Mrs Brenda Clark

Greenways Care Home

Inspection report

6-8 Victoria Road
Southwick
Brighton
East Sussex
BN42 4DH

Tel: 01273591573

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Greenways Care Home is a residential care home providing personal and nursing care to 14 people aged 65 and over at the time of the inspection. The service can support up to 15 people.

People's experience of using this service and what we found
There was no effective system in place to monitor the quality of the service. We identified seven breaches of regulation; these shortfalls had not been identified by the provider. There was no system in place to monitor the quality and safety of the environment or the care provided. We identified numerous maintenance issues, many of which had been reported, which had not been rectified.

People told us they felt safe at the service. However, people were not always protected from risks. People's individual risks had not always been fully assessed. Thorough recruitment checks had not always been carried out and documented which posed a risk of employing unsuitable staff. Safeguarding procedures had not always been followed to ensure people were protected from the risk of abuse.

Medicines were not always managed safely, there was no guidance in place for 'as required' medicines. However, spot checks had identified poor medicines administration on one occasion and action had been taken to prevent recurrence.

The decoration and some of the fabric of the building was in poor condition. Due to the poor quality of ensuite floors and poor maintenance not all areas could be thoroughly cleaned, putting people at risk of infection. There were insufficient measures in place to protect people from the risk of burns and scalds. People were unable to adjust the temperature of their rooms. Radiators had makeshift covers constructed of a variety of different materials. These were poorly fitted and in some cases, hanging off. A number of maintenance tasks at the service had been reported several months ago and were still unattended to.

People did not always receive individualised care which met their needs and preferences. For example, people had a 'bath day' each week. People could not always choose when to have a bath and there was no shower available. People's care plans did not always contain sufficient information about the care and support they required. There were no completed plans in place to support people at the end of their lives.

People were not supported to have any community links. People told us they were sometimes bored and would like to go out, however they were not able to unless they had relatives to take them out. People told us they were not allowed to go out. They said they had been told it was not safe; however, none of these people had legal restrictions on their liberty in place.
People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

The poor condition of the service did not promote people's dignity. However, people told us staff were kind.

Staff were respectful and warm when they spoke about people. We observed kind and caring interactions. People were very positive about the food, there was a good system in place to identify people's preferences and any specific foods they should avoid. People were supported to be independent in their personal care and mobility.

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

The last rating for this service was Good (published March 2017).

This was a planned inspection based on the previous rating.

Enforcement
We have identified breaches in relation to individualised care, safe care and treatment, safeguarding, staff recruitment, cleanliness and quality of the environment and the management of the service 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 for 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not effective.

Details are in our effective findings below.

Inadequate

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-Led findings below.

Inadequate

Greenways Care Home

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 Care Act 2014.

Inspection team
The team consisted of one inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Greenways is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with 11 people who used the service and three relatives about their experience of the care

provided. We spoke with 11 members of staff including the provider who was also the registered manager, senior care workers, the cleaner and care workers and the cook who was the deputy manager.

We reviewed a range of records. This included four people's care records and multiple medication records. We looked at four files in relation to recruitment and staff supervision. A variety of records relating to the management of the service were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at staff rotas. The provider sent evidence of work carried out to make water temperatures safe.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm. At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- Risks were not always assessed, and people were not always protected from avoidable harm. The provider had not always identified and mitigated environmental risks. People were at risk of scalds as hot water from the taps exceeded the recommended safe temperature of 43 Celsius in all 14 of the taps we checked. There were no records to demonstrate the temperature of hot water had ever been checked.
- People were at risk of burns from uncovered radiators. Whilst radiators had been covered with makeshift covers some of these were loose, had fallen off, or did not cover radiators completely. Radiators exceeded the safe surface temperature of 43 degrees and were at a temperature of 50 Celsius and did not have any controls to turn them down.
- People's individual risks were not always recorded accurately. For example, one person living with dementia had left the building twice and been found by members of the public. The risk assessment in place did not include the information that this had happened twice. The person's care records had not been updated to reflect they had left the service a second time to ensure staff knew how to keep the person safe.

The provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Some risks had been identified and managed. For example, there were plans in place to prevent one person from smoking in their bedroom.
- People told us they felt safe, "Yes I do feel safe here. I know I am safe because I sleep well at night and if I didn't feel safe, I wouldn't sleep. ", and, "Oh yes, I feel safe because the staff are so kind. I have no concerns or problems." A relative told us, ""I feel overall [Name]is safe."

Using medicines safely

- Medicines were not always managed safely. Some people had been prescribed additional medicines on a 'as required' (PRN) basis. There were no protocols in place to inform staff when these medicines were required and information about the safe administration of these medicines for the person concerned. One person had received one medicine daily rather than 'as required'. There was no guidance on medicine administration records (MARs) to guide staff about this. The provider had not contacted the GP about this.
- One person had their MAR signed to evidence a person had received their medicine twice daily, however it was prescribed once daily. A senior staff member checked the medicines and advised this was a recording error.

We found no evidence that people had been harmed however the provider had failed to manage medicines safely. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

● There was good practice regarding the application of creams. Body maps were in place and staff signed to say these had been applied. Medicines were stored safely and there were effective systems in place to ensure sufficient stocks. Medicines were disposed of safely.

Preventing and controlling infection
People were not suitably protected from the risks from cross infection.
● Some people's ensuite bathroom walls had mould on them. Mould can be a serious risk to people who are vulnerable to chest infections.
● There were areas of the service which could not be cleaned properly and posed a risk of infection. Flooring in the majority of ensuite bathrooms was worn, stained and not sealed around the edges. This meant there were gaps where bacteria could lodge.
● Tiles were missing in some ensuite bathrooms which meant walls could not be cleaned thoroughly.
● Radiator covers were makeshift and had been constructed of unpainted wood and MDF. This meant they were porous and could not be wiped clean.
● One of the pipes from the washing machine had been leaking for several months. This meant water, potentially from soiled laundry, could leak onto the floor. There had been a build-up of limescale from this which meant it could not be thoroughly cleaned. There was a piece of flooring missing from the front of the washing machine which meant the laundry floor could not be cleaned thoroughly.

We found no evidence that people had been harmed however the provider had failed to robustly assess and reduce the risk of cross infection. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff understood how to reduce the risk of cross infection. They used personal protective equipment.
● The service had been cleaned thoroughly where possible by staff.

Staffing and recruitment
● The provider did not always carry out thorough checks before employing new staff at the service.
● One person had no references on file to confirm if they were suitable for the role. The registered manager said they had called the staff member's referees and received verbal references, however, there was no record of this. A second person had discrepancies in their dates of employers and this had not been checked to check the accuracy of their employment history.
● There was no record of any interview undertaken, date or assessment of competency or suitability checks for three members of staff.

We found no evidence that people had been harmed however the provider had not ensured staff recruited were of good character and suitable for their role. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff files showed the provider had carried out Disclosure and Barring Service checks to ensure potential staff have no criminal convictions which would make them unsuitable to work with vulnerable people. Staff files also contained proof of identity.
● There were enough staff deployed to meet people's basic care needs.

Systems and processes to safeguard people from the risk of abuse
● Staff were unclear about people's right to go out alone. We were told, "Nobody here goes out alone."

Another member of staff told us, "I wouldn't let any of them out on their own. I 'd worry about roads."

● One person told us, "They won't let me go out on my own because of my age but they don't take us out." A second person said, "Until I came here this year, I used the buses every day, but I am not allowed to go out unless there is somebody with me. I would be safe, but they say no." A third person told us, "I feel safe because staff are around me, but I would like to go out and they say I am not safe."

● Staff told us there were not enough of them to take people out.

● The front door was locked with no information to advise people they could leave if they wished.

● When a person went missing from the service this was not reported to the local safeguarding authority. This meant there were no safeguarding arrangements or plan in place to ensure the incident was investigated internally or externally. We have made a safeguarding alert to the local authority about this.

