Guinness Care and Support Limited

Greenhill Residential Home

Inspection report

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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

Overall summary

Greenhill Residential Home provides care and accommodation for up to 36 older people, which may include people living with dementia. On the day of the inspection 32 people were living at the home.

The home had previously been inspected in December 2014 and was rated as "Good".

The inspection took place on 11 and 13 May 2015. The first day was unannounced and was undertaken in response to information we had received in relation to the care of people at the home.

The registered manager was not available during the inspection. 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. Management cover had been provided by an interim manager from Guinness Care and Support Ltd Quality Assurance Team. A newly appointed manager had commenced employment on the first day of our inspection.

Summary of findings

People living at the home were not protected from receiving unsafe care. Prior to the inspection the community nursing service and the local authority's safeguarding team shared concerns with us about the quality of the care people were receiving and we identified areas of concerns during the inspection.

Staff had failed to recognise or seek prompt medical attention for one person whose health had deteriorated over several days. They failed to ensure people were receiving sufficient food and fluids to maintain their health. One person had been admitted to hospital with dehydration. Staff were not giving medicine as prescribed to ease people's pain.

Care plans did not provide accurate and up to date information about people's care needs. Some care plans had been written some years before, and although these plans were reviewed regularly, changes were not transferred into the care plan. Information to ensure people were safe in the event of a fire was out of date and not accurate as it had not been updated since 2013.

Many of the people who lived at Greenhill had some degree of dementia and required support from staff to anticipate and meet their care needs. During our observations we saw varying quality of the support provided to people. At times people were not always treated with dignity and respect and at other times staff were seen to be to be kind and caring.

Staff had varying understanding of The Mental Capacity Act 2005 (MCA). Some said they were unsure and others said "it's about supporting people to make decisions." Some people living at Greenhill may have to have their liberty restricted to keep them safe. Greenhill provided locks on the exit doors as some people were at risk of harm should they leave the home unsupervised. People were still able to access the secure garden. Authorisation had been sought for the restriction to people's liberty through the use of these locks.

People were being supported by sufficient numbers of staff to meet their needs. However, this included a number of agency staff who did not know people well, and care was task orientated rather than person-centred. The home employs an activity coordinator. We saw a small number of people enjoying a quiz but this activity was interrupted and it was not clear how well staff supported meaningful engagement for people.

The home's quality assurance reviews and audits highlighted areas of concern in relation to the management of the home and the quality of the care provided. However, sufficient action had not been taken to resolve these issues and protect people from receiving unsafe care. The home was working cooperatively with the local authority's quality support team and the safeguarding investigations.

Safe recruitment processes were in place and appropriate checks had been undertaken to ensure staff were suitable to work with people who lived in the home. Staff said they received "lots of training" and could ask for more. Staff received regular and very recent supervision, due to the care issues raised by the community nursing and safeguarding teams: these supervisions included observations of their care practice.

Staff had an understanding of abuse and how to report it. The home was co-operating fully with the safeguarding investigations underway. People told us they felt safe at the home and two visitors told us they had no concerns over their relative's care or safety.

Most of the people who were able to share their experience of living in the home told us they felt well cared for and relatives told us they were happy with the care provided at the home. People said they enjoyed the meals. We saw people being asked their choice both at breakfast and lunchtime.

We recommend the provider seeks advice and guidance from a reputable source about the provision of positive and individualised activities for people living with dementia.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The overall rating for this provider is 'Inadequate'. This means the home will be placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Summary of findings

- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains 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 the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Summary of findings

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 home was not safe.

People were not protected from receiving unsafe care. Staff had failed to recognise or act upon people's deteriorating health.

People did not always receive their medicines as prescribed.

Information to ensure people were safe in the event of a fire was out of date.

Risk assessments did not provide clear guidance to staff on how to reduce risks to people's health and safety. Staff had failed to follow guidance to keep people safe.

People were supported by sufficient numbers of staff however information provided to staff about people's care needs was not accurate.

Is the service effective?

Requires improvement

The home was not always effective.

Records were not completed in sufficient detail to ensure people were receiving enough to eat or drink to maintain their health.

Staff had varying understanding about The Mental Capacity Act 2005.

Authorisation had been sought to restrict people's liberty with the use of locks on exit doors.

Is the service caring?

Requires improvement

The home was not always caring.

People were not always treated with dignity and respect. Some staff did not talk to people they were supporting.

Other staff were kind and caring, showing compassion towards people.

