Greenroyd Residential Home Limited

Greenfield House

Inspection report

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26 October 2017

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This unannounced inspection took place on 19, 24 & 26 October 2017.

Greenfield House is situated in Morecambe and is registered to provide care and accommodation for up to 33 people living with dementia. All accommodation is offered on a single room basis. The home has a variety of communal areas for people to use. There are passenger and stair lifts for ease of access between floors. There were twenty people living at the home at the time of the inspection visit.

At the time of the inspection visit there was no registered manager in place. The registered manager left the service and de-registered with the Commission in July 2017. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service was last inspected on 12 and 13 December 2016 and was rated as Requires Improvement. This was because we identified a breach to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014 and a breach to CQC Registration Regulations 2009. Following the inspection visit we asked the registered provider to submit an action plan to demonstrate how they intended to make the required improvements to meet the fundamental standards. The registered manager told us improvements would be in place by 01 February 2017.

At this inspection visit carried out October 2017, we found the required improvements had not been made. Breaches to Regulation 12 of the Health and Social Care Act (2008) Regulated Activities 2014 and Regulation 18 of the 2009 Care Quality Registration Act remained. The registered provider failed to have suitable systems for the safe management of medicines. Processes did not allow for all medicines to be suitably accounted for. Stock check balances identified discrepancies between stock held and stock administered. We identified one occasion when one person did not have their prescribed gel in stock because the registered provider had run out. Reporting processes to ensure the Commission received statutory notifications were inconsistent and not all notifications were received by the Commission as legally required. In addition, breaches to Regulations 11, 13, 15, 17, 18 and 19 of the Health and Social Care Act (2008) Regulated Activities 2014 were identified as part of this inspection process.

We identified five safeguarding incidents had occurred at the home since the last inspection visit. There was no evidence to show all these incidents had been investigated or referred on to the local authority safeguarding team. Staff told us they had reported concerns to management but were unsure what action was taken after information had been shared.

At this inspection visit there was no cleaner employed at the home. Procedures for carrying out cleaning tasks were unclear and staff told us they did not have time to carry out additional cleaning duties. Infection control processes were inconsistent. We noted malodours throughout the communal areas and some

bedrooms were dirty. During the inspection visit we found stained bed bases, stained chairs and a carpet and door with faeces on it.

Risk was not suitably identified, managed and addressed. Risk assessments for people with specific medical conditions were not always in place to support staff to give effective care and treatment. When people displayed behaviours which challenged the service we found risk management plans were not in place to direct staff protect the person and other people who lived at the home.

Equipment at the home to support staff manage risk was not suitably maintained and fit for purpose. On the first day of our inspection visit we found the door security system was not sufficient and jeopardised the security of the home. The call bell system was not fit for purpose and not fully functioning. The fire alarm had not been serviced since 2015. Areas of the home were in a poor state of disrepair.

Deployment of staffing did not always meet the needs of people who lived at the home. Staffing levels had not been reviewed to reflect the needs of people who lived at the home, including those individuals who displayed behaviours which challenged the service. Poor deployment of staff meant oversight of people who lived at the home was inconsistent. A high rate of accidents and incidents were unwitnessed by staff.

Staff told us they were not fully equipped with the required skills and knowledge to carry out their role. We viewed records maintained by the registered provider and found training for staff was out of date and missing. This lack of training had impacted upon the quality of care provided.

Staff told us they received supervision with a manager of the senior management team. Staff questioned the effectiveness of this however as they said they were not always listened to.

Care records were inaccurate and had information missing. Care plans and documentation did not always identify people's risk and did not always reflect people's health needs. Care records were not consistently updated when people's care needs had changed.

Auditing systems at the home were inconsistent and ineffective. This meant concerns identified during this inspection process were not identified by the registered provider and proactively managed.

Processes for ensuring consent was suitably achieved were inconsistent. Care and treatment given was not always in line with the consent provided. Procedures for ensuring people were lawfully deprived of their liberty were not always followed.