The provider had failed to operate an effective system to identify, report and investigate abuse. This was a breach of regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff had received training in safeguarding people from abuse. They told us, "I would tell the senior." One of the senior staff told us they would report it any concerns to the local authority.

● Staff training in safeguarding was conducted every three years; one member of staff was out of date with this training.

We recommend the provider consider the frequency of safeguarding training in line with published guidance.

Learning lessons when things go wrong

● The provider did not always learn lessons when things went wrong.

● There was an accident book but no log of other incidents. This meant the provider could not be sure they had identified learning from any incidents.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Adapting service, design, decoration to meet people's needs

- The decoration of the service and some of the fabric of the building was in poor condition. We found flooring in poor condition, with holes and worn spots. The provider had been made aware of these issues but had taken no action. The hall carpet had a hole and was torn. This had been reported in the maintenance log, but no action had been taken. Laminate flooring in one bedroom had deteriorated and was peeling at the edges. In February 2019 the carpet in one bedroom was identified as needing attention as it was very worn. No action had been taken at the time of our inspection.
- People were unable to adjust the temperature of their bedrooms. Staff told us the heating was either on or off. People were unable to adjust the temperature of their bedroom. One person told us, "I can't turn it down in my room and it's much too hot."
- The maintenance log showed that some issues had been reported repeatedly, however no action had been taken. Issues reported included mould in people's bathrooms. These bathrooms had extractor fans which had been reported as broken, in some cases this had been reported nine months previously and entered in the maintenance log regularly.
- One bathroom had a broken fan with the casing cracked revealing electric wiring. The fan was stuck open leaving a gap in the window.
- People had access to one bath at the service. This bath had been leaking for over nine months. There was a towel on the floor under the bath which was soaked from the leak. People did not have access to a shower. The maintenance log recorded that the cold tap for this shower was not working. As the average water temperature from the hot taps was between 49 and 51 Celsius this meant the shower could not be used without risk of scalds.
- The blinds had fallen down in the conservatory. This meant it was too hot for people to use when the sun was shining.

We found no evidence that people had been harmed however the provider had not ensured the premises were properly maintained. This was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, the provider has sent evidence to demonstrate water temperatures have now been adjusted to safe levels.

Staff support: induction, training, skills and experience

● Staff supervision was not effective. Supervision is dedicated time for staff to discuss their role and personal development needs with a senior member of staff. The registered manager told us supervision lasted "About 10 minutes", and they discussed issues with staff such as fire and food labelling. Staff then signed a form to confirm they understood. There was no system to support staff to discuss any difficulties or improvements to people's needs or ensure staff performance and progress was monitored. This was highly important given the issues within the service.
● Staff received training through the provider's essential training programme which included Moving and Handling, MCA and DOLs, Food handling and Hygiene, Medication and Fire awareness. The staff training matrix recorded that many staff had not received all training which the provider had deemed essential. The failure to provide effective training had impacted on staff providing safe and person centred care.

We found no evidence that people had been harmed however the provider had not staff received suitable support. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff received an induction on starting at the service. Records showed this was signed off when completed.
Ensuring consent to care and treatment in line with law and guidance
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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
● Staff were not always confident in describing best interests' decisions.
● Staff assumed people had capacity.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were assessed by the provider before admission to the service.

Supporting people to eat and drink enough to maintain a balanced diet
● Everybody we spoke with was very complimentary about the food. People told us they received ample portions and always had choice. The menu was varied and people were involved in choosing meals. Comments included, "The food is very good, and my favourite is the Sunday roast," and, "They (the staff) come around every day to see what we want to eat. We have a choice of two things. If we didn't like it, they would cook something else."
● People had the option of a hot meal in the evening as well as at lunch time.
● Preferences and dietary needs were catered for. A senior member of staff had developed a form which advised staff of people's preferences and any specific diet. This for was very accessible and easy to use. People were weighed regularly and the records we viewed showed people maintained a consistent weight.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● People were supported to access healthcare professionals. One person told us, "I had a fall a couple of weeks ago and hurt my hip. They called the Doctor the next morning as I had a terrible pain on my left-hand side."

● People were seen by the district nurse where needed and a chiropodist visited the service.

