Rooks (Care Homes) Limited

Green Hill

Inspection report

Station Road
Crowhurst
Battle
East Sussex
TN33 9DB
Tel: 01424 830295
Website: www.rookscare.co.uk

Date of inspection visit: 10 and 13 July 2015
Date of publication: 14/10/2015

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

Overall summary

We carried out an unannounced comprehensive inspection at Green Hill on the 10 & 13 November and 3 December 2014. Breaches of Regulation were found. We carried out a focussed inspection on the 8 March 2015 in response to concerns about the safety of people. Breaches of regulation were found and we served a warning notice under Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of staffing. We undertook an inspection on 10 and 13 July 2015 to follow up on whether the required actions had been taken to address the previous breaches identified.

You can read a summary of our findings from our inspections below.

Comprehensive Inspection of 10 and 13 November and 3 December 2014.

Summary of findings

There were not enough staff to meet people's needs. This impacted on the support that people were provided with at meal times and on the discrete supervision that was required to keep people safe. One meal time was disorganised and people did not receive support at the time they needed it. People left their food uneaten. Equipment and some parts of the accommodation were not maintained to a clean and hygienic standard and areas of the home had an unpleasant odour. The quality monitoring processes were not effective as they had not ensured that people received safe care that met their specific needs. The systems used by the provider to assess the quality of the home had not identified the issues that we found during the inspection.

The home had not taken into account people's abilities to make decisions for themselves. Whilst people at Green Hill lived with dementia, some people were able to share their wishes and preferences about day to day choices. Staff were not following the requirements of the Mental Capacity Act 2005 (MCA). Nor had they taken action to review care delivery and support with regards to the Deprivation of Liberty Safeguards (DoLS) for people whose liberty may be being restricted.

Staff training had not been provided. The training programme identified that medication training, safeguarding adults at risk, moving and handling and infection control had not been undertaken for up to two years. There was evidence that other learning was not always put into practice.

People had meals, snacks and drinks, which they told us they enjoyed. We were told that some people had had been involved in planning menus. Food was returned uneaten at lunch time and no alternatives offered. Records for food and drink not eaten were not kept. This had not ensured people received enough food and drink to maintain a balanced diet.

There was a system to receive and handle complaints or concerns. However not all had been dealt with in line with their complaint policy and procedure.

The staff on duty knew the people they were supporting and the choices they had made about their care and their lives. People were supported as much as possible to maintain their independence and control over their lives. People were treated with kindness and patience. The staff in the home spoke with the people they were supporting in a respectful manner.

People were able to see their friends and families as they wanted. There were no restrictions on when people could visit the home. All the visitors we spoke with told us they were made welcome by the staff in the home.

The provider used safe systems for the recruitment of new staff.

You can read the report for this comprehensive inspection, by selecting the 'all reports' link for Green Hill Care Home on our website at www.cqc.org.uk

Focussed Inspection on 13 March 2015

As a result of further concerns, we undertook a focused inspection 8 March 2015 to look into those concerns. This report only covers our findings in relation to this topic. You can read the report from this focussed inspection, by selecting the 'all reports' link for Green Hill Care Home on our website at www.cqc.org.uk

Although people told us that they felt safe in this home, there were times when there were not enough staff to meet people's needs. This impacted in a negative way on the support that people were provided with in the early mornings and on the discrete supervision that was required to keep people safe. Breakfast was disorganised and people did not receive support at the time they needed it and little choice was offered. Not all people ate breakfast. Equipment and some parts of the accommodation were not maintained to a clean and hygienic standard and areas of the home had an unpleasant odour. The provision of heating and hot water at the time of the inspection had not ensured people were warm and safe from the risks of the cold and poor personal hygiene.

Comprehensive Inspection on 10 & 13 July 2015.

After our inspections November, December 2014 and March 2015, the provider wrote to us to say what they would do to meet legal requirements in relation to care and welfare, assessing and monitoring the quality of service provision, respecting and involving people, keeping people safe and meeting people's nutritional needs.

Summary of findings

We undertook this unannounced inspection to check that they had followed their plan and to confirm that they now met legal requirements. We had also received some anonymous concerns prior to this inspection that were included in our planning. We found improvements in the safety of the environment and in the laundry provision. However the provider had not met all the breaches in the regulations.

Although people told us that they felt safe in this home, there were times when there were not enough staff to meet people's needs. This impacted on the level of support that people were provided with for personal care, stimulation and interaction and on the discreet supervision that was required to keep people safe.

Some parts of the accommodation were not maintained to a clean and hygienic standard and areas of the home had an unpleasant odour. The quality monitoring processes were not effective as they had not ensured that people received safe care that met their specific needs. The systems used by the provider to assess the quality of the home had not identified the issues that we found during the inspection.

People told us that they, and their families, had been included in planning and agreeing to the care provided. However staff told us they never involved people in their care plan or reviews. This was confirmed by three people who could tell us their views on the care received. People had an individual plan, detailing the support they needed and how they wanted this to be provided. However people did not always receive support in the way they needed it. We found that some people's support was not provided as detailed in their care plans and some people's changing needs were not accurately reflected. The lack of meaningful activities for people meant their personal wishes were not always considered or alternatives offered. For example, there were people who wished to go for walks regularly and this was not reflected in their care plans or integrated in to the activities programme.

