Kirkley Limited

Greenways Care Home

Inspection report

Greenways Care Home
Marton Road
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Warwickshire
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Date of inspection visit:
04 January 2017
13 January 2017

Date of publication:
13 March 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

The inspection took place on 4 & 13 January 2017. The inspection visit was unannounced on 4 January 2017 and we agreed to return on 13 January 2017 so we could speak with the registered manager who was not present during 4 January 2017.

Greenways Care Home is a residential home which provides care to older people including some people who are living with dementia. Greenways Care Home is registered to provide care for up to 27 people. At the time of our inspection there were 23 people living at the home.

There was a registered manager in post. 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.

When we inspected the home in March 2016 we found breaches in the governance of the home and in medicines management. This meant the legal requirements and regulations associated with the Health and Social Care Act 2014 were not being met. A requirement notice was issued to the provider to tell us what action they would take to make improvements. At this inspection we looked to see if the provider and registered manager had responded to make the required improvements to meet the regulations. Whilst we found some areas of improvement had been made, we found some areas had deteriorated.

There were not enough staff on duty to respond to people's health needs and to keep people safe. The registered manager and deputy manager regularly supported staff on shift which meant some quality checks and improvement actions were not always identified and resolved. This affected the quality of service people received.

The requirement notice following our last inspection had not been fully complied with. Systems to assess the quality of the service provided were not always effective because improvements had not been identified, sustained and fully implemented. Some risks associated with the management of medicines and people's care and treatment had not been identified because effective checks were not undertaken.

There was a lack of management oversight by the provider and registered manager to check delegated duties had been carried out effectively. The quality monitoring systems included reviews of people's care plans, health and safety checks and checks on medicines management. These checks were not regularly reviewed or records completed so it was difficult for the provider to be confident people received a quality of service they deserved.

Accidents, incidents and falls were not always analysed to prevent further incidents from happening. Risks to people were not always properly assessed and staffing levels did not always support safe levels of care.

Some fire safety checks had not been completed for over 12 months and the registered manager could not be certain staff and people knew what actions to take in the event of an emergency.

Care plans provided information for staff that identified people's support needs and associated risks. However, some care plans and risk assessments contained important health information and advice, which was not written into people's care plans or followed, to ensure staff provided consistent support that met people's changing needs. Care plans were reviewed although some information required updating to ensure staff had the necessary information to support people as their needs changed.

Some people felt their physical and mental stimulation was limited because they were not proactively supported to pursue their own hobbies and interests. Some people told us there were limited things to do.

People were not always offered food and drinks that were suitable for their individual dietary needs and preferences. People were supported to eat and drink which minimised risks of malnutrition but there was limited interaction and conversation with those staff who supported them. Staff relied upon senior staff or the registered manager to update them when people's medical needs had changed, but this did not always happen.

At the last inspection we found people were not supported in line with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). At this inspection there were some improvements in how people's capacity was determined, but further improvements were still required. Where people had family members acting as power of attorney or lasting power of attorney, there were no effective systems or checks that confirmed those people had responsibility and authority to make decisions. Mental capacity assessments were completed but they did not always reflect people's levels of fluctuating capacity. The registered manager said no one had a DoLS in place at the time of our inspection.

Staff knew how to keep people safe from the risk of abuse. People told us they felt safe living at Greenways Care Home and relatives agreed their family members felt safe and protected from abuse or poor practice.

People were complimentary about the staff, despite the limited time they had to spend with people. Staff understood people's needs and abilities and relied heavily on information at shift handovers, However, on day one of our visit, the deputy manager did not have a handover before they started their shift. The registered manager had no effective systems to monitor when refresher or further staff training was expected. People felt staff had the necessary knowledge to support them and felt staff were kind, caring and had the experience to care for them

Staff protected people's privacy where required but we saw one example where a person's respect and dignity was not maintained.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which two were continued breaches.

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. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Staff did not always support people who had been identified as being at risk and risk assessments were not always updated to reflect people's current health needs. Where people were identified at risk of harm, measures were not taken to keep people safe. Calculations that set staffing levels were not always followed or prescriptive enough to determine safe staff numbers. Staff understood their responsibility to report any observed or suspected abuse and medicines were administered at the right time, but not always recorded correctly when given.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Systems were not effective to record and ensure staff completed essential training to meet people's needs. Where there was conflicting information about people's capacity to make specific decisions, mental capacity assessments had not always been considered. There were no checks in place to ensure people whose decisions were made on their behalf, had legal authority to do so. People were supported to maintain their health and referred to external healthcare professionals when a need was identified, but some people identified at risk, had not always received the support in line with specialist advice.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff provided care in a kind and sensitive manner, however there were periods of time when staff were not available or attentive to people's needs. People told us when staff spent time with them, staff were patient, caring and understanding. However, we saw an example where a person's respect and dignity was compromised and information displayed within the home, did not always protect people's privacy.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People and their families were not always involved in planning how they were cared for and supported. Staff understood people's preferences, likes and dislikes and how they wanted to spend their time but there was minimal physical and mental stimulation for people, which did not always meet their needs.

