# Greengates Care Home Limited

# Greengates

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Inadequate |

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|---|---|
| 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

We undertook a full comprehensive inspection on the 15 and 16 February 2017. This inspection was prompted by the notification of a death, which indicated concerns. This incident is subject to a criminal investigation and as a result, this inspection did not examine the circumstances of the incident. However the information shared about the incident indicated potential concerns about the management of risk of insufficient staffing levels and the monitoring of people's whereabouts. The inspection in February 2017 examined those risks.

During the inspection at Greengates Care Home in February 2017, we found the provider did not meet some of the legal requirements in the areas we looked at. After the inspection, the provider wrote to us with an action plan of improvements that would be made to meet the legal requirements in relation to the law.

Following the inspection in February we continued to receive concerns about the quality of care and support that was being provided. We met with the provider to discuss these concerns in July 2017. At this meeting the provider told us improvements at the service had been made and they were now meeting the legal requirements. After the meeting we continued to receive concerns about the service.

We undertook this inspection, on 26 and 27 July 2017, to review the improvements the provider had told us they would make. The first day of the inspection was unannounced. We found on this inspection the provider had not taken all the actions required to make the necessary improvements. After this inspection, there have been two allegations regarding potential abuse at the home. The local safeguarding team and the police were investigating the allegations. The Management had taken appropriate action in terms of staff suspension whilst the investigations were taking place.

Greengates Care Home is registered to provide accommodation which includes personal care for up to 54 older people, some of who are living with dementia. At the time of our visit 26 people were using the service. The service has capacity for up to 35 people in single occupancy rooms having changed some rooms which were double occupancy. The bedrooms were arranged over two floors, with only three bedrooms situated on the first floor. These bedrooms were not in use during this inspection. There were communal lounges with a dining area on the ground floor with a central kitchen and laundry.

A registered manager was no longer employed by the service. The service had recently appointed a new home manager who will be applying to become the registered manager. 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.

At our last inspection, training records confirmed staff received training on a range of subjects. However, the training information was not available during this inspection. Due to this, we could not confirm what

training staff had undertaken. Not all staff we spoke with were knowledgeable about safeguarding vulnerable adults. Some staff were not able to tell us the actions they would take in protecting vulnerable people from the risk of harm or abuse or how they would report concerns.

At our last inspection staff had not received training on how to support people to manage distressed behaviour or how to physically restrain people. This training had been booked for 31 July 2017. New staff who had recently joined the service told us they had not received an induction or training to support them in their role.

Whilst the provider had systems in place to monitor the quality of service to ensure improvements were identified, these were still not effective. Audits that had been undertaken since our last inspection in February 2017 had not addressed the issues we had raised. They did not contain information on what it was that was being audited, specific findings during the audit and any outcomes or actions to be taken. During our inspection in July 2017, 17 people had body maps in place which identified unexplained bruising, marks or skin tears. The audits completed had not identified these incidents and action had not been taken to review these. The provider was unable to confirm if these incidents had been referred to the local safeguarding team.

The provider had not undertaken any spot checks at night. This is despite the incident in February 2017 and two allegations of abuse which had all occurred at night.

For people who needed an air flow mattress due to risk of pressure ulceration, the settings for these were not being monitored and audited. If mattresses are set at the wrong setting in relation to the person's weight this would increase the risk of the development of pressure ulceration.

During a meeting with the provider in July 2017, we raised concerns with regard to the fire safety arrangements on the first floor. The provider had not identified these issues in their audits.

People were not always protected by the prevention and control of infection. Seating and walls were damaged making them difficult to clean. Housekeeping staff were not aware of infection control protocols.

Improvements had been made to ensure risks to people's safety had been assessed and plans put in place to minimise these risks. Risk assessments were now in place for those people at risk of choking and to support people to access the outside areas or their community. However, some areas of assessment still required improvement to ensure people's care plans contained accurate and up to date information. Some of the assessments we reviewed contained contradictory information relating to the consistency of people's food and fluids. Some of the risk assessments contained generic statements which were used in all of the assessments we looked at.

At our last inspection the service was not meeting the requirements of the Mental Capacity Act (2005). During this inspection we found some assessments to determine people's capacity to make decisions had been started. We saw evidence that best interest discussions had taken place where people were assessed as lacking capacity. This still required improvement to ensure all people who required an assessment received one.

Some people's care plans continued to lack important information in order to provide staff with guidance in how to meet people's care and support needs. Some care plans contained contradictory and inconsistent information. Care plans were not always person centred and did not contain information on how people wished to receive care.

People and their relatives spoke positively about the food provided. However, we continued to observe that people did not always have drinks available close by. Where people required their food and fluid intake monitoring, records did not contain targets on how much fluid the person should be encouraged to drink each day. Where people had gaps in the recording of their food intake it was not recorded if the person had refused the food and if any alternatives were offered.

The storage and administering of medicines were managed safely. Improvements had been made around the management of covert medicines. However, some protocols for 'as required' (PRN) medicines still did not always give clear guidance to staff on when these medicines should be administered. People were supported to access appropriate healthcare professionals to ensure they received ongoing healthcare support.

Improvements were required to ensure staff knew how to protect people's privacy and dignity. Staff were heard discussing people's personal care needs in front of others. People and their relatives spoke positively about the staff.  Staff continued to be knowledgeable about people's care and support needs.

The service employed three activities co-ordinators who were responsible for providing daily activities. During our two day inspection we observed some people were not always engaged in meaningful activities and some people experienced little social interaction. Some people had accessed trips out to the local community since our last inspection.

During our last inspection we spoke with the registered manager regarding staffing levels and how these were met. They told us they did not use a formal dependency tool but assessed the staffing levels through observation and how care tasks were completed by staff. Since our last inspection the service had introduced a formal process for assessing the dependency of people to determine the level of staff required. As a result of this, staffing levels had been increased.

The staff records we looked at showed appropriate recruitment and selection processes had been carried out to make sure suitable staff were employed to care for people.

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.

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."

Following the inspection, we took urgent action to reduce the risks and to protect people from poor care. We found continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. You can see what action we told the provider to take at the back of the full version of the report.

Following the inspection we took enforcement action. Prior to the completion of this enforcement action the provider took the decision to close the service. The provider and CQC worked with the local authority to support people to find alternative accommodation.

## 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**

This service was not safe and continued to require further improvement.

People were not supported by staff who had received training in safeguarding people. Staff did not know what actions to take should they suspect people were at risk of harm or abuse.

The provider had not undertaken any spot checks at night. This is despite the incident in February 2017 and two allegations of abuse which had all occurred at night.

Improvements had been made to ensure risks to people's safety had been assessed and plans put in place to minimise these risks. However, some areas of risk assessment still required improvement to ensure people's care plans contained accurate and up to date information to ensure they received safe care.

The storage and administering of medicines were managed safely. However, some protocols for 'as required' (PRN) medicines still did not always give clear guidance to staff on when these medicines should be administered.

People were not always protected by the prevention and control of infection.

People's dependency levels were assessed to ensure there were sufficient numbers of staff to meet people's needs. □□

### Is the service effective?

**Inadequate**

This service was still not consistently effective and continued to require further improvement.

