Greenfield Close Residential Home Limited

Greenfields Close

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 17 and 22 October 2018, and the first day was unannounced. Greenfields Close is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Nursing care is not provided at this service.

Accommodation for up to 30 people is provided in four residential buildings: Greenfields (17 people), The Stables (five people), Klosters (four people) and Aspen (four people). There is also a building for activities, training and administration (The Lodge). There were 26 people living at the service at the time of our inspection. Greenfields Close is designed to meet the needs of people diagnosed with a learning disability and/or autism. Some people living at the service also receive care in relation to their physical disability.

The service did not have a registered manager at the time of our inspection visit. The previous registered manager left in July 2018, and the new manager started in September 2018. They have now registered with us. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The care service has not been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service cannot live as ordinary a life as any citizen. People living at Greenfields Close were not consistently supported to increase their independence. People and their relatives were not involved in planning or reviewing care and support.

People were not protected the risk of abuse. The systems in place to identify and deal with concerns had not worked to safeguard people from abuse. People were not protected from risks associated with their care and support. Medicines were not managed safely. There was no analysis of accidents or incidents to enable the provider to identify themes or trends in poor or unsafe care provision, or to demonstrate that lessons were learnt.

There was not enough staff to provide people with the support they were assessed as needing. People were not consistently supported to maintain their health. People's needs and choices were not assessed in line with current legislation and guidance.

Where people could not consent to their care and treatment, the provider had not followed the Mental Capacity Act 2005 (MCA). People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible. The policies and systems in the service did not support this practice.

Staff did not have training the provider identified as necessary to deliver care effectively. People were at risk of receiving care from staff whose skills and knowledge was not assessed or monitored. People and relatives were not consistently supported to participate in planning or reviewing their care. People who needed support to communicate were not always able to meaningfully participate in making decisions about their care.

Confidential personal information relating to people's care and support was not stored securely. People experienced varying levels of support to maintain interests and hobbies.

People knew how to raise concerns or make a complaint. However, concerns and complaints were not clearly resolved, and the provider did not have clear information about areas where improvements were needed.

The service was not well-led. Systems in place to identify whether people were receiving the safe care they were assessed as needing did not identify issues where care needed to improve. During this inspection we identified shortfalls across all the key questions we ask about services. This included failures in safe care practices, poor infection prevention and control measures, medicines management concerns, staffing levels and a lack of staff training and supervision. Feedback had not been acted on to improve the quality of care for people living at Greenfield Close.

We found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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.

People were not kept safe from the risk of abuse. People were not protected from risks associated with their health needs. There was not enough staff to provide people with the support they were assessed as needing.

Is the service effective?

Inadequate

The service was not Effective.

The provider could not demonstrate whether people's restrictive care was proportionate. Staff did not have training the provider identified as necessary to do personal care effectively. People were not consistently supported to maintain their health.

Is the service caring?

Requires Improvement

The service was not consistently Caring.

People did not consistently receive kind and caring support. People and relatives were not consistently supported to participate in making decisions about planning or reviewing of their or their family member's care.

Is the service responsive?

Requires Improvement

The service was not consistently Responsive.

People experienced varying levels of support to maintain interests and hobbies. People were at risk of not being able to express and receive communication in ways they understood and which met their needs. There was no evidence that the provider had ensured actions from complaints investigations were carried out.

Is the service well-led?

Inadequate

The service was not Well-Led.

Systems in place to identify whether people were receiving the safe care they were assessed as needing had not identified the issues we found on this inspection. Checks and audits did not identify that service users were not consistently involved in planning and reviewing their care. There was no system in place to review incidents to identify risks to people.

Greenfields Close

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.

The inspection took place on 17 and 22 October 2018, and the first day was unannounced. The inspection was prompted by information about allegations of abuse shared with us by whistleblowers and the Local Authority. These allegations are subject to investigation by the local authority, and this inspection did not examine the circumstances of the allegations. However, the information shared with CQC about the allegations of abuse indicated potential concerns about how the provider ensured people were protected from the risk of abuse. This inspection examined those risks. At the time of our inspection, nine safeguarding investigations were being carried out by the local authority.

The inspection visit was carried out by three inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The second day of our inspection was carried out by two inspectors.