Is the service well-led?

Inadequate

The service was not well led.

The provider and registered manager's management systems were poor. Actions identified as requiring improvement at our last visit had not been addressed by the provider. There were a number of continued shortfalls in relation to the service people received and a lack of effective checks meant people continued to receive a service that fell below their expectations.

Greenways Care 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 on 4 January 2017 by one inspector and was unannounced. The registered manager had to leave the service early on the day of our visit due to sickness, and it was therefore agreed with them that we would return on 13 January 2017 when they would be present. At our second inspection visit, two inspectors and an expert by experience visited the home. An expert by experience is someone who has experience of someone using this type of service.

Before the inspection visit we looked at our own systems to see if we had received any concerns or compliments about Greenways Care Home. We analysed information on statutory notifications we had received from the provider. A statutory notification is information about important events which the provider is required to send us by law. We considered this information when planning our inspection to the home.

The provider is required to send us a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Prior to this inspection, the provider had not returned this form to us but we provided the registered manager with an opportunity to share with us examples of good practice.

This inspection was a follow up visit to check improvements had been made in management of the service and management of medicines. During this inspection, we asked the registered manager to supply us with information that showed how they managed the service, and the improvements they had made.

To gain people's experiences of living at Greenways Care Home, we spoke with 10 people, four relatives and two visiting friends of people who used the service. We spoke with the registered manager, deputy manager, six care staff, and the cook. We looked at three people's care plan records to see how they were cared for and supported. We looked at other records related to people's care such as medicine records, daily logs, risk

assessments and care plans. We also looked at quality audits, feedback results, incidents and accidents at the home and examples of health and safety records.

Inadequate

Is the service safe?

Our findings

The provider's policy for managing risk was not consistently followed and actions were not taken to keep them safe. Some people were placed at increased risk because staff did not know important information that protected people from risk.

For example, one person had been risk assessed for the use of bed rails on 11 August 2016. The risk assessment stated the person was 'unlikely to climb over the rails'. On 28 August 2016 the person had been taken to hospital following a fall after they had climbed over the bed rails. The risk assessment had not been updated to take into consideration this increased risk. There was no evidence other options such as a hi/low bed had been considered to reduce the risks.

This person's discharge information from the hospital stated they were on a normal diet but required all fluids to be thickened with one scoop of thickener per 200mls of fluids (this was to reduce the risk of choking). It was advised that a referral to the community SALT for a review should be arranged. There was nothing in the person's care records to indicate their fluids needed to be thickened. Staff we spoke with told us that nobody in the home needed to have their fluids thickened and the registered manager confirmed this. When we told the registered manager about this person, they told us, "I had missed this" and were unaware about this important advice from the hospital. This person had never had their fluids thickened in line with SALT guidance, and had not been referred to SALT for a further assessment since returning to the home in August 2016. Following this, the registered manager did not inform us of any action they had taken to mitigate this risk and failed to take prompt action, such as notifying staff before they left the home at 2.00pm.

Before we left the service, we thought it important to speak with the care and senior staff members and tell them about this person. Staff were concerned they did not know and we referred them to the person's care records and asked them to inform the deputy manager when they came on duty as they may wish to seek prompt advice.

This person's discharge information also said they needed to wear a splint because of weakness in their right hand. The splint when worn was designed to support and maintain their movement. One staff member told us that nobody in the home needed to wear hand splints. The registered manager confirmed the splint was not being worn as set out in the discharge letter and said, "It's in the wardrobe, and [person] doesn't wear it." Care plans or daily records did not record the person required a splint. Some staff were not told this person was required to wear one, so did not offer any encouragement or prompting to remind them of the importance of following specialist healthcare advice.

The provider did not manage people's risks to their health and well-being well. Systems to monitor and protect people at risk from falling were not always consistent. Staff and records confirmed most of the falls that occurred each month were unwitnessed, often in people's rooms. For example, in October 2016 12 people had fallen and 10 falls were unwitnessed. One person had fallen five times and had been hospitalised as a result of a fall. There were no records that explained why this had happened and the

injuries sustained. In September 2016, 18 falls were recorded, with 17 falls recorded as unwitnessed. Again, there was no action taken or further assessments to determine why they had fallen.

