Care Quality Commission

Leonard Cheshire Disability

Greenhill House - Care Home with Nursing Physical Disabilities

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service
Greenhill House – Care Home with Nursing Physical Disabilities is a residential care home providing personal and nursing care for up to 38 people with physical disabilities as their primary need. People also had complex needs including a learning disability, autism, mental health, acquired brain injury and life limiting health conditions. At the time of the inspection there were 38 people living at the home.

The home has three buildings. Four people lived in flats for more independence. Everyone else was in one of the two main buildings on the site. Communal spaces were available in both such as lounges and dining rooms. There were also shared bathrooms.

People's experience of using this service and what we found
People were not supported by enough staff who had the right skills or were deployed effectively to meet their needs and wishes. Medicines were not always being managed safely and people were not protected from cross-contamination. The home had not been well managed, and many shortfalls were found. The provider and new management had identified most of these already and action was being planned to rectify them.
Right Support:
People were not being supported by enough staff to maximise their choice, control and independence. Access to the community for people to receive support in line with their wishes was not in place. Support around medicines and infection control was not always safe.

Right Care:
Care plans were sometimes incomplete or had not been updated so lacked details for staff to follow to ensure consistent care was delivered. They also had not identified or mitigated all risks to people. A high level of agency staff led to people receiving inconsistent care not always in line with their needs and wishes.

Right Culture:
Staff lacked the culture, values, behaviours and attitudes to ensure people had care in line with current best practice guidance, legislation and standards. They would not correct each other or ensure the provider's values and systems were being followed.

The new management displayed a high level of transparency and placed the people at the heart of everything. Detailed action plans were in place to rectify the shortfalls so people could live confident,

inclusive and empowered lives. However, it was too early to say if this would be successful.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 13 March 2021).

Why we inspected
We received concerns in relation to staffing, risks to people and management of the home. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Greenhill House – Care Home with Nursing Physical Disabilities on our website at www.cqc.org.uk.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment including management of risks, infection control and medicine management. We also found issues with staffing and staff culture at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service well-led? The service was not always well-led. Details are in our well-led findings below.	**Requires Improvement**

Care Quality Commission

Greenhill House - Care Home with Nursing Physical Disabilities

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
Three inspectors carried out this inspection and an Expert by Experience carried out phone calls to relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Greenhill House – Care Home with Nursing Physical Disabilities is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Greenhill House – Care Home with Nursing Physical Disabilities is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager

This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. A new manager had been in post for two months and was in the process of submitting an application to register.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 11 people. 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 spoke with 18 staff including four representatives of the provider on site, the new manager, the new deputy manager and staff including nurses, care staff and auxiliary staff.

We looked at 11 care plans including associated records such as daily logs and medicine records. We observed care and support being delivered across both buildings. We looked at a range of records used to manage the service including training, policies and procedures, health and safety and other operational documents.

On the telephone we spoke with the nominated individual and 10 relatives. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also sought feedback from a range of health and social care professionals who regularly visit the home; three of them responded.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management
● Systems were not always effective to manage health and safety risks. One staff member showed us that multiple slings had not been regularly checked on their system. The manager was unable to determine whether these were all still in use.
● Environmental risks were found around the home which had not been identified or acted upon by the management. For example, bed rails placed people at risk of entrapment or injury. One person had a cover on only part of their bed rails. This meant there were exposed bars which limbs could have become trapped in. Other bed rails were in place with no covers, placing people at risk of harm or entrapment.
● People were not always being kept safe in relation to risks to their health, safety and wellbeing. Inconsistent practices were found, and reviews were overdue for some to ensure the assessments were current. Others lacked appropriate guidance for staff. For example, one person at risk of pressure ulcers had a note in the care plan about the need for a skin integrity risk assessment. There was not one completed, so the person was at risk of inconsistent and unsafe care.
● Another person was identified at risk of malnutrition. It was documented that this person should be assessed monthly. They had not been done. Other people with bed rails had risk assessments which had not been reviewed since 2018 and 2020.
● Staff were not consistently completing daily monitoring to allow risks to people to be assessed. One health professional shared concerns about how they could not effectively provide treatment in line with people's needs due to poor daily records. For example, they were unsure which investigations were required due to people's daily records having minimal recordings so they could identify patterns.