The home had not taken into account people's abilities to make decisions for themselves. Whilst people at Green Hill lived with dementia, some people were able to share their wishes and preferences about day to day choices. For example having a cigarette.

Staff were not following the requirements of the Mental Capacity Act 2005 (MCA). Nor had they taken action to review care delivery and support with regards to the Deprivation of Liberty Safeguards (DoLS) for people whose liberty may be being restricted. The MCA and DoLS are regulations that have to be followed to ensure that people who cannot make decisions for themselves are protected. They also ensure that people are not having their freedom restricted or deprived. We saw evidence of isolation for one person which had not been considered as a restriction to their liberty.

Whilst staff training had been provide for some staff, we found that not all new staff had undertaken essential training before working unsupervised in the home. Staff had not all received an induction that assured the provider that they were competent to provide care and support people safely. There was also evidence that other learning was not always put into practice, such as safe moving and handling practices. The provider did not have a system to assess staffing levels and make changes when people's needs changed. There were times when people had not had their individual needs, such as continence promotion, met as the staffing levels were not sufficient. Therefore we could not be assured that there were enough suitably qualified and experienced staff to meet people's needs.

People had meals, snacks and drinks, which they told us they enjoyed. Choices for breakfast were not visually offered. Food was returned uneaten at lunch time and no alternatives were offered. Records for food and drink not eaten were not kept. This had not ensured people received enough food and drink to maintain a balanced diet.

There were some positive aspects of care at the home. People were treated with humour and some people enjoyed the interaction with staff.

Medicine practices had improved and we saw that medicines were administered safely. We raised concerns regarding the recording and administration of covert and crushed medication

People were able to see their friends and families as they wanted. There were no restrictions on when people could visit the home. All the visitors we spoke with told us they were made welcome by the staff in the home.

Summary of findings

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. The service 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.

Summary of findings

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

Green Hill did not provide safe care and was not meeting the legal requirements that were previously in breach.

People told us they felt safe at the home and with the staff who supported them however this is not what we observed.

Risk assessments that informed safe care delivery were not always correct, up to date and did not reflect people's changing needs.

There were not enough suitably experienced or qualified staff on duty to meet people's needs consistently and safely. Poor moving and handling practices were observed. Staff training in managing challenging behaviour had not been provided to meet people's identified needs.

Senior staff had not informed CQC of required statutory notifications of deaths in a timely manner.

There were recruitment procedures undertaken before staff started employment at Green Hill.

Staff had received training in how to safeguard people from abuse and were clear about how to respond to allegations of abuse.

Is the service effective?

Inadequate

Green Hill did not provide effective care and was not meeting the legal requirements that were previously in breach.

People's rights were not protected because the Mental Capacity Act 2005 Code of Practice and the Deprivation of Liberty Safeguards were not followed when decisions were made on their behalf.

Although people received enough to eat, some people did not receive the support they needed to eat their meal.

Whilst staff had had some training and supervision, it had not been regular or put into practice to ensure people received care which was based on best practice. Specialist training in dignity and dementia had not been undertaken by all staff. New staff did not have a full induction that ensured their competence to deliver good care before working unsupervised.

Is the service caring?

Requires improvement

Green Hill was not consistently caring and was not meeting the legal requirements that were previously in breach.

Summary of findings

People were positive about the care they received, but this was not supported by our observations. Care mainly focused on getting the job done and did not take account of people's individual health and social needs. People were not always treated with respect nor was their dignity and privacy promoted.

We saw some nice interactions between staff and people who lived in Green Hill. Staff and people were seen to have a comfortable banter when time allowed.

Is the service responsive?

Requires improvement 

Green Hill was not consistently responsive and was not meeting the legal requirements that were previously in breach.

Care plans and risk assessments had recently been changed to a new format. However not all were clear, or written in a person specific way or evidenced a review when changes were identified. Therefore people did not always receive support in the way they needed it.

There were not enough meaningful activities for people to participate in to meet their social needs; so some people living at the home felt isolated and bored.

Visitors told us they felt comfortable giving verbal feedback to the staff about the care their relative received.

Some staff were seen to interact positively with people throughout our inspection. It was clear some staff had built rapport with people and they responded to staff well.

Is the service well-led?

Inadequate 

Green Hill was not well-led and was not meeting the legal requirements that were previously in breach.

Although there were systems to assess the quality of the service provided in the home we found that these were not effective. The systems used had not ensured that people were protected against the risk of infection or of receiving inappropriate or unsafe care and support.

The home had a vision and values statement, and whilst displayed in the reception area not all staff clear on the homes direction. The leadership in the home had not identified the poor practices observed during our inspection. The lack of suitably experienced staff had not been addressed.

There were no records that identified people, their families or staff had been consulted about the running of the home.

Staff told us that they now felt supported by the management.

Green Hill

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. The inspections checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, looked at the overall quality of the service, and provided a rating for the service under the Care Act 2014.