Some safety checks were not always effective to ensure people remained protected, in the event of an emergency. The registered manager said fire equipment was checked by external contractors, although we were not given records to support this. The registered manager said time constraints meant they had not had an emergency fire drill for 13 months and were not confident, staff knew what to do in an emergency situation. The registered manager knew this was against safe fire protocols, but said there was limited time to plan and arrange them with staff, without affecting the delivery of care.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some care plans documented where risks were identified, and described the equipment needed and the actions staff should take to support people safely. Some risk assessments were reviewed regularly and we saw evidence that where people were unwell, the risk assessments identified an increase in the level of risk. For example, one person's risk of falls had increased at a time when they had a urinary tract infection. The person had been referred to their GP, and a sensor mat put by the side of their bed to alert staff when the person got out of bed so they could provide support and assistance. Staff were aware they had to be extra vigilant to minimise the risks to this person. One staff member told us, "If they need two carers (to mobilise safely) we make sure they have two carers and if they need walking frames or trollies, we make sure they have them."

We saw throughout our inspection, that staffing levels were not adequate and there were not enough staff to keep people safe. We were concerned that staffing levels and the dependency needs of the people impacted on the levels of care and support people received. We spoke with staff and asked them whether people were protected from risk and if they did all they could to keep people safe. Staff told us it was not always possible to observe people throughout the day, especially people needing the assistance of two care staff and people at risk of falling. Staff also said that at certain times of the day such as mornings, they were busy and it was difficult to spend time observing people to ensure they remained safe. One staff member said, "We just can't do it." Some staff told us they provided 'task based' care because they went from supporting one person to another, or helping another staff member where someone required two care staff. Sometimes, staff told us they had to prioritise who they went to first, so people had to wait.

Staff did not always have the time to support people in a way they needed to help keep them safe and protected from risks. Staff said some people required two care staff to help them move safely. However staff recognised this left people in communal areas and their own rooms unchecked, especially those vulnerable to falling, because there was 'no eyes and ears' around the home. On the first day of our visit, we saw periods of time where people were left unobserved in communal areas of the home for at least 20 minutes. A high number of people spent time in their rooms and staff said it was not always possible to check as regularly as they wanted to.

A high number of people spent time in their rooms. One person told us they wanted to socialise with others but said they were encouraged not to go downstairs. This person told us they were at risk of falling and, "They (staff) don't like me going around with my frame as they don't like me to fall." They said this meant they spent more time in their room and on occasions, felt isolated, especially when they wanted to talk with others. This person could not understand why they did not leave their room, but thought it was for other reasons rather than because it was what they wanted to do. People who lived on the first floor and who spent time in their own room said they did not see staff often.

One person said, "Staffing seems a bit of an issue, there should be at least two care (staff) on the upper floor, I must admit I didn't see any. I saw a cleaner, but not a carer." Other people said they did not wait too long for help.

Out of 23 people, 4 people were assessed as high dependency and two people as medium dependency, which meant six people needed support from two care staff to keep them safe, when receiving personal care or with mobilising. On the first day of our inspection visits, the registered manager was unwell and had left the service by 09:30am. This left three care staff to support 23 people without any managerial support. From 2.00pm that afternoon, staffing levels dropped to two care staff. When both staff members went to assist people upstairs, this left no one on the ground floor to supervise, support or engage with people.

The registered manager completed staff rotas and told us they completed a 'monthly needs analysis'. The registered manager said, "We definitely need four on each shift so it runs as it should. We need four (care staff) in the morning and three (care staff) in the afternoon, although I don't know why it drops." People's dependencies were calculated as low, medium and high needs. We asked how the identified need calculated safe staffing levels. The registered manager told us the dependency levels of people had no bearing on the number of staff provided to support people. This meant they could not be certain there were enough staff to support people's needs. They also told us they often had to support care staff to meet people's needs because of staff absences or because there were no available staff to put on the rota. We asked why staffing levels were lower on the first day of our visit, they told us, "It's because I was off sick."

We asked the registered manager if they had available staff to call upon to increase the rotas, but they did not. They told us they were looking to recruit additional staff which would help but in the short term, they did not have the resources. The registered manager said they had asked the provider for agency staff which they knew would help, but this had not happened. The registered manager said the provider was mindful of costs and had not given them authority to use agency staff to cover and support staff levels.

This was a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Staffing.

Where incidents and accidents resulted in people requiring treatment from other healthcare professionals, it is the registered manager's legal responsibility to notify us. Prior to this visit, we found the registered manager had not notified us of six serious injuries which resulted from people falling. We looked into some of these incidents during our inspection. We were concerned the registered manager had not taken positive action to see why some people who were identified at risk of falls, continued falling, and what interventions could be taken, to minimise the risk of further falls and potential injuries.

