifts to manage the voids. This was a breach of Regulation 18 of the Health and Social Care Act (2008) (Regulated Activities) 2014.

Staff who worked at the home told us they felt unsupported and were not appropriately trained to carry out all tasks required of them. The registered provider had started to appraise staff skills but did not have a training programme developed to demonstrate these training needs would be met in a timely manner. This was a breach of Regulation 18 of the Health and Social Care Act (2008) Regulated Activities 2014.

Staff had a sound knowledge of safeguarding and were aware of their responsibilities for reporting any concerns. However processes in place did not ensure all safeguarding alerts were communicated to management and reported accordingly. This placed people at risk of harm. This was a breach of Regulation 13 of the Health and Social Care Act (2008) Regulated Activities 2014.

The registered provider had suitable arrangements in place for managing medicines. Medicines were safely stored and appropriate arrangements for administering them were in place. Staff had been assessed by the registered provider prior to being permitted to administer medicines.

People's healthcare needs were not consistently monitored and referrals were not always made to health professionals in a timely manner when people's health needs changed. This was a breach of Regulation 12 of the Health and Social Care Act (2008) Regulated Activities 2014.

Staff had an awareness of The Mental Capacity Act and Deprivation of Liberty Safeguards. When people lacked capacity we saw evidence that decisions were made following a best interest's process.

Relatives and people who lived at the home spoke positively about staff providing care. We observed positive interactions between people who lived at the home and staff. Staff displayed compassion, patience and understanding. People were treated with dignity and respect.

People who lived at the home and relatives did not express any complaints about the food provided. However staff raised concerns about the new systems of work in place to ensure people had a suitable and sufficient diet. We have made a recommendation about this.

Staff told us they were sometimes limited to providing social activities due to other constraints. However, we observed social activities being provided for people who lived at the home. The registered manager said there were plans being developed to improve social activities.

Feedback from relatives in regards to service quality was positive. The registered provider engaged with people who lived at the home and their relatives to ensure service quality was appropriate to people's needs.

Staff told us morale was low and relationships with the registered provider were limited. Staff did however have confidence in the registered manager and had begun to foster positive relationships based on trust with them.

The registered manager acknowledged there were concerns in the ways in which the service was being managed and organised. They said they were committed to making improvements to ensure the service was safe, effective, responsive and well-led.

The overall rating for this service is 'Inadequate' and the service is therefore 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.

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 told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not consistently safe.

Staff had some knowledge of principles of safeguarding but did not always identify safeguarding concerns as they occurred. Processes were in place to protect people from abuse but we found these were not consistently applied.

Suitable arrangements were in place for management of all medicines.

The provider had failed to ensure that staffing levels were deployed to ensure the safety and welfare of the people who lived at the home.

Risks had not been appropriately managed and monitored to ensure people were safe.

Is the service effective?

Inadequate

The service was not always effective.

People's health needs were not consistently monitored to ensure advice was sought from health professionals in a timely manner, where appropriate.

People's dietary needs were met; however there was concern about the availability of food and the ways in which it was made available.

The registered provider had begun assessing staff skills and training requirements but had no formal structure in place to demonstrate how peoples training needs were going to be met.

Staff had an understanding of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and the relevance to their work.

Is the service caring?

Requires Improvement

Staff were sometimes caring.

Staff treated people with patience, warmth and compassion and respected people's rights to privacy, dignity and independence.

People who lived at the home, relatives and visitors were positive about the staff who worked at the home.

Staff had an understanding of each person in order to deliver person centred care but person centred care was not consistently provided.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The registered provider had started making improvements to deliver a person centred service. However care plans were not consistently completed for all people who lived at the home. This hindered person centred care being provided.

The management and staff team worked closely with people and their families to act on any comments straight away before they became a concern or complaint.

The registered manager was in the process of improving and implementing social activities for people who lived at the home.

Is the service well-led?

Inadequate

The service was not well led.

Staff told us communication was poor. Staff morale was low and staff did not feel supported by the registered provider.

The registered manager had started to develop good working relationships with the staff team.

The registered manager acknowledged the service currently being provided was not sufficient and expressed a desire to implement changes to improve service quality.

Greenfield House

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.

We undertook this inspection in response to some concerns we had received in relation to the care being provided at the home. This inspection took place on 03 and 04 March 2016 and was unannounced. On the first day there were two adult social care inspectors carrying out the inspection. One inspector returned on the second day.