Recruitment processes for ensuring staff were suitably qualified to work with people who may be vulnerable were not suitably implemented as suitable checks were not consistently applied. □

We received mixed feedback about the quality and suitability of the food provided at the home. We observed meals being served at the home and found the meal time support did not promote and enhance a positive experience. In addition, not all meals had a suitable nutritional value. We have made a recommendation about this.

The registered provider had a system for managing complaints. We received mixed feedback about the effectiveness of the complaints system at the home. We have made a recommendation about this.

Observations made during the inspection process showed that staff providing direct care and support was positive. We observed staff being patient and kind with people. People who lived at the home told us they

had good relationships with the staff.

We observed some activities taking place at the home. Staff told us these were limited as they did not always have time to carry out activities. We have made a recommendation about this.

We received mixed feedback about the effectiveness of the management team at the home. People who lived at the home were aware as to who to speak with if they had concerns. Two of four relatives spoke positively of the management team and their willingness to provide good quality care. Staff said the registered provider did not always listen to them and recommendations to improve the quality of care were not always considered.

We received conflicting information from relatives of people who lived at the home about the ability to make suggestions and drive change at the home. One relative told us they were not consulted with, whilst the remaining relative told us they offered support and guidance to the nominated individual but was not listened to. Another relative told us they were only consulted with when things went wrong at the home.

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

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

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

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

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

Procedures were not consistently established and followed to ensure safeguarding concerns were suitably managed.

Processes for ensuring staff were suitable for working with people who may be vulnerable were not consistently implemented.

Risk was not consistently addressed and managed within the home.

Suitable arrangements were not in place for safe management all medicines.

The premises were not suitably maintained to ensure people who lived at the home were safe.

Is the service effective?

Inadequate

The service was not effective.

Processes for ensuring people were lawfully deprived of their liberty were inconsistent. DoLS applications failed to accurately reflect restrictions in place.

Staff did not have suitable and sufficient up to date training to meet the individual needs of people they supported.

Nutritional and health needs were sometimes met by the service. However, good practice guidelines were not consistently followed to enhance the dining experience for people.

People's health needs were not consistently met in a timely manner.

Is the service caring?

Requires Improvement

The service was not always caring.

People told us positive relationships were sometimes limited due to staff not having time to spend with them.

We observed staff being kind and patient with people who lived at the home.

People were not always treated with dignity and respect.

Equality and diversity was not always reviewed and considered.

Is the service responsive?

Requires Improvement

The service was not always responsive.

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

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

Activities were available for people who lived at the home but these did not always keep people suitably occupied.

The service had a complaints system in place. We have made a recommendation about this.

Is the service well-led?

Inadequate

The service was not well led.

Systems for reporting statutory notifications were weak and notifications were not provided to the Commission in a timely manner. Procedures for responding to safeguarding concerns were ineffective.

There was no registered manager at the home. Processes in place to ensure suitable oversight at the home were weak.

Documentation did not always reflect people's assessed needs

and risks. Records reviewed were sometimes inaccurate and incomplete. Quality audits of the service were weak and ineffective.

Staff said they did not feel valued and described morale at the home as low.

Greenfield House

Detailed findings

Background to this inspection

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

This inspection took place over three days on 19, 24 and 26 October 2017. Each visit was unannounced. On the first day of the inspection the inspection team was made up of two adult social care inspectors and an expert by experience. The expert by experience was a person with experience of caring for older people. On the second day two adult social care inspector's visited the home. One adult social care inspector returned alone on the third day to complete the inspection process.

Prior to the inspection taking place, information from a variety of sources was gathered and analysed. We spoke with the Local Authority contracts and safeguarding teams as well as the Clinical Commissioning Groups responsible for commissioning care. We used the information provided to inform our inspection plan.