At our last inspection we found the service had breached Regulation 12 because they had not administered medicines safely. During our previous visit we found staff's ability to administer medicines safely had not been checked by the registered manager, and staff had not received training to refresh their understanding and skills in relation to the safe administration of medicines. Where people required pain relief in the form of patches on their skin, we found staff had not completed body maps or patch position records to make sure the correct amount of patches had been applied and in the right places. At this inspection, we found some improvements had been made, however further improvements were still needed.

People told us they received their medicines when required. We checked examples of medicines administration records (MAR) and found most people had received their medicines as prescribed. Stock counts were checked daily which meant medicines stocks could be checked against medicines administered and any errors investigated.

During the first day of our visit we checked the medicine administration of a person who had a patch medicine for pain relief. A senior staff member told us they had been told to administer this but did not complete the MAR for this person. They told us because they had only administered this person's medicines and not those of all the people in the home, they did not have to sign. Later in the day, when the deputy manager undertook the administration of medicines, they were unaware until we told them that the patch medicine had been given to the person. The deputy manager told us they had not received a handover when they started their shift. Without our intervention, this meant the person might have received more medicine than was prescribed to them. We checked this person's patch record and found since 3 December 2016, patch locations were not being recorded. Staff told us they put the patch medicines where the person preferred and, "We always know where it goes." When asked where staff would place it if it had come off, staff did not know. A lack of consistent recording and not following manufacturer's guidance could place the person at risk, such as increased skin irritation.

To address staff being competent to administer medicines, the provider's action plan said, 'Senior staff are already undertaking further accredited training'. We spoke with the deputy manager and three senior staff. They all confirmed since the last inspection, they had not received any medicines training, or had undertaken assessments to demonstrate they were competent to administer medicines. The registered manager confirmed training had not been arranged. They said they were trained to administer medicines but told us and records confirmed, their last medicines training was in 2009. This was in conflict with what the provider told us in their action plan, about how they would seek improvements by training all senior staff who administered medicines. The registered manager said they completed regular audits but did not supply us with any records to confirm what checks were made, and what improvements or learning was taken.

Some medicines required to be kept in a fridge, were kept in a food fridge in the kitchen. These medicines belonged to people who no longer lived at the home, which should have been returned. The registered manager and staff were unaware of these medicines and the potential risks this could have caused. Safe practice is to have a designated medicines fridge or at least, keep medicines in a box, away from possible contamination.

This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe living at the home. For example one person said they felt safe knowing they could request assistance, "Because I've got my bell" and they showed us it was close to hand.

All staff were clear about the different kinds of potential abuse, and told us they had received training on how to protect people from abuse or harm. Each staff member was aware of their role and responsibilities in relation to protecting people and what action they would take if they suspected abuse had happened within the home. All staff said if they say anything of concern, they would tell the registered manager. One staff member said, "We make sure they are not at risk at all. If we have any concerns we report it to the manager." When we asked whether the provider had a whistleblowing policy they responded, "I have never heard of it." However, when we asked what they would do if they observed poor practice by another member of staff, they responded, "Straightaway, I would stop them. I would speak to them about it and report it to the manager." The registered manager said they knew what to report and since our last inspection, we did not find any safeguarding concerns.

Requires Improvement

Is the service effective?

Our findings

People felt staff had the right skills to look after them because they felt relaxed when staff supported them. People were confident they were supported by staff who, "All seem to know what they were doing."

Staff told us they had regular training to ensure their skills were maintained. One staff member described their training as 'very good' although staff could not recall what training they received and when. At our last inspection the system to improve training records was discussed with the registered manager who assured us they would update their training records, so they knew when refresher training was due. We asked to look at training records to help us determine what training staff had received. We could not be confident staff training was up to date and reflective of people's needs. The registered manager's system and knowledge of staff training was minimal because it relied on their memory, rather than effective records to demonstrate what training staff received. We had limited confidence staff had received essential training when required because staff and the registered manager had not received medicines training, which the provider told us was being completed.

The provider did not always have up to date and accurate assessments of people's capacity to make decisions for themselves. 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.

Most people's ability to make day to day decisions was assessed. However, we identified one person who had been assessed as having capacity to make their own decisions. Their assessment described their decisions as 'constant and reasonable'. However, during both days of our inspection visit we spoke with this person on several occasions and some of their statements indicated a level of confusion. One staff member told us about this person who said they did get confused and anxious about their finances. At our last inspection in March 2016, we spoke with this person and they were raising similar concerns around their finances as they were now. We discussed this person's concern with the registered manager in March 2016, and suggested they considered assessing this person's ability to consent to care and treatment, which they agreed to do. At this inspection, there was no indication that action had been taken to assess the person's mental capacity or to inform staff, how to manage their continued anxieties.