Prior to the inspection taking place, information from a variety of sources was gathered and analysed. This included notifications submitted by the provider relating to incidents, accidents, health and safety and safeguarding concerns which affect the health and wellbeing of people. We also contacted the local authority and we received no information of concern.

Information was gathered from a variety of sources throughout the inspection process. We spoke with eleven staff members who worked at the home. This included the registered manager, the registered provider and nine staff who provided direct care.

We spoke with six people who lived at the home to obtain their views on what it was like to live there. We observed interactions between staff and people to try and understand the experiences of people who lived at the home.

We spoke with six relatives to see if they were satisfied with the care provided.

To gather information, we looked at a variety of records. This included care plan files relating to nine people who lived at the home and recruitment files relating to three staff members. We viewed other documentation which was relevant to the management of the service including health and safety certification & training records.

We looked around the home in both communal and private areas to assess the environment to ensure it was conducive to meeting the needs of people who lived there.

Inadequate

Is the service safe?

Our findings

Prior to the inspection taking place we were alerted to concerns about staffing levels at the home. We used this inspection to see if staffing levels and staffing deployment was sufficient to meet the needs of the people who lived at Greenfield House.

We reviewed how the service was being staffed to make sure there was enough staff on duty at all times, to meet people's needs and keep them safe.

We asked people who lived at the home and their relatives what they thought of current staffing levels. One person who lived at the home told us, "Staff are good. There's just not enough of them." A relative we spoke said, "They (the staff) are very busy. They do their best."

On the morning of the first day of inspection there were five members of staff on duty providing direct care. A student was also working at the home supporting staff as part of their work experience. The registered provider also visited the home later that day and provided hands on support when required. There was however no cook on duty and no laundry assistant. The registered manager explained they were cooking that day and laundry tasks would be carried out in the afternoon. The person responsible for organising social activities was also not working.

The registered manager said there was five staff on during the week days, reducing to four in the evenings. The registered manager said staffing at weekends was difficult and acknowledged only four staff were on duty during the day at weekends. The registered manager said they were hoping to increase staffing levels at weekends once they had recruited more staff. On the first day of inspection the registered manager was providing direct care despite being on the duty rota for administrative tasks. The registered manager said they were contracted to provide hands on support when staffing levels did not meet the current need.

We spoke with nine members of care staff, every member of staff said staffing was a problem. Staff said they did not have time to complete all their tasks and provide one to one support to people when required. Staff told us staffing levels were sometimes reduced to three members of staff. They said they were unable to carry out their full duties diligently. One staff member said, "Staffing levels are a concern." And another staff member said, "Staff are pushed." And, "We can't be in two places at once."

Staff told us routines had changed since the change of ownership and staff were now being expected to carry out additional duties including writing care plans. Staff said they did not have time to do this. One staff member said, "We have to rush about and do the best we can." During the course of the inspection we overheard one staff member expressing dissatisfaction at being asked to complete a task. They said, "This is ridiculous. I haven't even had my break yet."

At breakfast time we observed one person was left sitting in the dining room for one hour and ten minutes. After an hour the person was looking unsettled tapping on the table waiting for staff to support them to mobilise. At lunchtime we observed staff moving in between people offering support. We did not see staff

sitting and assisting people with their meal to ensure all needs were met. One staff member told us they could not be sure who had eaten what as they did not have the capacity to closely supervise people over the lunchtime period.

During the course of the inspection we observed one person required intense support on a one to one basis. Information in the person's care plan stated this person would need one to one support when they displayed certain behaviours. We noted staffing levels did not allow for the care plan to be consistently followed and this person was left unsupervised whilst displaying these behaviours during the morning. We observed one person who lived at the home looking for staff for reassurance when this person was displaying challenging behaviours. They said they often had to go looking for staff for assistance.

Staff said extra staff were not drafted in to help when the person's needs changed. The registered manager would help out if they were on shift and available. Staff confirmed they could not always meet this person's needs with the current staffing levels. When staff did provide intense support to this person other people's needs were affected.

Staff told us staffing levels did not meet the needs of the people who lived at the home. Staff said there had been no assessment of people's needs to dictate the number of staff required. Staff said there was a high number of people living at the home who required two members of staff to assist them. This meant that at times when staff were attending to people's needs there was no oversight in the communal areas. One staff member said, "We don't like leaving people unsupervised but what can we do?"

