Greenroyd Residential Home Limited

Greenroyd Residential Home

Inspection report

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22 March 2017

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This unannounced inspection took place on 09, 16 and 22 March 2017.

Greenroyd is a large detached property situated in a rural location close to Morecambe and Lancaster. The home is registered to for up to twenty three people living with dementia. The home has three floors. There are three lounges and two dining rooms on the ground floor. There is a lift and stair lift for people with limited mobility. All rooms are single and have en suite facilities. Private car parking facilities are available.

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

The service was last inspected 05 November 2014. At this inspection we found the service was meeting all the fundamental standards and was rated as, 'Good.'

At this inspection visit carried out in March 2017, we found not all requirements had been met and the registered provider was not meeting all the fundamental standards.

We looked at how the service managed risk to keep people safe. We found risk was not appropriately addressed and managed. We found not all risks were identified. When risk assessments were present they were not consistently followed. We also found when risks were evident; these were not always addressed proactively. This was a breach of Regulation 12 of the Health and Social Care Act (2008) Regulated Activities, 2014 (Safe care and treatment).

People were not always protected from the risk of abuse. Staff responsible for providing care and support had knowledge of safeguarding procedures and were aware of their responsibilities for reporting any concerns. However, when people had unexplained injuries these were not reported to the local authority safeguarding team and the Care Quality Commission (CQC) for review. We identified a high number of safeguarding concerns that had not been reported to management or external bodies. This meant systems to ensure people were safe from abuse were not consistently followed. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2014 (Safeguarding service users from abuse and improper treatment).

We looked at records maintained by the service. We noted records were not always accurate and up to date. We found accident reports did not always reflect the injuries people sustained. Entries within care records contained inaccurate information and body maps which were used to highlight people's injuries were not accurate and up to date. Care records were not consistently updated when people's care needs had changed. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 (Good Governance.)

During the inspection visit we reviewed the auditing systems established and operated by the registered provider. We found that auditing systems in place were ineffective and failed to identify the concerns we identified during the inspection process. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 (Good Governance.)

Deployment of staffing did not meet the needs of the people who lived at the home. We observed people sat and waited for over an hour before their meals were served. We observed one staff member supporting two people to eat a meal at the same time. During the inspection process we found 234 incidents had been reported by staff on accident forms over a fourteen month period. Of these incidents, 177 were not witnessed by a staff member and 74 occurred during the night time. There were only two staff on duty during the night and there was no evidence to show that staffing levels had been considered and reviewed following the number of falls. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014 (Staffing).

During the inspection visit we identified nine safeguarding incidents that should have been reported to the CQC. We found 15 serious injuries had occurred at the home but these had not been reported to the CQC as required. This was a breach of Regulation 18 of the Care Quality Commission Registration Regulations 2009 (Notification of other incidents).

We found care documentation was not consistently person centred. Care plans were task focussed and did not consider providing support in an individualised way. Relatives we spoke with told us that person centred care was not always carried out. We have made a recommendation about this.

People who lived at the home and relatives said the food provided at the home was good. They told us there was plenty of choice and their nutritional and health needs were met. Systems were in place for managing people's dietary needs. We noted input from health specialists when people were at risk of malnutrition.

We looked at how medicines were managed by the service. We found good practice guidelines were followed to ensure people received their medicines safely and accurately.

People and relatives said staff were caring. We observed some caring interactions during the inspection process, however noted some interactions where dignity and person centred care was not delivered. We have made a recommendation about this.

We received mixed feedback about the provision of recreational activities at the home. Six of the seven relatives told us they were happy with activities provided. On the days of the inspection visits we observed activities taking place at the home. Staff told us they sometimes changed activities to meet people's needs.

Staff had a sound understanding of the Mental Capacity Act 2005 (MCA) and the relevance to their work. Mental capacity was routinely assessed and good practice guidelines were referred to when a person lacked capacity. We saw evidence of robust processes being followed to ensure people were only deprived of their liberty lawfully.

Staff praised the variety of training on offer and said they felt supported within their role. They told us they could make requests for training when they felt they required additional support and guidance and action was always taken to meet their training needs.

Suitable recruitment procedures were implemented which meant staff were correctly checked before starting employment.

Systems were in place to seek feedback from people who lived at the home, staff and relatives as a means to develop and improve service delivery. We noted there was a low response rate and discussed the reasons as to why this might be with the registered manager.

We received mixed feedback about the responsiveness of the management team to making improvements. Two relatives said they had made suggestions for improvement but no action had been taken. We discussed this with the registered manager at feedback.

