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Greetwell House Nursing Home

Inspection report

Greetwell House
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Tel: 01522521830

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Greetwell House Nursing Home is registered to provide accommodation for up to 25 people requiring nursing or personal care, including older people and people with physical disabilities. There were 19 people living in the home on the day of our inspection.

We inspected the home on 8 November 2016. The inspection was unannounced.

The home had no registered manager. The last registered manager left in May 2016 and the home had been without a permanent manager since that time. At the time of our inspection visit, two of the nurses were providing some management support to the home, in addition to their nursing duties. A registered manager is a person who has registered with CQC to manage the service. Like registered providers ('the provider') they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During our inspection we found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had failed to properly assess and mitigate risks to people's safety; staffing levels were insufficient; staff did not always respect people's privacy and dignity; people did not receive person-centred care that met their needs and personal preferences; the ratings of previous CQC inspections were not on display in the home and the provider had failed to establish systems and processes to mitigate risks relating to people's health, safety and welfare and to assess, monitor and improve the quality of the service.

We also found one breach of the Care Quality Commission (Registration) Regulations 2009.This was because the provider had failed to notify us of issues relating to the safety and welfare of people living in the home.

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

We have taken action against the registered provider to ensure that they make the necessary improvements to become compliant with legal requirements. You can see what action we have taken at the end of the full version of this report.

We found other areas in which improvement was required to ensure people received the safe, effective, caring and responsive service they were entitled to expect.

Although people's healthcare needs were monitored and supported through the involvement of a range of professionals, some people said they did not always receive prompt medical attention when they were unwell.

The systems for the induction and training of staff were not consistently effective. Additionally, staff were not provided with sufficient supervision and support.

At times, staff supported the people who lived in the home in a task-centred way and failed to establish warm, friendly relationships with them.

CQC is required by law to monitor the operation of the Mental Capacity Act, 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves. At the time of our inspection, DoLS authorisations had been granted for three people living in the home and two further applications were in the process of being assessed by the local authority. Although staff had an understanding of the MCA, their use of best interests decision making processes did not always ensure people's legal rights were fully protected.

In a small number of areas, we found the provider was meeting people's needs effectively.

The recruitment of new staff was managed safely. People were provided with food and drink of good quality that met their needs and preferences. Staff encouraged people to maintain their independence.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not consistently protected from the risk of falling.

Some parts of the home were unclean and laundry arrangements created a risk of cross-infection.

Some aspects of the premises and equipment were unsafe.

There were insufficient staff to meet people's care and support needs.

Some people's medicines were not managed safely in line with good practice and national guidance.

The recruitment of new staff was managed safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The systems for the induction and training of staff were not consistently effective.

Staff were not provided with sufficient supervision and support from senior staff.

People's healthcare needs were supported through the involvement of a range of professionals, although some people said they did not always receive prompt medical attention when they were unwell.

The provider's use of best interests decision making processes did not always ensure people's legal rights were fully protected.

People were provided with food and drink that met their needs and preferences.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not always treated with dignity and respect.

Staff did not consistently respect people's privacy.

At times, staff supported people in a task-centred way and some interactions lacked warmth.

Is the service responsive?

Inadequate

The service was not responsive.

People were provided with insufficient stimulation and occupation to meet their individual needs and wishes.

The provider's approach to care planning was ineffective in ensuring staff supported people in a responsive and person-centred way.

People and their relatives knew how to raise concerns although the provider did not maintain a record of any formal complaints received.

Is the service well-led?

Inadequate

The service was not well-led.

There was no registered manager.

The provider had failed to ensure suitable alternative management arrangements were in place to ensure the effective running of the home.

The provider had failed to make the improvements identified as necessary at our last full inspection of the home.

The systems for auditing and monitoring the quality of service provision were ineffective.

The provider had failed to notify CQC of issues relating to the safety and welfare of people living in the home.

The provider had failed to display the ratings from previous CQC inspections as required by the law.