Care plans showed that where people had the capacity to consent to their care and treatment they had signed to do so. People had signed to consent to staff supporting them with their medicines and being weighed regularly to maintain their health and wellbeing. The registered manager was aware that people's capacity to make some decisions could fluctuate, because of a change in people's health. For example, one person's care plan recorded that a person was much more confused and muddled because they had a urinary tract infection. The care plan informed staff to give the person every opportunity to make their own decisions and be involved as they wished in the life of the home without putting themselves or others at risk.

Staff sought people's consent before providing care and support and respected people's right to refuse. One staff member told us, "If they refused I would ask them why. If they didn't feel very well, that is fair enough and we would ask them the next day." Staff told us that if they were concerned that someone's refusal for personal care was impacting on their health and wellbeing, they would report it. They explained, "You can't force anybody to get in the shower. I would speak to [registered manager]."

One person's care plan contained information that two relatives had power of attorney for financial matters. The registered manager confirmed they did not hold copies of power of attorney documentation, and had not had sight of it. It is important that registered managers take the appropriate steps to assure themselves people have the legal right to make health and financial decisions on behalf of people living in the home.

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). At our last inspection, the registered manager had limited understanding about restrictions on people's freedoms and liberties. At this inspection the registered manager had not submitted or identified any applications that were required to restrict people's freedoms. However, the registered manager was still unclear with what was meant by a restriction. From speaking with people, relatives and reviewing some care plans, we felt people's liberties were not unnecessarily restricted. However, the registered manager and provider need to assure themselves any necessary applications are submitted when people's freedoms could be restricted.

During mid-morning we saw people being given tea or coffee but nobody was asked what they would like. When we asked the member of staff, they said they knew people's preferences. They explained, "I have asked them in the past and I just remember it now." We observed staff prompted people to drink their drinks to help maintain their hydration. One person told us staff always made sure they had a drink.

People had mixed opinions about the quality and quantity of food provided. One person told us, "We had a nice dinner today, yesterday it looked like, well I wouldn't like to tell you." Other comments people said about the food were, "The food is very good, but sometimes I don't get enough" and "I chose today a battered fish, which is a good portion, but if you ask me, meals are getting smaller and smaller." The cook told us they had informed people of the choices on the menu that morning. but some people said they could not remember being offered this. One person said they told staff their food preferences but it was not always listened to. They told us, "I do not eat green vegetables, I can only eat root vegetables. Last week they gave me a cabbage. Well that is a green as far as I remember and they didn't have replacement to offer."

We checked food stocks because at the last inspection we found that food was kept beyond its 'best before' and 'use by' dates. This time we found some fresh produce such as green vegetables and yoghurts had gone past their best before date. The cook assured us out of date food would not be given to people and fresh produce was being delivered the next day. Bacon, sausage and tubs of cheese were cling film wrapped, but no date of opening or use by date was recorded. We gave the registered manager people's feedback about the food, and expired food stocks. They said following our last visit they had made improvements with the food quality being provided. This did not support what people had told us and the registered manager said, "I am disappointed."

People were referred to other healthcare professional if there was a change in their health. Details of GP visits were recorded, together with the outcome of the visit, medicine prescribed and whether the family had been informed. A relative confirmed that staff were good at letting them know if their family member was unwell. "They always ring and let me know."

Requires Improvement

Is the service caring?

Our findings

People and relatives told us they believed their family members were well cared for by staff. A visiting friend told us the person they visited had been at Greenways a few months and they thought they were looking well. Both visitors said they thought the environment and support people received was welcoming and friendly. One relative told us, "They (staff) are lovely, very good."

At the previous inspection visit, we had concerns people's privacy was not always maintained. For example, a chalk board displayed people's names with dates when their patch medicines were due for change. On the first day of this inspection visit, the chalk board was still being used to record three people's names. Staff told us it acted as a reminder, even though the persons MARs recorded the same information. When we mentioned the impact on people's privacy, staff agreed it was unnecessary, but did not remove it. The registered manager told us following our 4 January 2017 inspection visit, when they returned to the home they removed it but gave us no reason why they had failed to take action after our visit in March 2016.

We saw a lack of adequate staffing had an impact on staff's ability to treat people with respect. All bedrooms were used for single occupancy and some had en-suite toilet facilities. This meant people could be assisted with their personal care needs in the privacy of their own room. On the first day of our inspection visit, one person we spoke with told us they had to use a commode in their bedroom but could not understand why staff did not physically take them to their en-suite toilet, other than because, "I am at risk of falling." We saw this person had used the commode prior to lunchtime when we spoke with them. At lunchtime, we walked past their room and they were eating their meal, on a table, with the used commode next to their chair. The commode had not been cleared away. We made three further visits and over a four hour period, the commode was not emptied and in the same place. During this time, staff had taken the person's meal, cleared the meal away and brought up afternoon tea, without emptying the commode. The person told us the commode had not been cleared away and could not understand why. We asked staff why this was. One staff member said it was the staffing numbers and lack of time, "Especially now as there are only two of us."