The registered provider had a system for managing complaints. Relatives told us they were confident they could raise complaints and concerns and felt they would be listened to. Relatives said the management team was approachable and they were confident if they had any concerns action would be taken.

Staff were positive about ways in which the service was managed and the support received from the management team. They described a positive working environment.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

You can see what action we have asked the registered provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not always safe.

People who lived at the home and relatives told us people were safe we found evidence however to suggest otherwise.

Staff were aware of their responsibilities in responding to abuse. However procedures were not followed to ensure safeguarding concerns were reported to external bodies.

Appropriate numbers of suitably qualified staff were not deployed to meet the needs of people who lived at the home.

Risk was not addressed and managed consistently within the home.

The service had suitable recruitment procedures to assess the suitability of staff.

Suitable arrangements were in place for management of all medicines.

Is the service effective?

Requires Improvement

The service was sometimes effective.

People's health needs were monitored and advice was sometimes sought from other health professionals, where appropriate.

People who lived at the home praised the food on offer. Nutritional and health needs were met by the service. However, good practice guidelines were not consistently followed to enhance the dining experience for people.

Staff had access to ongoing training to meet the individual needs of people they supported.

Staff had an understanding of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and the

relevance to their work.

Is the service caring?

Requires Improvement

The service was sometimes caring.

There was an emphasis on task focussed care. Personalised care was not always delivered.

Dignity was not consistently promoted throughout the service.

People who lived at the home described staff as kind and caring.

Is the service responsive?

Requires Improvement

The service was sometimes responsive.

People's care records were kept under review and staff sometimes responded when people's needs changed.

Care plans focussed upon task orientated care and did not always incorporate peoples preferred needs and wishes.

The service had a complaints system that ensured all complaints were addressed and investigated in a timely manner.

Is the service well-led?

Inadequate

The service was not well led.

Processes for reporting statutory notifications were inconsistently followed.

The service had implemented an auditing system but this was not fully operational or effective and did not appropriately manage risk. Risk was managed reactively rather than proactively.

There was poor oversight of the service. Procedures for responding to safeguarding concerns were ineffective.

Staff described a positive working environment where they felt supported by the management team.

Greenroyd Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place over three days on 09, 16 and 22 March 2017. The first and last day of the inspection visits were unannounced.

On the first day, the inspection was carried out by two adult social care inspectors. One adult social care inspector visited alone on the second and third day to complete the inspection visit.

Prior to the inspection taking place, information from a variety of sources was gathered and analysed. We spoke with the Local Authority contracts and safeguarding teams as well as the Clinical Commissioning Groups responsible for commissioning care. We did this to check if they had any concerns. We were made aware the local authority safeguarding team was in the process of investigating safeguarding concerns raised about the service.

We reviewed information held upon our database in regards to the service. This included notifications submitted by the registered provider relating to incidents, accidents, health and safety and safeguarding concerns which affect the health and wellbeing of people.

Information was gathered from a variety of sources throughout the inspection process. We spoke with ten members of staff. This included the registered manager, the care manager, the chef, and seven members of staff who provided direct care.

We spoke with five people who lived at the home to seek their opinion of the service. Because people were

living with dementia we received limited feedback. We therefore carried out a SOFI (short observational framework for inspection.) This allowed us to try and understand what people were experiencing through observations. In addition, we spoke with seven relatives to obtain their views about service provision.

To gather information, we looked at a variety of records. This included care plan files relating to nine people who lived at the home. We also looked at medicine administration records relating to people who received support from staff to administer their medicines.

We viewed recruitment files belonging to three staff members and other documentation which was relevant to the management of the service. This included health and safety certification, training records, team meeting minutes, accidents and incidents records and findings from monthly audits.

We looked around the home in both communal and private areas to assess the environment to ensure it met the needs of people who lived there.

Inadequate

Is the service safe?

Our findings

People who lived at the home and relatives told us people were safe whilst residing at Greenroyd Residential Home. Feedback included, "My [relative] is safe here." And, "It's nice to live here. They do look after you."

Although people and relatives told us people were safe, we found evidence this was not always the case. At this inspection visit we looked at how safeguarding procedures were managed by the service. We did this to ensure people were protected from any harm. Staff told us they had received safeguarding training and were confident they could identify and report abuse. When asked staff could describe different forms of abuse and said they would report any concerns to management. One staff member said, "I would report it straight away to the manager."