Before our inspection visit we reviewed the information we held about the service including notifications the provider sent us. A notification is information about specific events which the service is required to send us by law. We sought the views of Healthwatch Nottinghamshire, who are an independent organisation that represents people using health and social care services. We also sought the views of external health and social care staff, and commissioners from the local authority. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority or by a health clinical commissioning group. Commissioners also undertake monitoring of the quality of services.

During the inspection visit we spoke with nine people who used the service. We spoke with 11 care staff. We also spoke with the deputy manager, manager, area manager and provider's operations director. We looked at a range of records related to how the service was managed. These included 13 people's care records and we looked at how medicines were managed for 12 people. We also looked at four staff recruitment and training files, and the provider's quality auditing system.

On this occasion we did not ask the provider to send us a Provider Information Return (PIR). This is a form that asks the provider information about the service, what the service does well and improvements they plan to make. However, we offered the provider the opportunity to share information they felt relevant with us. We asked the provider to send us information relating to the governance of the service, for example, staff training information, and they send this to us when we asked for it.

Inadequate

Is the service safe?

Our findings

People were not kept safe from the risk of abuse. Staff were unclear about their responsibilities to recognise and report unsafe or abusive care practices. Prior to our inspection visit, we were made aware of nine abuse allegations in relation to care practices. Although the provider had now acted to train staff in safeguarding adults, the local authority investigations into the allegations had determined that abusive care practices had taken place. Evidence from staff and records showed that although staff received training in recognising and raising concerns about poor or abusive care, they had not always felt confident to speak up and report their concerns. The provider agreed that the culture in the service had not always supported staff to report concerns, or for those concerns to be acted on. The systems in place to identify and deal with concerns had not worked to safeguard people from abuse.

People were subject to physically restrictive care practices which had not been assessed as safe or proportionate for them. Staff told us they were not trained to use physical interventions with people, and training records confirmed this. We saw an incident where staff used physical intervention on one person. We also saw incident records which stated staff used physical intervention to prevent people harming themselves or others. Staff confirmed they had done this, and the manager accepted this. There were no safeguards in place to ensure staff used the less restrictive techniques they were trained to use. People were subject to physical restraint when this was not proportionate or in their best interests.

These were breaches of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not protected from risks associated with their care and support. People had risks associated with their health needs assessed, but risk assessments and care plans did not contain up to date information. This meant staff did not have consistently accurate information about risks and how to mitigate them. For example, one person was at risk from their self-injurious behaviours. Their risk assessments and care plans did not have information for staff on how to mitigate these risks. Staff told us and we saw records that the person had caused an injury through self-harm. There was no evidence that the person received medical attention. There was no evidence the person's care was reviewed to ensure staff were providing appropriate support.

People were placed at risk of choking. The person referred to above was at risk of choking. Staff confirmed this was the case, but did not know what action they would take if the person started to choke. The person's eating and drinking risk assessment and care plan did not provide guidance of dietary modifications to reduce the risk of choking. There was no evidence the person had been referred to Speech and Language Therapy for assessment in relation to risk of choking. This placed the person at risk of choking on food which was not prepared correctly.

Medicines were not managed safely. People felt staff supported to manage their medicines well. However, we identified issues that put people at risk in relation to the management of their medicines.

Several people were prescribed medicines as and when required (PRN) for pain relief. Protocols for these were not in place for four people to provide staff with guidance on why and when the medications should be used. The reasons PRN medication are used should be recorded on the medication administration record (MAR), but we found this was not done consistently. We also found gaps in recording on MAR records for two people in relation to their topical medicines. Staff were unable to confirm if people were getting their topical medicines as prescribed. This put people at risk of not receiving their medication as prescribed.

Medicines were not consistently stored at the required temperatures. Records showed the temperature in the medication storage areas was above the acceptable range. Staff and records were not clear what action had been taken regarding this. This meant there was a risk people's medicines would not be effective because they were not kept at the right temperature. We spoke with the provider about this who said they would act to ensure medicines were consistently stored at the correct temperature. In both Greenfields and The Stables, we found utensils used for giving medicines, such as spoons and pots, were not clean. The medicines room in Greenfields was not clean.