We carried out a comprehensive inspection in November and December 2014 and a focused inspection in March 2015. These inspections identified numerous breaches of regulations.

We undertook a comprehensive unannounced inspection of Green Hill Care Home on the 10 and 13 July 2015. This inspection was to check that improvements to meet legal requirements after our inspections in November, December 2014 and March 2015 had been made.

The inspection team consisted of three inspectors. During the inspection we spoke with 10 people who lived at the home, three visitors, six care staff members, a director and the manager. The manager is also the provider.

We looked at all areas of the building, including people's bedrooms, bathrooms, the lounge areas and the dining areas. Some people had complex ways of communicating and several had limited verbal communication. We spent time observing care and used the short observational framework for inspection (SOFI), which is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed the records of the home, which included quality assurance audits. We looked at five care plans and the risk assessments included within these, along with other relevant documentation to support our findings. We also 'pathway tracked' people living at the home. This is when we followed the care and support a person's receives and obtained their views. It was an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

We also spoke with two social workers who were undertaking assessments of two people during the second day of the inspection.

Inadequate

Is the service safe?

Our findings

At our last inspections in November and December 2014 and in March 2015 we found breaches of Regulations 12, 22, 23 and 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These Regulations now correspond to Regulations 12 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because risk assessments did not always include sufficient guidance for care staff to provide safe care. Others risk assessments were not being followed. The cleanliness and maintenance of the building put people at risk from cross infection and injury.

In March 2015 we issued a warning notice in respect of Regulation 22 – Health and Social Care Act 2008 (Regulated Activities) Regulations 2010- staffing. This now corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were not sufficient numbers of suitably qualified staff to keep people safe.

An action plan was submitted by the provider that detailed how they would meet the legal requirements by 30 June 2015. At this inspection however we found the staffing levels and staff deployment did not promote people's health, safety and wellbeing and delivery of care was not always safe. Therefore the provider was still not meeting the requirements of Regulations 12 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe living at Green Hill. One person told us, "Safe, bit like a prison though living here." Another person said, "I have no concerns, I'm content and safe here."

This inspection found whilst the cleanliness of the environment had improved, there were still concerns regarding the cleanliness of individual bedrooms and equipment and infection control procedures. For example there was a very strong odour in one bedroom that was traced to the person's mattresses. Urine had soaked through the plastic covering and pooled between the two mattresses in use,. This had not been checked by staff either when making the bed or cleaning the room. Chairs in bedrooms and lounges were not always clean which was a potential cross infection risk. There were a number of rooms that had strong unpleasant odours. We spoke with the domestic who told us that there was no daily cleaning schedule or check list completed as far as she knew. She also told us that she had not received any training such as infection control, hazardous chemicals, safeguarding or fire evacuation. She was unaware of any cleaning procedures or protocols that should be followed to prevent cross infection. Communal bathrooms were not always checked and monitored. One visitor found a toilet that was extremely unclean and not attended to until we identified it to staff an hour later.

We tried to wash hands, there was no single use soap or paper hand towels in people's rooms. A care staff member said we could wash our hands in communal toilet. However there was no soap or hand towels there either. We used a key fob to get to next corridor of the home where we visited the laundry and staff bathroom where again there was no soap or paper towels. We asked staff how they washed their hands and staff could not answer. Gel hand sanitisers were not equipped and ready for use. This meant there was a potential risk of cross infection from one person to another

Slings used for moving people on the electrical hoist were unclean and odorous. There was no plan for staff to follow for changing and washing of slings. This meant staff could not be assured the slings were clean and hygienic for use.

We observed three examples of poor moving and handling practices. For example staff encouraged one person to pull herself up using a walking frame. The person couldn't manage to stand so the staff pulled the person upright under their armpits and taking the weight of the person as the person had bent knees. This placed both the person and staff at risk from injury. When we spoke to the staff members, they knew it was poor practice but still undertook the move. This had not promoted this person's safety.

Accident and incident records were not all completed in full nor had action plans been put in place to prevent a reoccurrence. There were also some injuries seen that had not been recorded. For example, one person we spoke with had a bruise on their forehead that had not been recorded. The manager told us that accident forms would be completed.

These issues were a Breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service safe?

At this inspection staffing levels were not regularly assessed or monitored to make sure they met people's needs. The manager was unable to show us how they determined how many staff should be on duty each day. There were 16 people living at Green Hill. The number of staff was fixed at three care staff during the day and two care staff at night. One of the day staff came in at 7am to allow the night senior care staff member to administer medicines. There was no flexibility in the staffing numbers displayed on the rota. This did not take into account the higher needs of some people who were unwell, living with dementia and behaviours that challenged, who required complex care.

Our observations and use of SOFI identified that that there were not sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in the home to meet people's needs.

People did not get reactive care because of a lack of staff. A staff member said they often found there were not enough staff on duty and this meant some things didn't get done. Staff told us they did not have time to interact with people because there were not enough staff on duty. One member of staff said, "Sometimes we just have two (staff). People don't get the support they need." On further discussion we were told this was due to sickness or staff not coming in. We were informed later that the management team will then work with staff, however this was not recorded on the rota.