Systems were not consistently assessing, monitoring and mitigating risks to the health, safety and welfare of people placing them at risk of harm. This is a breach in Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider and new management had already put in actions to review all care plans to ensure they were consistent. They had prioritised the highest risk people.
● The provider gave assurance that they would make sure all slings were checked and safe to use.
● People at risks of seizures had plans in line with best practice for staff to follow.

Using medicines safely
● Medicines were not always managed safely. On the first day of inspection poor practice was witnessed by the inspection team. This included staff trying to administer multiple medicines at once and not witnessing medicines administered being taken. This meant there was a risk of people receiving the wrong medicine or

missing medicines. The inspection team intervened at the time and informed the manager.
● Medicines were placed at risk of damage being stored at temperatures outside of manufacturers' guidance. No records of temperatures had been made for the last seven days to ensure they were in the safe range.
● People were placed at risk of pain or agitation because clear guidance was not always in place for 'as required' medicines. One person spoke little English and had lived at the home since February 2022. No systems or guidance were in place to help them to communicate when they were in pain or to monitor their pain levels. This meant members of staff, including new and agency staff, could miss the signs that they were in pain.
● Other people who had medicines for when they became distressed or agitated lacked detailed guidance to ensure consistent, safe and appropriate administration in line with their needs. Additionally, it placed people at risk of over-medication. Medicine protocols had guidance limited to "for agitation." There was nothing to inform staff of steps to take to reduce agitation before resorting to the use of medicines.
● Systems were not effective to ensure changes in medicines were effectively communicated. One health professional had previously raised a range of concerns to the local authority safeguarding team as result of their instructions not being followed. They provided examples when people required more or less of a medicine and this had not been actioned in a timely manner. This meant people were being placed at risk of their conditions not being managed well through prescribed medication.

Systems were not in place to manage medicines placing them at risk of harm. This is a breach in Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● A new deputy manager, who was a nurse, started during the inspection to help rectify all the concerns around medicines. They had already put in a new communication system which was positively received.
● People were positive about the support they received. One person told us, "[Staff] tell me about different medicines I take."

Staffing and recruitment
● People had mixed views about the staffing levels and quality at the home. One person told us staff were, "Really brilliant." Whilst another said, "All the good staff have left and most now are agency and they do not know what they are doing." People had to sometimes wait for staff especially at busy times. In one building call bells were ringing and not being answered promptly. Staff were seen waiting for agency staff to reappear to complete a task. Other people had to wait until staff were available for their basic care. One person shared a distressing situation which occurred at night due to waiting too long for their call bell to be answered. Staff appeared to lack direction during shifts which meant staff were doing what they could when they could. Team leaders were not ensuring people's needs were being met in a timely manner and directing care staff about tasks that needed completing. Staff were found congregating in offices rather than prioritising people. Consequently, this impacted people's quality of life.
● Relatives echoed this mixed feedback. Comments included, "There seemed to be enough staff around whenever we have been there, as far as I can see", "I would say things have gone downhill. Staff are leaving and there are mainly agency staff" and, "The staffing has been very up and down."
● Staff raised concerns about the level of staff. Many complained that agency staff often do not turn up for allocated shifts. Comments included, "Some days it is great, and some days staffing is terrible. Weekends are a big issue. Most of the time agency are ineffectual" and, "Staffing has been a problem for the last two years. [Staff] have left because they have not felt appreciated. They rely on agency and you end up looking after them and doing your job."
● Records demonstrated there were shortfalls of staff levels on certain days. For example, the week ending September 2022 and beginning of October 2022. For example, in the first week of inspection one of the main

buildings only had two care staff to support up to 17 people for three out of seven days. The rotas clearly showed weekends were often below the safe staff levels we had been told. No systems had been in place to identify accurately the levels of staff required. Neither had there been consideration around skills mix, deployment and leadership of shifts. This impacted people who were not supported effectively by enough staff for them to have a quality life considering their needs and wishes.

