Greenfields Care Home Limited

Greenfields Care Home

Inspection report

130 Dentons Green Lane
Dentons Green
St Helens
Merseyside
WA10 6RA

Tel: 01744808949

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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**

Summary of findings

Overall summary

This inspection took place on 13 and 14 December 2018 and both days were unannounced.

Greenfields Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

Greenfields Care Home is registered to provide accommodation and personal care for people living with dementia, older adults who may have physical disability, and mental health care needs. It is situated in St. Helens in Merseyside. Accommodation is provided on two levels, with a lift to both floors and wheelchair access to all parts of the home. The home can accommodate up to 30 people. At the time of this inspection, there were 28 people who lived in the home.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We previously inspected this service in May 2016. After this inspection we received concerns regarding the provisions of activities in the home. We carried out a focused inspection in May 2017 and looked at the questions, Is the service responsive? and Is the service well led? The concerns were not substantiated. The registered provider was compliant with all regulations at that time and the service was rated overall 'good'.

During this inspection in December 2018 we found shortfalls in relation to the management of risks associated to receiving care. This was because people at risks of falls and unintentional weight loss had not always received adequate support following falls or excessive weight loss. Accident and incidents had not been analysed to identify patterns and ensure lessons were learned. Assessments had not been undertaken before equipment such as bedrails and bed levers were used. There were shortfalls in the safe management of medicines and staff recruitment procedures were not robust to protect people.

Consent was not always sought where it was necessary to monitor people's movement in their bedrooms. There were significant shortfalls in staff training supervision and appraisals. Quality assurance systems were not effective in identifying shortfalls or areas where the service was not meeting regulations and failure to drive improvements. In addition, there was a failure to inform CQC of significant events or incidents in the home. The provider had not always shared information about injuries with people's relatives and information provided to CQC through the Provider Information Return (PIR) was not accurate. We had concerns about the provider's ability to meet their duty of candour.

These shortfalls were six breaches of Regulations 11,12,17,18 and 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There was a breach of regulation 18 of the Care Quality Commission

Registrations Regulations. We made a recommendation in relation to medicines management. You can see what action we told the registered provider to take at the back of the full version of the report.

Full information about the CQC's regulatory response to any 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.

Although staff knew how to spot abuse and the reporting procedures, they had not received up to date safeguarding training. Risk assessments had been developed to minimise the potential risk of harm to people who lived at the home. However, this was not consistent across the care records we reviewed, and the risk assessments were not always accurate. Staff had not always sought medical advice where people had experienced unwitnessed falls which included head injuries. Some significant incidents had been reported to the local authority and the Care Quality Commission however, there was no formal system to analyse incidents and falls to identify trends and patterns. There was no evidence of how the care staff and the manager had learnt from the incidents.

People were not adequately supported against the risk of unintentional weight loss and professional guidance had not always been sought in relation to nutritional needs.

Some areas of medicines management were managed safely. However, staff had not updated their training and competence in the safe management of medicines and we noted some areas of improvement for 'as when required medicines' and storage of medicines. The registered manager took action to address this after the inspection.

We made a recommendation about the safe management of medicines.
Safe recruitment procedures had not always been followed to ensure new staff were suitable to care for vulnerable adults.

Arrangements were in place for training staff however we found significant shortfalls in training. None of the staff had received appraisals and staff supervisions were not provided in line with the organisation's policy. People and their relatives told us there were enough staff to meet their needs. Staffing levels were monitored to ensure sufficient staff were available.

Governance arrangements and quality assurance processes were poor and not effectively implemented to monitor the quality of the care provided and take appropriate action where required. Several areas in the home were not audited and the audits that had been done were not effective. Prompt action had not been taken where shortfalls had been identified. There was no evidence to demonstrate that the provider had regularly sought people's opinions on the quality of care provided. The quality assurance processes were not robust and needed to be improved to ensure they identified where the service was not compliant with regulations. There was a lack of oversight from the provider on the registered manager and the running of the service.

The provider had considered best practice and had been involved in the trial of innovative practices in collaboration with other agencies. However, the shortfalls we identified in people's care showed that best practice had not been used to enhance the of the care provided.

People were happy with the care and support they received and made positive comments about the staff and spoke highly of the registered manager. They told us they felt safe and happy in the home and staff were caring. People were comfortable in the company of staff and it was clear they had developed positive trusting relationships with them. However, our records showed that there were incidents in the home which had compromised people's safety.

The staff who worked in this service made sure that people had choice and control over their lives and supported them in the least restrictive way possible. However, some improvements were required to ensure that consent was sought for use of aids that restricted people's movements.

The majority of people's care and support was kept under review however this was not consistent throughout the records we checked. Relevant health and social care professionals provided advice and support when people's needs changed. People's nutritional needs were not adequately managed to reduce the risk of malnutrition. Advice from professionals was not always sought when people had lost significant weight.

The home was clean, and comfortable for people to live in. The environment was dementia friendly and the home had adaptations designed to suit the needs of people living at Greenfields Care Home however we found two windows were not fitted with window restrictors.

Staff respected people's diversity and promoted people's right to be free from discrimination.

There was a strong drive to facilitate community and social inclusion. People had access to a range of appropriate activities inside the home. People were supported to maintain and develop their independence. They knew how to raise a concern or to make a complaint. The complaints procedure was available, and people said they were encouraged to raise concerns and were confident they would be listened to. Improvements were required to demonstrate how people's complaints had been received and investigated including how outcomes had been shared with people.

The registered manager took corrective measures to rectify a some of the concerns soon after the inspection. They also sent us evidence to show that they had referred people who were at risk to their GPs

and/or specialist professionals following our inspection visit. However, we would have expected these issues to have been identified by the provider and rectified without our intervention.