At our last inspection the service was not meeting the requirements of the Mental Capacity Act (2005). During this inspection we found that improvements were still required to ensure people's capacity to make decisions had been assessed and best interest decisions were being recorded.

People spoke positively about the food. However, we observed that people still did not always have drinks available close by.

Information on training staff had attended was no longer available. Newly appointed staff told us they had not received an appropriate induction or training.

People were supported to access appropriate healthcare professionals to ensure they received on-going advice and treatment.

## Is the service caring?

**Requires Improvement**

This service was still not consistently caring and continued to require further improvement.

Improvements were required to ensure staff knew how to protect people's privacy and dignity. Staff were heard discussing people's personal care needs in front of others. People and their relatives spoke positively about the staff. Staff continued to be knowledgeable about people's care and support needs.

We observed some positive interactions between people and staff. However, some people were left for long periods of time with little interaction. Interactions for these people were task focused.

People looked relaxed and comfortable in the presence of staff. Staff engaged some people in conversations and people were encouraged to make daily choices.

## Is the service responsive?

**Requires Improvement**

This service was still not consistently responsive and continued to require further improvement.

We saw some people's care plans continued to lack important information in order to provide staff with guidance on how to meet people's care and support needs. Some care plans contained contradictory and inconsistent information. Care plans were not always person centred and did not contain information on how they wished to receive care.

Some people were not engaged in any meaningful activities and some people experienced little social interaction. Staff did not have the time to sit and chat with people.

There was a procedure in place to ensure complaints were dealt with in a timely manner.

## Is the service well-led?

**Inadequate**

This service was not well-led

The systems in place to monitor the quality of service to ensure improvements, these were still not effective. 17 people had body maps in place which identified unexplained bruising, marks or skin tears. The audits completed had not identified these incidents and action had not been taken to review these.

A registered manager was no longer employed by the service. The service had recently appointed a new home manager who will be applying to become the registered manager.

Staff spoke positively about the new manager. They felt he was visible and already supporting them with personal development opportunities.

# Greengates

**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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We carried out this inspection over two days on the 26 and 27 July 2017. The first day of the inspection was unannounced. Two inspectors attended both days of the inspection. Before we visited, we looked at the previous inspection report and notifications we had received. Services tell us about important events relating to the care they provide using a notification. .

We used a number of different methods to help us understand the experiences of people who use the service. This included talking with eleven people who use the service and five visiting relatives about their views on the quality of the care and support being provided. During the two days of our inspection we observed the interactions between people using the service and staff. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at documents that related to people's care and support and the management of the service. We reviewed a range of records which included ten care and support plans and daily records, staff training records, staff duty rosters, staff personnel files, policies and procedures and quality monitoring documents. We looked around the premises and observed care practices.

We spoke with the home manager, deputy manager, the activity co-ordinator, six care staff, and staff from the catering and housekeeping department. We contacted four health and social care professionals for their views on the service but did not receive any feedback. We have however been in regular contact and received feedback  the local authority and safeguarding teams since February 2017.

Inadequate

# Is the service safe?

## Our findings

At the inspection in February 2017 we found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that the service was not safe.

The service did not have robust systems in place to ensure and review the quality of care at the service during the night, to ensure people received safe care. Appropriate action had not been taken to identify and safeguard people from potential abuse.

At our last inspection in February 2017 the registered manager told us they regularly undertook unannounced spot checks at night. During these visits they informed us that they did a check of the building and ensured monitoring records had been completed. In February 2017 the registered manager told us there had never been any issues raised during their night time checks. However, these checks had not been recorded to evidence they had taken place and any outcomes identified. Following the inspection in July 2017 we were told no unannounced spot checks had been undertaken since February 2017. After the inspection in July 2017, there had been two allegations regarding potential abuse at the home during the night. These are currently under investigation by the police and Wiltshire Safeguarding team. This is in addition to an unexpected death that occurred during the night at the service in February 2017. The lack of quality assurance systems at night did not identify poor practice safeguarding people from abuse and support the staff culture at the service.

At this inspection it was identified that 17 body maps had evidence to show people had bruising which had not been reviewed or investigated. These had not been monitored or reviewed to identify any trends. The lack of monitoring meant that potential actions to prevent reoccurrence had not been identified. These had not been picked up in any audits and actions had not been taken to identify why these had occurred. The provider could not confirm if all of these incidents had been reported appropriately to the local safeguarding team. This demonstrates that appropriate action had not been taken to identify and safeguard service users from potential abuse.

Policies and procedures remained in place to inform staff of the action they needed to take if they suspected abuse had taken place or people were not receiving a safe service. The new home manager was clear about when to report concerns and the processes to be followed to inform the local authority, police and CQC. Since their appointment they had raised several safeguarding referrals in line with procedures. However, not all of the staff we spoke with were able to tell us the actions they would take in protecting vulnerable people from the risk of harm or abuse. One staff member told us "I have had no safeguarding training, I would go and see the head if I had concerns". This staff member was unable to tell us where else they could take their concerns if they felt the manager was not dealing with it effectively. Another staff said "I would make sure residents are safe. I would report concerns to manager, but I don't know who to speak to outside of the home". Other staff commented, "Safeguarding is about keeping people safe, I would report it to the manager, but externally I don't know, I wouldn't take it outside of the home" and "I would report it to the senior or manager, or CQC. I am aware of the different types of abuse including physical, mental and verbal abuse".

During the inspection, we found staff supervisions or one to one meetings had not been taking place consistently. We saw two members of staff's supervision record stated they had not received supervision since June 2016. One to one meeting would provide staff with the opportunity to raise safeguarding concerns with the provider

This is a breach Regulation 13, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Risks to people's safety continued to be assessed and regularly reviewed. Where people previously did not have risk assessments that identified areas such as choking and accessing the outside areas, these had now been completed. However, some of the assessments contained contradictory information and were not robust. For example, we saw in one person's risk assessment and care plan dated 1 June 2017, the person required a texture D diet for food and a stage two thickeners for their fluids. However, information held in the kitchen was different. We spoke with staff who confirmed the person required stage three thickeners for their fluids and their food pureed. This meant staff were following out of date information and the person was at risk of receiving inappropriate consistency of food and drink. This would increase the risk of aspiration or choking. Information from the Speech and Language Therapy (SaLT) team was not available, which meant staff were unable to clarify what consistency of food and drink the SaLT team had advised.

In another person's care plan a risk assessment was in place for times when they displayed distressed behaviour. One of the actions to support the person during these times was to ensure they were not in an area of the home that was too noisy. However, throughout our inspection this person was in the same seat and had to experience many noises coming from the corridors, lounge and dining room. This person was unable to move independently and was therefore reliant on staff to meet their needs. Staff did not encourage this person to spend any time away from this environment or in the garden, which their care plan stated they enjoyed. This person's care plan further stated they benefitted from one to one interaction. We saw staff only engaged with this person during task focused care and not through any activities or other interactions. This would impact on the person's wellbeing and increase the occurrences of distressed behaviour.