People weren't being attended to in a timely manner because of a lack of staff. During lunch time one person was not given the support they needed to eat their meal because staff were supporting other people in the communal areas. We heard one person call out for a long period of time trying to attract staff attention.

There people living in the home presented with behaviours that were challenging. There was a lack of understanding shown in how these behaviours were managed. There was entries written in daily notes that raised concerns of how staff reacted to the person. For example for one person an entry stated 'really bad mood' and 'awful mood'. When we looked at their risk assessment it stated 'bad behaviour', with no other explanation or reason for the challenges they were presenting or how to manage the behaviour. Staff we spoke with had not had training in managing behaviours that challenged. Staff could not tell us how to manage a potential aggressive incident. One staff member said, "We walk away until they calm down." A senior staff member who was helping new staff through their induction period had not had any training in dementia care. This meant that staff did not have the necessary skills to care and support the people living at Green Hill.

Many people in the home were mobile and enjoyed walking around but were not able to identify risk to themselves such as trip hazards. For example one person was becoming tired and was constantly stepping over a step unsupported by a staff member. The staff were not able to monitor the whereabouts of people who were at risk of falls, injury and of becoming disorientated as to where they were. We found one person had managed to leave the communal areas and enter another wing of the home. This was unknown to staff until another person shouted that they were there and disturbing them.

We observed two instances where one person was at risk from another person in a communal area. Visiting health and social care professionals intervened as staff were not visible to prevent the person from being struck. We observed a third instance where staff did intervene but not before the person had been threatened and shouted at. A member of staff said, "We can't be everywhere." Staff knew the risk potential but had not ensured the risk was minimised by appropriate deployment of staff.

Not all shifts had suitably qualified and experienced staff. One new member of staff for their induction had completed one shift shadowing with an established member of staff and then worked alone with no essential training. This meant care delivery was potentially unsafe and could put people at risk.

Only senior care staff were trained to administer medicines. We saw one example on the night shift rota that had no senior staff available. We asked how medicines were administered in this scenario and were told the manager came in at 7am to administer medicines. However there was no documentation to support this or records of medicines that are given as required such as pain relief or sedation during the night. The manager said that she would stay overnight in the staff accommodation if necessary. However this again was not recorded. There was no evidence to show that people were offered or received medicines at night when senior care staff were not available.

People had personal emergency evacuation plans (PEEPs) which detailed how they should be supported and how

Is the service safe?

many staff were needed to help them should there be a need to evacuate in an emergency. However we were not assured that staffing levels at present especially at night were suitable for safe evacuation procedures. Two people according to the evacuation procedure needed two staff to move them to safety which meant there were no staff to co-ordinate the evacuation or assist other people. We brought these to the attention of the manager.

These issues were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safeguarding policies and procedures were up to date and appropriate for this type of home in that they corresponded with the Local Authority and national guidance. There were notices on staff notice boards to guide staff in whom to contact if they were concerned about anything and detailed the whistle blowing policy. 'Whistleblowing' is when a worker reports suspected wrongdoing at work. Officially this is called 'making a disclosure in the public interest.' Staff told us what they would do if they suspected that abuse was occurring at the home. Staff confirmed they had received safeguarding training. They were able to tell us who they would report safeguarding concerns to outside of the home, such as the Local Authority or the Care Quality Commission.

However staff had not recognised that inadequate management of behaviours that challenged were a potential safeguarding concern.

The provider had appropriate arrangements in place for the safe receipt and disposal of medicines. There were records of medicines received, disposed of, and administered. Clear medication policies to guide staff were available. We looked at nine people's MAR charts and found that the recording was accurate and clear. Staff told us that people were currently taking their medication as prescribed. Skin creams were recorded by care staff on a separate recording sheet. This assured us that the records showed people were given their medicines as prescribed.

Inadequate

Is the service effective?

Our findings

At our last inspections in November and December 2014 and in March 2015 we found breaches of Regulations 18, 14, and 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These Regulations now correspond to Regulations 11, 18, 9 and 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because care delivery was not always effective and consistent, there was a lack of mental capacity assessments and DoLS referrals and mealtimes were not an enjoyable experience. We could not be assured that people's nutritional needs were met.

An action plan was submitted by the provider detailing how they would meet their legal requirements by 30 June 2015. Whilst some improvements have been made the provider was not fully meeting the requirements of Regulation 9, 11,18and 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection, we found mealtimes to be a rushed experience for some people. Staff lacked oversight of people's food and fluid intake and people were at risk of dehydration.

This inspection showed us that the quality of meals was not consistent and people were not offered a choice at breakfast. Comments from people were varied and included, "You know who's cooking because it's better on some days." We were also told by someone who was a vegetarian, "Now I just eat what they put in front of me" and "if you stuck to being a vegetarian you got very hungry." This person told us that they loved macaroni cheese. This was not reflected in the person's care plan.