Although staff told us they were confident in identifying and reporting abuse we found processes had not been followed to raise awareness of concerns. During the inspection visit we looked at recorded incidents that had occurred at the home. From the completed records we viewed we identified nine incidents where people had been found in communal areas with unexplained injuries. Staff had reported these in care records as unwitnessed falls but no one had seen the incidents occurring and how the injury had happened.

We spoke with the registered manager about these and asked how they could be certain the injuries had been sustained as a result of an unwitnessed fall. They could not give assurances these incidents had occurred as a result of a fall or that these incidents had been investigated to look for the cause of injury.

We discussed identifying and responding to abuse with the registered manager at feedback and they acknowledged that incidents should have been reported to the Local Authority safeguarding team and the CQC.

This was a breach of Regulation 13 of the Health and Social Care Act 2008, (Regulated Activities) 2014 (Safeguarding service users from abuse and improper treatment) as systems were not implemented and followed to ensure people were protected from abuse and harm.

We looked at how the service addressed and managed risk. There was a variety of risk assessments to review and manage risk. These included risk assessments for management of pressure ulcers, falls and malnutrition.

We looked at assessment procedures for managing people at risk of harm from falling. We noted required actions were not consistently followed as specified upon the risk assessment tool. The falls risk assessment stated if a person had more than three falls in one week they were to be referred to the falls prevention officer. We identified six people who had fallen three times in a period of one week. We asked the registered manager if any people had been referred to the falls prevention team as indicated on the risk assessment. The falls prevention team are a team of professionals who work with people defined as 'at risk of falling' to minimise risk of people falling. The registered manager told us no referrals had been made as people who lived at the home did not fit the criteria set by the falls team. We looked at multi-disciplinary team meeting

notes and noted there had been some referrals to physiotherapists and doctors for advice and guidance to manage the risk but this had not been consistently applied to all people who had repeatedly fallen.

We noted one person had been repeatedly found on the floor by their bed at night times. We noted there was no evidence to suggest their care plan and risk assessment had been reviewed to take these falls into consideration. We spoke to the registered manager about systems to manage the risk of people falling from bed. The registered manager told us they did not use bedrails due to associated risks including entrapment and increased falls from height.

Whilst walking around the home we observed one person being nursed in bed with bedrails. The registered manager said staff were not supposed to use these and that a mat was used to protect the person from harm from falling. We asked a member of the management team about the usage of bedrails for clarification. They told us bedrails were in place for three people who lived at the home. We looked at the care records for two of these people and noted there were no risk assessments for the safe usage of bedrails.

This was a breach of Regulation 12 of the Health and Social Care Act 2008, (Regulated Activities) 2014 (Safe care and treatment) as the registered provider had failed to ensure risks were appropriately addressed to mitigate and manage risk.

We spoke with people who lived at the home and relatives about staffing levels. People told us they were happy with current staffing levels and were confident they met their needs. Feedback included, "I think the staffing levels are reasonable. There is usually someone around if needed." And, "If I need to find someone (member of staff) I can find someone fairly quickly."

We asked staff their opinion on staffing levels. They told us the number of people who lived at the home had recently decreased. They said current staffing levels allowed them to comfortably carry out their tasks. During the inspection visits we noted the morning shift staff were not rushed and had time to meet people's needs in a timely manner. We checked response times to emergency bells and found staff responded within a minute of the bell sounding.

Although we received positive feedback in regards to staffing levels we found deployment of staffing was not always consistent to meet people's needs. On the afternoon of the second day of the inspection visit one person asked to go to the bathroom. We had to seek assistance from a staff member as there was no one present in the communal area. It took one staff member eleven minutes before they could find another staff member to help them assist the person to the bathroom.

Analysis of completed accident reports evidenced that staff had found people in bedrooms upon the floor or with unexplained injuries 74 times in a fourteen month period. We looked at staff rotas and noted two staff were employed to meet the needs of people who lived at the home during the night shift. Staff confirmed staffing levels at night never increased to more than two staff.

The registered manager said staffing levels at night met individual need as they were supported by assistive technology to monitor people and alert them when people required assistance. They told us people had monitoring systems within their bedrooms to track movement. Any movement triggered the alarm system which alerted staff to respond. We were informed there were six pieces of equipment within the home to manage this. This meant that not all people's movement could be monitored if so required and staff could not be effectively deployed at all times during the night.

We noted one person's care plan stated the person was to be monitored when in communal areas. We identified the person had experienced fifteen incidents in communal areas that were unwitnessed. This demonstrated staff were not always effectively deployed to ensure the person was monitored as stated within the care plan. We discussed this with the registered manager. They said they could not provide constant over-sight for this person as they were not funded to do so. This was not clear within the care plan.