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

Throughout the inspection process we gathered information from a variety of sources. We spoke with six people who lived at the home to seek their views on how the service was managed. We found not all of those who lived at Greenfield house were able to communicate fully with us. Therefore, during our inspection, we used a method called Short Observational Framework for Inspection (SOFI). This involved observing staff interactions with people in their care. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with four relatives and twelve members of staff. This included the nominated individual, and a manager who was overseeing the service.

To gather information, we looked at a variety of records. This included care plan files related to ten people who lived at the home. We also looked at other information which was relative to the service. This included health and safety certification, training records, team meeting minutes, policies and procedures, accidents and incidents records and maintenance schedules.

We viewed recruitment files relating to four staff members and other documentation which was relevant to recruitment including Disclosure and Barring Service (DBS) certificates.

As part of the inspection process we looked around the home in both communal and private areas to assess the environment to check the suitability of the premises.

Following the inspection visits we shared information with the local authority safeguarding team, the local authority environmental health services, the fire and rescue service and the local authority infection, prevention and control team.

Inadequate

Is the service safe?

Our findings

At the inspection visit carried out in December 2016, we found systems for ensuring the safe management of medicines were inconsistent. People did not always receive their medicines in a timely manner due to inappropriate ordering and supply of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008, (Regulated Activities) 2014. We asked the registered manager to complete an action plan to tell us how they intended to make the required improvements. The registered manager provided us with an action plan to state they would be complaint with the Regulation by February 2017.

We used this inspection carried out in October 2017, to check improvements had been made and medicines were being suitably managed. We found not all improvements had been made and a breach to Regulation 12 continued. On the first day of the inspection visit we identified medicines stock on the floor of a treatment room. The staff member responsible for medicines that day confirmed the stock had been received from the pharmacist the day before. They told us medicines were not routinely booked in on receipt from the pharmacy. They said they would be booked in by a senior member of staff later that week. This meant medicines on the premises could not be fully accounted for at all times.

We looked at stock checks of medicines in use and randomly spot checked four people's medicines. We did this by cross referencing information held upon the medicines administration record (MAR) and by counting the number of medicines in stock. We found two people's medicines stock did not balance. For example, one person's medicines stated there should have been 14 tablets in stock. We found there were 49 tablets remaining. In addition we found stocks of medicines for two people which were not documented on the persons MAR record as being in use. One person had 63 paracetamol tablets on stock but it was not recorded on the persons MAR record that these tablets were prescribed for the person. This demonstrated that medicines at the home could not be fully accounted for.

We asked the nominated individual about ordering processes for medicines at the home. They said controlled drugs were routinely checked in at the home as soon as they were received by the pharmacy. However, other medicine stocks were not routinely checked in immediately. We asked the nominated individual if stock checks of medicines took place. The nominated individual said stock checks were included upon the monthly audit and showed us a completed audit. The nominated individual said they checked stock by looking at people's medicines trays to ensure all medicines had been taken from the tray. They confirmed there were no provisions to ensure variable dose and medicines prescribed on an as and when basis were accurate. This demonstrated that checks upon medicines were ineffective.

During the inspection visit, it was noted the senior carer on shift signed to state that people who had creams and ointments prescribed had had these administered. We asked the senior carer about protocols. They confirmed staff providing care and support administered the creams and ointments but the senior carer on shift signed for the medicines. The senior carer could not provide us with assurances they were certain that creams and ointments had been prescribed as directed at the time directed despite signing to state they had. When people required medicines on an as and when basis, (PRN) we found PRN protocols were not in place. PRN protocols prevent mis-use of medicines and provide direction as to why the medicines are

required and the directions of use. This demonstrated systems to ensure people received the appropriate medicines, as directed, were ineffective.

During the inspection visit, we were made aware one person who lived at the home self-administered their own medicines. We reviewed the care record for the person and noted the person was known to have short term memory loss. There was no evidence within the person's care plan to show checks had taken place to ensure the person was competent to administer their own medicine.

This was a breach of Regulation 12 of the Health and Social Care Act 2008, (Regulated Activities) 2014 as suitable processes for the safe management of medicines were not in place.