People told us they were well cared for and relatives were pleased with the care provided.

Is the service responsive?

Requires improvement

The home was not always responsive.

Care plans were out of date and did not provide accurate information about people's care needs.

People were unsupervised for long periods of time and did not benefit from engagement in meaningful activities.

The home responded to concerns raised by people and their relatives promptly.

Summary of findings

Is the service well-led?

Inadequate

The home was not well led.

Insufficient action had been taken to prevent harm to people.

The home's quality audit system had not resolved issues of poor quality care.

People and relatives were encouraged to share their views about the home.

Greenhill Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was 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.

The inspection took place on 11 and 13 May 2015 and the first day of the inspection was unannounced. The inspection was undertaken by one adult social care inspector.

Prior to the inspection we reviewed the information we held about the home including the previous inspection reports and notifications we had received. A notification is information about important events which the service is required to send us by law. We also reviewed information we had received from health care professionals who had raised concerns about the service.

During the inspection we spoke with 14 people who lived at Greenhill, two relatives and eight members of staff, two of which were employed through an agency. We also spoke with a senior manager and a quality assurance manager from Guinness Care and Support Ltd: with the interim manager who was responsible for the management of the home in the registered manager's absence; and the newly appointed manager. Over the two days of the inspection we had contact with two community nurses and a GP. We looked around the premises and observed how staff interacted with people. Many of the people who lived at the home had some degree of dementia, and were not able to communicate with us in any depth about their experiences of being at the home. We used the Short Observational Framework for Inspection (SOFI) which is a way of observing care to help us understand the experience of people who could not talk with us. We spent time observing the care of people including observations over a mealtime, of medication administration and moving and handling practices.

We looked at three records related to people's individual care needs. We reviewed two staff recruitment files and staff training records. We also looked at records associated with the management of the service, including quality audits, which were provided to us by the senior manager during and following the inspection.

Inadequate

Is the service safe?

Our findings

The home was not safe.

Prior to this inspection concerns had been raised with us over the quality and safety of the care and support provided to people. At this inspection, we found people had received unsafe care and treatment which breached Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the first day of this inspection we raised concerns over how staff had responded to one person whose health had deteriorated over several days. Daily care notes, record of contact with the GP and food and fluid intake records indicated staff had failed to act upon changes to this person's health. Although we were informed staff had contacted the person's GP on 8 May 2015, and the "out of hours" community nursing service over the weekend of 9 and 10 may 2015, there was no information held in the care home's records of this person's significant health changes being discussed with the GP who visited this person on the afternoon of 8 May 2015, or the community nursing service. Neither was there evidence staff had sought advice over continuing to administer a medication to control diabetes when this person was not eating. This person was reviewed by a doctor and admitted to hospital.

People's pain management had not always been attended to. Records showed that pain relieving medicines had not always been administered when people were in pain, in spite of them being prescribed to be taken when required. Some people may have suffered pain unnecessarily.

Risks to people's health and welfare had been assessed and these included the risk of poor nutrition and hydration, developing a pressure ulcers and the risk of falls. However, we found that either there was insufficient guidance for staff to reduce these risks, or staff had failed to implement the guidance provided. For example, we saw one person who was at risk of poor nutritional intake and of choking on food had not been assisted to eat their meal and had been left alone with the food. Documents relating how to support people with their mobility did not provide sufficient detail for staff to support people safely.

Some of the information to ensure people were safe in the event of a fire was out of date and not accurate, having not been updated since 2013. For example, it identified one person as being able to mobilise, "walks with a frame and support of 1 carer". However this information was out of date as this person was no longer able to walk. It did not identify all of the people living in the home. This meant in the information provided to the emergency services would be incorrect.

Prior to this inspection concerns were raised with us about people not receiving their medicines as prescribed. Members of Guinness Care and Support quality assurance team provided us with copies of recent audits of the medicine practice at the home. These identified issues including medicines not being signed for and some medicines not being given. An action plan outlined what steps the home had taken to address these issues.

We looked at the records relating to medicine administration. Medicine administration records (MAR) confirmed oral medicines had been administered as prescribed. However, we found the arrangements for topical creams did not ensure people would receive them as prescribed. Clear instructions were provided for staff about how to apply these creams; however these instructions had not been followed.

We observed medicines being administered: people received their medicines safely and on time and staff provided an explanation of what the medicine was for. People's medicines were administered by senior staff who had received appropriate training to carry out the role.