We asked the registered manager if they had used any dependency rating tools for calculating staffing levels. They advised us the registered provider decided on staffing levels and no formal systems of assessment were in place. The registered manager said they had no input into the number of staff on shift.

We looked at accident reports stored in the accident file for the months of January and February 2016. There were eleven documented incidents of unwitnessed falls. This meant there was no member of staff present at the time of the incident. This demonstrated staff deployment was not effectively organised as there was lack of oversight when accidents had occurred.

The home had four lounges; one conservatory and one dining room downstairs for communal use. We saw people were often unsupervised in these areas. We highlighted concerns about deployment of staff with the registered manager in relation to the layout of the home. The registered manager agreed they needed to look at how staff were deployed throughout the building to promote people's safety.

Staff said they were concerned about the number of staff that had left employment since the registered provider purchased the company. One staff member said, "We have lost eleven good staff." Staff told us the registered provider had not recruited any new staff to cover the voids. They said there was an increasing expectation upon them to cover shifts. One staff member said, "We are expected to cover all these extra shifts."

We asked the registered manager about plans for recruiting more staff. The registered manager confirmed a significant number of staff had left employment. Staffing levels at weekends had been reduced to four staff because of lack of staff availability. They told us the registered provider was dealing with this matter. They confirmed one new staff member had been identified to commence work. However, they were still awaiting clearance for them to start. No other staff had been employed to fill the voids.

This was a breach of Regulation 18 of the Health and Social Care Act (2008) Regulated Activities 2014 as the registered provider had failed to ensure suitable numbers of staff were recruited to meet the needs of the people who lived at the home.

We looked at how safeguarding procedures were managed by the provider. We did this to ensure people were protected from any harm. Staff told us they had completed safeguarding training with the previous registered provider. Staff were able to describe the different forms of abuse. They were confident if they reported anything untoward to the registered manager this would be dealt with. Staff were aware of reporting procedures and the option of reporting incidents direct to the appropriate bodies.

Staff told us they were aware of what constituted abuse. However, we found evidence not all incidents were reported as per the organisations safeguarding procedure. We observed one person at the home demonstrating repeated challenging behaviour. Whilst demonstrating these behaviours we noticed other people responded by verbally abusing the person. Another person threatened to assault the person. This placed the person at risk of harm from other people who lived at the home.

We looked at the daily records for this person and identified an incident whereby another person who lived at the home had assaulted this person. This incident had not been reported as a safeguarding concern.

We asked the registered manager about this incident. The registered manager said no one had made them aware of the incident and consequently it had not been reported as a safeguarding alert. The registered manager said they now had concerns for this person's safety and could not guarantee this person would be kept safe at all times. We made a referral to the Local Authority safeguarding team in relation to this incident.

This was a breach of Regulation 13 of the Health and Social Care Act (2008) Regulated Activities 2014 as the registered provider had failed to ensure suitable systems were in place to monitor report and respond to safeguarding concerns.

We looked at how risks were managed and monitored by the registered provider to ensure people were kept safe. We did this to ensure people were suitably supported and risks to their safety and well-being were being appropriately managed. We found risks were not consistently managed by the registered provider.

Prior to the inspection we were informed one person had received a serious injury following a fall. At this inspection we looked at what systems had been put in place by the registered provider to minimise further risks of falls. Accident reports relating to the person showed the person had fallen a further three times following discharge from the hospital. This conflicted with information provided to the Care Quality Commission prior to the inspection taking place. We queried this with the registered provider. They explained staff had completed accident reports but they had been misfiled and as a consequence the falls had not been communicated to management.

We looked at the care plan and risk assessment relating to this person. The care plan for the person had been completed but had not been updated or reviewed to reflect that falls had occurred. The risk assessment for this person had not been fully completed by the registered provider and consequently there was no indicative score or action plan as to how to manage the falls. No controls had been put in place to reduce the risk of this person falling. We spoke with the registered manager about this. They acknowledged the risk assessment had not been completed and said they were hoping to complete this with family within the next week. We made a safeguarding alert to the Local Authority for this person.

We looked at accidents and incidents that had occurred at the home. The registered manager had implemented a system to ensure there was a central record of all accidents and incidents. We were informed however staff were not fully aware of the system and this had caused some problems in monitoring accidents and incidents.