Some people had a sensor mat in place to alert staff if they were moving around their bedroom so staff could offer support. However, one person's sensor mat had been wedged down behind their bed. We asked staff why this was put there and were told people did not go back to their rooms so there was no need for the mat to be out. This person was observed frequently walking about the home. There was a risk that staff would not have always been aware if they chose to return to their room. This meant the risk was not being effectively managed to keep this person safe and decrease the risk of falling.

Some risk assessments were not always person centred. At our previous inspection, some of the risk assessments contained generic statements which were used in all of the assessments we looked at. For example, mobility and falls assessments noted that people were to 'wear appropriate footwear' as a preventative action. These had now been updated to include what footwear people should wear. We also observed that during this visit people were now wearing footwear. However, a generic risk assessment had been completed for all people using the service to access the outside areas. The risks to people as described in their risk assessments were all the same and not tailored to people's individual needs. Only the name of each person had been added to the risk assessment. No further individual risks had been identified for people where required. Some people were living with dementia or have poor mobility. The lack of specific risk assessments did not ensure that the numbers of staff required to supervise people or to reduce the risk of falls had been considered in order to keep people safe.

We observed that the cleaning trolley was often left in corridors and outside of people's rooms unattended

and contained chemicals that were unsafe to be left accessible to vulnerable people. During the inspection one inspector had to remind a member of the housekeeping staff to secure their trolley somewhere safe as they walked down the corridor leaving it unattended.

People were not always protected by the prevention and control of infection. Infection control was not being safely managed in the service. Housekeeping staff we spoke with were unable to explain what steps should be taken to reduce the potential of cross contamination and manage infection control. For example, what to do if there was an outbreak of sickness or other infection. This staff member told us they had not received any training since working in the home, to enable them to be safe and effective in their role.

We saw cleaning schedules were being completed to show what areas and rooms had been cleaned. The cleaning schedule stated that people's bedrooms should receive a deep clean every six weeks. However, this had not been happening. One staff told us "I have only done three deep cleans since I have been here, I am not sure how often we are meant to do a deep clean". The staff member had worked at the service for around three months. The deputy manager said this had been an issue during the management changes and whilst they had been recruiting new staff. They confirmed the rooms were meant to be deep cleaned every six weeks. This failure to adhere to the cleaning schedules increased the risk of the spread of infection.

During our inspection, a yellow bag that contained waste materials had been taken out of the waste bin and put into a bath and left instead of being taken straight to the appropriate outside bins. This increased the risk of the spread of infection. In addition the odour from this bag could be smelt in the bathroom and was not a nice experience for anyone wishing to use this space. We went to access another toilet and saw the large waste bin had been moved in front of the toilet, making this toilet inaccessible. The bin was heavy and large and would have been a struggle for a person to move and they would have been at risk of injury.

Another toilet we looked at had the toilet seat missing. Above the toilet the shelf was piled high with towels, people's clothes, a person's watch, shampoo, conditioners and shower gel with the lid missing. The use of communal toiletries increases the risk of the spread of infection. The bathrooms were not maintained to a standard suitable for people to use. One staff told us "We have issues with the bathrooms, the toilet seats keep coming off".

Chairs and walls were damaged making it difficult for them to be cleaned. We asked if there was a schedule in place to ensure hoist slings and equipment were regularly cleaned. There was no information to indicate if or when slings and equipment had been cleaned.

These concerns continued to be a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our last inspection on 15 and 16 February 2017 we found concerns with how medicines were managed and risks to people's safety were assessed. These were a breach of Regulation 12, Safe care and treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found on this inspection the provider had not taken all the actions required to make the necessary improvements.

For people prescribed medicines to take 'as required' (PRN) protocols, detailing how and when the medicines should be taken, were mostly in place. However, these were kept in their care plans and not alongside the MAR's which meant staff administering medicines did not have easy access to this information. Staff were recording when they gave a person their PRN medicine and the reason why. One person did not have a PRN protocol in place. Staff told us this was because the person had recently started taking this medicine and one needed to be put in place. Another person did not have protocols in place for

two of their PRN medicines. Staff said this person was having their medicine regularly not as PRN, as agreed with the GP but the pharmacy had not updated this on the MAR's. One person's protocol did not record why they needed their PRN medicine. We saw this had been detailed in their mental wellbeing care plan but this did not link to the protocol so the information sat separately and did not guide staff to look at it. This would increase the risk that people would not be supported to receive their PRN medication as and when required.

We saw one person was asked by staff if they would like any pain relief but the person was able to state they were alright and did not require any. For people that were unable to communicate if they were in pain, there was no information recorded in their care plans on how they would express pain so staff could monitor the signs. One person's medicine care plan stated 'Staff to be vigilant and look for signs of pain' but there was no detail on what these signs looked like. There were no pain charts in place for staff to use to assess people's pain and ensure they received their medicine in a timely manner. One staff member said "We haven't got pain charts in place, we are talking about it and going to implement them. We look at people's facial expressions, tone, agitation and movements". The manager told us new medicine sheets were to be implemented with PRN guidance and much more detailed information of why and when to give people their medicine.

We saw one person's MAR's indicated they had not been receiving their medicine (Memantine) for the treatment of dementia. Staff told us it had run out on Sunday 23 July 2017 and the supplier had still not sent it by Thursday 27 July 2017 during our inspection. The staff member said they would be chasing this up again today. We saw this had also happened for another person who was meant to take their medicine daily. We asked staff about their ordering and stock checks and were told they had requested the medicine in advance of it running out. However, regular checks and audits had not been completed during the management changes to ensure medicines were being correctly managed and any issues identified. One staff told us "I would know if any medicines were missing, I will count through the medicines once a week but that's not something definite we have in place or all do, but we have had a chat about doing this. The manager has brought in to place that the medicine handler on each shift must check the MAR's before leaving for any gaps".

Some people were supported to have their prescribed topical medicines or creams applied after personal care and staff would then record that this had been completed. We saw there were many gaps in the recording of creams. One member of staff told us "It's something we are working on reminding staff to sign for creams". As staff had not signed the charts we could not assured that people were receiving support to have the creams applied as prescribed.

The service had made improvements to medicine administration and we saw this was being conducted safely. We observed one staff member during the administration of people's medicines and saw this was done safely. The staff member ensured people were in an upright position to receive their medicine and a drink was offered for them to take their medicines with. The staff member explained what the medicine was and what it was for. They stayed with the person whilst they took the medicine before returning to sign the medicines administration chart (MAR). We saw the staff member refer to one person's medicine as their "fizzy water". This showed staff used the term the person was comfortable with.

One person was receiving their medicines in a covert manner (covert is the administration of medicines in disguised form, usually in food and drink). We saw this person had a care plan in place detailing who had been involved in making the decision and how the person could receive their medicine. Signed authorisation and approval was in place from the GP and the pharmacist for the person to have their medicine this way. One staff member told us "We are still telling [X] when giving medicine but it's more

because they needed their medicines crushing as they were struggling to take them. Mostly we have been able to get them in liquid form". The staff member also told us if anyone refused their medicine on a regular basis a conversation would take place with the GP about changing the format of the person's medicine or trying to administer it at a different time of day to see if this helped.