Staff told us there was a nice atmosphere in the home. One staff member said, "It has a nicely homely feel. It is not a big home and the residents all seem to get on." Staff spoke to people in a kind way when they assisted them with a task. However; we noticed opportunities for social stimulation were not always recognised or responded to by staff meaning that people sat for long periods of time with little or no interactions. For example, one person returned from a visit with another healthcare professional where they had treatment that they were not looking forward to. They were sitting in the lounge and when they saw a staff member, they waved and said, "I'm back." The staff member who was in ear shot, walked past without acknowledgement and the person looked at us, but did not say anything. Five minutes later, the same person saw staff again and said, "I'm back", then the staff member asked briefly how it went, before leaving to go and support someone else. On a number of occasions we saw staff walk through communal areas where people were sat without acknowledging them. We also observed staff sitting at dining tables, writing daily records. There was no attempt to sit with people and talk with them, whilst they did non personal tasks.

We saw some pleasant, friendly interactions between staff and people across both days of our inspection, despite time constraints on staff. For example, one person walked into the communal lounge and a member of staff stopped and had a conversation with them about the weather. There was lots of use of people's preferred names that gave them a sense of personal identity. People were relaxed with each other and in staff's company. One person told a passing staff member they would like to go outside for a cigarette after they had drunk their coffee. The staff member remembered and came back ten minutes later to support the person to go outside. Another person started sneezing. A staff member asked if they would like a tissue and immediately went to get them one. Staff were considerate when they needed to speak with someone. We saw one staff member woke someone up by gently stroking their arm. Staff spoke discretely when offering to support this person with personal care.

Staff treated people with patience. One person asked for a cup of tea and a staff member brought it to them straightaway. When the person said they wanted it without sugar, another staff member immediately replaced it for them. Where possible, people were supported to be as independent as they needed. For example, one person maintained their own hearing aids and another person was able to walk independently with a frame. We saw staff walking by the side of the person, encouraging and praising them for walking by themselves. They did not hurry the person and walked alongside them at the person's pace.

Staff promoted people's choice and independence. When people were offered biscuits with their mid-morning drink they were given the tin so they could choose which they wanted themselves. Some people had their drinks in cups whilst others preferred their drinks in mugs. A staff member told me, "Some people like a big drink and some people prefer a more dainty cup."

People in communal areas looked well presented with some wearing shoes or slippers. One person's care records said they preferred to wear trousers and a top and we saw they were dressed according to their stated preferences.

Relatives and visitors told us they could visit whenever they wanted and said staff always made them feel welcome and offered them a drink. During both days of our inspection, relatives and visitors arrived at the service and spent time talking to the people they came to see. We saw when visitors arrived, people became more alert and engaged and were pleased to see them, chatting and smiling at each other.

Requires Improvement

Is the service responsive?

Our findings

A relative told us that care was responsive to the needs of their family member. They told us, "[Person] has always had what they needed." While people felt staff attended to their needs, the speed of delivery varied, dependent on staffing levels. One person told us it's, "Depending how many of them are on duty, but I know they will come sooner if they possibly can."

The layout of the home meant it was difficult for staff to see where people were to ensure they remained safe. Staff said it was okay in the communal areas but the first floor and corridors meant they could not cover all aspects of the home. A high number of people spent time in their own rooms. People said staff did check on them, but mainly when passing rather than stopping to check they needed anything or wanted time to interact with others. We asked them if they were encouraged to spend time with others, or whether staff helped them pursue their interests. Most people preferred their own company, but one person told us they would like to go downstairs but said they did not, because they were at risk of falling. They said they were not encouraged which put them at risk of isolation.

People were assessed before they moved to the home to ensure their needs could be met. However, there was inconsistency in the level of personal information obtained about people. Some care plans contained detailed information about the person's background, formative years, family, work life, interests and hobbies. There was also information about the person's preferences, likes and dislikes so staff knew how to provide care in a way that met the person's individual needs and habits. There was evidence that staff had requested photographs and personal mementoes' that could help the person to remember important and happy events in their life. Yet two care plans did not contain any information about people's backgrounds and staff did not know why. This information is vital to provide person centred care based on people's likes, dislikes, preferences and taking into account their past experiences. It is especially important if people start losing some of their memories as staff then have the knowledge to start meaningful conversations and prompt people's memories.

Other parts of care plans did not provide guidance so that staff could offer a consistent approach in and respond to and meet people's needs. For example, one person's care records contained a very detailed catheter care plan. This plan provided staff with all the information they would need to manage the catheter safely and respond to any changes which might indicate an infection or blockage. However, this person's manual handling care plan had conflicting information, stating they were unable to walk and required staff assistance to use a wheelchair when transferring. Their falls risk assessment stated they were mobile with one or two staff and their gait was steady. Contradicting information had potential to place people at increased risk because staff did not have accurate information to respond to when people's needs changed.