We looked at weight records maintained by the registered provider for people who lived at the home. Monthly records of weights had been transferred from the old registered provider's documentation to the new provider's documentation at the beginning of the year. Current weights were documented on the new forms but previous weights had not been considered or reviewed. The records had not been audited to look at people's overall weight loss. We identified one people had lost a significant amount of weight over a twelve month period but no concerns had been identified by the new registered provider.

We spoke with the registered manager to clarify whether any action had been taken to address the risk of malnutrition to this person. The registered manager confirmed no action had been taken as they had not identified any risk. The registered manager took immediate action to review the persons care and referred the person to a dietician. We made a safeguarding alert to the local authority for this person.

Monitoring of people's weights was not consistently followed. One person's care plan stated the person was at risk of malnutrition and was to be weighed on a weekly basis. There were no records to show this was completed. Another person's care plan stated staff should record all food and nutrition records for the person. There was no record in the person's file. Staff could not confirm a food and nutrition record was in place.

This was a breach of Regulation 12 of the Health and Social Care Act (2008) Regulated Activities 2014 as the registered provider had failed to ensure systems were in place to assess the risks to the health and safety of people receiving care and doing all that was practicable to mitigate any risks.

We looked at recruitment procedures in place at the home to ensure people were supported by suitably qualified and experienced staff. To do this we reviewed three staff records. All of the records were relating to staff who had been employed under the previous registered provider. We noted these records were incomplete and disorganised. The registered provider was in the process of recruiting one new member of staff. However, the registered manager said they did not have access to these records as the registered provider was managing this.

Staff told us they had been unable to commence work without completing a Disclosure and Barring Service (DBS) check and being able to provide a DBS certificate to the employer. A valid DBS check is a statutory requirement for all people providing a regulated activity within health and social care. However we could not find evidence in staff files to demonstrate these checks had taken place. The registered manager could not confirm that staff had completed a DBS check and were of good character and suitable to work with vulnerable people.

The registered manager said they were aware of their responsibilities when employing new staff and the need to ensure staff had completed a Disclosure and Barring Service (DBS) check however no action had been taken to ensure the suitability of staff recruited by the previous employer.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014 as the registered provider failed to have systems in place to ensure staff employed were of good character.

We looked at how medicines were managed within the home. Medicines were stored securely within a trolley which was locked away when not in use. Storing medicines safely helps prevent mishandling and misuse. Tablets were blister packed by the pharmacy ready for administration. Creams and liquids were in original bottles. PRN medicines were kept separate to medicines prescribed every day. PRN medicines are prescribed to be used on an "as and when basis. We observed medicines administered to three people. Medicines were administered to one person at a time. Staff asked people to consent to taking the medicines and then observed people taking medicines before signing for them.

Medicines Administration Records belonging to each person had a photograph upon them so the person could be identified prior to medicines being administered. They clearly detailed any known allergies of the person. This minimised any risks of people being administered medicines which may cause harm. The registered manager said they had carried out observations of staff administering medicines to ensure they were competent to do so.

During the course of the inspection we undertook a visual inspection of the home. We did this to ensure it was adequately cleaned and appropriately maintained. The home was free from odours and was clean and tidy. On the first day of inspection we were informed the home had recently had a problem with the roof. This had resulted in a ceiling falling in. The registered provider had taken suitable action to ensure the room was blocked off to prevent people from accessing it. The registered provider had also developed a store room to securely store all chemicals and cleaning products. They said this protected people from coming into contact with chemicals which may have an adverse effect upon their health.

Sinks had thermostatic valves on them to prevent people from scalding. We checked the water temperature in several bedrooms and one bathroom. The water temperature was comfortable to touch. We looked at windows and noted restrictors were fitted. This prevented any risk of people falling from windows at height. Equipment used was appropriately serviced and in order. Patient hoists and fire alarms had been serviced within the past twelve months.

Inadequate

Is the service effective?

Our findings

People who lived at the home praised the standard of care provided. One person said, "Staff look after me to be fair." Another person said, "I would rather be at home but I am looked after." Another person said, "I would tell staff if I was worried or unwell. It's up to them to help me."

Relatives told us they were reassured their relative's needs were met by the provider. They said they did not have to worry about care provided. They were consulted with and updated regularly One relative said, "Things have changed since [new registered provider] has taken over. I have definitely seen a difference. We have a lot more contact."