Greetwell House Nursing Home

Detailed findings

Background to this inspection

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

We visited Greetwell House Nursing Home on 8 November 2016. The inspection team consisted of an inspector, an inspection manager, a specialist advisor whose specialism was nursing 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. The inspection was unannounced.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form the provider completes to give some key information about the home, what the home does well and improvements they plan to make. The provider returned the PIR and we took this into account when we made the judgements in this report.

In preparation for our visit we also reviewed information that we held about the home such as notifications (events which happened in the home that the provider is required to tell us about) and information that had been sent to us by other agencies including the local authority contracting and safeguarding teams.

During our inspection visit we spent time observing how staff provided care for people to help us better understand their experiences of the care they received. We spoke with six people who lived in the home, seven visiting relatives or friends, one of the two nurses who were providing some management support to the home ('the person-in-charge'), the owner ('the registered person'), five members of the nursing and care staff team, and two members of the kitchen team. We also spoke with two local healthcare professionals who visited the home during our inspection visit.

We looked at a range of documents and written records including six people's care records and staff recruitment and training records. We also looked at information relating to the administration of medicines and the auditing and monitoring of service provision.

Inadequate

Is the service safe?

Our findings

On our last full inspection of the home in February 2015 we found the provider to be in breach of the Health and Social Care Act 2008, as there were insufficient staff to meet people's needs. In September 2015 we conducted a follow up inspection and found that staffing levels had improved and the breach of regulations had been addressed. However, on this inspection people told us that staffing levels were, again, a cause for concern.

Everyone we spoke with told us that there were insufficient staff to meet their needs. For example, one person said, "Last Friday, they were so short of staff, I had to miss my bath." Another person said, "I had to wait two weeks for a bath." Staff also shared their concerns. One staff member told us, "Staffing levels were lower in the summer when we had a couple of empty bedrooms. Just recently we've started getting four [care staff] in the morning. [But] it's not enough when you are looking after them properly. [We] can't get everyone down for breakfast. [And] now we've got to make the beds as well. When I was on last week [there were] four on in the morning. But the nurse took one carer off halfway through the morning shift. They sent them home so they could do the night shift." Another staff member said, "[There is] not enough staff. Sometimes we need an extra pair of hands. If we were getting a resident up and [realised that] they needed an extra carer it means someone else is left [to wait] for a while."

Reflecting these comments, during our inspection visit we saw occasions when staff appeared to lack sufficient time to properly meet people's individual needs. For example, on one occasion we watched a member of staff supporting someone to eat yoghurt. The staff member stood over the person, rapidly feeding one spoonful after another into their mouth. On another occasion, we observed one person tell a member of staff that another person was slipping down in their chair. But no one came to check the person or help them adjust their position, increasing the risk that they might fall out of their chair or sustain some other injury.

People also shared their worries about the safety of night staffing levels, when only two staff were on duty in the home. Some people were particularly concerned about what would happen if an ambulance had to be called in the middle of the night. The person-in-charge confirmed, that should this ever happen, the person would have to travel in the ambulance on their own, as both night staff would have to stay in the building. Staff also expressed their concerns about the potential impact of the night staffing levels on people's safety. They told us that one of the two members of staff on duty at night was expected to do the laundry which was in the basement of the home and also to undertake cleaning duties. As many of the people who lived in the home required two members of staff to support them if they needed to move during the night, this meant that the provider could not be assured that people's needs would always be met in a safe and timely way.

People also told us that staff were too busy to spend time interacting with them socially. For example, one person said, "The staff are too busy to spend time with us." Reflecting this comment, throughout our inspection visit we saw people sitting for long periods of time with little stimulation or occupation and only occasional interactions from passing staff. One staff member told us, "[We] don't often have time to sit and chat to them." Another member of staff said, "We go round and chat when we can. [But] there is not really

enough time to do this. [We] would like more time."

When we discussed staffing levels with the person-in-charge she told us that afternoon staffing had been increased about two months ago, at the registered person's suggestion, to reflect the fact that more people were living in the home. However, despite the feedback we had received from people and staff, she said she thought that morning staffing levels were "adequate." The person-in-charge also told us there was no dependency tool or other systematic approach for reviewing people's needs and the staffing levels required to meet them.