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.

There were risk assessments in place however some risks were not adequately monitored. Accidents and incidents were recorded however there was no analysis to identify trends and learn from incidents.

Risks of falls and unintentional weight loss were not adequately managed.

Staff had not received ongoing training in safeguarding, fire safety and moving and handling.

People's medicines were not always safely managed.

Safe recruitment practices had not always been followed. There were sufficient staff available to meet people's needs.

People and their relatives felt safe in the home and were protected against the risk of abuse.

Risks of infection had been managed and equipment serviced regularly. However there was no business continuity plan to assist in emergencies.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not been provided with ongoing training , appraisal and supervision and professional development.

People's consent was sought however not all people who required DoLS had been referred to the Local Authority for authorisation. Consent had not been sought for using monitoring technology such as mention sensors and bedrails.

The environment was maintained to provide safety and comfort for people. However, call bells were required in communal areas to provide people with means of summoning for assistance.

People enjoyed their meals and told us they had choice.

In some cases people were supported with their healthcare needs however this was not always consistent.

Is the service caring?

Requires Improvement

The service was not consistently caring.

While we observed caring relationships and received positive feedback, evidence from our inspection shown in this report did not demonstrated a caring service.

People did not always receive medical attention following head injuries.

Staff knew people well and good relationships had developed between people and the staff.

People were encouraged to maintain relationships with family and friends.

Staff respected people's rights to privacy, dignity and independence. Where possible, people were able to make their own choices and were involved in decisions about their day.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's changing needs and risks were not consistently monitored to prevent re-occurrences or further deterioration.

Care plans had been reviewed after incidents however this was not consistent.

There was a drive to promote social inclusion. People were supported to take part in suitable activities in the home.

Majority of the people had a care plan that reflected the care they needed and wanted. However, this was not consistent throughout the records we reviewed.

People told us they knew who to speak to if they had any concerns or complaints and were confident they would be listened to. We received positive feedback from people and their relatives about life in the home.

There were protocols to support people with their end of life

planning however improvements were required.

Is the service well-led?

Inadequate

The service was not well-led.

The systems to assess monitor and improve the quality and safety of the service were inadequate. Several areas of care delivery had not been audited and systems for providing oversight on the registered manager and staff was not robust.

Systems and processes for ensuring lessons were learnt from incidents were not in place. Practices for promoting honesty and transparency were not robust.

Notifications about key events and incidents had not always been submitted to the Care Quality Commission.

Improvements were required to systems for seeking feedback from people living in the home, visitors and staff.

People made positive comments about the registered manager and staff. They felt the service was well managed however our findings did not show the home was effectively managed.

Greenfields 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 13 and 14 December 2018.Both days were unannounced. The inspection was carried out by one adult social care inspector.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

Before the inspection we reviewed the information we held about the service such as notifications and safeguarding information. Following the inspection, we asked for feedback about the service from community-based health and social care professionals. We received positive feedback about the service from two health and social care professionals.

Prior to this inspection CQC were aware of allegations of inappropriate moving and handling practices. This had been brought to the attention of the Local Authority safeguarding team who were undertaking their own investigations. We therefore did not look into this specific allegation in detail. However, we observed and reviewed the moving and handling practices in the home.

During the inspection, we used a number of different methods to help us understand the experiences of people who lived in the home. We observed interactions between care staff and people and the environment. We spoke with the registered manager, the deputy manager, one senior carer and four care staff. We spoke with nine people who lived in the home and four visiting relatives. One relative contacted us after the inspection visit.

We looked at a sample of records including six people's care plans, incidents records, and other associated documentation. We reviewed three care staff recruitment and induction records, staff rotas, training and

supervision records, medicines records, internal audit reports, maintenance certificates, policies and procedures.

Inadequate

Is the service safe?

Our findings

We looked at how risks to people's health and well-being were assessed and how people were monitored so they could stay safe and have their freedom respected. We found accidents and incidents had been recorded and, in some cases, support had been sought from emergency services and health professionals where this was required. However, this was not always consistent. We found staff had not always sought medical advice where people had experience unwitnessed falls including falls involving head injuries. We saw records showing three people had 'bumps' to the back of their head following falls, however no medical advice had been sought. In addition, there was no evidence to demonstrate that staff had undertaken post falls observations to observe people for possible injuries following these falls.

Accident and incidents had been recorded in each person's individual record. However, there was no evidence to demonstrate how all accidents and incidents that had occurred had been analysed to identify any potential patterns and trends with individuals or throughout the home. In addition, incident records were not adequately completed; they had not been overseen by management to check whether staff had taken the correct action to support people. For example, we found incident records that showed two people had been involved in incidents while being assisted to transfer from chairs with standing aids, and one person had injuries associated with use of bedrails. However, we found no review of the risk assessments had been completed following these incidents. We also found bed levers were used to support people. There was no bedrail or bed lever risk assessments to show how risks associated with bedrails and bed levers had been considered before these aids were introduced. This meant that people who used bedrails and bed levers were at risk of further incidents and potential injuries. Although injuries had occurred due to use of these aids, no lessons learnt process had been undertaken to prevent further occurrences. We immediately informed the registered manager of these concerns and asked them to take action. They informed us that staff were not supposed to use the bedrails and that risk assessments would be carried out for bedrails and bed levers.

Whilst some relatives told us they were informed of any significant injuries and accidents, we found a significant number of incident records where there was no evidence to suggest relatives had been kept informed of incidents involving their family members or whether people had been asked and declined to have their family members informed.