Previously there had been concerns around how long the medicine round was taking which had an impact on people who were on several administration doses throughout the day. These doses needed to be evenly spaced so the medicine was effective. Action had been taken to address this and a sheet was in place in the front of the MARs detailing who needed their medicine regularly throughout the day so staff were all aware. There was a sheet in each person's MAR for staff to record the time they gave the medicine so they could check that the intervals between doses were spread appropriately. One staff told us "I try to start medicines early so everyone on four hourly medicines can have theirs by 9.30am in time for the lunchtime administration".

These concerns continued to be a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our previous inspection we spoke with the registered manager regarding staffing levels and how these were met. They told us they did not use a formal dependency tool but assessed the staffing levels through observation and how care tasks were completed by staff. A lack of a formal dependency tool did not assess if staffing levels remained sufficient if people's needs changed or numbers of people living at the service increased. These concerns were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found on this inspection the provider had taken the actions required to make the necessary improvements.

A dependency tool had been implemented by the service, to enable them to identify how many staff were needed. This was reviewed each month. Staffing levels have been increased to six staff throughout the day and three night staff. Staff absences were now being covered by agency staff. Following the inspection we received information from the local authority that staff were not deployed effectively. For example, on the night shift three staff were on duty. Two of these were staff from an agency. It was observed that the two agency staff, who would not know people well, were providing care and support while the permanent member of staff completed cleaning tasks.

One visitor to the home told us "We used to have to always find someone when she wanted a wee as she needs two carers and there would be a delay. Sometimes when we have come there hasn't been the staff and we had to go to the kitchen to find someone". Another visitor told us "Staff are not always around. Sometimes you have to go and look for someone for support". One person told us "There is enough staff".

Staff told us the service was still using agency staff to ensure appropriate levels of staff were in place but they had seen an improvement in staffing levels. Comments from staff included "There seems enough staff, they are busy but it seems alright", "The agency we are using feel like our own staff and like coming in here", "We have had agency in and this has been settled now, some agency come on a regular basis", "The agency we have are very competent" and "The manager is doing interviews and applications are coming in. The manager wants people with experience, as it is a hard home, people have complex needs. Today we are using agency but it's not been too bad".

The five staff records we looked at showed appropriate recruitment and selection processes had been carried out to make sure suitable staff were employed to care for people. Appropriate checks were undertaken before staff commenced work.

People we spoke with all felt safe living in the home and told us they had no concerns about their safety commenting "I do like it here, I feel very safe", "Yes I feel safe living here" and "I'm quite happy enough, I feel safe, no worries".

Relatives we spoke with did not raise any concerns about the safety of their family member. Their comments included "I feel he is safe. Staff are sweet and patient" and "Yes they keep her safe. They are very mindful of what she needs and remind her to use her frame".

Inadequate

# Is the service effective?

## Our findings

During our last inspection on 15 and 16 February 2017 we looked at how the provider was meeting the requirements of the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards (DoLS). We found that not everyone had an assessment to determine their capacity to make decisions and best interest decisions had not always taken place where people were deemed as lacking capacity. This was a breach of Regulation 11, Need for consent, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found on this inspection the provider had not taken all the actions required to make the necessary improvements.

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.

The service had started to implement capacity assessments. Capacity assessments assess people's ability to make a specific decision such as consenting to care. However, not all people deemed as lacking capacity had these assessments in place. This still required further improvement. For example, staff managed one person's cigarettes. They would keep their cigarettes in the care office and this person would ask staff when they wanted one. There was no mental capacity assessment in place or evidence of any best interest decisions made. There was no signed consent to show the person was happy with this arrangement

Everyone in the home was receiving hourly checks at night. This had been put in place in response to an incident as a blanket approach, rather than considering each person's individual needs. There was no evidence that consent to this had been lawfully obtained from any of the people using the service. One staff member said "Unless they state they don't want to be checked they will be. We go in quietly and no one has complained they are being disturbed".

For people that lacked capacity to make decisions or consent to their care we saw some mental capacity assessments had been completed. However, these often lacked information on how the decision had been made and who had been involved in this process. One person had a best interest checklist in place for support around personal care, assistance with medicines and leaving the building alone. A DoLS had been applied for there was no evidence staff had considered the least restrictive way of caring for this person

We saw evidence in some care plans that people or their representatives were involved in planning care. Where decisions were made by someone other than the person, appropriate documents were now in place to validate the decision making process was lawful. Where it had been identified that representatives had lasting power of attorney, it was now clear if this was for finances, health and welfare or both. However, one person was not sleeping at night and their care plan stated a sensor mat had been put in place. It was recorded that this had been discussed and decided with the person's family as the person would not understand the reasons for having it in place. However, the family did not have lasting power of attorney

(LPA) in place to make these decisions on behalf of the person. (LPA is a legal process that lets you appoint one or more people to help you make decisions on your behalf). There was no record of a mental capacity assessment or best interest decision in relation to this aspect of their care.

During this inspection we found staff's knowledge around mental capacity was variable. Not all staff were able to explain what it meant or how they supported people effectively around this. Staff comments included "I don't know about this, it could be they (people) need assistance or what level they are at", "I don't know much about this, I don't know what lacking capacity means", "Not being able to make own choices, if can't communicate by voice or movement we show people objects or pictures" and "People lack capacity to decide for themselves, we still give choices about what clothes they want to wear and what they would like to eat".

These concerns continued to be a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection, the deputy manager explained that where needed, applications for DoLS authorisations continued to be submitted. Applications had been submitted by the provider to the local authority. More urgent DoLS had been authorised, whilst others were awaiting a response. Where DoLS applications were in place, the deputy manager continued to review these to ensure the application was still relevant for the person's needs.

During our last inspection on 15 and 16 February 2017 we found that staff had not received training on how to support people to manage distressed behaviour or how to use restraint safely, if required. This was a breach of Regulation 18, Staffing, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found on this inspection the provider had not taken all the actions required to make the necessary improvements.

Since our last inspection staff had still not received training in supporting people to manage distressed behaviours. Staff continued to support people who at times could display distressing behaviour to others or staff. We reviewed one person's daily records and saw incidents recorded including 'Kicking doors', 'Unsettled and shouting', 'Being very violent, picked up a table and threw it at staff. Head-butted a member of staff causing a lump to their head' and 'When assisted to bed got very aggressive and banged head on the door and hitting staff'. Staff had recorded on one occasion that 'The more you take him to his bedroom the more agitated he gets, been shouting and kicking off and refused medicines'. This was not appropriate terminology and did not show an understanding of people's needs. The care plan recorded this person benefitted from a walk in garden if they became agitated. However, staff were not following this. We were informed that training to assist staff with supporting people to manage their behaviour had been booked for 31 July 2017.