There were suitable secure storage facilities for medicines, including refrigeration when necessary. Medicines entering the home from the pharmacy were recorded when received and when administered or refused. This gave a clear audit trail and enabled the staff to know what medicines were on the premises. We checked the records of some medicines against the stocks held and found them to be correct.

The senior manager confirmed agency staff were employed by the home to ensure sufficient staff were on duty to meet people's needs. An assessment of people's personal care needs indicated whether they required support from more than one member of staff, and the senior manager confirmed staffing levels were arranged accordingly. The same agency staff were booked for eight weeks at a time to provide consistency for people. At the time of our inspection there were 10 care staff on duty, including two senior care staff, who were supported by laundry, cleaning, catering and administrative staff as well as the interim manager. Some people told us staff took a long time to

Inadequate

Is the service safe?

answer call bells while others said staff came quickly. One person said, “Things have changed recently, the bells are not answered” and another person said, “there are plenty of staff to help me.”

Safe recruitment processes were in place. Appropriate checks had been undertaken to ensure staff were suitable to work with people who lived in the home.

Staff had received training in recognising and reporting abuse and had an understanding of what might constitute abuse and how to report it. The home had a comprehensive policy and procedure for the reporting of concerns about abuse and relating to whistleblowing. When safeguarding concerns had been raised, the home co-operated fully with the investigations underway.

People told us they felt safe at the home, comments included, “yes, they are very good” and “yes, I feel safe.” Two visitors told us they had no concerns over their relative’s care or safety.

Communal areas of the home and people’s rooms were clean and tidy, but some areas of the home had unpleasant odours, particularly some of the lounge room armchairs and one bedroom, making these areas unpleasant to spend time in.

Requires improvement

Is the service effective?

Our findings

People did not always receive effective care.

Some people needed support with eating and drinking and did not always receive this in a way that met their needs. We saw food and fluid intake records were in place for a number of people. These records were not completed in sufficient detail and were not appropriately reviewed to ensure people were receiving enough to eat or drink to maintain their health. We looked at three people's food and fluid charts for the previous five days. One person's record indicated the most fluid they had to drink was 600mls, and the least they had drunk in one day was 50mls. Another person's record was scant. It had only one or two entries on two days and had not been completed for three days. The third person's record had not been completed for four days. Records of how much people had eaten were also inconsistent with many meals not recorded. Staff said they were unsure who was responsible for monitoring these records and there was no evidence staff had sought advice to improve the amount that some people ate and drank.

This was a breach of Regulation 14 (1) (2) (b) (4) (d) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff had varying understanding about The Mental Capacity Act 2005 (MCA). Some said they were unsure and others said "it's about supporting people to make decisions." The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. Assessments of people's capacity to make decisions, such as whether they could manage their medicines themselves were in the care files. Family members were involved in sharing their experiences of their relative's preferences and care needs and these were recorded in the care files.

Some people living at Greenhill may have to have their liberty restricted to keep them safe. Deprivation of Liberty Safeguards (DoLS) provide legal protection for these people. Greenhill provided locks on the exit doors as some people were at risk of harm should they leave the home unsupervised. This was considered the least restrictive measure to protect people as it allowed people the freedom to walk around the home, and people had access to the secure garden. It is necessary for restrictions to be authorised by the local authority's DoLS team, regardless of whether people challenged the use of these locks or not. The senior manager confirmed that applications for authorisation had been made.

Staff said they received "lots of training" and could ask for more. The home used a self-assessment in relation to identifying training needs, and staff could personalise their training to meet their specific requirements. They confirmed they were encouraged and supported to undertake National Vocational Qualifications. Training records showed that staff had received training relating to their roles and responsibilities. This included training to keep people safe including safe medicine administration, safeguarding, moving and handling, infection control, food hygiene and fire safety. Dementia care training had been arranged for shortly after this inspection. Newly employed staff completed an induction which included shadowing more experienced staff and commencing the new care certificate induction and qualification.

Staff received regular and very recent supervision, due to the care issues raised by the community nursing and safeguarding teams: these supervisions included observations of their care practice. The senior manager had recently put a more challenging supervision system in place to check care staffs' understanding of infection control principles. The interim manager had undertaken frequent observations of care and records of these were made available.

People said they enjoyed the meals; comments included "we have a choice of two or three meals. We get plenty to eat", "the food is nice" and "very good." We saw people being asked their choice both at breakfast and lunchtime. One person requested bacon and tomatoes and this was provided. Another person said they woke early and always had two breakfasts. A list in the kitchen alerted care and catering staff about people's nutritional needs, such as requiring a soft diet or a diet suitable for someone with diabetes.