We looked at individual care records relating to nine people who lived at the home. Of the nine care plan files we looked at we found seven files had incomplete information. A variety of assessments were in place to assess people's nutritional needs, fluid needs, tissue viability and mobility needs. However these remained incomplete. One person's care records identified the person at risk of constipation and said a care plan was required for managing this condition. This was not in place. Another person had a care plan in place which stated they required their blood sugars to be monitored by staff. There was no evidence of this occurring. We spoke with the registered manager about this. They said this was inaccurate information within the care plan and it needed reviewing to accurately reflect the person's health needs. This had not been done. They said they were aware care plans were incomplete. The registered manager was aware care plans were not at the required standard. The registered manager said, "I have my work cut out."

We looked at how people's health needs were met. People sometimes had access to their general practitioner when they were unwell. We noted one person however had fallen at the home. Records showed this person was unsteady on their feet following the fall but no referral for advice and guidance was made to a health professional until sixteen days after the fall.

This was a breach of Regulation 12 of the Health and Social Care Act (2008) Regulated Activities 2014 had not responded appropriately and in a timely manner to the persons changing needs.

Prior to the inspection taking place we received information of concern regarding the quantity and quality of food provided to people who lived at the home. We used this inspection to look at how people's nutritional needs were being met.

People who lived at the home had no complaints about the food. Comments from people who lived at the home included, "The food is alright. I wouldn't say its top notch but I can't grumble." And, "The food is ok." And, "The food is alright, there is always plenty of it."

Relatives said they thought the food was good. One relative said, "[Relative] has settled in well and likes the food." Another relative said, "My relative's only complaint is they never get a choice. My [relative] does get confused so I am not sure if this is the case."

We asked staff if people were offered choices at meal times. We received mixed feedback about this. Two staff members said people were only offered one meal. One staff member said, "There is only one option and no stock available to give another option."

On both days of inspection we saw there was a choice of two main lunchtime meals on offer. The registered manager told us the registered provider had changed the way in which food was purchased in order to cut down on waste. Food was now purchased in accordance with the menu. We were informed all main meals were now made from fresh.

On the second day of inspection we noted the cook had made home-made chips and hand battered fish. We looked at the set menu and saw the food cooked matched that on the set menu.

On the first day of inspection we noted one person was given a tomato omelette for lunch. The person had been asking for potatoes. The person never ate the omelette and was not offered potatoes. We noted this omelette was then reheated and given to the person again at tea time. We brought this to the attention of the registered manager and they could not explain why this meal had been served again at tea time. We have made a recommendation about this.

On the second day we asked the cook how they ensured they met people's nutritional needs. The cook informed us they were aware some people had recently lost weight but they felt this weight loss was due to their health condition rather than the change in menu. The cook said a food and nutrition chart had been developed that day for one person who had been identified as at risk of malnutrition.

The cook told us menus in place were going to be amended slightly to meet people's needs. They told us they were responsible for making fresh cakes and biscuits every day for snacks in between meals. The cook said they had enough food to provide for people but acknowledged it was, "just enough."

During the inspection we looked at stock levels of food maintained at the home. It was acknowledged there was sufficient stock in the cupboards. However there was little fresh fruit available for people for healthy snacks. We discussed this with the registered provider and registered manager; they agreed to review this immediately.

A selection of drinks and snacks were offered throughout the day in between mealtimes.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. We noted there were no capacity assessments carried out for each person who lived at the home. The registered manager said these had been carried out by the previous registered manager and were filed with each DoLs application that had been made. We saw evidence in three people's files that best interests meeting had been held to make a decision on behalf of the person when the person was lacking capacity.

We spoke with staff to assess their working knowledge of the MCA. All staff we spoke with were aware of the need to consider capacity and what to do when people lacked capacity.

We spoke with the registered manager about the Deprivation of Liberty Standards. (DoLs.) The registered manager told us they had completed DoLS training. Applications had been made to deprive people of their liberty were ongoing and six applications were still required. The registered manager confirmed following the inspection these applications had now been made.

We spoke with staff to see if they had the relevant skills required to do their role. Staff said the new registered provider had promised training but nothing had yet been agreed.

Staff expressed concern about the lack of training offered to enable them to carry out their roles proficiently. Staff said they still lacked training to support them to manage behaviours which challenged. This caused problems in particular when dealing with one person. One staff member said, "We've no guidance so we all try different things to try and calm the person." On the day of inspection we saw staff were unable to diffuse challenging situations in a timely manner.