During our last inspection people were supported by staff who, for the most part, had access to a range of training to develop the skills and knowledge they needed to meet people's needs. However, during this inspection, the training matrix which confirmed the training staff had attended was no longer available at the service. During the inspection we could not confirm what training staff had undertaken in order for them to carry out their duties. Action had not been taken to maintain an accurate record of staff training from the time that previous training records went missing until the inspection on the 26 and 27 July 2017.The deputy manager assured us that the service continued to use an external training company to provide classroom based learning for staff to ensure they were kept up to date.

We found not all staff training had been kept up to date during the management changes the service had

experienced. Some staff had not received any training before starting in their role and were working without this. Staff told us "I have not had any training since being here; they haven't mentioned training to me. There is a folder and that has all the information in I think", "I have had no training yet, there was a discussion about it, I have had no safeguarding or dementia training", "I have had no recent training, I have got some on the way I think. Last September I renewed my infection control and manual handling", "I have had no training in managing people's behaviours" and "Not had any training recently, I have got some next week".

During this inspection we found new staff had not been provided with induction training before working independently. Staff told us "I didn't really shadow anyone, I was shown what to do when I started and have carried on like that" and "My induction came from staff who were here, I didn't shadow, it was a case of find out for yourself. I spent time just getting to know people at first, I spoke with them, I could have looked in the files but there were so many". Some staff did not have any information recorded to show that they had received an induction into the service. Staff that had received an induction had not had the opportunity to sit down with their line manager and review their probationary period, discuss their progress and raise any concerns they had. This meant these staff were not being appropriately monitored to ensure they were competent and safe in their new roles.

These concerns continued to be a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home was in need of redecoration and repair in some areas. For example, we saw a black mark on one bathroom floor and a heater guard that had a dent in it. Five tiles in one bathroom were all cracked. Skirting boards and handrails around the home were marked and the paintwork was chipped. One ceiling panel was missing outside of one person's bedroom following issues with a leak and the carpets in some areas were heavily worn and at times threadbare. Staff told us "They could improve the decorating and carpets" and "The building needs updating".

During our last inspection on 15 and 16 February 2017 we found that people did not always have drinks available close by and were not always offered a choice of what they wanted to drink. Action had not been taken when one person had lost weight over several months. This was a breach of Regulation 9, Safe person centred care, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found on this inspection the provider had not taken all the actions required to make the necessary improvements.

We observed one person who sat at a table several times without being given their lunch. When a meal was not presented the person got up and continued to walk around the building. This person was seen throughout our inspection to walk around continuously occasionally sitting down. It was only when this person sat in someone else's seat and proceeded to eat their unfinished lunch did staff intervene and offer the person their lunch. The person then sat down next to a member of staff who was supporting another person to eat their lunch. After two mouthfuls of food this person got up to leave the table. The person's plate was then cleared away by the staff member without them encouraging the person to eat more lunch or offering alternative. We approached a senior member of staff to make them aware of this situation.

We observed two people had got up late on the first day of our inspection. One person was assisted to eat their breakfast at 10:55 and the other person was assisted to eat their breakfast at 11:20. Both people ate all of the breakfast offered to them which was a full bowl of cereal. One person was also offered biscuits. We then observed that both of these people were then assisted to eat their lunch which was two courses and had finished their meals by 12:43. There was no communication between staff about these people only just having had breakfast and arrangements explored for them to possibly have their lunch a little later.

People still did not always have good access to drinks. We saw that jugs of squash continued to be placed on a cupboard in the corner of the lounge and on a window sill where not everyone would think to look. For people that were not able to mobilise independently they often sat for long periods of time without a drink next to them. They were reliant on when staff came round with a drink. For two people who were in their bedrooms there were no drinks or jugs available for them to help themselves to a drink. One staff told us "Sometimes they might have drinks in their rooms, or these are in the lounge".

Information on people's food preferences and needs were not always recorded in a person centred way. For example, one person's care plan stated 'I have always loved my food and will eat most foods'. There was no information to say if the person had any favourite foods or particular preferences. Information on people's preferences held by the catering staff still required updating from our last inspection. One person's information still stated they liked 'pureed food' although this was actually a recommendation from the SaLT team.

At the last inspections in August 2016 and February 2017 the registered manager advised us they would be looking into producing some pictorial menus to support people to visualise their meal choice. This was also to support people who were not able to remember what they had chosen earlier in the day. During this inspection we saw that this had not been implemented. A menu was displayed on the entrance to the dining room in small print. There were no menus on the table or pictorial menus in place for people who needed information in this way.
These concerns continued to be a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed the mealtime experience for people during lunchtime and saw that improvements had been made. Most people were supported to the dining room to eat their meal and only a few stayed in the lounge areas. People were asked for their menu preference during the morning before lunch. People, for the most part, were reminded of their menu choice when given their meal. People were offered a choice of drinks.

One person was assisted by staff to eat their meal and we observed they were supported in a dignified manner. The staff member told the person what the meal was and asked what drink they would prefer with their meal. People were assisted to eat their meal at a pace appropriate to them.

People and their relatives spoke positively about the food choices. Their comments included "I like the food, my favourite is fish and chips", "I really enjoy the food here, it's very nice", "My dad told me one day he was full up from all the food he had eaten. He didn't even want the snacks they offered later" and "[X] goes on about the food a lot so I think she likes it".

People continued to have access to health and social care professionals as required. Records showed this included doctors, district nurses and opticians. This ensured people received effective healthcare and treatment.

One person was using a specially adapted recliner chair to support them with their posture. We saw this person was using a normal armchair on the second day of our inspection and their body was completely bent over with their head touching the arm of the chair. We raised this with a staff member who agreed they did not look comfortable and asked another member of staff to assist in repositioning this person. Staff explained that the occupational therapist visited the previous day and felt the chair was actually making the person's posture decrease further and asked that they stopped using the adapted chair. However, the armchair was not supporting the person appropriately either. The staff said they would continue to monitor this person.

Requires Improvement

# Is the service caring?

## Our findings

During our last inspection on 15 and 16 February 2017 we found that people's dignity was not always respected. This was a breach of Regulation 10, Dignity and respect, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found on this inspection the provider had not taken all the actions required to make the necessary improvements.

People did not always have their dignity respected by staff and staff were not always appropriate about what they wrote about people or how they spoke about them. For example, one staff member told us "Some people are very challenging, I don't envy the staff." Another staff commented "I don't chat to people that much, I personally am here to do a job, I'm here for a purpose, I won't ignore them but I'd be failing if I didn't do my job".

Staff on shift were allocated to support certain people and help them with their personal care. This included assisting people to get up, washed and dressed. During our inspection we saw one staff's allocation list had been put on the desk in the care office. It recorded who they had supported and any assistance given. We saw that inappropriate and disrespectful comments had been documented about people. For example, one entry recorded that the person was 'Spaced out'. Another entry recorded a person was 'Away with the fairies '. This demonstrated the culture of the home needed attention to ensure people received care from staff that were respectful and acted in appropriate ways. We raised our concerns with the management team who told us this would be addressed with staff. The manager told us they had been on the national dignity website and printed off statements to give to staff and planned to ask them questions in relation to this to improve their awareness and practice.