The breakfast was cereal, toasts and cups of tea and coffee. There was only one type of bread on offer and the cereal was not visible so people did not have a choice. No offer of juice or any other drink. Everyone had white bread and jam and we could not see individual preferences considered.

There was a choice of meals offered verbally. On the day of the inspection the main course was fish pie which looked appetising, but the pureed version was not attractively presented. Both people on pureed food ate extremely well however. The second choice, sausage salad was not appetising as it was hot sausages, mash potato and gravy with cold salad. One person said, "It's not good, even the lettuce is hard." Another said, "Wrong choice today, it's not very nice." Those that had the sausage salad did not eat much and no alternative was offered. People ate outside which some people enjoyed but two people found the sun too hot and ate very little. Fresh fruit was not offered despite one person requesting it. Staff told us jelly was available for people who were not drinking enough but we did not see this offered throughout the day. We also noted that there were no condiments or napkins offered.

Staff told us they monitored people's food and fluid intake and watched for any signs of weight loss and malnourishment. However staff were not recording this. We looked at peoples weights but there were not consistently recorded for people. One person photograph in January 2015 told us that person had lost weight but this was not reflected in care documentation. We discussed this with the staff who said this person had deteriorated. Discussion with the new cook identified that they were not aware of which people required a special diet and relied on a notice board that was not clear to see. The cook was unsure of what food requirements were needed for people living with diabetes and was unsure of why a person on pureed food was also having solid finger food as detailed on the notice board. We were told by staff later that the pureed food was preferred by the person but the enjoyed cheese and biscuits. The pureed food was not for a swallowing problem. We were also told by a person who was a vegetarian that they were not often given a vegetarian meal. The poor communication by staff with the cook about dietary needs meant that people were not always receiving food that met their needs and their preferences. .

These issues are a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with told us they understood the principles of consent and therefore respected people's right to refuse consent. However we saw that covert administration of medicine was in place for three people. Covert medication is the administration of any medical treatment in disguised form. This usually involves disguising medication by administering it in food and drink. As a result, the person is unknowingly taking medication**.** The consent documentation in the individual's medication administration record stated the medication was to be crushed. There was no mention of the medication to be

Is the service effective?

hidden and this had not been discussed with health professionals as a best interest decision. There was also a lack of discussion with the pharmacist about the suitability of crushing the medicine.

Senior staff working told us they had received training on the Mental Capacity Act 2005 (MCA) however mental capacity assessments were not consistently recorded in line with legal requirements. We saw that the mental capacity assessment for one person said they did not have the capacity to consent but we found other consent forms within the person's care plan that stated they had the capacity to consent.

Whilst Deprivation of Liberty Safeguards (DoLS) had been submitted, there was some practices that staff had not considered as restrictions to people's liberty. For example one person was isolated in a spare room without considering the implications of the isolation, both socially and mentally. There was no guidance in the care plan as to the reasons for the isolation or any evidence of a best interest meeting. Nor was there any rationale given of how this was an effective way to meet their needs. This person was not able to move themselves and therefore their liberty was deprived.

These issues are a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were told staff had received essential training in looking after people, for example in safeguarding, food hygiene, fire evacuation, health and safety and moving and handling. We found that there were new staff working that had not completed any essential training. One new staff member worked one night 'shadowing' before working alone. This staff member had not completed any essential training in caring for the people living at Green Hill. This meant that they were placing people at risk of ineffective care. One staff member said, "I think we need better training, more face to face so we can ask questions." One staff member told us they had learnt many things to enhance their care delivery. This staff member gave us an example which was safe moving and handling. However we observed two separate occasions where people were not moved or supported safely by that staff member.

The statement of purpose for Green Hill states that they provide specialist dementia care, but not all staff have received training in dementia care, or understanding behaviours that challenge. One senior care staff member told us that they had not yet undertaken any dementia training and had not worked in a dementia service before. This staff member was responsible for the care delivery of people who live with dementia and new inexperienced staff. This meant that people were at risk of not receiving the care they require.

Staff told us that they received supervision from senior care staff. However the senior staff had not received training in how to undertake supervision. One staff member said that supervision wasn't really set up yet to be useful." Another staff member said they had not received supervision since being employed. This meant that staff had not received appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Staff were not being appropriately supervised and we observed poor practises in the delivery of care.

These issues are a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our inspection in November and December 2014 we found care plans lacked detail on how to manage and provide specific care for people's individual needs. For example, in the areas of diabetes and continence management. This inspection found that people's care plans lacked detail to provide person specific care for their individual needs. For example, care plans identified when a person was incontinent, but there was no guidance for staff in promoting continence such as taking to the toilet on waking -or prompting to use the bathroom throughout the day. There was no information of how often personal care in relation to continence should be provided. Throughout our inspection we identified that continence management was a concern. We saw that one person was left in damp clothing until we prompted staff to offer the person a change of clothing. Another example was managing people's challenging behaviour. For one person there had been a number of recorded incidents of 'awful' behaviour and verbal aggression. The care plan did not explore how to manage this or a plan of prevention. We found there was no guidance for staff in managing situations before they escalated.

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

Inadequate

Is the service effective?