The provider's failure to deploy sufficient staff to meet people's care and support needs and to ensure their safety at night was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although some people and their relatives told us that they felt safe living in the home, during our inspection visit we identified multiple concerns about people's safety and welfare.

We looked at people's care records and saw that a range of possible risks to each person's safety and wellbeing had been considered and assessed, for example skin care, mobility and nutrition. However, the provider's management of some of the identified risks was ineffective and did not keep people safe from harm, particularly in respect of the risk of falling. For example, one person's care plan recorded that they had fallen four times in the previous 12 months, on one occasion sustaining a serious injury requiring hospital treatment. Despite this pattern of regular falls, there was no evidence that staff had taken any action to minimise the risk of further falls, such as making a referral to the local NHS falls service. When we spoke to the person-in-charge about this person's most recent fall, in which they had sustained a cut to their head, they said, "[We haven't taken any] precautions as a result of the latest accident. There is no need for any change." Another person had fallen at least 15 times in the previous three years and, again, there was no evidence that staff had sought professional advice or considered any additional measures to reduce the risk of further falls. Some care staff told us that they did not look at people's individual care plans, further increasing the risk to people's safety. For example, one staff member told us, "I haven't looked at [the] risk assessments. I know that's strange."

We identified concerns with the cleanliness of some areas of the home which presented an increased risk to people's health and safety. The sluice room was dirty with a large amount of faeces in one of the sinks which was also rusty and worn. We found high level cobwebs in two bathrooms although one of the housekeeping staff told us these rooms had been cleaned the day before our inspection. Light pull cords in some of the toilets and bathrooms had become extremely dirty, creating a risk of cross-infection. We also identified concerns about the laundry arrangements in the home. Staff told us that any soiled laundry was sealed in special red plastic bags which were then put into red cotton bags and taken to the laundry to be washed. However, staff said that there weren't enough of the red cotton bags which meant that red plastic bags were sometimes left loose on the floor of the laundry, creating a further cross-infection risk. One staff member told us, "[I've seen] red bags just sitting on the floor [of the laundry] waiting for someone to put them in the machine." Staff also expressed their concern that there was only one, domestic-type washing machine, which was used for all the laundry in the home including table cloths and soiled sheets. Almost six weeks before our inspection visit, a local authority contract monitoring officer had visited the home and asked, as part of a wider action plan, that the provider identify a member of staff to take on the role of infection control link practitioner, as part of a county-wide initiative to improve standards in this important area. However, at the time of our inspection this had not been done which meant staff lacked a valuable opportunity to keep up to date with best practice guidance.

We also identified some concerns with the safety of the premises and equipment. For example, we noticed that the lift that serviced the ground and first floors of the home had a large crack in the glass entrance door. Although this had been taped up, it still presented a risk of injury to anyone using it. When we raised this issue with the person-in-charge she acknowledged that the door had been damaged for several months. The ground floor bathroom had insufficient space to accommodate a hoist safely and staff told us that one of them had trapped their hand a number of times. Staff told us they had raised this issue with senior colleagues but that no action had been taken.

We reviewed the provider's management of people's medicines and found that this was not consistently safe. The storage and administration of most people's medicines were managed correctly. However, the arrangements in place for any 'controlled drugs' (medicines which are subject to special legal requirements) did not meet the requirements of good practice and national guidance, as there was no system in place for regular stock checks of these medicines. There was no evidence of regular checks of the temperature of the medicines fridge, to ensure medicines were kept at the correct temperature and were safe for people to take. Additionally, the fridge was operating above the correct temperature for safe storage of medicines and was in urgent need of defrosting and cleaning to rectify this issue.

Taken together, the provider's failure to properly assess and mitigate risks to people's safety was a breach of Regulation 12(2)(a),(b),(d),(e),(g) and (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were aware of how to report any concerns relating to people's welfare. They had received training in this area and understood how to escalate concerns to external organisations, including the local authority safeguarding team and CQC. However, some staff said they were unwilling to do this because senior staff might be able to identify who had raised an alert. This reluctance to use procedures designed to safeguard and protect people, created a further potential risk to people's safety and welfare.