We observed staffing over meal times. On the first day of the inspection visit two people were sat in the dining area for over an hour before their lunchtime meals were served. The registered manager said one of these people was independently mobile and could have moved from the area if they wished. We noted the other person required support to mobilise. We observed another member of staff returning one person's meal to the kitchen for reheating as it had gone cold before the staff member could support the person with the meal.

On the second inspection visit we noted one staff member was deployed to one dining area where six people were eating. Two people required some support with eating and drinking. We observed the member of staff sat between the two people supporting them both at the same time to eat and drink. We observed one person bending over towards the staff member with their mouth open, waiting for some food whilst the staff member had turned their back to support the other person. On one occasion the member of staff had to leave the dining area to get a drink for another person as the person was repeatedly shouting for refreshment.

We spoke with the registered manager about staffing levels. They told us staffing levels were reviewed and adjusted to meet the needs of people who lived at the home. There was no evidence to show that staffing levels had been considered and reviewed despite the registered manager being aware there was a high number of accidents and incidents during the night. The registered manager said they were in the process of trying to identify a staffing dependency tool to ensure people's needs were met.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014 (Staffing) as the registered provider had failed to ensure staff were effectively deployed at all times.

As part of the inspection visit we undertook a visual inspection of the home. During the walk around we found two communal bathrooms were in poor state of repair. One bathroom ceiling had water damage stains on the ceiling and bathroom worktops had pealed, making them difficult to clean. We spoke to the registered manager about these conditions and they advised the senior management team had already identified the bathrooms as in need of refurbishment. We saw minutes of a senior management meeting which confirmed this was in hand.

Whilst walking around the home we noted there was a stair case which was accessible to people who lived at the home. This was not alarmed but secured with a gate at the top. At the previous inspection visit we had made a recommendation that the registered manager reviewed the gate for security. The registered manager said they had consulted with the fire and rescue service and were unable to secure the gate as it was a fire exit. They had however fitted the gate with a spring so the gate would automatically spring back across the top of the stairs when not in use.

Whilst reviewing accidents and incidents we found there had been two incidents where people had been found with injuries at the bottom of the stairs. We asked the registered manager what systems were in place for managing risk of people falling on the stairs. They told us they did not have a written risk assessment for these and they risk assessed people on an individual basis and if people were at risk of falls they would try to offer a downstairs room. We spoke to one relative whose family member had fallen down the stairs. They

confirmed they had been consulted with regarding the management of the risk associated with their family member using the stairs. Following the inspection visit we made a referral to the Local Authority Health and Safety team for further guidance.

During the walk around the home we noted strong malodours in communal living areas. We spoke to the registered manager about this. They told us the carpet cleaner owned by the home had been problematic and they were looking at purchasing a new one. They said they were also in the process of replacing chairs in the communal areas. They told us the cleaner carried out a schedule of works to try and maintain the odours. We saw evidence a cleaning audit carried was carried out by a senior on duty each day. The registered manager said they oversaw this but did not document when they had completed audits.

We found good practice guidelines to address infection control were not consistently applied. For example, communal towels were stored in bathrooms and paper towels were not available for handwashing. On one occasion we observed a member of staff handling dirty laundry without wearing gloves. Following the inspection visit we made a referral to the Local Authority infection prevention and control team to request a visit to the home to review infection control processes.

We looked at the arrangements for the management of medicines. We watched a senior carer giving people their medicines. They followed safe practices and treated people respectfully. We looked at systems for managing controlled drugs. Staff knew the required procedures for managing controlled drugs and records were appropriately maintained.

Medicines kept at the home were stored safely. Appropriate checks had taken place on the storage, disposal and receipt of medicines. This included daily checks carried out on the temperature of the rooms and refrigerators which stored medicines.

Staff told us they could not administer medicines without being trained. All staff trained to administer medicines undertook regular competency tests. Staff told us only one staff member per shift was allocated the task of administering medicines. This was to promote consistency and prevent any medicines errors from occurring.

We looked at recruitment procedures to ensure people were supported by suitably qualified and experienced staff. To do this we reviewed three staff files. Full employment checks were carried out prior to staff starting work. The service kept records for each person employed. Two references were sought and stored on file prior to an individual commencing work. One of which was the last employer. When gaps in employment history were present on application forms, these had been discussed and been explored with each applicant.

The service requested a Disclosure and Barring Service (DBS) certificate for each member of staff prior to them commencing work. A valid DBS check is a statutory requirement for people providing a personal care service supporting vulnerable people. The service checked this documentation prior to confirming a person's employment. Staff told us they could not start work without a valid DBS certificate.