We observed some positive interactions between staff and people using the service. However, we found improvements were required to ensure each person was treated in a way that maintained their dignity. For example, one person told us their privacy was not always respected by staff commenting, "Staff don't knock on my door, they just come in". We observed one staff member go straight into someone's room without knocking. They then apologised and quickly shut the door when they realised the person was having support with personal care at that time.

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

People's preferences were not always adhered to and they did not always receive care in a person centred way. For example, one person told us their preference was to have a bath but this had not been happening. This person's care plan recorded 'Staff to offer me a bath on a daily basis'. We reviewed the bath and shower chart, which staff used to record who had been supported to have a bath or shower each day. Records showed this person had not received either a bath or a shower from 1 May 2017. This meant this person's wishes were not being respected. One staff member told us "We have a schedule when they have a bath; seniors tell us who is having a bath". This was not person centred or promoting people's choice. Staff were meant to record water temperatures on the chart but this had not been happening.

We saw during a period of two weeks, eight people had not received a bath or a shower in this time. In another period of three weeks two people had not received a bath or a shower. We saw for one person who was rarely receiving a bath or shower; their care plan stated their personal likes and wishes was to have a bath but this had not been upheld. One staff member told us "At the moment the bath chair is in the wrong position so people are having showers, I am not sure if it's getting fixed, the manager is aware".

Two people were left for long periods of time without any social interaction in the smaller communal area. Both of these people had to listen to noise from the larger communal area, dining area and entrance area. They did not have the opportunity to sit and listen to one thing. The television is situated in the smaller lounge and throughout our inspection we observed staff turn the television over without asking people what they would like to watch. At times it was also left without any volume so those people who were sitting in this area could not hear anything. One person, who was unable to communicate verbally and had little social interaction, was promised a hand massage after their lunch on the first day of our inspection. The person looked responsive to this suggestion, holding on to the staff member's hand. However, the activity did not take place after lunch and no explanation was offered.

Most people spent their day in the lounges or dining areas of the home until they returned to their bedroom in the evening. We observed some people spent their days in the same chair and received very little or no interaction outside of basic care tasks. One visitor said "They all seem to be quite happy, the one's that aren't asleep".

Whilst people moved freely around the home, people were seen to still be restricted from accessing the gardens and outside space. Although some of the doors to the garden were unlocked, staff did not encourage people to go outside, or assist people who could not mobilise independently to spend time in the fresh air. We observed one person open the door and go out into the garden. A staff member quickly brought them back inside. We asked another member of staff why this person was not allowed to spend some time outside. They told this person had been putting themselves on the floor and they panicked staff a little bit. However, the staff had not taken the time to walk around the garden with the person so their wishes could be respected, whilst ensuring they were kept safe. One person told us "We do as we are, I don't go outside, we don't go outside, everyone is the same. I wouldn't mind going outside".

Whilst the dining experience on both days of the inspection had improved, interactions between staff and people remained inconsistent. For example, we observed one member of staff on the second day of our inspection assisting someone with their breakfast. They approached the person and said hello and told them what breakfast was. They sat the person up in their reclining chair without informing them they were about to do so. They then proceeded to assist the person with their meal, in silence with no further conversation. Once finished, they then went on to support another person with their breakfast, again with no conversation about what was happening.

We observed staff continually walking through the communal areas with little interaction with people or observation as to what was happening. For example, we saw one person in the smaller lounge lifting their walking frame off the ground whilst they were in their chair and holding it above their head in an unsafe position. A member of staff walked past the person and made no attempt to discourage them from this or support the person. We immediately raised this with another staff member who went to assist the person to safely put it down.

Another person was observed trying to take off their clothes protector after their meal. Three staff members walked past this individual whilst they were trying to take it off over their head. None of the staff sought to support the person with this. We asked the person if we could support them to take it off.

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

People were mixed in their responses of the care and support they received commenting "I don't know if I have had breakfast, I am always the last to be sorted", "I'm all right, I think, yes I'm fine", "It's nice living here, I may go into the garden if it is warm enough later", "I find the staff alright", "Staff are kind, I think I get on with them I do. I'm happy as ever will be here" and "If I've got to stay I've got to stay. Staff are very good".

Relatives spoke positively about staff and the support their family member received. Their comments included "The staff are first class. Patient and understanding of individual clients. All staff are approachable", "The staff are lovely. They know people well and have developed good relationships. (X) loves some of the staff" and "Staff are lovely. They are getting to know him better now".

We saw some positive examples of staff interacting with people in a kind and caring manner. For example one staff member offered a person a drink and something to eat when they saw they appeared to be searching for food. Two staff were observed supporting a person to walk and one said "You can do it in your own time". This person was given time and lots of encouragement. Another staff was heard saying to a person "I will settle you into a nice comfy chair and then go back and fetch you a cardigan". One staff told us "We have enough time to spend with people, we don't rush residents." People looked relaxed and comfortable in the presence of staff and sought assistance when required.

Requires Improvement

# Is the service responsive?

## Our findings

During our last inspection on 15 and 16 February 2017 we found that people did always receive person centred care. This was a breach of Regulation 9, Person centred care, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found on this inspection the provider had not taken all the actions required to make the necessary improvements.

Some people's care plans, assessments and risk assessments continued to lack important information to guide staff on how to care for people safely and in ways they preferred. This meant people were at risk of not receiving care that was responsive to their individual needs. For example, one person did not mobilise independently but the pressure risk tool stated they were not at risk of pressure ulceration which was not accurate. We observed them sitting for long periods of time. This had been regularly reviewed and was last reviewed in June 2017. We saw this person had a repositioning chart despite the pressure tool stating they were not at risk. We spoke with the management team about this person and were informed that they were waiting for an occupational therapist to assess them. They said the care plans did need to be updated as were not a true reflection of this person's needs. There was conflicting information around this person's level of capacity as their care plan stated they could not retain information in order to make a decision. However, a risk assessment about being left alone in the garden recorded that the person was fully aware and understood why staff had to supervise them.

Risk assessments continued to be reviewed regularly, however for some people there was still no information recorded about any measures taken or events that had happened in each month of the review. For example, one person who had broken their leg in July 2016 had a mobility risk assessment in place. This was reviewed each month but did not identify when changes had taken place. We saw entries on the person's assessment which identified changes in their care needs. For example, the person was being transferred using a hoist but the care plan stated they were using a handling belt. This change was not noted on the monthly review and there was no date on the care plan to identify when this change had happened. This meant information did not clearly inform staff whether the person should be transferred using a hoist or a handling belt.

At our last inspection we looked at the care plan of one person who experienced epileptic seizures. Their care plan stated if the seizure lasted longer than five minutes then staff were to call an ambulance. Since our last inspection information detailing what this service user's seizures looked like and how to support them during this time was still not available to ensure they received person centred support. We observed this person continued to be left unobserved for significant periods of time without staff checking on them. Whilst they were in the lounge area, staff often passed this person without any interaction. We spoke with one member of staff who said the person had not experienced a seizure for a "few years" but this was not reflected in the care plan.