Care plans were reviewed and relatives told us they felt involved in care decisions. We saw evidence that some people's care plans were amended to take into account any changes in their health, For example, when one person was unwell and not sleeping, their care plan stated they needed to be checked regularly and their call bell placed to hand. One person's care plan said they liked to read a particular newspaper each day and a local newspaper every Friday, which they did. On the second day of our inspection visit we

observed the person with the newspapers and they enjoyed talking with one of our inspectors about an article in the local paper. However, other care plans were reviewed but critical information had not been identified, followed and relevant information passed to staff. Some improvements had been made following our last inspection visit, but the registered manager said further improvements would be made if they had more time dedicated to achieve this.

People received task based care and staff said there was limited time available for them to engage with people to offer physical or mental stimulation. One staff member told us, "Sometimes we don't do activities because there aren't enough staff." We asked staff whether there was enough going on to keep people stimulated and occupied, "If there is an activity lady on, there is enough, but they could probably do with a bit more." From speaking with people and our observations on both inspection visits, we could not be sure action was taken to ensure people who stayed in their bedrooms were not isolated socially. When we asked whether staff had time to sit and talk with people in their bedrooms, staff said, "We would do if there was more of us here."

Some people felt involved and enjoyed some activities, such as staff taking them into the garden which they enjoyed or for walks outside, close to the home. Some people said they liked the external entertainers that provided opportunity for them and others to join in exercises to music or have a sing song. Some people said there were opportunities to take part in a monthly religious service.

To seek feedback from people and relatives, the provider's action plan sent to us following our inspection in March 2016, agreed to keep a comments book in the hallway, but it was not present on day one of our inspection. Speaking with people, we found they were not aware of this book. Increased meetings were to be arranged for people to share feedback but the registered manager said these had not taken place due to time constraints.

People said they had not made any complaints although some people told us they were not entirely happy with aspects of the service. Relatives said if they were unhappy, they would approach the registered manager. The registered manager said they had not received any complaints since our last inspection and because they were working alongside staff in a care role, people could approach them anytime. They said people had not approached them so they believed there were no issues and were disappointed when we told them of our findings.

Inadequate

Is the service well-led?

Our findings

The service was not well led and systems to monitor the quality of care to people were not effective. The providers own quality assurance systems failed to identify areas of concern we found during our visit that affected the delivery of care.

At our last inspection we found a number of concerns that we asked the provider to put right. Following that visit, the provider sent us written information about how they would improve the service. This 'action plan' told us they would have continuous questionnaires seeking feedback, monthly risk assessment evaluations so they could be more responsive to risks and that they would make improvements to the quality and safety of the service. At this visit, we found the provider had not undertaken the actions they told us they would make. There were a number of continued and significant shortfalls in the way the service was led.

We continued to find the risks to people's health and well-being had not always been assessed appropriately to ensure people were safe. We continued to find that medicines were not being managed safely and staff had not received the training and checks required for the provider to be assured staff were safe to administer medicines. We continued to find concerns about nutrition and the storage of food. We continued to find peoples' views and opinions had not been either listened to or acted on.

We were also very concerned at the number of falls people had and the lack of processes to ensure the service had done everything it could to reduce the risks of people falling again. We had not been alerted to a number of falls where people had required treatment from other healthcare professionals. The registered manager had failed to undertake their statutory responsibility in notifying those to us.

We were concerned that staff had not acted on advice provided by healthcare professionals to meet people's changing needs. For example a person discharged from hospital who had risks associated with choking, was not given fluids in line with specialist advice as staff had not been made aware. Staff had not encouraged them to wear a splint because they were not aware.

Some people had been identified at risk of skin damage and had pressure relieving equipment to reduce the risks. However, there were no effective checks and information to ensure the registered manager and staff knew what the right settings should be, and how to check. Staff said, "We don't touch it, (external contractor) comes in and checks every three months," We checked three pressure relieving mattresses which should be set to people's weight and found these were not set correctly. In some cases, they exceeded the person's weight by 85kg. The lack of consistent and effective checking placed people at increased risk.

The provider agreed to focus on involving, listening and making improvements from people's feedback. At the last visit, people were not confident to share ideas and suggestions. The provider sought people's feedback following our last inspection visit however people told us little had improved. The provider displayed the results from the survey, but people living at the home, the registered manager and staff said 'It is difficult to understand what they mean' because actions were not displayed. Next to the results, we saw a

note entitled "Response to resident questionnaire", dated 23 March 2016. We were told it was written by the provider, albeit not signed. Part of this note read, 'having noted some of your comments we would wish to say that Greenways is not offering a five star service. We wish to promote a homely feel with good home cooking and our fees reflect that level of service." We asked the registered manager and staff about this note so they could explain what was meant. A comment was, "I think it is condescending."