● People had oral care plans in place which described any assistance they needed. A senior member of staff told us they had been working on improving oral health care, but it was very difficult to find a dentist.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence

- Staff were able to describe how they protected people's dignity during personal care. However, even people who were assessed as independent were unable to have any time alone in the bath.
- Staff told us, "Everybody is supervised when they have a bath, they can leave [Name]. Everybody else, no. People don't really like the bath." Another member of staff said, "People cannot be left in the bath. We explain to them it is about safety."
- The poor maintenance of the service did not promote people's dignity or demonstrate respect. People's ensuite bathrooms had missing tiles, flooring in need of attention and in some cases mould on walls. The condition of the makeshift, unpainted radiator covers also impacted on people's dignity.
- People's care records identified where they were independent. Staff always knocked on people's doors before entering their rooms. Doors and curtains were closed before any personal care was delivered.

Ensuring people are well treated and supported; respecting equality and diversity

- One person said, "It was my Birthday last week and they forgot to make me a cake and I asked them why they hadn't. They made me a cake the next day and the owner said she was sorry and bought me some chocolates as well."
- People living at the service had good relationship with staff. Staff were kind in their approach to people. One person said, "The staff are so kind, I have no concerns or problems." A relative told us, "It's not a clinically clean home but it is friendly, the rooms aren't pristine, but [Name] is safe here."
- Staff spoke kindly and respectfully about people, they said looking after people was important to them. We were told, "I love the residents, "and, "I like to care for people. I do my best."
- People were treated as individuals and staff we spoke with knew them well.

Supporting people to express their views and be involved in making decisions about their care

- Some effort was made to ascertain people's views. We were told this usually consisted of the registered manager asking people at lunchtime if they had anything to raise. People also had the opportunity to ask for specific meals; we saw evidence that these were provided.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs. At the last inspection this key question was rated as good.
At this inspection this key question has now deteriorated to inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support

● People did not always receive personalised care which met their needs and choices. People were not able to choose how often, when, or how they had a bath. A rota showed that people had an institutionalised 'bath day' and time.

● One person said "I only have a bath once a week, it's not enough but still that's it. My bath day is [Day] I am not left alone, it's not a proper bath it's a medical bath." Another person told us, "I have a bath once a week and sometimes twice."

● People were unable to choose between a bath or a shower. One person's care records stated they preferred a shower. Although there was a shower this was not accessible for them as it was over a bath.

"● One person's care plan identified they suffered from depression. Their care plan stated, "I have dementia and I am not orientated to time or place. I have a history of depression and I can suffer from low moods at times." To support them with this the plan stated, "I need you to be patient and understanding with me if I become confused as to where I am." There was no information on how to help orientate them or how to help them when they were low in mood.

● Another person had diabetes. There was no care plan in place to advise staff how to support the person with this. For example there was no guidance on how to identify potentially life-threatening hypoglycaemia, or advice on monitoring the person's feet to minimise the risk of infection.

● The provider did not have plans in place to support people at the end of their life. People had a template for an end of life care plan in their care records, however this had not been completed. Each person's records contained the same statement with no information about their choices or preferences.

● At the time of our inspection the service was not supporting anybody at the end of their life.

The provider had failed to ensure care plans provided enough detail for staff about people's support needs, choices and preferences. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● The provider told us that they had increased the amount and range of activities offered to people, however people told us they were often bored. Typical comments included, "I get bored, there isn't enough for me to do. When I came here, I didn't know what to expect but I want to get out more. I end up watching television as there is nothing else to do." A second person told us, "If I tell the staff I am bored and frustrated, they say you are doing fine, and nothing happens."

● A third person said, "I don't take part in the activities because I don't like them."

● On the first day of our inspection the service was visited by a church group. There was no activity in the afternoon and most people retired to their rooms. Of the four people in the lounge, three were asleep.
● People told us, "I came for respite care in the past and now I have moved in. I wish there were more people to talk to." A member of staff told us, "Nobody goes out alone."
● Visitors told us they were always made welcome and could visit any time.