The gardens were secure and attractive. We saw staff accompanying one person out into the garden at their request. Staff said that during better weather the garden doors were left open for people to wander freely. Raised flower beds had been created to allow people to continue to see the plants and to garden if they wished more easily.

Requires improvement

Is the service caring?

Our findings

The quality of interaction between staff and people were variable.

Many of the people who lived at Greenhill had some degree of dementia and required support from staff to anticipate and meet their care needs. During our observations of staff interactions with people, both in general during the inspection and during our period of SOFI observation, we saw people were not always supported by staff who treated them with dignity and respect. For example, we saw one person being assisted to have a drink. The staff member spoke initially to this person telling them what they were doing but then they had no more conversation with them though out the activity. The member of staff was watching the television while giving the person their drink. We also saw staff delay in responding to someone who had requested to go to the toilet and it took several minutes for staff to assist them as they were talking to other people, causing this person to worry.

This was a breach of Regulation 10(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other interactions showed staff to be kind and caring. We saw one person calling for help saying they were frightened and a staff member sat with them, holding their hand and gently talking to them to alleviate their anxiety. Staff told us about their caring role. They said they felt caring was "to make people feel happy", "to respect dignity and choice" and "to build a relationship with people." One staff member said "I care about the residents."

The home provided care to people at the end of life. Care files contained information about people's wishes in relation to their care at this time. For example, one person's wishes were recorded, "would like a photograph of her husband with her." However the community nursing service told us changes to people's care needs were not being communicated to all staff, particularly the agency staff, meaning people's needs were not being met appropriately. For example, changes to how frequently one person was to have their position changed had been decreased to reduce their discomfort upon moving, and some staff were not aware of this.

There was some guidance for staff within care plans about how to best care for people. Entries included "things I enjoy and things I don't enjoy" and "what makes a good day and what makes a bad day" and people's preferences were recorded. For example, one person's care file indicated "likes to sit in the garden and listen to the birds" and another "likes a cup of tea beside his bed when he gets up." There was also some guidance for staff relating to people's abilities and how these should be encouraged and maintained. We saw entries such as "is able to manage her personal care, likes to be clean and fresh, would like staff to check she is well dressed" and "if you show me I can choose what I want to wear."

Most of the people who were able to share their experience of living in the home told us they felt well cared for. Comments included, "they (the staff) are very good, I've got no complaints", "very happy (with the care)" and "we are well looked after." Relatives told us they were happy with the care provided at the home and comments included, "she is well cared for, no problems. If I have any issues I can talk to the staff" and "the staff are kind and caring."

Requires improvement

Is the service responsive?

Our findings

The home was not always responsive.

The senior manager recognised the care plans did not provide accurate information about people's care needs. A member of the quality assurance team had been working with staff to update these plans. However, many were still to be updated and did not have sufficient detail to enable staff to understand the care and support needs people had. People's specific needs relating to dementia were not described. For example, one person's care plan stated "can get confused, staff to sit with (name) and offer reassurance" but there was no explanation of what it was like for this person to be living with dementia. Care plans had been reviewed each month but there was no record of whether people had been involved in reviewing their care needs and how they wished to be supported.

Agency staff were reliant upon the daily handover report to understand people's care needs as they said they had not had time to read people's care plans or risk assessments before starting to care for them. The version of the report the staff were using on 11 May, the first day of the inspection, was dated 5 May 2015 and contained information about people which was no longer accurate. This placed people at risk of not having their needs recognised or met.

The home employed staff to provide group and individual activities. During the SOFI observations, we saw the activity coordinator encourage people to be involved with a quiz. While people were seen to enjoy the quiz, only five of the 32 people living in the home were involved. We saw people had not been asked if they wanted to participate in advance. The quiz was interrupted by one person requesting to go to the toilet. The activity co-ordinator had to stop the quiz to assist another member of staff rather than staff recognising the importance of continuing with the activity and allowing the coordinator to continue. For the hour of our observation we saw people engaged in a meaningful activity for 10minutes. People were seen to be unsupervised and either passive or asleep in the lounge during both mornings of our inspection. The layout of the lounge, with chairs around the periphery of the room and a table in the middle, did not encourage people to have conversations with each other or to enjoy the games and magazines available on the table.