These concerns continued to be a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were not following the guidance in people's care plan appropriately. For example, one person liked to smoke and would go outside to have a cigarette throughout the day. We looked at the risk assessments in place for this person and saw that they were not allowed to be outside in the garden without being supervised by a member of staff and were not to be left alone. We walked past this person when they were outside and saw that no staff were with them. One staff member walked by the open door to the garden and shut it so the person was left outside alone and was not visible to any staff.

When people were at risk of malnutrition a Malnutrition Universal screening Tool (MUST) was used to assess the person's level of risk. Monitoring charts had been put in place to support people who were at risk. However, these were not being completed properly and were not being checked to ensure any concerns identified could be acted upon. Two people had food and fluid charts to ensure their intake was sufficient, as they were at risk of dehydration and malnutrition and had been losing weight. One person did not have anything recorded on 26 July. On the 23 July it was not documented if this person had eaten or been offered anything for their evening meal or before bed. Their last meal had been at midday. On 24 July it was recorded that they had no breakfast, nothing for lunch and did not eat until mid-afternoon. On 25 July they ate at lunch and then had nothing else recorded until the 27 July. There was no information to say if food had been offered and declined or if any alternative had been sought.

Monitoring charts for another person had no evening meal recorded on three days. On the fourth day there was nothing recorded after midday until the evening, and this was only recorded as a few sips of a supplement drink. It was not known if staff had forgotten to record what these people had eaten or if they had not received any food or drinks during this time. These people were at risk of losing weight. We raised these concerns with the management who were also unable to confirm if people had received their meals. We saw one person get up during their lunch and leave their meal after a couple of mouthfuls. Staff made no attempt to go after this person or give them finger foods that they could walk with. One inspector informed staff that this person had still not eaten any of their meal. We saw that a meeting had taken place with the deputy manager and this person's family, who requested this person be offered finger foods when they walked away from their meal. The care plan had not been updated from this meeting to ensure this information was recorded and for staff to be aware to offer this person appropriate foods to encourage them to eat. This meant the service was not supporting this person appropriately and they remained at risk of malnutrition. Records did not show these monitoring charts were being reviewed and any actions taken if required.

We saw one person was being weighed monthly and had lost a significant amount of weight. In January 2017 they had weighed 45kg and five months later in June they weight had dropped to 31.1kg, losing over 14kg. The person's care plan stated this had been discussed with the GP and the person was on supplements and a food intake chart so staff could monitor them. However, we could not find this person's food monitoring chart and staff told us they were not recording food intake for this person. We raised our concerns with the management team. The deputy manager informed us that in July the person had put on a little weight so they were no longer being monitored. This was after one increase in weight, despite the significant amount of weight the person had lost. The manager agreed this was not a safe practice and that it had not been managed appropriately, to ensure the person was not at further risk. The manager told us the person should have been monitored for a longer period to ensure they were no longer at risk and this would be reinstated.

We saw there were inconsistencies in the recording for people that needed repositioning charts and support to change their position to prevent pressure sores. Staff were recording on the charts when they had given personal care to the person and thus changed their position. On one person's chart it recorded that they did not receive any personal care from 1.45pm until 10pm, a total of eight hours. For another person their

repositioning chart showed they had received personal care at 11am and nothing further until they were assisted to bed at 6.10pm. We raised our concerns with the deputy manager who said staff would have done more, but as nothing was documented she could not confirm that this had happened.

Staff told us they had a handover at the start of each shift change. We saw handover sheets were used to record information about people so the next shift would know if any changes had occurred. A message had been documented in the staff communication book asking staff to write appropriately on handover sheets and not simply record everyone was 'fine'. However we saw staff had continued to write this way. On the handover sheet for 25 July, 18 people were recorded as being 'fine'. This did not enable staff to receive detailed information about the person's well-being.

During our inspection one person had received a visit from an occupational therapist which had resulted in their specially adapted chair being declared as no longer fit for purpose. The occupational therapist had told staff it was doing further harm to the person's posture instead of being beneficial. We looked at the handover sheet to see if staff had documented this change and saw it recorded that an occupational therapist had visited. There were no details of the outcome or directions from the visit. This demonstrated that information was not always appropriately shared between shifts to ensure all staff knew about changes affecting the people they supported.

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

Three staff were now employed as activity coordinators to plan and deliver events for people to participate in. One staff member told us "We only really had an activity meeting a week ago, but we know what we are doing now and things are settled now. We have ball games, one to one games and the sensory room. Trips out have been recently started. People have gone to the park as far as I'm aware. We have discussed two trips out, one in summer and one at Christmas, but that's in the early stages of sorting it out".

The service had purchased a new activity board to inform people which activities would be taking place on which days so they could choose to attend. However, during our inspection we saw what was stated on the board did not correlate with what actually took place. For example, on the second day of inspection it showed the sensory room would be used and in the afternoon a football event would take place. Neither of these activities happened. One person told us "There's not an excessive amount to do, but there are things to do if you want". Another person said "At certain times there are things going on, I like to hear singing and speak with people but they are all busy".

Pictures of people participating in activities were displayed, however the pictures dated back from January and February 2017.There were no recent pictures displayed. We saw one member of staff showing a relative some pictures they had recently taken of their loved one on a walk to the shop. The staff member was using their personal phone. We queried this and were told the service camera could not be found so they had used their personal phone. The staff said they sent the pictures to the deputy manager's email and then deleted them straight off their phone. There was a risk that people's confidentiality may be breached due to photographs not being taken on a secure camera.

Staff spoke positively about the activities provided and told us there had been improvements. They said "It's been a bit slow to start but activities are happening now, there's someone always to talk to them, but most just want to sleep. They play a lot of music, there's the sensory room and some dance", "I have seen improvements, people have started to go out of the home. The activity board is more interesting and has picture cards", "We have a fair budget for activities, we have booked outside entertainers, three lots since I

have been here, whatever we ask for we get" and "There is loads going on now and residents are loving it". One visitor to the home said "I think they have enough to do, there's an assortment of needs that differ a lot in what they can do".

We observed a music and movement activity and saw the people present appeared to engage with this and enjoy it. People were given feathers to wave in time to the music and the two activity staff led the activity for people. One to one activities with people who did not want to participate or a smaller group activity was not an alternative. Two people in the smaller lounge were not involved in activities and received very minimal interactions other than task based ones throughout the two days of our inspection. One staff told us "[For people who don't do group activities,] I feel I'm better at one to one. If you listen or hold their hand you're half way there, that's sometimes all they need. People are asked what they like to do. We have an activity book and record if they joined in and liked it".

Other activities which took place included a planned trip to the park but this had not been offered to many people to join. One person was asked if they wanted to help a staff member make some beds but the person refused. Another staff came and offered to play a game with the same person which they agreed to do later. We saw that one afternoon outside entertainers came in and sang for people in the main lounge. Some people who were sat in the smaller lounge were not offered the choice to participate in this activity yet they had to listen to it from where they were seated.

These concerns continued to be a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There continued to be a procedure in place which outlined how the provider would respond to complaints. We looked at the complaints file and saw a recent complaint had been dealt with in a timely manner. Relatives said they knew how to raise their concerns and felt they would be listened to. Their comments included "I am happy to raise any concerns. I would speak with the manager" and "I would feel I could complain. I would raise any concerns. I once raised concerns about my dad having a rattling chest and they had already called the GP".