The provider had failed to provide people with opportunities to meet their social needs. This was a breach of regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● People's individual communication needs were assessed and recorded in care plans.
● Staff knew people well and responded to their individual communication needs.

Improving care quality in response to complaints or concerns
● The provider had received a card from one relative which said, "Thank you for looking after my nan," and a second card stated, "Thanks to you all for looking after my mum."
● The complaints file held by the provider had one complaint in it which had been made via the CQC. The provider responded to this complaint stating the allegations were untrue and that nobody else had made a similar complaint. This response was on file at CQC.
● One person told us, "If I have any concerns, I will see [Name]."

Inadequate

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
There were some quality assurance systems in place, however these had not always been effective.
● We found seven breaches of regulation at this inspection. None of the shortfalls had been identified by the provider before our inspection.
● Medicines audits had identified poor staff practice but had not identified the incorrect administration of 'as required' medicine or lack of guidance for these medicines.
● We identified widespread maintenance issues. Many of these had been repeatedly noted by members of staff in the maintenance log; but no action had been taken. Where repairs had been made they were not always carried out safely or to provide a homely environment. For example, radiator covers were makeshift, unpainted and did not cover the whole radiator.
● There was no system in place to identify any health and safety risks to people at the service. For example, there was no evidence any water temperature checks had been taken to protect people from the risk of scalding from hot taps.
● Care plan audits were undertaken, however these only audited the presence of particular information rather than the quality of the plans.
● The provider had not followed regulatory requirements for safe recruitment of staff and there were no effective systems in place to ensure any shortfalls were identified and missing information obtained.
● The Food Standards Agency had identified that opened food items were unlabelled with date of opening. The provider met with all staff to discuss this. However, we found a range of unlabelled condiments in the fridge at our inspection.

Continuous learning and improving care
● The provider did not have a system in place to record and learn from incidents. No incidents were recorded apart from falls in the accident book. There was no system in place to identify any near misses or repeat incidents in order to improve safety.

The provider had failed to monitor the quality and effectiveness of the service. This was a breach of regulation 17 (Good governance)) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Due to lack of a system for recording of incidents we were unable to determine if the provider was notifying us of incidents as required.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● People living at the service were unsure who the registered manager was. One relative told us, "I don't know who is in charge here." Other people mentioned different names of staff.

● Staff morale was mixed. Staff comments included, "I mostly like it", and, "It's mixed." Staff told us they worked well as a team and felt supported by seniors.

● Staff supervision records and meeting minutes contained information about instructions given to staff, but no evidence staff could make suggestions to improve the running of the home or people's experience.

● Relatives received a quality assurance survey last year, and responses were positive. However, people living at the home had not received a survey. This year's survey for relatives had just been sent out.

● The registered manager told us, "I know people are getting a good service by asking them and the quality assurance form. I always say I'm available and they can come to me and I'd rectify it."

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

● People's care records contained information about who to contact in the event of any incident. Relatives were informed, for example, following a fall.

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

● Residents had meetings during lunch time. Nobody had raised any issues at the last two meetings. People had been involved in deciding on new additions to the menu. One person had suggested short trips out, but nothing had yet been organised.

● There were no links with the community apart from the local church volunteers. People were not supported to access the community or to attend any external events except hospital appointments. A number of people expressed a desire to go out. Resident's meeting minutes stated, "Nobody wanted outings." The registered manager also told us, "We are planning a tea across the road but we're not going far."

Working in partnership with others

● The service worked with local health providers.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to provide person-centred care and support which met people's needs and respected their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to robustly assess the risks relating to the health safety and welfare of people. Medicines were not always managed safely. The provider had failed to robustly assess and reduce the risk of cross infection

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 The provider had failed to operate an effective system to identify, report and investigate potential abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had not ensured the premises were properly maintained and hazards were

mitigated.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not carried out robust checks to ensure staff recruited were of good character and suitable for their role.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure staff were supervised and had completed all mandatory training.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to operate effective systems to monitor the quality, safety and effectiveness of the service.

The enforcement action we took:

we issued a warning notice