Staff also said they had not received any moving or handling training. Staff said this impacted upon the way they supported people and even though there was a hoist present at the home they were unable to use it. We spoke with the registered manager about this and they confirmed moving and handling assessments had not yet been completed and no one at the home was trained to be a moving and handling assessor. They advised us that no person in the home currently required hoisting but moving and handling assessments were due to formally take place in the next week.

Staff told us they were now responsible for updating care plans. They said they had not received any training in this area and were not fully aware of their responsibilities.

We asked the registered manager about planned training. The registered manager said the registered provider was dealing with this. We saw the registered provider was in the process of appraising all staff to see what their training requirements were prior to planning training. This appraisal process was not yet complete. We asked the registered manager if a staff training grid was in place. They confirmed there was no training matrix in place to show any training was booked or a staff development plan was in place.

This was a breach of Regulation 18 of the Health and Social Care Act (2008) Regulated Activities 2014 as the registered provider had failed to ensure there were suitable numbers of adequately trained staff on duty at all times.

We spoke to staff about supervision. Staff confirmed they had received a supervision session with the new registered provider since they had taken over the business. Staff said they had faith in the new registered manager and said they were not afraid to discuss any concerns they may have in between supervisions.

We recommend the registered provider reviews systems in place in relation to the meal planning and delivery of food to people who live at the home.

Requires Improvement

Is the service caring?

Our findings

People were complimentary about staff providing care at Greenfield House. One person said, "It's quite good living here." And, "There are one or two staff that are alright." Another person said, "Staff are polite."

Relatives spoke positively about the commitment from staff. One relative said, "Staff are really caring." Another said, "The staff are very good. My [relative] has done nothing but praise the staff"

We observed positive interactions throughout the inspection between staff and people who lived at the home. Staff checked the welfare of each person to ensure they were comfortable and not in any need. We observed one staff member supporting a person who had fallen asleep in their chair. The staff member saw the person was sitting awkwardly in the chair. The staff member went over and helped the person settle into a more comfortable position providing a pillow to support them.

We observed one staff member stroking a person on their arm as a sign of affection as they walked passed. This was positively received by the person and the person smiled back at the staff member.

People were treated with patience. We observed one person being supported to mobilise. The person was walking slowly using their walking frame. A staff member followed them and offered constant verbal reassurance letting the person know they were there if they needed help. We observed staff trying to empathise with a person who could not verbally communicate. Despite the person striking out at staff, staff spent time with the person trying to establish their needs.

Privacy and dignity was considered at all times. We observed staff discreetly placing a blanket over a person's knee to protect their dignity. We observed staff attending to a person who was ill. Staff ensured the person was comfortable and then moved the person to their bedroom to protect their dignity and to give them privacy. We observed staff members knocking on people's doors and asking permission to enter rooms.

Staff showed an interest in people who lived at the home. Staff had a good knowledge about people's life histories. We overheard one staff member talking to a person about their life history. They took time to listen to the person and asked questions about their experiences.

Staff responded when people were showing signs of being upset. We saw one person was showing signs of being anxious. Staff immediately went to find the person's soft toy which was used as a comforter. Once the person had their comforter we saw their anxieties decreased.

All the relatives we spoke with commended the service provider on the hospitality provided. Relatives said they were welcome to visit at any time and could have privacy if people wanted it. We observed staff offering visitors drinks when they visited.

Staff recognised the importance of maintaining family relationships and celebrating significant events. One

person was celebrating a birthday on the second day of inspection. Staff had purchased a gift for the person in acknowledgement of their birthday. Another relative told us they were shortly going to be celebrating an anniversary. The registered provider was supporting the family to have a family celebration at the home for family and friends. The relative said they were hosting a party at the home.

Requires Improvement

Is the service responsive?

Our findings

The registered provider told us they had started making changes to service provision to ensure the service was more responsive to people's needs. The registered provider had introduced naturalised wakening. People were now supported to get up when they chose rather than when it met the needs of staff. Processes had been put in place to give people more person centred personal care in the morning. The registered provider had also opened up areas within the home to allow people the opportunity to visit their bedrooms when they wished. People now had freedom of movement throughout the full building.

One staff member was positive about the changes implemented and said, "Since [registered provider] took over, people are getting more person-centred care."