We also looked at documentation relating to the health and safety of the home. We noted all required certification was up to date, regular maintenance checks took place and comprehensive records were maintained.

Requires Improvement

Is the service effective?

Our findings

People who lived at the home and their relatives told us they received effective care. Feedback included, "[Relative] has improved since moving here." And, "[Relative] is well cared for here." And, "As far as I am aware my [relative] gets to see a doctor when they need one."

We looked at how the service met people's dietary needs. We spoke with four people who lived at the home about the food provided. All four people were satisfied with the quality and range of food. Feedback included, "The food is alright. There's enough for me." And, "The cake is good."

We spoke with the chef. They told us food was delivered to the home on a weekly basis and all meals were prepared from fresh. They said part of their role was to make home-made cakes which were provided as snacks twice a day in between meals. They said the menu was based upon traditional home-made foods and said they were designed in consultation with the registered manager and from feedback from staff.

On the first day of the inspection visit we noted meals were blended for four people who lived at the home. We asked a senior manager about people's requirements and they told us meals were blended for some people who had difficulties chewing meat because they chose not to wear dentures. We saw this was consistent with their care records.

People who required special diets had this detailed within the care records. For example, we saw when people had diabetes and restricted diets. Dietary information was shared with the chef. We noted when people were at risk of malnutrition systems were implemented to promote weight gain.

We observed meal times at the home. We did this to understand the experiences of people who lived at the home. Tablecloths were placed on the table prior to people eating a meal. We noted there were no condiments placed upon the table for people to access. The registered manager told us these had been removed following several incidents at meal times which had resulted in meals being spoiled. There were no drinks available on tables at mealtimes. We observed three people asking for drinks with their meals. We spoke with the registered manager about this. They told us they had stopped placing drinks on the table at meal times as people often poured their drinks onto their meals. Following feedback the registered manager said they were going to review systems to look at means of making drinks available to people at mealtimes.

We recommend the service reviews and implements good practice guidelines to enhance the experience of meal times for people who live at the home.

During the inspection visit carried out in November 2014, we made a recommendation that the environment in which people were living was reviewed to make it more dementia friendly. Whilst walking around the home we found signs had been placed on people's bedrooms door and bathrooms to highlight these rooms to people. We found signs of bedrooms were universal. There were no photographs on doors of people which would act as visual prompts to remind people that was their room. We did not see any other improvements to make the home more dementia friendly. For example, bathroom toilets were not fitted

with contrasting seats to make them standout.

We recommend the service consults with and implements good practice guidelines in relation to dementia friendly environments.

We asked staff how they supported people to maintain good health. Staff said they monitored the health of people and would seek advice and guidance from the registered manager if they were concerned. On the second day of the inspection visit we overheard the registered manager speaking with a family member of a person who had recently been admitted to the home. The registered manager offered the relative the opportunity to register their family member with a local optician and dentist that visited the home on a frequent basis. This showed us there was a framework in place to manage people's health care needs.

Individual care records showed health care needs were sometimes monitored and action taken to ensure health was maintained. We saw evidence of partnership working with the speech and language team, dieticians and general practitioners.

We spoke to a health professional who was visiting the home. They told us they had no concerns with the standards of care delivered at the home. They said recent recommendations to improve care had been taken on board by the management team and routinely implemented at the home.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). During the inspection visit we noted the home was kept secure at all times with secure access. The registered manager said because of these restrictions DoLS applications had been submitted for all people who lived at the home. We saw evidence these had been completed.

We looked at care records and found the service acted lawfully when supporting people to make decisions. We noted when people did not have capacity and decisions were to be made good practice guidance was consistently followed.

We spoke with staff to assess their working knowledge of the MCA. Staff we spoke with were aware of the need to consider capacity and what to do when people lacked capacity. One staff member said, "We have had the training and it was very good. It made me think differently."

Relatives told us they thought staff were appropriately trained to meet the needs of the people who lived at the home. One relative said, "I have no known reason as to why I would think they aren't trained."

We looked at staff training to check staff were given the opportunity to develop skills to enable them to give effective care. The registered manager maintained a training matrix to document the training needs of staff. They told us training was planned on an annual basis and was developed in conjunction with staff's annual appraisals.

Staff praised the training opportunities made available by the registered manager. Feedback included, "We have training for everything. They are good for offering training." And, "The training is good we have in house training and other courses are available." Staff told us training was flexible and tailored to meet the needs of people who lived at the home. For example, one person moved into the home with a stoma, so the registered manager arranged for stoma training for all staff.