Bottles of medicines and inhalers were not dated to enable staff to identify when they were opened, and when they should be discarded. For example, one person had two bottles of prescribed medicines not dated with opening date. Another person had a liquid medicine that staff confirmed was being used past the date it should be discarded. This meant there was a risk people received medicines that were out of date and not effective. We spoke with the manager about this and they confirmed action would be taken to address all the medicines issues.

The home was not sufficiently clean in all areas, therefore people were not consistently kept safe from the risk of acquiring infections. There was a range of issues we identified which put people at risk. Several areas of Greenfields building, including people's bedrooms, were malodorous. In one kitchen in Greenfields, we found that food in fridges was not labelled with the date of opening. This meant it was unclear to staff when the food should be disposed of. In Aspen, we found out of date and mouldy food in the fridge. Two wheelchairs used by people living in Greenfields were not clean, with dried food on footplates and a lap belt. These unhygienic practices increased the risk of people being exposed to infection.

There was no comprehensive system to enable the manager or provider to review accidents and incidents. Staff told us, and we saw records where individual incidents were documented; these did not consistently record action taken to reduce immediate risks and ensure people were safe. Staff told us, and records confirmed they were not consistently debriefed after incidents to identify learning and improvements in the quality of care. There was no analysis of incidents to enable the provider to identify themes or trends in poor or unsafe care provision, or to demonstrate that lessons were learnt.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was not enough staff to provide people with the support they were assessed as needing or to ensure their safety. One person said they did not always receive their 1:1 support hours. Records we saw for this person's care confirmed this, and we saw there were times during the inspection where they did not have support from staff as stated in their care records. Staff told us and records showed another person needed two staff to support them when they were agitated. Staff told us and records confirmed that the person was often awake at night and agitated, requiring two staff to support them. Staff said that at night, there were only two staff available in the building, and one of the staff was needed for 1:1 support for another person. Staff told us there were not enough of them to provide the support people were assessed as needing. The manager confirmed the service was using a high number of agency staff (500 hours per week). The majority

of agency staff did not have training in positive behaviour support. One agency staff member confirmed they had not had any training in behaviours which may challenge, and records supported this. The manager said the provider was actively recruiting permanent care staff to ensure people had a stable staff team to support them. The lack of staff, including staff with appropriate skills to manage behaviours that challenge, placed people at risk of not receiving the support they were assessed as needing, particularly when agitated or distressed.

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

Staff told us, and records showed the provider undertook pre-employment checks, to help ensure prospective staff were suitable to care for people. This included obtaining employment and character references and disclosure and barring service (DBS) checks. A DBS check helps employers to see if a person is safe to work with vulnerable people. This ensured staff were of good character and were fit to carry out their work.

Inadequate

Is the service effective?

Our findings

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. Where people did not have capacity to make certain decisions themselves, the provider had not consistently ensured assessments of their capacity were done. For example, one person had 1:1 support for 12 hours each day. They also had an alarm on their bedroom door so staff knew their whereabouts. There was no capacity assessment or record of a best interest decision for these care practices. Another person was not always able to make decisions about their care. Staff confirmed the person used limited non-verbal communication to express their views, and was not able to make complex decisions. There was no evidence to demonstrate whether their capacity had been assessed, or best interest decisions made in accordance with the MCA. The provider had not ensured they sought people's informed consent to care and treatment. Where people could not consent to their care and treatment, the provider had not followed the MCA. This put people at risk of receiving care that was not in their best interests.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. DoLS applications had not been consistently made for people who lacked capacity to consent to restrictive care practices. For example, one person lacked capacity to consent to most daily care decisions, and they were not free to leave the service. Staff confirmed this was the case. The provider could not evidence whether a DoLS had been applied for. There was no evidence that the restrictions in the person's care were reviewed regularly to ensure they were lawful and less restrictive. The manager confirmed that records relating to some people's DoLS applications were missing. They confirmed this meant staff were unable to ensure people were protected by the safeguards in DoLS. The provider could not demonstrate whether people's restrictive care was lawful. People were receiving restrictive care that was not in their best interests.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff did not have training the provider identified as necessary to deliver care and support effectively. For example, 35 out of 47 staff had not done training in positive behaviour support. 33 staff had not undertaken any first aid training. The majority of agency staff did not have training in positive behaviour support. One agency staff member confirmed they had not had any training in behaviours which may challenge, and records supported this. These were training courses the provider deemed mandatory for all staff.