Although we were informed there had been a move towards person centred care we saw person centred care was not always delivered. One relative told us they had given the registered provider articles from the person's home to allow them to settle smoothly into the new environment. The person was experiencing some confusion and it was thought these verbal cues would reduce the person's anxiety. These articles were not placed in the person's room for over a week. We also noted one person was displaying some behaviour which challenged. The person's care plan stated the person did not like loud noise. The person was sat underneath a speaker that was switched on and playing music. Staff did not recognise this trigger and tried to remove it to decrease the challenging behaviours. We also observed another person becoming visibly upset when she was given a biscuit to eat. We overheard the person saying, "They have given me a biscuit to eat. I've no teeth in." We then watched the person struggling to eat the biscuit. We noted the person was missing their teeth. The person was wearing them on our second day of inspection.

Care planning systems had been changed under the new registered provider. Historical care plans devised by the previous provider had been removed from files and replaced with the registered provider's new format. Care plans covered topic areas including allergies and special diets, medical conditions, mobility, communication and continence.

We observed inconsistencies in care plan records relating to four people who lived at the home. The four care plans had missing documentation or were not reviewed on the stated date. One care plan had not been reviewed on the stated date. Another two care plans had not been reviewed and updated following significant events. Another person's care plan stated all incidents of challenging behaviour were to be documented on a behavioural monitoring chart (ABC chart.) The ABC chart had been completed on two occasions. We compared the ABC chart to the person's daily records and identified seven situations in which the person had displayed challenging behaviour. These had not been reported on the ABC chart.

We discussed our findings with the registered manager. The registered manager confirmed they had recently changed the system and were supporting care workers to be involved in reviewing care plans. The registered manager said they were still in the process of completing and reviewing care plans and was aiming to have them all completed by the end of March. The registered manager said staff needed further training and assistance in this area and they intended to provide this.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 as the registered provider was not maintaining an accurate, complete and contemporaneous record in respect of each person who lived at the home.

We looked at two files relating to people who had moved into the service since the registered provider had registered the service. Care records demonstrated the registered manager carried out a detailed pre-assessment of each person before they moved into the home. They captured relevant information relating to the care support requirements of the person. This ensured people's needs were documented and met from the onset of the service.

Where care plans had been fully completed they detailed people's personal preferences and own abilities as a means to promote independence, wherever possible.

We looked at activities on offer at the home to ensure people were offered appropriate stimulation throughout the day. People who lived at the home provided us with mixed feedback about the provision of activities. Two people told us skittles and ball games were sometimes provided. One person said, "Nowt goes on, I just sit here."

On the first day of inspection we observed the volunteer playing ball with people. We observed people laughing and joking and taking part in the activity. We also observed people being supported to play dominoes in the dining room. We saw art work that people who lived at the home had completed at an earlier date. On the second day we observed staff and people who lived at the home having a quiz. People were readily participating and enjoying the conversation that arose from the quiz.

Although we observed various activities taking place staff expressed concern about the activities offered. One staff member said there used to be a musical entertainer coming in fortnightly but this had decreased to once a month. Another staff member said they were expected to carry out recreational activities with people but said this was dependent upon them having time to fit such activities in.

The registered manager told us they had designated one member of staff to be the activities coordinator for the home. The member of staff told us they were excited to complete this role. We were informed the role was to be incorporated within their working hours as a carer and no extra hours had been scheduled to undertake the activities. We looked at a plan the activities coordinator had devised for the on-coming month. We noted activities were scheduled for every day. The staff member advised other staff would be expected to follow the plan when they were not present at work to complete the tasks. We were told the registered provider was looking for ways in which they could raise funds to purchase materials and equipment to improve activities at the home.

The registered manager said they were also hoping to build up links with the local community and were hoping to work with a nearby school and church inviting them into the home to spend time with people who lived at the home.

The registered manager fostered a culture of open communication and promoted the rights of people who lived at the home. People were encouraged to speak out about the service if they were unhappy with any aspect of the care. We observed the registered manager and the registered provider asking people throughout the inspection process if they were ok and happy with the service. We observed one person shouting they were unhappy. The registered manager responded immediately and enquired to see what was making the person unhappy.

We were informed the registered provider was holding a residents and relatives meeting in the oncoming week. A relative confirmed this meeting was taking place. Relatives said communication had improved since the registered provider had purchased the business and they were kept up to date with all changes.