Lessons from significant incidents and events in the home had not adequately been shared and used as learning points to reduce further incidents. During our inspection the registered manager informed us they would introduce a system for overseeing all accident and incidents that occurred in the home and a system to analyse and share lessons from significant events with staff.

Following our inspection visit the registered manager completed a report which demonstrated that they had reviewed people who were at risk of falls and unintentional weight loss and what actions they had taken to ensure they receive safe care.

Health and safety checks had been carried out however we noted that two windows on the first floor did not

have window restrictors to protect people from risks of injury. We spoke to the registered manager who took immediate action to rectify this. Regular maintenance checks had not been undertaken for the safe use of bed levers which can pose a risk of entrapment and other injuries.

Before the inspection we had received concerns about unsafe moving and handling practices in the home. Our observations during the inspection showed that people were safely assisted where they needed assistance with their transfers. However, we also saw records which showed two people had suffered falls while being assisted by care staff to transfer with standing aids. We noted that all staff had not refreshed their training in the moving and handling of people and one had not received any training in this area. In addition, ongoing training had not been provided to support staff with health emergencies, and fire safety. This meant people could not be assured they would be supported by staff who had up to date knowledge on health and safety.

Risk assessments had been undertaken in keys areas of people's care such as skin integrity, falls, and nutrition. In some cases, the registered manager had reviewed risk assessments and took appropriate action when people's needs, or risks had increased. For example, we found they had reviewed one person's nutritional needs when they had lost weight. There was a review and update in their care plan to demonstrate the change in risk and changes to the measures that were required to minimise the risks to this person's health and wellbeing. In addition, they had requested other health care professionals to undertake reviews where necessary. However, during the inspection we noted risk of unintentional weight loss and malnutrition were not robust across the home.

We found three people at risk of unintentional weight loss and malnutrition were not adequately supported. We found two people had lost six kilograms in weight within three months and another person had lost over three kilograms. We saw no evidence to demonstrate that the registered manager had considered referring the people to specialist professionals or their doctors. The provider's own policies and national guidance require staff to inform people's doctors. This meant that the registered manager had not acted on the identified risks and taken appropriate action to reduce any further deterioration. We reported all concerns above to the local authority safeguarding team immediately after the inspection and received confirmation from the registered manager that relevant referrals had been made to specialist professionals.

This meant that arrangements for managing risks in the home were not robust and did not ensure that lessons were learned from significant events.

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

Recruitment checks were carried out before staff started working at the home. Staff recruitment records contained completed application forms that included some reference to their previous health and social care experience, their qualifications and employment history, two of the three files contained references that were of poor quality. Only one reference had been obtained for the staff members and in one case the references were from friends or close associates of the applicant. The service had not taken steps to ensure that references were obtained from former employers especially those employers involved in health and social care as is required by regulations.

The application form used in the service required staff to provide up to five years of previous employment history. However, regulations require that care staff provide their full employment history. The recruitment records did not contain copies of photographic identity records. The registered manager informed us that they had seen the identity records for staff however did not take copies. They informed us they would keep

copies going forward. Following our inspection they took action to obtain the missing references and had started to review the recruitment processes.

We looked at how medicines were managed in the home. In majority of the cases medicines had been managed safely. The home used an electronic system for recording medicines administration, (eMAR). Staff could use a hand-held device to check what medicines were prescribed and when to give them. Medicines were stored securely in the medicines room.

Personalised information for a significant number of people who were prescribed medicines to be taken "when required" (PRN) had also been excluded from the eMAR system. For example, one person was prescribed Glyceryl Trinitrate Spray (GTN) to use in the event of an angina attack. However, there was no guidance such as PRN protocols for staff to know when this medicine was to be used and whether the person was able to ask for the medicine. This meant people who are unable to ask for their medicines could not be assured they would receive their medicines effectively. We noted some medicines with short shelf life had not been dated when opened which meant staff may not know when the medicines should be discarded.

We checked the arrangements in place for the management and storage of controlled drugs which are medicines which may be at risk of misuse. We found appropriate secure storage was provided. There were appropriate security arrangements to monitor the medicines cupboard. The fridge and the temperature of where overflow medicines were stored was being recorded daily to ensure those medicines were stored correctly and safely. We found topical creams were not stored securely in people's bedrooms which increases the risk of medicines misuse. Following the inspection, the registered manager took action and completed PRN protocols for all people who required them. They also completed risk assessments for people who could store their own topical creams in their bedrooms.

Staff who administered medicines had not updated their training in medicines management. In addition, there were no competencies checks undertaken after training. Some medicines audits had taken place but had failed to identify the issues we found at this inspection. The registered manager informed us they carried out medicines audits at six-months intervals and were not able to show us evidence of the completed audits. However, the organisation's policy required that 'audits were undertaken regularly'. The shortfalls above meant that people could not be assured they would receive their medicines safely from staff who were competent.

We recommend the provider to consider best practice and national guidance in the safe management of medicines. This can be found on National Institute of Clinical Excellence (NICE) and Social Care Institute of Excellence.

People who used the service told us they had no concerns about their safety at Greenfields Care Home. People told us they felt safe and secure with the care they received. Comments people made to us included, "I feel safe here and I would speak to [name removed the manager] if I have any problems", "I feel safe here and I like living in this home." Comments from relatives were all positive. They included, "Yes, it's one of the best and I don't have any problems with [relatives] safety", "I have confidence that my [relative] is safe here, it's better than where they have been before" and, "Oh yes no concerns at all about safety."