We looked at records relating to four staff members' supervision and checks on their work. There was no evidence they were receiving regular supervision or checks on their care delivery. Staff confirmed most of

their training was done online, and there was no evidence that staff competency to deliver care was checked. The manager confirmed there were areas where staff were not up to date with training, and had acted to book staff on training where this was identified as required. However, at the time of our inspection, the provider had not ensured staff involved in delivering and managing care had the necessary skills to carry out their roles effectively. This put people at risk from staff who did not always have appropriate training, supervision or checks on their skills.

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

People were not consistently supported to maintain their health. For example, one person showed self-injurious behaviour regularly. Their records contained a letter from their consultant dated 22 August 2018. This asked staff to arrange a comprehensive physical health review to explore the causes of their self-injurious behaviour. Incident records showed the person had six episodes of self-harm in September 2018. There was no evidence from staff or records that the health review had been arranged. The person was at risk of continued harm as medical advice had not been acted on.

Another person told us they had diabetes. We spoke with staff and reviewed records relating to how this was managed. We identified that staff did not seek medical advice when the person's blood sugar levels were high, as stated in the care plan. For example, on 29 August 2018, the person's blood sugar levels were high, and the care plan stated GP advice should be sought. There was no evidence from staff or records that this happened. There was no evidence from staff or records that the person was supported to have their diabetes reviewed by their GP or diabetic nurse. The person was at risk from poor health because they were not supported to access medical advice in relation to their diabetes.

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

People's needs and choices were not assessed in line with current legislation and guidance. For example, staff were not familiar with The Department of Health guidance, "Positive and Proactive Care: reducing the need for restrictive interventions, April 2014." This guidance is clear that behaviour support plans must detail responses to be used by staff when a person starts to become anxious, aroused or distressed. The behaviour support plans that were used by staff did not contain sufficient detail to enable staff to provide consistent, effective and safe support. This meant people were at risk of receiving support that did not meet their needs. We found staff were using an out of date copy of the British National Formulary (BNF). BNF publications reflect current best practice as well as legal and professional guidelines relating to the uses of medicines. The provider had not ensured there was up to date medicines guidance available to staff. There was a risk people received care that did not meet with current legislation.

People's needs were not consistently met by the adaptation, design or decoration of Greenfields Close. Three of the buildings were spacious and designed for people living with physical or sensory health needs. The fourth building, Greenfields, had a main hallway which was not suitable for larger wheelchairs or mobility aids. We saw staff struggle to move one person in their specialist chair from the lounge to their bedroom across the hallway. Staff confirmed it was difficult to manoeuvre the person's chair without coming into contact with the walls. People were supported to make choices about decorating their personal space, and their bedrooms were personalised. People had access to a large garden area, and this was designed to give easy access to people using walking aids or wheelchairs.

People were offered a varied menu, with options available for people with specific dietary requirements.

Where people expressed views about wanting different options, or different times for their meals, their preferences were met. We saw staff offer people pictorial menus to help them choose meals. People who needed assistance or encouragement to eat were supported by staff. Staff knew who needed additional support to eat, and offered this support in a calm and unhurried way. People were supported to have sufficient to eat and drink.

Staff told us and evidence showed they kept daily records of key events relating to people's care. Staff shared information with colleagues throughout the day and at shift handover. This meant that staff knew what action was needed to ensure people received care they needed each day.

Requires Improvement

Is the service caring?

Our findings

People did not consistently receive kind and caring support. One person commented they felt they were not supported to make their own choices about everyday activities. Another person said, "I can't choose to lie in bed [in the mornings]." Not all staff had enough knowledge about people's needs. For example, during the inspection visit, three people were guided by staff to sit in front of a television. The staff member supporting them did not ask them about programme choices, and sat watching television for 25 minutes before attempting to interact with people. This was not respectful of people's choices.