We spoke with two members of staff who had been recently employed to work within the service. They told us they undertook an induction period at the commencement of their employment. They said this included shadowing more senior members of staff at the start of their employment. This allowed them to develop their skills and confidence before working unsupervised. One staff member said, "My induction was great. I was showed everything and was signed up for training."

We spoke with staff about supervision. Supervision is a one to one meeting between the staff member and a senior member of the staff team to discuss any concerns and training needs. Staff confirmed they received regular supervision. They said managers were approachable and they were not afraid to discuss any concerns they may have in between supervisions.

Requires Improvement

Is the service caring?

Our findings

We received positive feedback about the caring nature of staff who worked at Greenroyd Residential home. Feedback included, "The care is good. The staff are wonderful." And, "They [The staff] look after you here. They don't bother you." And, "It's brilliant here. The staff are very caring"

As part of the inspection process we looked at how dignity in care was promoted for people who lived at the home. The registered manager showed us a display on the main entrance wall. The display was created to celebrate dignity day and included person centred information about each person who lived at the home. We spoke to the care manager who was a dignity champion at the home they said, "Staff sometimes get caught up in task focussed care. They forget to see the person. This display is meant to encourage staff to see the person and promote dignity."

Although we were shown pieces of work to promote dignity of people, we noted dignity was not consistently addressed within the home. On the first day of inspection we noted one person was in the dining area eating their breakfast cereal using their hands. Two members of staff were in the room at the time. We discussed this with the registered manager and they told us this was the person's expressed preference. We looked in the person's care records and noted there was no reference in the care records to the person choosing to eat foods with fingers.

We spoke with the care manager about delivering person centred care. They told us they promoted person centred care by encouraging staff to see the people as individuals. They gave an example where they had identified staff calling a person by a shortened version of their name. They said they had highlighted the importance to staff about calling the person by their preferred name and not the shortened version. Whilst on the inspection visit we overheard staff on two occasions calling the person by the shortened version of their name. We highlighted this to the care manager who said this was unacceptable.

We asked relatives about the standard of care provided at the home. Two relatives told us that individualised care was not always delivered. One relative said, "Staff do a really good job. But they just don't always see the person." Another family member said, "Sometimes staff aren't as attentive as they could be." They told us they often found their family member wearing the wrong glasses. They told us they had raised this with staff but they still found their relative wearing incorrect glasses. We looked at the care plan for this person and noted there was no reference to the correct glasses for the person.

We viewed minutes from a recent team meeting. One relative had attended the team meeting to discuss with staff what it was like being a relative visiting their family member at the home. They spoke about their routines and rituals they shared with their family member prior to their family member moving into the home and how it was important to them as a family unit these rituals continued. The registered manager said they have invited the relative along to increase empathy between staff as a means to improve the service delivered. We spoke to the relative as part of the inspection visit. They told us that since they had provided the talk, staff sometimes showed more empathy and understanding but this was not consistent.

We observed some positive interactions taking place between staff and people who lived at the home. We observed staff offering reassurance to a person when they looked startled. The staff member told the person they were fine and not to panic. They stroked the person's arm and quietly reassured them until the person looked relaxed once again.

We heard another staff member making a person comfortable in the bathroom. The member of staff respected the person's privacy and left them in the bathroom when they were comfortable. The staff member reminded the person there was a call bell at their side which could be pressed if they needed assistance. They did this to make the person feel comfortable and safe.

We observed staff making small talk with people. One staff member was telling a person about the job they did before they became a carer. This helped promote communication. Another person was communicating with a member of staff but could not always find the correct words. The staff member was patient and tried to pre-empt what the person was requesting. Staff allowed the person to finish talking and did not interrupt conversation.

Staff told us they hoped to make the home as welcoming as possible for people and their visitors. One staff member said, "We are working in people's homes. Relatives can visit whenever is convenient for them. It's an open house."

Other visitors we spoke with commended the ways in which they were welcomed at the home. One person said, "We can visit when we like. We turn up unannounced and we are always welcomed. [Relative] always looks clean and tidy whenever we turn up." Another relative told us the home had gone to extra lengths to accommodate a family member who visited the home. They told us the staff set up a table in the person's bedroom and served the two people lunch in the privacy of their own room. They said, "The home is by and large very flexible."

We observed visitors at the home and noted they were able to access communal areas and family member's bedrooms. Visitors looked at ease at the home. One relative praised the attitudes and personalities of the staff they said, "They [the staff] are so accommodating with everything. You only need to ask the staff and they are there for you."