The registered provider had procedures in place to minimise the potential risk of abuse or unsafe care. There was a safeguarding policy and information on how to report safeguarding concerns was on display. Care staff that we spoke with knew how to report concerns. Evidence we saw demonstrated that care staff were able to report concerns if they suspected people were at risk of exploitation or harm. This meant

people living and working in the home were familiar with the safeguarding procedures. In addition, a member of the staff team was appointed as the safeguarding champion. They attended the local champion's forum. The registered manager told us information from this forum was disseminated to both staff and people who used the service. One staff member told us, "We look out for any concerns of abuse and we report to the manager." We saw examples of how staff had acted when they noticed unprofessional behaviour among their fellow staff members. However, staff had not received up to date safeguarding training and one staff member who was new to care had not received any training in safeguarding adults.

The service monitored and regularly assessed staffing levels to ensure sufficient staff were available to provide the support people needed. During our inspection visit, staffing levels were observed to be sufficient to meet the needs of people who lived at the home. However, we noted that there were a significant number of incidents of unwitnessed falls that had been recorded in communal areas. This demonstrated that staff deployment in the home was not always effective and some areas of the home had been left without adequate supervision. Comments from staff included, "There are enough of us and we help each other. If we are struggling the manager will get agency staff to support us."

People made positive comments about the cleanliness of the service. There were infection control policies and procedures for staff to refer to and staff had been trained in this area. An infection control champion had also been identified to share best practice in this area. Staff were provided with protective wear such as disposable gloves and aprons and suitable hand washing facilities were available to help prevent the spread of infection. There were contractual arrangements for the safe disposal of waste. The environmental health officer had awarded the service a five-star rating for good food safety and hygiene practices. However, infection control audits were undertaken once a year by the Local Authority. The home had not undertaken their own regular infection control audits. This meant that the provider could not identify shortfalls in a timely manner.

There were systems to manage the safety of portable appliances, electrical devices and to ensure that water in use at the home was safe for consumption and within safe operating temperatures. Equipment such as hoists, wheelchairs, mobility aids and lifts were also serviced regularly to ensure they were functioning correctly and safe for use. We noted that all the lifting equipment had been checked for safety and serviced by a specialist contractor as recommended by manufacturers.

There was a review of the weekly fire safety check and checks on the fire alarm system. This meant that full and thorough checks were taking place to ensure that people were not put at risk from fire. However, some staff had not been provided with fire safety training and/or updated their training.

There was key pad entry to enter and exit the home; visitors were asked to sign in and out which would help keep people secure and safe.

Requires Improvement

Is the service effective?

Our findings

We looked at how the registered provider trained and supported their staff. Records showed that staff completed an induction when they joined the service. Some care staff had also received national vocational qualifications. However, we found significant shortfalls in training for existing care staff and new care staff. None of the care staff who worked at Greenfields Care Home had received up to date training in all areas that the provider had deemed mandatory for the role. This included, safeguarding, moving and handling, infection control, fire safety, mental capacity and medicines managements among other courses. None of the staff had received an annual appraisal where they were eligible. In addition, we found care staff had not received supervision in line with the provider's policy. Of concern were three staff who had not received training in using lifting equipment for hoisting people. The organisations' training policy stated that all staff were to receive annual renewal of their training however some courses were overdue by nine months. This meant that the provider had failed to follow their own polices on staff development.

We also noted that the internal checks carried out by provider did not include checks on whether staff were completing training, appraisals or supervision as required. This meant that the provider had not adequately monitored whether staff were keeping up with the training they were required to undertake. This meant that people could not be assured they would receive effective care from a staff team that were skilled and knowledgeable. We spoke to the registered manager and asked them to address these shortfalls without delay. We also informed them to ensure that three staff without moving and handling training were not allowed to assist people with their transfers until training had been completed. The registered manager acted on this immediately and booked training. Following the inspection, they informed us they would be booking further training for all other areas. In their PIR the registered manager wrote, 'Staff receive full training to ensure that they have a clear understanding of each area and also their responsibilities.' However, we found this was not the case.

There was a failure to ensure that all staff had received such appropriate support and training as is necessary to enable them to carry out the duties they are employed to perform.

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

All people we spoke with gave us positive feedback about the caring approach from the staff. Comments from people included; "The staff here know how to support me. They manage things for me including when I need to see my nurse", "The staff don't do very much for me, so don't need to ask for my consent very often" and, "They support me with everything that I need; I'm much better in here than before; that's what my family think as well."

Comments from relatives were positive, they included; "Care staff are generally good and have the necessary skills", "The care plan that we have in place is followed. The optician visits my [relative] regularly."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of

people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and in hospitals, this is usually through MCA application procedures called the deprivation of liberties authorisation (DoLS).

We checked to see if the provider was working within the principles of MCA. The staff who worked in this service made sure that people had choice and control over their lives and supported them in the least restrictive way possible. We observed staff asking people for their consent before they provided care and treatment such as with administering medicines or with moving from one part of the home to another. Staff told us they understood the importance of gaining consent from people. Where people had some difficult expressing their wishes, they were supported by their relatives or an authorised person such as an advocate. Some consent records had been completed in relation to medicines management, photography and health observations. However, we noted that consent had not been sought for use of assistive technology such as motion sensors and the use of bedrails. The sensors were used to monitor people's movements in their bedrooms to maintain their safety. There were coded keys pads to some areas of the home and the main entrance to maintain people's safety.

DoLS authorisation requests had been made for some people. However, records we looked at identified up to three people living at the care home who were at risk of being deprived of their liberties because they lived with a dementia and experienced difficulties in communicating their needs or giving consent. These people were not free to leave the care home. In addition, their care included restrictive practices such as use sensor motions, key pads and bedrails to keep them safe, they lacked mental capacity and were under constant supervision by the staff team for their own safety. Formal authorisations are required where it is necessary to restrict the people for their own safety and the measures in place should be as least restrictive as possible. However, the provider had not sought relevant authorisations from the local authority. We also noted staff had not received or updated training in MCA/DoLS.