The registered manager said following people's feedback, the choice and quality of food had improved. However some people told us they did not remember being offered a choice, some did not enjoy the food and some said the portion sizes were reduced. At the last inspection, some food stocks were out of date. We checked this time and found food items such as fresh vegetables, fresh fruit and yoghurts exceeded best before dates. The registered manager said, "I am disappointed" and said they trusted those staff to make checks themselves. They did not have an effective system of checks when tasks were delegated to others.

Speaking with the registered manager and reviewing their audit systems we identified a lack of proactive management and leadership which affected the quality of service. For example, we looked at the processes used to ensure people received safe and effective care, from staff who were trained and qualified to provide that care. The system that monitored training had not been updated since our last visit. We asked for the latest copy, and the registered manager said they did not have a schedule that informed them when staff training was required. The registered manager said staff had completed training but they were unsure who required specific training updates. They also said a lack of adhering to planned one to one meetings with staff reduced opportunity to review staff's training needs and this was not in line with the providers' action plan.

Effective systems to monitor safety checks were not in place. Some fire safety checks were not completed which had potential to place people and staff at risk, in the event of emergency. The registered manager said the provider visited once a week and completed environment audits, however these checks were not effective to show what issues required improvement. A book recorded what weekly checks were made, such as water temperatures and maintenance repairs, but it was not clear what safe ranges were, what had been rectified and what issues were outstanding.

From speaking with staff and the management team (registered manager and deputy manager), they felt the home was not always supported by the provider. Comments were, "We could do with more staff" and "We need agency staff." The registered manager said they needed additional help and support because they spent time helping staff on the floor. They said if time on the floor was reduced for them and the deputy manager, it would help them complete the management checks and give them time to upskill and empower the deputy manager to take on responsibilities. We asked if they had raised these issues with the provider and we were told they had, however there were no actions to support this or what was done to provide that support. We were told a typical comment from the provider to the registered manager was 'we will look at this' with minimal positive action taking place.

On the second day of our inspection we spent time with the registered manager and asked them what had changed and improved since our last visit. They told us, "Following the last inspection I was disappointed, I have got audits in place and now I like to think we have a good service." We asked the registered manager a number of times for audit records and actions plans they were working towards. They said, "To be honest, I don't have any, I don't record them."

We highlighted some of the concerns we found that had not been rectified since our last inspection. For example, a board in the communal dining room was still being used to record when people's patch medicines required changing, medicines not been signed for when administered and staffing levels affecting

the delivery of care. Also, food stocks not being effectively monitored to ensure people's meals were prepared using food that was in date and a lack of audits and improvements. The registered manager said, "I'm disappointed, we don't get time to do things, it's having the resources."

Following our ratings inspection in March 2016, it is a requirement of the regulations for the provider to display their overall rating. A full copy of the inspection report was displayed on the 'residents' noticeboard, however this did not fully comply with the regulations and the provider's legal duty. We discussed this with the registered manager who admitted this was an oversight and assured us they would display the correct ratings poster.

The registered manager told us staffing levels at times impacted on them directly, which prevented them completing timely management checks, falls analysis and to oversee the home to the quality they wanted. They said, "I do help out, it affects the management, we need more staff."

This was a continued breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people were pleased with the level of service they received. Relatives and visitors of people using the service were pleased with the environment and the support people received.

Staff felt people received good care, one staff member said, "The staff they have and the job they do, I think we do quite well." Staff told us they were committed to delivering a good quality of service and wanted to but felt staffing numbers continually limited this from happening. Staff felt supported and respected by the registered manager and each other. Staff said they could raise their issues with the registered manager but were not confident they would be addressed, especially if it needed support from the provider. Most of the staff said they received one to one meetings, but these were not frequent although staff said if they had a concern, they would approach the registered manager without delay. Staff said one to one meetings when held, were useful and the registered manager acknowledged they were not always completed at the required intervals.

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 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not being provided in a safe way because risks were not managed and action was not taken to minimise the risks to people's health and wellbeing. Regulation 12(1)(2)(b). Medicine management was not effective to protect people from potential harm. Regulation 12 (1)(2)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems or processes were not robust, established and operated effectively to ensure risks to people were reduced and to provide a good quality service to people. Regulation 17 (1) (2) (a) (b)(e).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing arrangements were not consistent to ensure there was sufficient numbers of suitably qualified, competent and skilled staff to meet people's care and welfare needs. Regulation 18 (1).