Staff told us they had recently lost a number of people who lived at the home through ill health. Staff spoke fondly of people when remembering them. One staff member said, "It's hard not to get attached. I cry when people pass away."

Requires Improvement

Is the service responsive?

Our findings

We asked relatives of people who lived at the home if they felt the service responded to people's needs. Two of the relatives we spoke with told us they had asked for changes to be made at the home and said the management had promised to take action. One relative told us they had asked for Wi-Fi to be available in bedrooms so they could use technology to communicate with family but this had not happened. Another family member said they had asked for a picture of all staff to be placed in the hall so staff could be identified by name. They told us, "Sometimes they need a shove to get things done. They told us a board would be up in November but it still hasn't been done."

People we spoke with said they had no complaints about current service provision. Feedback included, "I have no complaints." And, "No, I have no complaints. It's alright here."

Relatives we spoke with told us they had no complaints at present. They told us they were aware of their rights and how to complain. Two relatives told us they had raised concerns in the past with the registered manager and they had dealt with their concerns appropriately. Feedback included, "If I had any concerns I wouldn't hesitate in discussing them." And, "I have no formal complaints. I have been vocal in meetings though and I have been listened to."

Staff told us they were aware of the complaints procedure and would inform a member of the senior management team if people complained. The registered manager kept a record of complaints made and they reviewed this on a regular basis to ensure action had been taken.

We looked at care records belonging to nine people who lived at the home. Care plans addressed a number of topics including personal care, diet and nutrition needs and personal safety. Care plans detailed people's own abilities as a means to promote independence. Relatives told us they were consulted when their family members care needs changed.

Of the care records we reviewed, we found person centred information was collected about people at pre-admission. However, this information was not consistently referred to within people's care plans. Care plans focussed upon task orientated care and did not always highlight people's preferences. For example, care plans did not highlight people's preferred times for going to bed and other preferred choices.

We recommend the service refers to and implements good practice guidelines to ensure person centred care is implemented within care planning records and care delivery.

We asked people who lived at the home about the variety of activities on offer. People were unable to tell us if any activities took place. During our inspection visit we observed some activities occurring. On the first day of inspection we overheard people singing to music. On the second day we saw people singing along and playing with a hat. We also saw one person was sat with a pack of dominoes. They said they had just been playing them with a member of staff. They told us, "It's the first time I've played them since I moved in here. It's something to do."

The home had an allocated activities coordinator. They told us they were employed as a care worker and the role of activities coordinator was an extra responsibility they had taken on. They were not allocated any extra hours to carry out their role. We noted a pictorial noticeboard was on display outside a lounge area to show people what activities were on offer for the on-coming two weeks. The registered manager told us they showed two weeks as this had been suggested by a relative so that relatives could plan visits around activities. We noted activities such as singing; pamper days and films nights were displayed on the planner.

We spoke to relatives about the activities on offer. Relatives told us activities took place. Feedback included, "I think they have had activities on." And, "They keep people motivated. They play bingo and families are encouraged to join in." And, "They have recently had a piper in for Burns night. "

Although we were told activities took place we were told the activities planner did not always reflect what occurred. One relative said, "We have visited and some of the set activities haven't always been on." We discussed this with a member of staff; they said they sometimes had to tailor activities to how people were feeling on the day. They said if people were sleepy they did not always want to take part in physical activity but would sometimes respond positively to music and singing.

Inadequate

Is the service well-led?

Our findings

Two relatives we spoke with told us there had been a decline in the standard of service provided since the registered manager purchased a second home. One relative said, "Things have changed over the last couple of years. The home isn't as good as it was." Another said, "Things changed about a year ago. It was missing something when [registered manager] wasn't here."

During the inspection process we identified nine safeguarding incidents should have been reported to CQC. We also identified fifteen serious injuries that had occurred over a fourteen month period which had not been reported to CQC. We raised our concerns with the registered manager. They said they were not fully aware of the reporting of safeguarding concerns and serious injury protocols.

Following the inspection visit we checked our information system which confirmed none of the highlighted incidents had been reported to the commission. This was a breach of Regulation 18 of the Registration Regulations 2009 (notification of other incidents) as the registered provider had failed to notify the commission of all required notifications.

During the inspection visit we reviewed the quality and accuracy of the documentation maintained by the service. We found inconsistencies in the quality of the record keeping maintained. For example, accidents and incidents records did not always contain accurate and up to date information. One person had fallen and the accident report stated the person had no apparent injuries but care records indicated the person had been taken to hospital where a fracture was identified. Another person's records stated the person had a 'gash to the head' when investigated by the care manager staff told them the person acquired a graze.