The lack of authorisation requests meant that the registered manager had not considered seeking authorisation for the restrictive practices. We discussed this with the registered manager and they informed us that they would complete the relevant documentation. Following the inspection, they informed us that they had applied for authorisation.

The provider had failed to comply with requirements of the Mental Capacity Act 2005 in respect of obtaining consent. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The environment had been adapted to meet the needs of people living at the home. Adequate living space was provided and furnished to help maintain people's safety, independence and comfort. We found the home had been decorated to meet the needs of people living in the different parts of the home. There was evidence to show that the provider had considered the needs of people living with dementia and those with sight impairment. We noted appropriate signage was in place throughout the home and there were crafts and photographs displayed on the corridor walls. Some areas of the home had been redecorated and ongoing plans to refurbish the home were in place including ongoing maintenance work and repairs.

People's bedrooms were decorated to their taste and a homely environment had been created with

personal items such as furniture, photographs, posters and ornaments. This promoted a sense of comfort and familiarity. Each individual was provided with a lockable cupboard for their personal valuables.

Staff told us communication was good. Regular handover meetings took place, communication diaries kept staff up to date about people's changing needs and the support they needed. Records showed key information was shared between staff. However, as noted in the 'safe domain', communication about significant incidents was not always effective to assist learning and risk reduction.

Staff completed a range of assessments to check people's abilities and review their support levels. They checked individual's needs in relation to safety, mental and physical health and medicines. Specific requirements for each individual had been identified. However, care files and risk assessments were not always accurate to demonstrate the correct risk levels and to incorporate professional recommendations such as guidance from dieticians.

There was a variety of choice for people to eat. We observed there was a menu with choices for people. People with special dietary requirements were supported to ensure their needs were met. People told us, "The meals are alright, it's not easy to cook for a lot of people" and "We get two choices and if you don't like what's on the menu you can ask for something else." All the people we spoke with confirmed they were offered meals of their choice. People had told us they were involved in menu planning and told us they received plenty to eat and drink.

During our visit, we observed lunch being served and people enjoyed their meals. The meals looked appetising and the portions varied in amount for each person; some were provided with extra helpings on request. We noted that some people could have benefitted from utensils such as plate guards to assist them in their eating. We discussed this with the registered manager and they informed us they will take action to ensure people who required these utensils were assessed. This would enhance people's dining experience and may help increase their nutritional intake.

We looked at how people were supported with their healthcare needs. People's care records included detailed information about their medical history and any needs or risks related to their health. Some people had been referred to professionals such as speech and language therapists and district nurses regularly visited people to review their health needs. However, this was not consistent. For example, people were not always referred to their GPs or dieticians and/or falls prevention professionals.

Appropriate information was shared when people moved between services such as transfer to other services or admission to hospital. The home used 'secure red bags' for sharing hospital transfer records. This was an initiative to improve the way services shared people's records and to reduce the risk of records going missing during a transfer between care homes and hospitals. These records are documents which promote communication between health professionals and people who cannot always communicate for themselves. This meant other health professionals had information about individuals care needs to ensure the right care or treatment was provided.

We looked at how technology and equipment was used to enhance the delivery of effective care and support. The service introduced assistive technology, they had internet access to enhance communication and provide access to relevant information. This also enabled people to have on-line contact with families and friends. The provider had an electronic care records system. However, they had not provided staff members with adequate number of computer workstations to allow easy access and input and access care records. We discussed with the registered manager who informed us that there were plans to provide staff with additional computers and handheld devices for inputting details of the care they provided. CCTV was

available covering the perimeter of the building to promote people's safety.

Requires Improvement

Is the service caring?

Our findings

People and their relatives told us they were treated with care, respect and kindness and they were complimentary of the support they received. All the feedback from people and visitors was positive. Comments from people included, "The staff are kind and they treat me with respect. You only need to ask, and they respond", "The staff are all kind and talk to you with respect." And, "They are a good bunch here, we are lucky to find this place, it's one of the best around here."

Similarly comments from visitors were positive. Comments included "Yes, the staff are very caring and kind. They will always call for a Doctor if [relative] is not well", I have no bad word about this place its better than the last one."

While we observed caring relationships and received positive feedback, evidence from our inspection shown in this report did not demonstrated a caring service.

Before the inspection we had been informed of concerns regarding the way a staff member had spoken to one person in the home. The registered manager had reported this to the local authority and enquiries were still in progress. We therefore did not look into the case but observed how staff interacted with people.

The overall atmosphere in the home appeared happy, calm and peaceful. We observed good relationships between staff and people living in the home and overheard laughter and encouragement during our visit. We observed staff interacted in a caring, friendly and respectful manner with people living in the home. People confirmed there were no restrictions placed on visiting apart from meal times and we saw relatives visiting as they wished.

During the inspection we observed people were treated with dignity and respect and without discrimination. People told us they could spend time alone if they wished. We observed staff knocking on doors and waiting to enter during the inspection. There were policies and procedures for staff about caring for people in a dignified way. This helped to make sure staff understood how they should respect people's privacy, dignity and confidentiality in a care setting. However, we noted that care staff had not renewed training in equality and diversity which would increase their awareness of human rights and equality.

People were encouraged to maintain their independence and to develop new skills. We noticed people were encouraged to do as much as they could for themselves and staff members only intervened when it was necessary. This helped people to continue maintaining their independent living skills.

People were dressed appropriately in suitable clothing of their choice. They also confirmed there were no rigid routines imposed on them that they were expected to follow. People were supported to maintain their relationships and visit their local community on their own where possible.