Inadequate

# Is the service well-led?

## Our findings

The service was not well led. During our last inspection on 15 and 16 February 2017 we found concerns with regard to systems that were in place by the registered provider to assure themselves that care and treatment was safe and effective. This was a breach of regulation 17.

Following the inspection in February, we continued to receive concerns about the quality of care and support that was being provided. We met with the provider to discuss these concerns in July 2017. At this meeting the provider told us improvements at the service had been made and they were now meeting the legal requirements. At this inspection we found that the timescales on action plan submitted after the inspection in February 2017 had not been adhered to despite these assurances. After the meeting we continued to receive concerns about the service which included two allegations of potential abuse.

At this inspection we found that audits that had been undertaken since our last inspection did not contain comprehensive information on what was being audited. The audits did not contain information on what it was that was being audited, specific findings during the audit and any outcomes or actions to be taken. For example, the medication audit contained the person's name, date of audit and comments which stated 'Audited when new medication arrived'. The actions taken to improve the service were not clear. There was no infection control audit in place to identify the areas of concern we highlighted. In addition, audits undertaken continued to be ineffective in identifying shortfalls for example, in fire safety and for people who needed an air flow mattress due to risk of pressure ulceration, the settings for these were not being monitored and audited.

Staff members' training information was no longer available in the service. We were told this was removed by the previous registered manager. As mentioned in other areas of the report, staff said they had still not received training on how to support people with managing distressed behaviours or in relation to safeguarding people from abuse. The registered provider had taken no action to rectify this issue at the time of the inspection

No unannounced night spot checks had been undertaken since our inspection in February 2017. This was despite the registered provider being aware of the death in February 2017 and two allegations of abuse, which occurred at night.

Due to the poor auditing systems we could not confirm that appropriate action had been taken to identify that accidents and incidents had been reviewed or investigated. These had not been monitored or reviewed to identify any trends. The lack of monitoring meant that potential actions to prevent reoccurrence had not been identified.

These concerns continued to be breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A registered manager was no longer employed by the service. The service had recently appointed a new

home manager who will be applying to become the registered manager. 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 new home manger told us they were reviewing the auditing process for Greengates Care Home and looking to implement a more robust system.

Maintenance, electrical and property checks continued to be undertaken to ensure they were safe for people that used the service. Servicing of equipment was carried out to ensure it remained fit for purpose.

The service continued to have appropriate arrangements in place for managing emergencies. There was a contingency plan which contained information about what staff should do if an unexpected event occurred, such as loss of utilities or fire. There were arrangements in place for staff to be able to seek out of hours management support should they require it.

Staff spoke positively about the new manager in post and told us they felt able to approach them with any concerns. Comments included "I have spoken to him and I could go to him more than the previous one [manager]", "The first thing the new manager does is come and say good morning to the residents. There has been an atmosphere but now it feels like Greengates can breathe again", "The manager is brilliant, fantastic, talks to you and is very approachable", "The manager is brilliant, if I need to say something he's really listening. The provider has been really good, I spoke to him about my concerns about previous management", "I have spoken with the manager, I tend to just come in and get on with my job. I see the manger walking around, his door is always open" and "The new manager is softly spoken, he's not the type to tell you off in front of others, he's an improvement". The manager was visible around the service, frequently walking around and chatting to people and staff to see if they were alright.

The manager was aware of the concerns surrounding the service and the areas needing improvement. The provider had sent an action plan stating the service was meeting the regulations that were previously breached which was not accurate and the breaches remained unmet at this inspection. However the manager told us they had since completed their own action plan and said "I have my own ideas of how I want to improve and take the service forward". They had completed an initial action plan which they shared with CQC. This looked at how they would make the necessary improvements to meet the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The new manager was currently seeking the views of people, relatives and staff on the service provided. One staff member told us they had completed a verbal feedback survey with people and told us "People do seem happy here, I did a little survey with people and it came across very favourably". The manager had held one staff meeting since joining the service in July 2017. They had held the meeting on 10 July 2017 to introduce themselves to staff and discuss some of the concerns raised by staff.

Staff spoke openly about the changes they had experienced since the last inspection and with different managers coming and leaving the service. Comments included "I know there are things we still need to do but I feel we are going in the right direction. There has been improvements, the team are working together", "Some staff are stressed and this has an impact on your workload, it is hard because of people's high needs", "There has been some improvements, the staffing has changed a lot, some staff left and then came back, some are off on sick", "It's been nine weeks of hell, the new manager has been here two weeks and things have been put in place" and "It feels more settled, some staff have left".

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 9 HSCA RA Regulations 2014 Person-centred care<br><br>Information on people's food preferences and needs were not always recorded in a person centred way. People were not always supported in a person centred way to meet their nutritional needs. People still did not have drinks close at hand.<br><br>People's preferences were not always adhered to and they did not always receive care in a person centred way. Some people's care plans, assessments and risk assessments continued to lack important information to guide staff on how to care for people safely and in ways they preferred.<br><br>Improvements were still required to ensure people were protected from the risk of social isolation and had access to meaningful activities to support them to follow their interests. |

**The enforcement action we took:**

We served the provider with a notice to cancel their registration.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 10 HSCA RA Regulations 2014 Dignity and respect<br><br>People did not always have their dignity respected by staff and staff were not always appropriate about what they wrote about people or how they spoke about them. |

**The enforcement action we took:**

We served the provider with a notice to cancel their registration.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or | Regulation 11 HSCA RA Regulations 2014 Need for |

| | |
|---|---|
| personal care | consent<br><br>Not all people who were lacking capacity had mental capacity assessments in place and best interest decisions recorded in line with the mental capacity act. |

**The enforcement action we took:**

We served the provider with a notice to cancel their registration

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Whilst risks to people's safety continued to be assessed and regularly reviewed, some of the assessments contained contradictory information. Some risk assessments were not always person centred.<br><br>People were not always protected by the prevention and control of infection. Infection control was not being safely managed in the service.<br><br>Protocols to ensure people received their medicines as required and safely were not always in place.There were many gaps in the recording of people's prescribed topical creams.<br><br>Staff had not always received the training necessary to ensure they had the competence and skills to provide care and support to people in a safe way.<br><br>Staff were not following the guidance in people's care plans appropriately to ensure they received safe care and treatment. Monitoring charts did not reflect the identified care and support people should receive. |

**The enforcement action we took:**

We served the provider with a notice to cancel their registration

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>The service did not have robust systems in place to ensure and review the quality of care at the |

service during the night, to ensure people received safe care. Appropriate action had not been taken to identify and safeguard people from potential abuse.

**The enforcement action we took:**

We served the provider with a notice to cancel their registration.

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Whilst the provider had systems in place to monitor the quality of service to ensure improvements were identified, these were still not effective. Audits that had been undertaken since our last inspection did not contain comprehensive information on what was being audited or any outcomes or actions to be taken to ensure improvements within the service. |

**The enforcement action we took:**

We served the provider with a notice to cancel their registration.