People told us the activities they had recently enjoyed, and these included a cooking session and making Easter bonnets. One relative told us, "there is usually something happening." We saw photographs of people engaged in activities and pictures people had drawn or painted on the wall in the dining room and lounge rooms. People's interests had been recorded in the care files, and some were more detailed than others, proving advice about engaging people at risk of isolation in meaningful activities.

We looked at the response the home made to concerns or complaints made by people living in the home or their relatives. The home had responded quickly to investigate and had responded to the person who raised the concern with their findings. We saw this during our inspection, when one person raised concerns over their laundry, and this was responded to immediately. One relative told us they had raised a concern recently and they were satisfied with how it had been responded to and resolved.

We recommend the provider seeks advice and guidance from a reputable source about the provision of positive and individualised activities for people living with dementia.

Inadequate

Is the service well-led?

Our findings

The home is not well led.

The systems and process at Greenhill for improving the quality and safety of the services provided were insufficient. The failure to assess, monitor and mitigate risks to people had been identified through internal audits and reviews but this had not prevented people from receiving poor care. Accurate and detailed records in respect of each person using the service were not maintained.

This is a breach of Regulation 17 (1) (2) (a) (b) (c) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Senior managers from Guinness Care and Support Ltd described the service's quality assurance and audit system. Members of the Quality Assurance Team undertook monthly reviews and audits with the management and staff at the home. Documents were sampled and issues relating to the care and welfare of people, medicine management and health and safety of the environment were reviewed. We were provided with copies of the more recent internal reviews which showed failings had been identified by the Quality Assurance Team in relation to medicine management, the accuracy of care records and staff ensuring people's needs were met. The home had implemented a Service Improvement Plan in February 2015 to address these issues. The actions identified included improving access to a nurse and management support over the weekends, additional administration support as well as staff training in issues relating to the needs of the people living in the home.

However, despite the additional support provided, we found insufficient action had been taken to ensure people received safe care. As a consequence, care needs were not fully recognised and addressed, people were not supported to receive sufficient diet and fluids to maintain their health and some people had suffered harm.

We saw staff were not managed effectively on a daily basis. Many of the staff were in the office at the same time while people in the lounge and dining room were left without staff support. This meant people did not have the opportunity to engage in meaningful activities, were unable to request assistance or staff weren't available to respond to people's needs.

Changes had been made to the home's management team prior to the inspection, with senior managers from Guinness Care and Support Ltd working in the home. Further changes had been made with the appointment of a new manager and the involvement of a consultant occupational therapist to assess people's mobility needs. The home was working cooperatively with the local authority's quality support team and the safeguarding investigations to identify how failings had occurred and what actions were necessary to protect people.

Residents' meeting had been held to encourage people and their relatives to share their views about the home. The minutes of a meeting in February 2015 showed a large number of people attended and one relative. Issues discussed included menu planning, activities and maintenance. There was no indication that actions from any previous meetings had been discussed and no actions had been set from this meeting. It was therefore not possible to ascertain if people had been able to influence the services and support provided at the home. The senior manager confirmed a further meeting had been planned to notify people and relatives of the current issues in the home and the action being taken to address these.

Staff told us they welcomed the changes, but at present it was unsettling. One staff member said they did not know who all the new managers were and another said "at least we are being listened to now." Recent staff meeting minutes identified areas for improvement and guidance for staff with regard to allocating staff duties, safer medication practices and checks to ensure people's need are being met.

The home produced a newsletter to provide people with information and inform them of planned events. The internal reviews had recognised people attended few activities out of the home and the senior manager said they would provide more community contact.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 10 HSCA (RA) Regulations 2014 Dignity and respect People were not treated with dignity and respect at all times. This is a breach of Regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People were not protected from receiving unsafe care and treatment. Staff did not seek prompt medical advice regarding people's changing health conditions or recognise significance of continuing to administer medicine which places people at risk of further deteriorating health. Risk assessments did not provide accurate information or guidance for staff or where guidance was provided it was not followed. People did not receive their medicine as prescribed. This was a breach of Regulation 12 (1)(2)(a)(b)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Insufficient action had been taken to ensure the quality and safety of the service was improved. This ass a breach of Regulation 17 (1)(2)(c) of the Health and Social Care Act (Regulated Activities) Regulations 2014

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs People's nutritional and hydration needs were not being met. This was a breach of Regulation 14 (1)(2)(b)4(d) of the Health and Social Care Act (Regulated Activities) 2014.