Useful information was displayed on the notice boards and along the hall ways. This informed people about how to raise their concerns, any planned activities, events in the local community and any changes in the

home. Information about advocacy services was displayed. The advocacy service could be used when people wanted support and advice from someone other than staff, friends or family members.

Requires Improvement

Is the service responsive?

Our findings

People who lived at Greenfields Care Home gave us positive comments about the staff team and the care and support they received at the home. All responses regarding life in the home were overwhelmingly positive and people shared with us details of the various activities they undertook. Comments from people included, "We have a lot going on, in the week here but I prefer not to join in.", "We get visiting performers and singers, anyone can join in."

Relatives shared positive comments about life at the home. Comments included, "My [family member] seems to enjoy days when they get young children visiting. It cheers her up." Another relative told us, "I can honestly say that they all genuinely care for the residents. There is a warm friendly atmosphere, and nothing seems to be too much trouble."

There was a strong emphasis on providing and supporting people with a variety of activities of their choice within the home. We saw people had been supported with crafts, arts, music and children from a local nursery visited the home regularly to provide interaction with people at the home. The registered manager had also engaged with a local university who had recently provided a pantomime performance in the home. In addition, there were festive events and a hairdresser visited regularly to support people. We noted the provider had responded to the spiritual needs of the people in the home. They had arranged for a local church to visit regularly and provide communion. This meant that people were supported to engage in meaningful and enjoyable activities and helped to reduce social isolation, stigma.

People's needs were assessed before they moved into the service. This was to ensure that the home and staff were able to meet people's needs before they decided to admit them into the home.

We checked how the provider ensured that people received personalised care that was responsive to their needs. Three of the care plans we reviewed contained adequate details to provide staff with guidance on people's various needs. We also noted that they had been written in a person-centred manner. Each care record contained a detailed personal and medical history. There were details of each individual's likes and dislikes as well as signs and symptoms for staff to look out for as an indication of when a person's health started to deteriorate. The care records had been developed, where possible, with contributions from each person and their family. In most cases the plans identified what support each individual required. However, we found the practice was not consistent in all care plans we reviewed. As noted in the management of people at risk of malnutrition and unintentional weight loss the care records had not always been reviewed when significant changes took place to include risk reduction measures.

There were systems in place to ensure staff could respond and share information about people's changing needs. In some case staff had involved professionals such as GPs when they felt the need to do so. Details of the reviews and any changes to the treatment were included in the care files. However, we noted that there was a lack of consistence in the registered manager and the provider's response to emerging risks such as unintentional weight loss and repeated falls from a bed. Cases of significant deterioration had not always resulted in review of the care plan and/or a referral to specialist professionals. This meant the provider was

not always responsive to ensure changes were monitored and measures were put in place in a timely manner to prevent further deterioration to people's health and well-being.

We checked if the provider was following the Accessible Information Standard. The Standard was introduced on 31 July 2016 and states that all organisations that provide NHS or adult social care must 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. We noted that people had communication care plans which detailed how they were supported to ensure they can communicate with others. Information was available in the home in different formats. In addition, the registered manager worked closely with a local optician service to ensure people received support with their sensory needs. We noted some posters in the home were written in an easy read and pictorial format. There was an up to date policy on accessible information standards. This demonstrated that the service had considered ways to ensure information was accessible to people.

We looked at how the service managed complaints. The service had a policy and procedure for dealing with any complaints or concerns, which included the relevant time scales and the contact details for Care Quality Commission (CQC) and external organisations. The complaints procedure was included in the service user guide pack. The registered manager informed us that they had received three complaints and had dealt with them appropriately. However, there was no written evidence to demonstrate how the complaints had been investigated and concluded including the written outcomes of the complaints. The organisation's policy required that where a complaint had been received formal or informal, they should be documented, and a written response provided to complainants. The registered manager informed us that they would put this into practice going forward. All people we spoke with and visiting relatives told us they were able to discuss any concerns during resident meetings; they also informed us they were aware of the complaints procedures and would feel free to approach the registered manager if they had concerns.

We received a significant number of compliments from relatives during this inspection and we saw some of the written compliments received by the registered manager. Compliments included, "During her time in Greenfields I feel that my [relative]'s health and well-being has improved." The home looks after [relative] very well and this gives me and my family peace of mind."

Records we saw and our conversation with the registered manager demonstrated that the provider had procedures in place to seek people's preferences and choices for their end of life care. There was a policy which guided staff to record where people wished to die, including in relation to their spiritual and cultural needs. Staff had received 'Six steps' end of life training. The programme aims to enhance end of life care through facilitating organisational change and supporting staff to develop their roles around end of life care. One care staff member had been nominated as an end of life champion. End of life care champions are supported to develop their knowledge, skills and confidence and encouraged to empower other care staff within the organisations to deliver quality end of life care. We however, discussed the need to ensure the end of life care plans in the home were adequately completed in line with current best practice and regulatory requirements.

Inadequate

Is the service well-led?

Our findings

There was a registered manager employed at Greenfields Care Home. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

We looked at how the provider demonstrated how they continuously learnt, improved, innovated and ensured sustainability in the service. We found there were up to date policies to assess quality of care and the maintenance of people's wellbeing. These identified various audits that needed to be completed in the home to monitor the quality of the care delivered and identify areas that needed improvement. Our review of records and discussion with the registered manager showed that regular audits had not been carried out in line with regulations and the provider's own policy.
Audits had not been completed in areas such as care files, accident and incident records, falls records and staff files. Some audits had been completed by external agencies annually in areas such as health and safety, infection prevention and control and medicines. However, the provider had not undertaken their own regular checks to identify shortfalls in a timely manner.