The provider had safe recruitment processes in place. We reviewed two staff personnel files and noted that suitable references had been obtained. Disclosure and Barring Service (DBS) checks had also been carried out to ensure that the provider had employed people who were suitable to work with the people who lived in the home.

Requires Improvement

Is the service effective?

Our findings

Most people we spoke with told us they felt well-cared for. For example, one person's said, "The care is pretty good." Talking specifically about the support they had received with their nutrition, one person told us, "I get weighed every Monday and have started to put on weight." Commenting on their experience of working with the staff in the home, a local healthcare professional told us, "I think the care is good. One lady [receiving end of life care] was treated very well."

However, the provider's approach to staff induction was not consistently effective in ensuring new recruits had the skills and knowledge to support people safely. For example, new members of staff participated in a structured induction programme which included initial training and a period of shadowing experienced colleagues before they started to work as a full member of the team. Reflecting on the 'moving and positioning' training they had received as part of their induction, one new member of staff told us, "I thought it could have been a bit better. [I] just watched videos. [I] thought it would have been more practical training. I didn't feel comfortable." We discussed this person's induction with the person-in-charge who said that staff had recently received practical moving and positioning training from an external trainer. However, she confirmed that this staff member and one other employee had not yet received the training, increasing the risk that people might not be supported safely in line with best practice.

The provider maintained a record of each staff member's annual training requirements and provided a range of courses to meet their needs. However staff told us that they had only recently started to receive this mandatory training. One member of staff said, "For ages, I was wondering why there was no training. At my last home [we were] continually doing one thing after another. It started up [here] a few months ago." We reviewed the provider's training record and saw, reflecting what staff had told us, that action had been initiated recently to ensure staff received the annual training the provider had identified as mandatory. However, there were still significant backlogs in several areas. For example, 13 staff (50% of the staff team) had still to complete their annual infection control training, including three members of the housekeeping team.

Even when staff had received recent training, we found that this was not always reflected in their practice. Although, as outlined above, almost all staff had recently received moving and positioning training, during the course of our inspection visit we observed one occasion on which staff lifted a person to a standing position by supporting them under their armpits. This outmoded practice can result in injury to the person being supported and to staff.

We identified concerns about the levels of supervision provided to staff which also created an increased risk that people would not receive safe, effective care. Recognising the importance of supervision in ensuring that staff had the skills and support necessary to perform their role, the provider's supervision policy stated that, 'The aim of supervision is to provide a regular opportunity for staff with their line manager to … develop understanding and skills within their work .. [and] … receive another perspective concerning their work." The policy also stated that supervision sessions should be held bi-monthly. However, staff told us that they were not provided with supervision in accordance with these policy requirements. For example,

one staff member said, "The last supervision I had was with [the home's last registered manager who left in May 2016]. [There is] no schedule of supervisions that I am aware of." Another staff member told us, "[I've] not had any supervision [and] there's nothing planned. [I am] not aware of the system. I don't know who my supervisor is." When we raised this issue with the person-in-charge she said that supervisions had been re-introduced recently but that, "[It's] taking a while to get it going." When we reviewed the provider's record of staff supervisions we saw that seven staff had received no supervision as defined in the provider's policy throughout the whole of 2016. Another three staff had received no supervision since March 2016.