Systems were not in place to ensure sufficient numbers of suitably competent and skilled staff were deployed at all times. This is a breach in Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The new management had already recognised this issue. They were in the process of redesigning the rota and had developed a dependency tool. Staff were being upskilled and team leaders were going to be empowered to run shifts. The provider had systems to continuously recruit permanent staff.
- People were supported by staff who had been through a recruitment to ensure they were safe. This included checks from previous employers and criminal record checks.

Preventing and controlling infection

- People were not being kept safe from the risk of infections. Throughout the inspection, staff were observed incorrectly wearing Personal Protective Equipment (PPE). One nurse was observed walking down a corridor with no mask. Staff had masks below their nose or nose and mouth. Some staff were observed removing masks to speak with people who had difficulty hearing. No alternative masks or visors had been explored. No staff were observed challenged each other for wearing PPE incorrectly.
- Staff lacked knowledge of how to correctly put on and take off PPE. They told us they had not received training since the beginning of the COVID-19 pandemic. In one part of the home, there were no prompts of the correct sequence. Aprons were not always available including in some bathrooms. Staff were seen with gloves and masks with no aprons on multiple occasions. This included walking between buildings and going into support people with intimate care. This meant there was a risk hand washing would not be completed and staff were coming into contact with bodily fluid.
- PPE was not always being disposed of safely. One red bin outside the kitchen was labelled, "main kitchen waste composting." There was discarded used face masks and gloves in it. It was so full the lid would not close.
- Cleaning was not able to fully prevent cross contamination because parts of the home were tired and had walls with scratches. Additionally, there were bedrails covers that were ripped and worn.
- Handwashing facilities were not always available to staff to reduce the risk of infections spreading. This included no handwashing basin within a food preparation area, so staff were using the main sink which is not in line with best practice around food preparation areas. Hand sanitiser dispensers had been filled with a soap packet requiring water or were found empty. A representative of the provider told us this was due to the hand gel replacements running out and assured us this had been rectified.

People were not being kept safe from infections being spread. This is a breach in Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Representatives of the provider and the manager had already identified most of the concerns around infection control and had plans in place to rectify them. During the inspection they purchased new bed rail covers.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was responding effectively to risks and signs of infection.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or

managed.
● We were assured that the provider's infection prevention and control policy was up to date.
We have also signposted the provider to resources to develop their approach.

● People were positive they could have visitors and relatives echoed this. Comments included, "We are planning a visit this Saturday", "[Person] comes home twice a month for Sunday lunch. His siblings pop into Greenhill House to see him whenever they can. Visiting is back to normal again" and, "We are back to normal visiting times."

Systems and processes to safeguard people from the risk of abuse
● People told us they were kept safe and most relatives thought their family members were. Comments included, "I very much like living here…I do feel safe", "[Person] loves living there, if you ask [them they] say[they] like it. We have no qualms about [their] safety" and, "[Person] is doing well. Safety is very good there."
● Staff were able to recognise signs of abuse and knew how to keep people safe. The manager was clear about their roles and responsibilities. They were already making referrals when required and following up open safeguarding investigations with the local authority.
● Systems were now in place to manage any allegations and examples were shown of concerns that had appropriate action. However, the new management of the home were still working through concerns from prior to them starting. The manager explained they had struggled to find the previous system. We ensured they had the information about notifications held by the Care Quality Commission.

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 MCA 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 when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was now working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met. The provider and new manager had identified shortfalls which they rectified. This included applying for any expired DoLS and creating a new monitoring system.