People and relatives were not consistently supported to participate in making decisions about planning or reviewing of their or their family member's care. People had mixed views about being involved in reviews of their personal care and support. Staff said reviews of people's care plans were not always done with people or their relatives, and records confirmed this. People were not given information about their care plans or reviews of care in ways that were meaningful to them; for example, in easy read or pictorial formats. The provider had not ensured people who required additional support with communication had their needs met consistently. There was a risk that key information from people about their care was not included in care planning.

There was no evidence the provider had considered how to match staff's skills and abilities with people's needs and preferences for support. For example, one person was being supported by a member of staff who confirmed they did not have experience or training in relation to using sensory equipment.

People were not consistently supported to maintain their dignity. One person did not have window blinds or curtains. Staff told us the person had pulled them down. Staff also said the person was prone to taking their clothes off, and the provider was looking at alternatives to provide privacy. However, at the time of our inspection, the person's bedroom was visible to others in the grounds outside. This did not ensure the person's dignity was respected.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People felt staff were kind and caring, and respected their privacy. We saw occasions where staff spoke kindly and respectfully to people, and demonstrated good knowledge of people's care and support needs. People had mixed views of whether they felt staff listened to them when they spoke about how they wanted to be supported. One person said staff listened to them, "Sometimes, but not often; when they [staff] want to."

Staff had variable understanding of people's preferences, personal histories and backgrounds. Some staff we spoke with demonstrated a good knowledge of the people they were supporting. However, other staff were not supported to develop this knowledge. One staff member told us about their dyslexia, and said this made accessing written information, such as care plans, difficult. They said they relied on other staff giving them accurate information about people's needs verbally. This meant there was a risk staff did not have

essential information about how people liked to be supported.

Staff understood when it was appropriate to share information about people's care. We saw staff did not discuss people's personal matters in front of others, and where necessary, had conversations about care discreetly. This meant information about people's care and support was shared verbally in ways which respected their confidentiality.

Requires Improvement

Is the service responsive?

Our findings

People had varying amounts of support from staff to engage in conversations or interests. Three people living in Aspen spoke about activities they enjoyed. One person said they had asked to go to a car event, and staff supported them to do this. Another person told us about a trip to Alton Towers which they enjoyed. However, other people living in Greenfields told us they were not supported to do activities. One person said, "I find it boring, there's nothing to do." Another person told us they watched a lot of television, and we saw this was the case. They told us staff did not ask what they wanted to watch, or if they wanted to do anything else. We looked at a third person's activity records. There was information about the activities they enjoyed, but no evidence from staff or records to demonstrate they were supported to do the things they liked. We saw some, but not all staff took opportunities to engage people in interesting conversations or activities. We saw that for some people they spent the morning passively watching television or falling asleep. People experienced varying levels of support to maintain interests and hobbies.

Care plans captured people's preferences, likes and dislikes. However, care records did not always capture person centred information about people's backgrounds, hobbies and daily routines. For example, all the staff we spoke with told us how people liked to spend their time and what was important to them. However, this information was not consistently reflected in people's care records, and people were not always supported to have these needs met. For example, one person liked to attend a religious service, but there was no evidence from staff or records they were supported to do this. People were at risk of not having their diverse needs understood or met.

There was no evidence staff were consistently using communication support to meet people's communication needs. People who did not communicate verbally were not consistently supported by staff using their individual communication preferences. For example, one person's care plan said staff should use objects of reference, pictures and photographs to communicate and help make choices. There was no evidence of this being used, either observed or in terms of available resources to do this. Staff said they did not use these resources, except objects of reference when, for example, choosing between two items of clothing. Another person used Makaton to support their communication. Makaton is a language programme using signs and symbols to help people to communicate. This was confirmed by staff, who said they did not use Makaton. The training matrix confirmed that no staff had training in Makaton, and 30 staff had not done the provider's mandatory communication training. People were at risk of not being able to express and receive communication in ways they understood and which met their needs.

The provider had not taken steps to meet the Accessible Information Standard (AIS). The aim of the AIS is to make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt able to tell staff if they were not happy with their care or support. However, there was

no evidence that people with limited or no verbal communication were supported to express their views in order to make a complaint. The provider had received two complaints in 2018, and we reviewed the records for these. There was no evidence that the provider had ensured actions from the complaints investigations were carried out. Although there were systems in place to investigate and respond in a timely manner, it was unclear if action was taken as a result of the complaints. There was a risk the provider would miss opportunities to improve the quality of the service following complaints.