Staff were aware of the Mental Capacity Act 2005 (MCA). This 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. However, we found that the provider's compliance with the provisions of the MCA was inconsistent and required improvement to ensure people's rights were fully protected. For example, there was a Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) order in one person's care file which set out guidance for staff at the home and emergency services to follow. However, this order did not comply with the principles of the MCA as it was not clear that this extremely important decision had been made in discussion with the person. There was a more recent order on file which had been properly completed, however this was a poor photocopy and was hidden behind the other form. This increased the risk that the person's wishes could be misunderstood in an emergency situation, leading to incorrect action being taken. Additionally, although some decisions that had been taken as being in people's best interests were properly documented in accordance with the MCA, others were not. For example, staff told us about one resident who did not like having a bath. We looked at this person's care file which stated that, if the person did not want to have a bath, staff should 'insist' as it was in the person's best interests. There was no evidence that the advice of relatives had been sought to understand what the person's preferences and habits had been prior to moving into the home. It was also not clear what 'insist' meant when care was being undertaken, whether this should be verbal or physical.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). At the time of our inspection, DoLS authorisations had been granted for three people living in the home and two further applications were in the process of being assessed by the local authority.

From talking to staff and looking at people's care plans, we could see that their healthcare needs were monitored and supported through the involvement of a range of professionals including GPs, district nurses and speech and language therapists. One local healthcare professional told us, "The staff are all very helpful." However, some people said they did not always receive prompt medical attention when they were unwell. For example, one person said, "I asked to see the doctor. I was told the doctor wasn't coming but had prescribed [name of medicine]. But the [medicine] never did arrive." Other people told us that one person was unwell and had been told the day before our inspection that the doctor was coming but they had not arrived. On the day of our inspection, the doctor did come to see the person. We raised this issue with the person-in-charge who told us that qualified nursing staff in the home used their professional judgment to decide whether or not to seek further advice. However, she also said that that the home had good relationships with local GPs who were always happy to visit if needed.

Requires Improvement

Is the service caring?

Our findings

Staff told us they were aware of the importance of supporting people in ways that helped maintain their privacy and dignity. However, during our inspection visit we saw that this was not reflected consistently in their practice. At our last full inspection of the home we also identified concerns in this area and told the provider that improvement was required. It was therefore disappointing to find that the necessary improvement had not been made.

For example, one family member told us that that when their relative first moved into the home, staff had put them in incontinence pads at night, even though they were fully continent. Although the issue had since been resolved, the relative told us that the person had been upset by the actions of the staff concerned. Commenting on this issue, the relative said, "There was no thought of dignity doing that to [name]." At the start of our inspection visit we saw staff making preparations for the hairdresser to wash and cut people's hair in one person's bedroom, despite the fact that the person was being cared for in bed and would have been in their room throughout. When we discussed this clear disregard of the person's right to privacy with the person-in-charge she said, "It's the way it's always been done." However, she then acknowledged that this practice could not continue and made arrangements for the hairdresser to see people in another part of the home. Additionally, we saw that one of the downstairs toilets had a door which opened inwards. This meant that the door could not always be closed, for example when a wheelchair user was in the toilet. A curtain was used to cover the open doorway but this did not close properly which meant people passing in the corridor, including members of our inspection team, caught sight of people using the toilet, comprising their privacy and dignity.

The provider's continuing failure to ensure people's privacy and dignity were promoted and maintained was a breach of Regulation 10(1) and (2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people we spoke with told us that staff had a caring approach. For example, one person said, "The carers are lovely." Staff also told us how important it was to support people in a kind and person-centred way. One staff member said, "I treat them as I would my gran or grandad. When I am old, I'd want [the] people caring for me to be nice." In the main corridor of the home we saw a sign which stated, 'Our residents do not live in our workplace. We work in their home." However, when we reviewed the provider's 'New Staff Information Booklet' which was given to newly recruited members of the care staff team, we saw that this set out a detailed series of 21 tasks that were to be completed each day between 8.00am and 7.30pm. These tasks included 'residents to be toileted, washed and dressed', 'lunch and feeding' and 'wash residents' hands and face, toileting and return clients to lounges'. During our inspection visit we saw this institutional, task-centred routine was reflected in the way staff interacted with people. For example, at lunchtime many of the people in one of the lounges required the use of a hoist to transfer them into their wheelchair. It was a hurried, functional process as wheelchairs were lined up and people removed to the dining room. Staff gave people instructions and did not explain what they were doing or ask people if they did indeed want to be moved. On another occasion, we observed a member of staff standing in one of the lounges making no attempt to engage socially with the six people sitting there. The staff member appeared ill at ease and was

unable to establish a friendly rapport with any of the people in the room. When they did speak to anyone, they stood over them rather than getting down to their level to try and make eye or hand contact.