People had access to external health care professionals. For example, dietary and nutritional specialists. The speech and language therapy team, who provided guidance for staff to follow, were involved for people who had swallowing problems. We read people had involvement from the physiotherapist, podiatrist, diabetic nurse specialist, optician and mental health team. However, there was a shortfall in the aspect of not involving the mental health nurse for advice in the management of people who had had behaviours that challenged.

Requires improvement

Is the service caring?

Our findings

At the last inspection in November and December 2014, the provider was in breach of Regulations 17 of the Health and Social Care Act 2008, (Regulated Activities) Regulations 2010 which now correspond to Regulations 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people had not always been treated with respect and had their dignity protected.

The concerns identified at the last inspection found Green Hill was not consistently caring. An action plan had been submitted by the provider detailing how they would meet the legal requirements by 30 June 2015. Whilst Improvements had been made and the provider was still not meeting the requirements of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People spoke highly of the care received. One person told us, “The staff are caring.” Another said, "She(staff member) is one of the best.” A visiting relative told us, “I’m happy with how care is provided.”

However we found that people’s dignity was not always promoted. People’s preferences for personal care were recorded but not always followed. We looked at a sample of notes, which included documentation on when people received oral hygiene, bath and showers. Daily documentation showed that people were not always receiving personal care in the way they wished. People we spoke with told us that they had not been offered showers regularly. One person said, “I had to ask the other day as they kept forgetting to help me shower.”

Care plans lacked details on how staff were to manage continence. One person had recently become incontinent at times due to forgetting to go to the bathroom. Staff said, “Just needs reminding and then is fine, but no one reminded this person or prompted them to use the bathroom during the inspection. This person had noticeably damp clothing but staff did not offer to assist the person to change until we asked them as the person had been in damp clothes for one and a half hours. Throughout our inspection we observed that people were not prompted and offered the opportunity to visit the bathroom. People who were not independently mobile were not taken regularly to bathrooms or to ensure they were comfortable if using continence aids.

We arrived at 6:15am and four people were up and dressed and sitting in the dining area. Three people were eating breakfast at one table whilst the fourth person was sitting at adjacent table being shaved by a staff member. The senior said she was instructing a new staff member on how to shave someone. However the staff member were not actually with them and was writing notes. When we asked the manager if this was accepted practice we were told, “Even if they had been training it should still be done in the bathroom or bedroom.” We visited people’s bedrooms and found that five were very sparse There were minimal personal effects on display and bedrooms lacked warmth and homeliness. There were stains on ceilings and some walls were in need of painting. When asked about personal effects one member of staff said, “They damage things so we hide them.” No thought had been given to displaying personal items in a way that was visual but safe. People who live with dementia respond to photographs and mementoes to keep memories alive. This did not promote people’s dignity or treat people with respect.

We noticed that three of the four people that were up at 6.15 am spent the morning asleep in a chair. We asked if staff had tried to resettle people in bed when they awoke, and staff replied they did sometimes. However no one was taken back to their rooms to sleep on either day of the inspection. Bedrooms were locked during the day so people could not access rooms to rest comfortably. We also noted that the patio doors in one corridor were locked which caused some distress to specific people. It prevented them for going on to the patio area as they wished to. This showed a lack of understanding about people’s needs and preferences and also identified that there were not enough staff to monitor the corridors. This meant peoples wishes were not being upheld. People were not asked if they would like to rest on their bed. At 6:30am the senior care staff member, asked their colleague to ‘go and wake (person’s name) up'. They then amended that to ‘go and see if (person’s name) was awake.’ We were then told they did not wake people up but we observed that between 6:30am and 7:00am two other people were woken and then dressed.

During the morning a senior member of staff noted that one person had been incontinent. They shouted across the room to another care staff member to change the person. This was not done in a discreet manner and impacted on the person’s dignity and privacy.

Requires improvement

Is the service caring?

The handover between night and day staff was very brief. The handover took place over the dining table and two staff walked away as handover begun. There was no privacy and the discussion was not very respectful. For example staff said 'X has been speaking gobbledygook all night." "XX "had an unsettled night." There was no explanation given of any action staff took. The daily notes were not reflective of the handover and the handover was only given to one staff member and did not mention all the people in the home.

Whilst we were talking to a person who was very chatty and engaged with us, a staff member interrupted without apology to say a relative was here to talk us. This was not done in a respectful manner and distressed the person we were speaking with.

We found people were not involved in decisions about their care. We spoke to care staff about how people were involved in their lifestyle choices and daily life. One staff member said she wrote down people's life histories. She also said, "We never involve residents in care planning." We then asked senior staff what a specific person's triggers were that made them angry. They said food, lack of privacy and lack of freedom. We asked them what they did to support them when they are feeling like this. Both staff said "There is nothing you can do. We just walk away and sometimes they calm down later and then we go back."