Learning lessons when things go wrong
● Lessons had not always been learnt when things had gone wrong. Systems had not been in place under the previous management in relation to analysis of patterns and concerns. Examples were found around medicine errors and seizure plans not being easily accessible for agency or new staff.
● The new management had already started to rectify this. For example, a system was now in place to monitor and analyse all safeguarding incidents so lessons could be learnt.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● People were not supported in a culture that was open, inclusive and empowering leading to poor quality of life. Examples were seen where staff and volunteers prioritised their own needs before people following an activity. This meant people's dignity and respect had been compromised.
● Many staff had a culture of spending time in offices rather than prioritising people. Occasions were noted throughout the inspection of multiple care staff spending time in offices rather than supporting people and their activities. No management of shifts occurred to ensure effective delegation of staff leading to quality of life for people was the priority.
● Staff lacked a culture of ensuring best practice and safe care was always followed to protect people's dignity and show respect. For example, no staff challenged others for incorrectly wearing PPE. No staff challenged others when observing poor practice of cleaning up a spill with people's clean towels rather than appropriate equipment.
● Many people spent long periods of time without interaction from members of staff. Not all staff acknowledged people when walking through areas. When people had expressed opinions or required support, some staff had not always respected this.
● People were not always supported by a culture of ensuring independence was paramount whilst respecting their differences. Examples were shared where people had lost skills since moving into the home. Other examples demonstrated a lack of understanding of people's protected characteristics.

Systems had not been in place to ensure people were treated with dignity and respect by staff due to a poor culture of accountability. This is a breach in Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The management had identified this shortfall and already had actions in place to rectify this. For example, supervision plans for all staff and members of the quality team to investigate individual concerns.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider had systems in place to manage and act on the duty of candour. The new managers were clear of their roles and responsibilities. Throughout the inspection they demonstrated their transparency when things had gone wrong.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

●Systems at the home had not always been in place to ensure the quality and safety of care for people. As a result, continuous learning and improvement had not always been prioritised. This was despite the provider having systems and oversight in place which could have been used. The provider identified the many shortfalls through their own quality improvement visit.

● Since the new management had started, they created a detailed action plan which had already highlighted most of the concerns found during the inspection. The manager and regional manager were overseeing the progress of this with the quality team checking their work.

● However, some new areas of concerns were identified such as concerns about the bed rails and how people communicated they were in pain. These have been added to the action plan and, where possible, prompt action had been taken to resolve the issues.

● The provider and management had not ensured current guidance, legislation and standards were in place at the home. For example, 'Right support, right care, right culture' was not embedded into practice for all autistic people and people with a learning disability.

● People and their relatives were positive about the new manager. One person said, "Things have been better here. The new manager is very nice and I get on well with them…They have the residents at heart. They are there for the residents not the staff they said. That says it all to them." The new manager was greeting people and clearly knew them well.

● Staff were generally positive about the new manager. Comments included, "I can definitely tell the new manager is sorting things", "I am feeling a tiny bit optimistic about the new manager" and, "I was on the fence at the beginning with [manager]. I think they have some good plans and if they stick to it the they will turn the place around."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The new manager wanted to involve people, relatives and staff of the improvements at the home. Comments included, "The new manager had a meeting recently and said things were going to be more 'hands on' in future" and, "[Manager] had a meeting with residents and relatives two weeks ago. My husband went and he was satisfied and felt more positive. They have promised more communication and getting activities up and running again."

● Staff had mixed feelings on how much they were currently being involved in the changes. Some were incredibly positive that the new manager would involve them. Whilst others were more reserved and felt communication could be better.

● The new manager was clear about their roles and responsibilities to involve others. They had already held multiple staff meetings, met with people individually and held a resident and relatives meeting. They were clear the people should be at the centre of everything whilst driving improvements.

Working in partnership with others

● The new management were developing strong links with other health and social care professionals. This included finding systems which would benefit all parties and ensure clear communication in place moving forward. One health professional was positive about steps already taken in relation to communication.

● People were not accessing the community in line with their needs and wishes. For example, people who wanted to attend religious services. People who were Deaf or blind were not having their needs met. We were told the COVID-19 pandemic had prevented lots of community links and so had recent staff levels. The new manager had plans to improve this situation.

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 Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always supported in a service that had a culture of dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not always receiving safe care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Systems were not in place to ensure sufficient numbers of suitably qualified, competent and experienced staff were deployed.