Care records were sometimes inaccurate and unclear. For example, we looked at recording of weights for one person. Staff had no guidance as to whether or not the recording should be in imperial or metric. Weights were therefore recorded in both. This made the information difficult to track. One staff member had misread the information and when reviewing the person's assessment stated the person had lost a significant amount of weight. Weight records showed this was not the case. Body maps maintained by the service to document people's injuries were not always complete and updated. For example, one person's body map indicated the person had a red mark on their body. This had not been updated when the person acquired a pressure wound on the site.

Care plans did not always provide staff with clear direction. For example, one person's care records stated that staff were to monitor the person. There was no indication as to how often they were to monitor the person and by what means. Another person had recently had a fall at the home and on advice from health professionals had put systems in place to keep the person safe. We noted the care plan however did not reflect the new procedures.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 (Good governance) as the registered provider had failed to ensure records maintained were accurate.

We spoke with the registered manager about audits. They showed us an auditing system that ran on an annual basis. The audit including medicines, hot water checks and competency checks of staff. It did not include auditing of accidents and incidents and care records.

We asked the registered manager about processes for auditing and reviewing care records. They told us they reviewed care records on a regular basis but they did not document this. We spoke with a member of staff responsible for updating records they confirmed the registered manager checked files for accuracy. This auditing system was ineffective however as there no evidence to show action was had been taken to remedy the concerns we identified within the quality and accuracy of paperwork.

During the inspection process we identified concerns at the numbers of accidents and incidents that had taken place at the home. We asked the registered manager what audits had taken place to review the incidents. They told us the care manager reviewed accidents and ensured they were documented in individual fall logs. We saw evidence this had occurred. There was no evidence however to show these accidents had been reviewed and processes put in place to reduce the risk of accidents occurring. This placed people at risk of harm and ineffective care.

Risks we identified during the inspection process had not been identified by the registered manager and improvements had not been implemented to improve outcomes for people who lived at the home. For example, despite there being a high number of people identified at risk of falls and evidence people were falling there was no up to date procedure to show how falls were to be suitably managed by the registered manager. Nor was there any reference to good practice guidelines for management of the risk. This meant improvement had not been considered and implemented to improve outcomes for people who lived at the home.

We found safeguarding protocols at the home were unclear and the registered manager was not fully aware of their responsibilities for reporting safeguarding concerns. Policies for managing safeguarding concerns had not been followed by the registered manager. There was a lack of transparency for reporting incidents. This meant that safeguarding concerns had not been dealt with objectively.

This was a breach of Regulation 17 of the Health and Social Care Act 2008, (Regulated Activities) 2014 (Good governance) as effective systems were not in place to ensure the safe care and treatment of people who lived at the home.

We found the vision and values of the senior management team were not always shared with staff and consistently followed. For example, staff had received training in providing person centred care but we identified short falls in staff providing this.

Although we found failings in the way the home was managed, we received positive feedback from relatives. Three relatives we spoke with told us the home was well managed. They said "The home is marvellous." And, "The managers are always asking if we are okay." And, "We are very impressed with [care manager.]"

Staff described a positive working culture, where teamwork was good and staff turnover was low. One staff member said, "The teamwork is good. We are a good team." Staff praised the responsiveness of the senior management team and said they were approachable. One staff member said, "[Registered manager] is a good boss."

Staff told us they had the opportunity to talk with other staff and the management through regular handovers and team meetings. Staff said they could raise any issues with the senior management team

whenever they wished. We observed this happening during our inspection visits. One staff member said, "[Registered manager] listens." A further two members of staff praised the caring nature of the registered manager and described them as supportive.

We asked the registered manager how they engaged with people to ensure they were receiving a quality service. They told us they sent out annual surveys to staff and relatives for feedback. Staff questionnaires were sent out every January before staff had their appraisals. The registered manager said they used information returned through appraisals to discuss any concerns raised. They said they looked at trends and themes. We reviewed these questionnaires and noted feedback was predominantly positive.

We asked about completed relatives surveys. The registered manager said they had been sent out this year but none had been returned. We asked the registered manager why they thought the response rate had been so low. They said this was partly due to the fact relatives were happy with the service and they spoke to relatives on a regular basis when they visited. We reviewed feedback from 2016 which was positive.

We looked at recorded compliments the service had recently received. Feedback included, "Thank you so much for the care and kindness you have shown [relative] and me." And, "We would like to thank you for all the heartfelt warmth towards us and the love and care."