We found the audits that had been completed had failed to identify some of the concerns we found during this inspection. For example, the provider's quality audit in May 2018 had failed to identify the shortfalls in staff training, annual appraisals and staff supervisions. The process had failed to identify where the home was not compliant with regulations. The health and safety audit had not identified the lack of window restrictors and lack of maintenance checks and risk assessments for bed rails and bed levers.

The registered manager informed us that they were aware of training shortfalls and had engaged the provider to address the issue. However, we found these concerns had not been addressed at the time of our inspection. This meant that there was a delay in ensuring that any identified shortfalls were rectified in a timely manner. In addition, we noted that the audit checks carried out were not up to date with best practice and current regulation, which did not fully support the registered manager and the staff to comply with regulations. For example, relying on annual audits by external agencies meant that shortfalls were not be identified in a timely manner.

We found systems for recording accidents and incidents were not robust as incidents were recorded in each person's individual file. There was no overall record of incidents in the home. This would be important to show the frequency and nature of incidents that had happened in the whole home and to identify any themes and patterns to establish measures for reducing them. This lack of analysis meant that we found a significant number of incidents that had been recorded with no evidence to show what had been done about them, especially where the incidents were repeatedly involving the same people. This meant that the systems for improving practices and care delivery through lessons learnt were not effective.

Before this inspection, there had been several incidents of falls involving head injuries the home. While some people we reviewed had risk assessments in relation to this, we found practices in the home in relation to

falls protocols and post falls support were not robust. For example, systems for observing people for post falls injuries and seeking medical advice were not robust. There was no evidence to show how staff had observed people for injuries following unwitnessed falls or sought medical advice for head injuries in some of the cases we reviewed.

The medicines audits carried out were not accurate. The audits had failed to identify the shortfalls that we identified in relation to medicines management. For example, we found medicines audits had not identified the lack of PRN protocols, lack of training and staff competences in medicines administration among other shortfalls. We also found shortfalls in staff recruitment practices which had not been identified by the audits. This meant that the registered manager and the provider had failed to assess, monitor and drive improvement in the quality and safety of the services provided.

Systems and processes for training, induction and supervision were inadequate and suitable training had not always been provided to staff to support the delivery of safe care. We found the provider had up to date policies which reflected current regulations, however they had failed follow their own organisational policies in up to ten areas. These included failures to ensure care staff received ongoing training and that only care staff who were trained were allowed to assist people with their transfers using lifting equipment such as stand aids and hoists.

We found the registered provider had not adequately provided oversight on the registered manager to check that they were compliant with regulations. Similarly, there was a lack of robust oversight on care staff and records of care from the registered manager which meant, in some instances they had not identified where staff members had not acted appropriately.

We spoke to the registered manager and the nominated individual of the home regarding the failures above. They started to take action to rectify some of the identified shortfalls during our inspection and immediately afterwards. They further advised that safety of people in the home was their utmost priority. However, we would expect the provider to have robust systems in place to oversee the care provided and to act without our intervention.

We checked how people who used the service, the public and staff were engaged and involved in the running of the home. Improvements were required to demonstrate how the registered manager and the provider sought people's views on the running of the service. People and staff told us their views were sought and that they could contribute to the running of the service. However, during the inspection there was no evidence of minutes of meetings between the registered manager and staff or people who lived at the home. We also noted that surveys had not been conducted to seek staff and people's views regarding the running of the service. The registered manager informed us that they had conducted meetings and arranged weekly walk in meetings for relatives, however, they had not kept the minutes to share with us. They also informed us that surveys had been undertaken in the past however, this had not been completed since our last inspection.

At our last inspection Greenfields Care Home was rated overall good and the home was compliant with all regulations however, at this inspection in December 2018 we found six new breaches of regulations. These findings demonstrated that there had been a decline in the quality of care people received. We found a lack of robust oversight and accountability from both the registered manager and the nominated individual. This meant that the governance systems and processes in place did not enable the provider to identify where quality and/or safety was being compromised and to respond appropriately and without delay.

The provider had failed to maintain good governance. This was a breach of Regulation 17 of the Health and

Social Care Act 2008 (Regulated Activities) Regulations, 2014.

We looked at how the providers promoted a culture that encouraged candour, openness and honesty to support organisational and personal learning. We found there was a policy in relation to Duty of candour which guided staff to act in a transparent manner when things go wrong. This also set out a commitment for open and transparent practices in the home. However, we found there had been nine incidents in the home where the regulation and policy relating to transparency had not been followed.

Records we reviewed showed one person had fell out of bed seven times and the records showed that families had not always been informed including in some instances where injuries were noted. Where serious incidents have occurred, providers must operate systems to allow them to share a step by step account of all relevant facts known about the incident in person and offer an apology where possible. This should include as much or as little information as the relevant person wants to hear including further enquiries that they would make in relation to the incident. Whilst there was a policy at the service we found this policy had not been effectively implemented and explanations of what had happened had not always been shared. This meant the provider had failed to follow their own policies and people could not be assured they would receive explanations of what had happened in the event of serious incidents in the home. We spoke to the registered manager about this and they informed us they had contacted relatives by telephone and some relatives confirmed this. However, a significant number of incidents records we saw showed this was not consistent.

Before the inspection we asked the provider to send us a PIR with specific details on what the service did to ensure compliance with regulations. In their PIR they informed us 'Risk Management plans are in place and are regularly reviewed including Business Continuity Planning and Staff have received safeguarding training, fire awareness training, health and safety training and also infection control training.' However, we found that the home did not have a business continuity plan and staff had not received up to date training including three staff who had not received training since joining the home. This meant that the information provided was not accurate which would impact on CQC's ability to effectively exercise its regulatory role.