People who lived at the home said they had no complaints about the service. We observed a complaints leaflet was on show in the main entrance to the home. Relatives we spoke with confirmed they currently had no complaints with the service. One said, "We are extremely happy with the new provider." And, "I have never had to complain."

Inadequate

Is the service well-led?

Our findings

Relatives praised the effectiveness and responsiveness of the new management within the home. Relatives described management as "Good." Another relative said, "We can definitely see a difference, for the better."

Although we received positive feedback from relatives of people who lived at the home, this conflicted with staff views about the way in which the home was managed by the registered provider. All staff providing direct care expressed some dissatisfaction in the way the service was managed. One staff member said, "I think there have been too many changes, too soon."

Staff felt leadership within the home was also poor. One staff member commented on the organisation as a whole and said, "It's not run properly." Another person said, "We have not had any training or support." And, "We are expected to know what we are doing." Another staff member said they didn't think there had been any improvements under the new management and described the home as, "just as bad."

Staff said communication within the organisation was poor. There were no handovers between shifts. This meant staff did not receive information relating to necessary support and healthcare visits. Staff said they did not receive daily handovers and information within daily records were only inputted once daily by a staff member working on the evening shift. One staff member said they only learned of one significant event when they read the information in the handover book. One staff member said feedback from the registered provider was poor and felt team meetings were a waste of time as the registered provider never listened.

Staff described team work as poor. One staff member said, "We have some good carers here but morale is so low." We spoke with the registered manager about the morale of the workforce. The registered manager acknowledged morale was low but said they were working hard to gain trust and confidence from staff.

The registered manager explained staff had been initially resistant to changes made but felt things were now improving. They said they had seen a change in staff attitude in the past two weeks and felt they were beginning to establish positive relationships with staff. Staff were now showing signs of being eager to learn. The registered manager said, "They have had a lot to cope with." The registered manager had tried to develop an open door policy so staff could come forward with any concerns.

Staff did praise the work of the registered manager who had been recently appointed. Staff said they had trust in the registered manager and described her as, "great." Staff expressed concern however stating the registered manager was often undermined by the registered provider. One staff member said, "[Registered Manager] is restricted in what they can do."

As part of our feedback we relayed our concerns and findings to the registered manager at the end of the inspection. The registered manager said they had no quality audit systems in place yet and as such had not picked up on any of the concerns we identified. The registered manager said they had spent the majority of their time working with staff and had left the administration to the registered provider. The registered manager said they had focussed their time on ensuring people's needs were met and that had meant

providing hands on care when staffing levels did not meet need.

This was a breach of Regulation 17 of the Health and Social Care Act (2008) Regulated Activities 2014 as the registered manager failed to have effective systems and processes in place to ensure compliance with the regulated activities.

The registered manager said they had plans in place to improve the home and objectives had been set between the registered provider and themselves. We asked to see the plans but were told there was no formal documented plan there had only been discussion.

The registered manager said they now understood they needed to take the lead and become responsible for managing the service. They said they were going to set themselves an action plan to ensure all the improvements are made. The registered manager said, "I am going to bust my gut to turn this home around."

The registered provider had begun to develop and foster an open and transparent culture with relatives and people who lived at the home. We saw evidence when mistakes had been made the registered provider spoke openly with relatives about this. Relatives told us communication had increased since the registered provider took over the service.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered provider failed to have suitable systems in place to ensure staff employed were of good character. 19 (1)

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 The registered manager failed to ensure care and treatment was provided in a safe way for service users. The registered manager had failed to assess the risks of health and safety of service users and had failed to do all that is practicable to mitigate such risks. 12 (1) (2) (a) (b)

The enforcement action we took:

warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered manager had failed to ensure systems and processes were operated effectively to prevent abuse of service users. 13 (1) (2)

The enforcement action we took:

warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered manager failed to have effective systems and processes in place to ensure compliance with the regulated activities. The registered manager failed to maintain securely an accurate, complete and contemporaneous record in respect of each

	service user. 17 (2) (c)

The enforcement action we took:

warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered manager failed to ensure sufficient numbers of suitably qualified persons were deployed to meet the needs of the people who lived at the home. The registered manager failed to ensure staff received appropriate training, support and development to enable them to carry out the duties they are employed to perform. 18 (1) (2) (a)

The enforcement action we took:

warning notice