We spoke with one person and we talked about what day it was. They said, "There is no calendar on the wall, I have no idea what day of the week it is." This person also told us that they had family buried in a neighbouring cemetery and said they would like to go there and visit them but this had not been offered. Staff we mentioned this to said "Yes they know the village well," and "I hadn't thought of that." The person could see landmarks from the rear of the premises that reminded them of places they had visited. Two people talked about the walks they would like to go on and said they weren't allowed to. They also said, "We don't really get the opportunity to leave the building or just go to the local public house or any church event." One person told us they had their cigarettes confiscated and they had to ask staff when they wanted one. There was no agreed a plan of action in relation to this person's wish to smoke in their care plan and their wishes were not met.

People were not always treated with dignity and respect and staff were not supporting the autonomy, independence or the involvement in the community of the people living in Green Hill. These issues are a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We did see that four bedrooms were very personalised and contained photographs and items to the individual. One person said, "It's my little haven, I love it. I have a beautiful view of the gardens."

We also saw that when staff had time the interaction between staff and the people who lived in green HIll was friendly and kind. People were comfortable with staff.

Visitors were welcomed throughout our visit. Relatives told us they could visit at any time and they were always made to feel welcome. A visitor said, "I come in each day and the staff always welcome me." The manager told us, "There are no restrictions on visitors."

Requires improvement

Is the service responsive?

Our findings

At the last inspection in November and December 2014, the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which now corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there was an acceptance by people living at Green Hill they had to comply with how care staff wanted to do things, such as task orientated care. Staff did not provide responsive care. There was also a lack of meaningful activities for people.

The concerns identified at the last inspection found significant failings and the delivery of care was not responsive to people's individual needs. An action plan had been submitted by the provider detailing how they would be meeting the legal requirements by 30 June 2015. Improvements had not been made and the provider is not meeting the requirements of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection staff told us they had recently changed the care plans and risk assessments. They said they felt the care plans were good and guided them in to looking after people properly. However care plans were not all reflective of people's changed needs and lacked detail of how to meet a person's changing needs. For example one person had developed some behaviours that were challenging both physically and mentally. The care plan reviews had not captured these changes. When we talked to staff they mentioned the person had changed considerably. There had been no amendment made that indicated a need for one to one time or that changes were needed to their mobility care plan. In another person's care plan there was no mention of recent incontinence and the need for prompting. Another person had swollen lower legs and staff said it was something that flared up. One staff member we spoke with was not aware of the swollen legs and how to assist to reduce the swelling. Another member of staff to put the legs on a stool. There was no recognition that the socks they were wearing were too tight and that the person was finding it difficult to mobilise. This was not reflected in the person's care plan. This meant that new staff would not be able to provide care in the way that was now required.

Mobility care plans did not contain guidance for staff to maintain what mobility people had or encourage people to retain their mobility. For example, they did not offer people the opportunity to move or stand when sitting for long periods of time in a chair or wheel chair. This meant that care delivery was not effective

At the last inspection, we found concerns with the lack of opportunities for social engagement and activities for people. The care plans did not fully reflect some people's specific need for stimulation. At this inspection we saw that activities were not planned and provided in line with people's interests and wishes. We saw that one staff member started a game of catch with a ball on the first day of inspection. It was undertaken in a doorway between two rooms and lasted for about 10 minutes as people did not want to play. No alternative activity was offered. We observed that one staff member sat with 8 people at a table in the dining area for half an hour whilst other staff took a break and no interaction or conversation took place.

Activities were not meeting people's individual interests and hobbies. At our last inspection one staff member had showed us a new activity book that she had been creating. This book was no longer in use. A sensory room was available but was not used for sensory sessions. The manager had also built a bar and café area, with shops that people could buy toiletries and sweets and a library. The plan was to use these areas to provide stimulation and promote independence. However these were not being used and we observed people were bored with little to occupy or distract them. People eventually started to doze off during the morning as there was no stimulation. We saw that the same occurred in the afternoon. People were not encouraged to participate in any form of meaningful activity or make use of the environment. One person told us that they had helped to plant tomatoes, "I used to like gardening." No further planting sessions or gardening 'jobs' had been planned or documented as being needed. Staff did not offer to open the library or shop for people despite that being available.

People told us that there were activities on offer sometimes and enjoyed them. One person told us, "We have had some entertainers that came in." However another person said they were, "pretty bored most of the time." We did see one person on the second day enjoying slicing strawberries for tea. However this was only offered to one person and other people were not encouraged to contribute to any other activity.

Requires improvement

Is the service responsive?

Whilst visitors were welcomed during the day and there were some activities on offer by the provider, there was a need to give more stimulation and individual activities to people over the course of the day. People were not receiving person centred care that reflected their preferences and met their needs.

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

A complaints procedure was in place and displayed in the reception area of the home and in other communal areas. People told us they felt confident in raising any concerns or making a complaint. One person told us, "Yes I know how to moan and I do." Another said, "I would tell one of the staff and I know it would be taken seriously." Complaints were recorded and responded to as per the organisational policy. A complaints log is kept.

Inadequate

Is the service well-led?

Our findings

At the last inspection in November and December 2014 the provider was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which now corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There were concerns identified within the quality assurance process, such as audits not being acted upon to drive improvement and identify shortfalls in care.