More positively, staff demonstrated their awareness of the importance of helping people to maintain their independence and to exercise as much choice and control over their own lives as possible. One member of staff said, "People choose when they go to bed. Some go up at half six [but] when I go [off shift] at eight there are still people up when I leave. One lady likes to stay up watching TV till ten." Another staff member told us, "We use [walking] frames where possible, rather than hoisting. To encourage a bit of mobility." Reflecting this approach, during our visit we saw staff supporting some people move around the home as independently as possible. We also saw the cook circulating through the home inviting people to choose what they wanted for lunch. One person said, "The cook asks us what we would like."

The person-in-charge told us that none of the people living in the home had the support of an advocate to help them make decisions and articulate their wishes to the provider and other agencies. Neither was information on local advocacy services provided to people when the first moved in. Advocacy services are independent of the service and the local authority and can support people to make and communicate their wishes. The person-in-charge had no knowledge of services in the local area but said she would, "go online and look it up", should the need arise.

Inadequate

Is the service responsive?

Our findings

At our last full inspection of the home we identified concerns about the amount of stimulation being provided to meet people's needs and wishes, particularly people living with dementia. We told the provider at that time that improvement was required. On this inspection we were concerned to find that no improvement had been made and that, on the contrary, provision in this area had got worse. There was no member of staff employed specifically to facilitate communal activities or other forms of stimulation and occupation. Also, as outlined earlier in this report, the care staffing levels in the home did not enable care staff to take on this role themselves. There was no programme of organised activities or events and, throughout our inspection visit, we saw people sitting in communal lounges for long periods of time with little or nothing to do. For example, on our arrival in the home we noticed a person sitting in the corner of lounge with no source of stimulation. They remained there throughout the day with very little interaction from staff, other than when they were supported to eat their lunch.

Reflecting the provider's failure to respond to people's need for stimulation and occupation, people and their relatives told us of their dissatisfaction. One person said, "I do not do anything." Another person's relative said, "[Name] gets no stimulation." Staff also expressed their concerns about the lack of stimulation in the home and the impact this had on people's well-being. For example, one relatively new member of staff told us, "They must wake up and think I will be sat all day again. No variety, the same old routine. It makes me sad. When I first started working here I asked, 'Is it always this quiet?' [I now know] it is." Another staff member told us, "It is a waste of life sat in a chair all day waiting for the next meal."

We raised our concerns with the person-in-charge who agreed that action was required. She said, "It's true. There's no activities organiser [and] no activities programme at the moment. People [are] left for long periods. [There's] no excuse." She told us that both she and the registered person had started to look at ways in which activities provision could be improved but said that no firm arrangements had yet been made.

We reviewed people's individual care plans and saw that they were detailed and addressed a range of needs including communication, personal hygiene and mobility. However, one of the plans we reviewed contained contradictory information which made it unclear to staff what the person's needs were. One document described the person as 'unable to communicate' whilst another stated they had no issues with communication. Care staff openly acknowledged that they did not look at people's care plans. For example, one staff member said, "I've never read anyone's care plan. I've never been shown them or told where they are." Another member of staff said, "I've never been encouraged to look at care plans. To be honest, I don't refer to them. If you see deterioration [in someone's health] you just work differently."

The provider's failure to have a system in place to ensure that care staff were familiar with people's care plans meant staff lacked knowledge of people's individual needs and preferences, limiting their ability to support them in a responsive, person-centred way. Acknowledging this shortfall, one staff member said, "I don't know if anyone has any hobbies or interests. If I read the care plans, it would be interesting to find out." As a further example of staff's lack of knowledge of people's individual needs and preferences, one

person's care plan stated that the person preferred to take their medicine off a spoon. However, when the medicine was administered, it was given in a dispensing cup in the same way as everyone else's medicine.