No-one at Greenfields Close was receiving care at the end of their lives at the time of our inspection. However, we looked at how end of life care was planned. There was no evidence that staff were trained or supported to discuss end of life care planning with people and their relatives. People and relatives were not supported to discuss their views and wishes on care at the end of life. This put people at risk of not being supported in ways they and their relatives wanted.

Inadequate

Is the service well-led?

Our findings

The service was not well led. During this inspection we identified shortfalls across all the key questions we ask about services. This included failures in safe care practices, medicines management concerns, staffing levels and a lack of staff training and supervision.

Systems in place to identify whether people were receiving the safe care they were assessed as needing had not identified the issues we found on this inspection. For example, checks to ensure care plans accurately reflected people's needs had not identified or addressed the issues we found on this inspection. One person's repeated incidents of self-injurious behaviours were not reviewed so that staff could identify the most appropriate way to manage the risks. Consequently, there was no up to date risk assessment or clear guidance for staff on how to reduce risks. Another person's diabetes was not well managed, and checks did not identify this. As a result, the person did not have support to access medical advice when this was needed. There was a risk that staff did not have up to date information about people's needs to provide safe care and support. The provider's action plan to address concerns did not detail on how the culture and care practices within the service would be improved to reduce the risk of abuse occurring.

Checks and audits did not identify that people were not consistently involved in planning and reviewing their care. For people who found verbal communication difficult, there was no evidence the provider had considered other ways of promoting effective and consistent communication. People's views about their care were not heard and acted on. There was a risk people's autonomy and independence was not enhanced in respect of making decisions about their own care.

Audits for medicines management had not identified issues with the storage temperature, and no action was taken to ensure medicines were consistently stored at a safe temperature. The audits had not identified that PRN protocols were not consistently in place, that bottles and inhalers were not consistently dated when opened, or that there were gaps in medication administration records. A medicines audit on 1 October 2018 had identified issues with one medicine room's cleanliness, but this had not been addressed. Because the audits had not identified these issues, there were no plans in place to address them.

There was no evidence of regular checks on the cleanliness of the buildings at Greenfields Close, and this had resulted in areas of the buildings presenting a risk of infection to people.

There was no system in place to review incidents to identify risks to people. This meant people continued to receive support that was unsafe and unlawfully restrictive. Opportunities to identify patterns in behaviours and triggers were missed, and people were not supported in ways which met their needs. Staff were also placed at risk of harm, both physically and psychologically, from people who had behaviours that challenged. Staff told us, and records showed they did not have support following incidents. The provider had not ensured there were systems in place to review incidents and take action to mitigate risks for both people and staff.

Confidential personal information relating to people's care and support was not stored securely. On 17

October 2018, we found records relating to people's care stored in The Lawns part of Greenfields kept in an unlocked kitchen cupboard. One person told us their records were kept in this cupboard, and showed us that it was not locked. There were also confidential records left on the sideboard in the lounge in the Paddocks area of Greenfields. Staff confirmed these were usually kept in a cupboard in the sideboard, which was not locked. The provider had not ensured confidential personal information was stored securely.

Feedback had not been acted on to improve the quality of care for people living at Greenfield Close. The manager told us the last full internal audit of the service was carried out in December 2017. An audit of the care at Greenfield Close was carried out by an external consultant in March 2018. This audit identified a range of issues including staff using language that was not person-centred or respectful, staff supervision not being consistent or effective, poor standards of cleanliness, people not always consulted or involved in key decisions, people care plans that were not reflecting current needs or risks, and ineffective quality assurance systems. There was no evidence of any action plan or work to address these issues, until a provider action plan dated 25 September 2018. The provider had not ensured that feedback was used to improve the quality of the service.

These were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service did not have a registered manager at the time of our inspection visit. 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. Greenfields Close had a manager who had been in post since 3 September 2018. Following our inspection visit, they registered with CQC. The manager had a good understanding of their role and responsibilities to manage and lead the service consistently well. The provider ensured CQC were notified of events as they are legally required to do.

The provider was displaying their ratings from the previous inspection as required by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.