The provider had failed to maintain duty of candour. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014.

We checked to see if the provider was meeting Care Quality Commission registration requirements, including the submission of notifications and any other legal obligations. We found the registered provider had notified the CQC of some of the incidents at the home including deaths that occurred in the home. However, during the inspection we found incidents of injuries that had not been reported. For example, two people had suffered injuries that required hospital treatment. We also found incidents that occurred during care delivery such as people falling while being assisted to stand using equipment, however we had not been notified of these incidents. These incidents should have been reported to the Care Quality Commission. The intention of this regulation is to ensure that the Care Quality Commission is notified of specific changes in the running of the service, incidents involving people using the service, allegations of abuse, or incidents and events that threaten the smooth running of the service. This is so that the Care Quality Commission can be assured the provider has taken appropriate action to support people. This also helps to ensure that the Care Quality Commission is able to undertake its regulatory duties effectively.

The provider had failed to make statutory notifications of notifiable incidents. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We received overwhelming positive feedback from people who lived at the home and their visiting relatives

regarding the registered manager and the staff at the home. Comments from relatives included, "The manager is friendly, and we can always approach him if we have any concerns", "The manager is approachable", "Yes, [name removed] is very approachable and he would listen and will take our views on board", and "The manager is approachable most people know him very well."

Visiting relatives told us, [name removed, registered manager] does his best, he has been improving the environment " and "This place really has helped to give me peace of mind because I could no longer manage to support my [relative] at home and the last care home was not good at all."

Similarly all staff we spoke with and visiting professionals were complimentary of the registered manager. Staff felt the manager supported them and listened. A member of staff commented, "[name removed] the manager knows how to support me and will make suitable adjustments to ensure I can continue doing my job safely," "[Name removed] as a manager is good. There is good communications and team work." While all staff we spoke with told us they felt well supported with supervision, training and appraisals and were up to date, evidence we found in governance records and speaking to the registered manager and the nominated individual contradicted this.

A professional at the local authority shared positive comments about the home and the registered manager. They informed us that over the years they had found the registered manager to be responsive and keen to provide safe care. They added that they would be assured that the registered manager would welcome support to improve the care and the running of the service.

The organisation had maintained close links with other organisations. They worked with organisations such as the local authority, local health care agencies, local pharmacies, schools, universities, social workers and local GPs. There was a system to ensure the service shared appropriate information and assessments with other relevant agencies for the benefit of people who lived at Greenfields Care Home. Improvements were required as identified throughout this inspection.

We also noted that the staff and the registered manager had utilised local initiatives with the local authority and local clinical commissioning groups (CCG) in areas such hospital admission processes and the introduction of champions in various areas of care. They offered work placements to local young people undergoing programmes such as the Princes Trust. In their PIR they wrote 'Home manager is a member of the Falls working group which is coordinated by the Public Health section of the local CCG. In the past 12 months we have completed the Six Steps Programme and also received a Platinum Award for the Care Home Charter as part of the well-being and improving lives local agenda. While these initiatives were examples of best practice, we found they had not always been adequately implemented in the home to improve practices in areas such as falls management and weight monitoring.

Staff we spoke with demonstrated they had a good understanding of their roles and responsibilities. Care staff had delegated roles including medicines management, catering and domestic duties. Each member of staff took responsibility for their role. However, improvements were required to show the registered manager was monitoring care staff in the home to ensure they were undertaking their roles and to ensure people were receiving appropriate care that met their identified needs.

Following the inspection, we spoke with the nominated individual who is also one of the directors of the service and they informed us they would be taking robust action to address all the shortfalls we identified. The registered manager also took immediate action to address some of the shortfalls relating to staff training. We shared our concerns with the local authority who informed us they would work closely with the home to improve people's safety.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify the Commission without delay of the incidents and significant events in the service including any event which prevents, or appears to the service provider to be likely to threaten to prevent, the service provider's ability to continue to carry on the regulated activity safely. Regulation 18 Care Quality Commission (Registration) Regulations 2009 -Notification of other incidents

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure that legal consent for care and treatment was obtained from people who used the service. Authorisations for deprivation of liberties had not been sought from relevant authorities. Regulation 11 HSCA RA Regulations 2014 Need for consent

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure that care and treatment was provided in a safe way for service users because; The provider had failed to do all that is reasonably practicable to mitigate risks associated with unwitnessed falls, and unintentional weight loss.

	Risk assessments relating to the health, safety and welfare of people using services were not adequately managed by people with the qualifications, skills, competence and experience to do so. And risks associated with use of equipment had not been adequately assessed and lessons has not been learnt from events. Regulation 12(1)(2)(a)(b)(c)(d) (h) HSCA RA Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The registered provider had failed to act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity. Regulation 20 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure that persons employed by the service provider in the provision of a regulated activity received such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18 (2)(a)(b) HSCA RA Regulations 2014 Staffing

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure governance systems were robust and systems or processes were not operated effectively to ensure compliance. The provider had failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; The provider had failed to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. ; Regulation 17 (1) (2)(a)(b)(c)(d)(e)(f) HSCA RA Regulations 2014 Good governance

The enforcement action we took:

Warning notices were served on the registered provider and the registered manager under Regulation 17 (2) (a) (b) (c) (e) (3)

The provider and manager were not able to provide adequate oversight, governance and supervision to staff and oversee the general running of the service, including ensuring the service was meeting regulatory requirements.

The provider and was not able to provide adequate oversight, governance and supervision to staff and oversee the general running of the service.