Although care plans described people's needs, they did not address how these needs could be managed in a person-centred way. For example, one person's care plan advised staff to seek advice from a family member but did not state in what circumstances this might be helpful and there was no record that this had ever been done. The same person's file also described how they could become challenging and resistant to staff undertaking personal care but did not describe how this could be managed or how they could be supported in a way that did not trigger this distressed behaviour. We also saw that aspects of the plans were generic and did not support a person-centred approach. For example, plans for people who had difficulty communicating contained statements such as 'observe [name] for signs of discomfort or distress'. Only the person's name had been changed and the plans did not describe each person's individual ways of expressing discomfort or distress. This meant staff lacked information on how to recognise important signals and triggers.

The provider's failure to ensure people received person-centred care that met their needs and personal preferences was a breach of Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Information on how raise a concern or complaint was provided in a 'complaints folder' in the reception area of the home, although this was dated 2007 indicating it had not been reviewed or updated for some time. The person-in-charge told us that this information was also included in a booklet that was supposed to be given to people when they first moved into the home, although she confirmed that the booklet had not been issued to people who had moved in recently. The person-in- charge told us she that was well-known to people and their relatives and this helped resolve any issues without the need for a formal complaint. Describing her approach she said, "I am out on the floor 8am to 8pm, whenever I am here. I know them all, residents and relatives. My door is always open and they just pop in." The person-in-charge said that any formal complaints were dealt with by the registered person. However, no formal record of these complaints was maintained.

Inadequate

Is the service well-led?

Our findings

The home did not have a registered manager. The last registered manager had left in May 2016 and the provider had failed to put in place suitable alternative management arrangements to ensure the effective running of the home. The registered person told us that he had appointed a new manager in September 2016 but that they had only worked for three days before taking a period of extended leave. The registered person told us that he was hopeful this person would return to their role and was therefore not taking steps to recruit a permanent replacement. However, shortly after our inspection visit, the person contacted us directly. They told us that they would not be returning and that they had made this clear to the registered person when they left. In the absence of a manager, the registered person had asked two of the nurses to provide temporary management support to the home. However, neither nurse had been given any dedicated office time and they were expected to discharge their new management responsibilities in addition to their continuing responsibilities as a nurse. On the day of our inspection, neither nurse was on shift although one of them came in on her day off to help support the inspection process, as the person-in-charge for the day.

Although staff told us that they found the person-in-charge to be approachable and supportive, she was clearly struggling to establish her authority in her temporary role. Talking of her relationship with the care staff, the person-in-charge said, "I don't feel in charge with the carers at times." Agreeing with her colleague, another nurse commented, "[The care staff] don't listen to the nurses, not me anyway." Care staff also voiced their concerns. One told us, "It's the worst place I have worked. We never seem to have a manager half the time. I wouldn't recommend it to others because of the way it is run. It's not well organised." Another member of staff said, "[The person-in-charge] is kind and helpful [but] the home needs a manager. If we had a manager, hopefully we could get it more organised."

The registered person's failure to ensure settled leadership arrangements and effective management systems and processes had helped to foster an unhealthy organisational culture in the home. For example, some staff said that they would not be comfortable raising concerns about senior staff or the provider. They told us they were aware of the provider's whistleblowing policy but said that where it was on display in the home meant that senior staff would be aware that they were checking it and would know who had raised concerns. As described earlier in this report, staff also told us they were aware of how to raise a safeguarding alert with the local authority, if they had any concerns about people's safety or welfare. However, some staff said they were unwilling to do this because senior staff could check the date of any referral against the staffing rota for that day, to work out who had raised the alert. This created an increased risk to people's safety and welfare.

Staff told us that they did not always work together in a mutually supportive way. One staff member said, "The atmosphere in the staff team is not very good sometimes. [We need] a bit more communication." Another member of staff said, "[Sometimes] you feel like you are not part of the team. I have felt like walking out and going home." Staff also expressed their concerns that confidentiality was not always respected. For example, one staff member told us that they had been asked to make a statement about an incident and that this had been discussed in the nurses' office with the door open, so that other staff had overheard.