The concerns identified at the last inspection found Green Hill was not well-led. An action plan was submitted by the provider detailing how they would meet their legal requirements by 30 June 2015. Sufficient improvements had not been made and the breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was not met.

Quality assurance is about improving service standards and ensuring that services are delivered consistently and according to legislation. This inspection showed us the provider still did not have effective systems in place to monitor the quality of care provided.

Although there were systems to assess the quality of the service provided in the home we found that these were not effective. The systems had not ensured that people were protected against some key risks relating to inappropriate or unsafe care and support. We found continued problems in relation to lack of infection control, odours in some areas of the home, staffing levels, delegation of staff, staff training, and the assessment and meeting of people's needs in relation to their changing needs. New risk assessments were in place but not completed correctly and not checked by the management to ensure effectiveness. For example, a risk assessment stated we bed rails were in place for one person who was also identified as being at risk from getting up and wandering, which was contradictory to managing risk. When we checked there were no bed rails and staff said they had made a mistake on the risk assessment. This had not been identified on the audits.

We saw that the shifts were not always well-led. There were times when staff sat with people and did not ensure all the people supported were safe and supported. We also observed that short cuts in care delivery were not picked up immediately and dealt with to prevent poor practices developing. This included poor practices that were undertaken by senior staff that placed people at risk from injury. For example, pulling people upright without using the appropriate equipment.

The provider had a vision and philosophy that stated "We (Green Hill) aim to identify the very nature of each person to ensure that our service satisfies and assures them in every aspect. However staff could not tell us how they ensure it in practice or what it meant. The culture of the home did not reflect person centred care as described by the statement. People's wishes were not always taken into consideration by staff, for example, visiting the cemetery and walks in to the village.

The staff training plan told us that new staff had not undertaken essential training to keep people safe. Induction for new staff was minimal and the competency of new staff was not assured before working independently in the home. Some induction check lists for new staff were not signed by their mentor as competent. One senior care staff member said "I presume they are ok as the manager said they could go on to working alone." No checks had been undertaken to ensure that new staff were competent. We looked at individual training certificates within staff files, these identified that some senior staff had attended training. However from observation the training was not being put in to practice to meet people's needs safely. For example moving people safely. This had not been identified by the management team through regular supervision of staff.

The provider had not sought expert advice and support as necessary when people's mental health needs changed. We saw that people who had behaviours that challenged staff and the other people who lived at green Hill were placed at risk from care that was inadequate.

All the issues above were a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We have not received the statutory notifications of deaths for three months in a timely manner. An unexpected death occurred in May 2015 that was not reported to Social Services or to CQC.

This is a breach of Regulation 16 of the Care Quality commission (Registration) Regulations 2009.

Inadequate

Is the service well-led?

Systems were now in place to obtain the views and new ideas of staff. We were told senior staff meetings were being held on a regular basis by the senior staff. One senior care staff said, "Usually the seniors meet together and put changes forward, it was their idea to have new daily notes. This was put forward and was to be implemented next week." Staff told us these were an opportunity to discuss any issues relating to individuals as well as general working practices and training requirements.Staff commented they found the forum of staff meetings helpful and felt confident in raising any concerns. Feedback from staff told us that staff felt supported, that communication had improved and they felt listened to. Visitors told us, “Communication has improved, the manager is always visible and we are welcomed by every member of staff.”

Staff commented on improvements that had been made and they felt they worked more as a team now. They commented that care and communication had improved considerably. One care staff member said, “I feel supported and can be honest when things are not right, I really feel listened to and I like coming to work now.”

The manager confirmed as an organisation they had been open and honest with staff and kept staff informed of the last inspection and the failings identified. Staff confirmed they been kept updated and involved in discussions on how improvements could be made. The staff felt they were important to the running of the home.

This section is primarily information for the provider

Enforcement actions

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

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 not ensured the safety of service users by assessing the risks to the health and safety of service users of receiving the care or treatment and doing all that is reasonably practicable to mitigate any such risks. Regulation 12 (1) (a) (b) (e) (g) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The provider had not ensured that there were sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in the service to meet service user's needs. Regulation 18 (1) (2) (a) (b) (c) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The provider had not ensured that service users were treated with dignity and had their privacy protected. Regulation 10 (1) (2) (a) (b) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent

This section is primarily information for the provider

Enforcement actions

Where people did not have the capacity to consent, the registered person had not acted in accordance with legal requirements.

Regulation 11 (1) (3) (4) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 CQC (Registration) Regulations 2009 Notification of death of a person who uses services The provider had not informed CQC of the death of service users by means of a notification. Regulation 16 (1) (a) (b) of the Care Quality Commission (Registration) Regulations 2009.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs The provider had not ensured that the nutritional and hydration needs of service users were met. Regulation 14 (1) (2) (a) (b) (4) (d) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had not ensured that service users were protected from unsafe care and treatment by the quality assurance systems in place. Regulation 17 (1) (2) (a) (b) (c) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Accommodation for persons who require nursing or personal care

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

The provider had not ensured that service users received person centred care that reflected their individual needs and preferences.

Regulation 9 (1) (a) (b) (c) 3 (a) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014