Although there were regular team meetings, staff told us they were not effective in promoting better team work and communication within the home. For example, one staff member told us, "We were asked to put all our concerns in a red book in the office. However, at the last team meeting all our concerns were ignored."

The provider had a number of systems in place to monitor the quality of service delivery but these were not consistently effective in promoting service improvement. Audits of equipment such as wheelchairs and mattresses were undertaken on a monthly basis and fire safety and electrical equipment had been checked and serviced as required. However, in other important areas including infection control, care planning and medicines, audits had not been conducted regularly. For example, the last medicines management audit had been conducted in April 2016, over six months before our inspection visit. Additionally, audits in some areas, including training, had identified areas for development and improvement but we found no evidence that action had been taken in response. This was compounded by the fact that some of the audit tools offered only 'yes/no' tick box options. This meant that they could not be used effectively to identify specific issues and describe what action had been taken to address them. We also found that some audits were completed incorrectly and contained potentially inaccurate information. For example one audit stated that every person's care record had a photograph of the person on file. However, three of the records we reviewed did not contain a photograph.

On our last full inspection of the home in February 2015 we identified concerns in a number of areas and told the provider that improvement was required. However, as detailed elsewhere in the report, on this inspection we found that the provider had not made the necessary improvements and, in some areas, there had been a further deterioration. The provider's failure to take effective action to address the areas for improvement highlighted at our last inspection meant people were not receiving the safe, effective, responsive and caring service they were entitled to expect.

Taken together, the provider's failure to establish systems and processes to mitigate risks relating to people's health, safety and welfare and to assess, monitor and improve the quality of the service provided and was a breach of Regulation 17(2)(a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider maintained records of untoward incidents or events. However, in preparing for our inspection visit, we noted that in the previous 12 months there had been several cases involving people using the service that had been considered by the local authority under its adult safeguarding procedures but which the provider had not notified to CQC, as required by the law.

This was a breach of Regulation 18(e) of the Care Quality Commission (Registration) Regulations 2009.

Neither the report nor the ratings of our last two inspections of the home were on display in the home, again as required by the law.

This was a breach of Regulation 20A(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The systems in place to enable people to make suggestions for improvement were ineffective. There was a suggestion box in the entrance hall. However, the person-in-charge was unclear about what happened to any suggestions that had been put in the box. There was no record of any suggestions that had been made or any action taken in response. Acknowledging the shortfall in this area, the person-in-charge told us that she had designed a new customer satisfaction questionnaire and planned to introduce it shortly.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered person had failed to notify CQC of issues relating to the safety and welfare of people living in the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The registered person had failed to ensure the ratings of our last two inspections were on display in the home

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	The registered person failed to ensure people received person-centred care that met their needs and personal preferences

The enforcement action we took:

Additional condition of registration imposed. The registered provider must not admit any service user to the location Greetwell House Nursing Home without the prior written agreement of the Care Quality Commission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	The registered person had failed to ensure people's privacy and dignity were promoted and maintained

The enforcement action we took:

Additional condition of registration imposed. The registered provider must not admit any service user to the location Greetwell House Nursing Home without the prior written agreement of the Care Quality Commission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The registered person had failed to properly assess and mitigate risks to people's safety.

The enforcement action we took:

Additional condition of registration imposed. The registered provider must not admit any service user to the location Greetwell House Nursing Home without the prior written agreement of the Care Quality Commission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
	The registered person had failed to establish

Treatment of disease, disorder or injury	systems and processes to mitigate risks relating to people's health, safety and welfare and to assess, monitor and improve the quality of the service provided

The enforcement action we took:

Additional condition of registration imposed. The registered provider must not admit any service user to the location Greetwell House Nursing Home without the prior written agreement of the Care Quality Commission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person had failed to deploy sufficient staff to meet people's care and support needs and to ensure their safety.

The enforcement action we took:

Additional condition of registration imposed. The registered provider must not admit any service user to the location Greetwell House Nursing Home without the prior written agreement of the Care Quality Commission.