As part of the inspection process we carried out a visual inspection of the home. We found areas of the home were not cleaned to a suitable standard. For example, we found chairs in communal areas were stained. The flooring in the dining area was stained and in a poor state of repair. We found beds in use with stained matter upon them. One bedroom carpet and door had faeces on them. Communal toilets were unclean and had malodours. Hand hygiene equipment was not readily available throughout the home.

We asked the nominated individual to show us the cleaning schedules maintained by staff to evidence that cleaning had taken place. The nominated individual was unable to locate any cleaning schedules for day time cleaning. We reviewed night time cleaning schedules and found these had not been consistently completed by night staff. When schedules had been completed they had been signed by a senior member of staff to indicate the cleaning was of a required standard. This however conflicted with what we saw as part of our visual inspection.

On the first day of the inspection visit we were made aware the home did not currently employ a cleaner. The cleaner had left the organisation seven weeks previous. The nominated individual said they had found a replacement cleaner but this had not worked out. They told us they had identified another person to take on the cleaning role but were still waiting for checks to be completed on the person. The nominated individual said in the interim they carried out cleaning duties alongside the manager and a cleaner from their other home.

We looked at a rota provided and saw the nominated individual had assigned themselves and the manager some cleaning duties throughout the week. This was not consistent however and did not cover all days of the week. This meant that cleaning duties were unassigned to staff and there was no person allocated cleaning responsibilities.

We asked staff about interim arrangements for cleaning at the home, in the absence of a manager. Staff told us they were expected to carry out additional cleaning tasks on top of their normal duties. They told us however they did not have time to do this.

On the second day of the inspection we carried out a joint visual inspection of the home with the manager. We pointed out all the areas of concern to the manager who completed a list of all required tasks. They agreed they would take immediate action and provided the nominated individual with a list detailing all required improvements. On the third day, we visited the bedroom where we had found faeces on the carpet. We found the faeces was still present upon the carpet.

We discussed the needs of the people who lived at the home. We were informed one person who lived at the home displayed some behaviour which challenged the service and compromised infection prevention and control processes. This behaviour had been identified as a concern in May 2017; however there were no

documented systems to manage the risk of cross infection.

The above matters show the provider was not meeting legal requirements in relating to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because they had failed to ensure the environment was suitably clean to prevent, detect and control the spread of, infections. We have made a referral to Infection prevention and control team at the local authority to inform them of our findings.

As part of our inspection planning, we noted there had been two incidents since the last inspection when two people had left the building unaccompanied due to the lack of security. Both people were living with dementia and assessed as requiring supervision when away from the home. We looked at security processes at the home to ensure lessons had been learned and improvements made. One staff member told us they did not think people were safe due to the lack of security on the main door. They told us the door had been reported as faulty as there was a delay in the time of the automated lock responding. They told us they were unsure as to whether or not this had been repaired.

During the inspection visit we tried the automated door lock and found the door did not lock until 50 seconds after the door had been shut. We brought this to the attention of the nominated individual. They acknowledged there were aware there was a delay in the door locking. They said in response to the delay on the lock they had left a note requesting staff remain at the door until the lock was secured. On the occasion we observed however this process was not followed. This meant security at the home was compromised. Following our discussion the maintenance person at the home reviewed the system and re-set the lock so the door lock secured within five seconds of the door closing.

We reviewed the effectiveness of the call bell system. We did this to check the system was fully working and to check the responsiveness of staff. Staff told us they were concerned about the effectiveness of the call bell alarm. They told us they could not guarantee to hear it in certain areas of the home when it was triggered. We tried the alarm to check the noise emitted. Whilst trying two alarms in the dining room and communal toilets we found the alarms were not activated when the call bell was activated. No one was aware the call bells were broken. The maintenance person at the home was called in to check the system so the fault could be mended. On the third day of the inspection we were informed the fault had been caused by a water leak in the electrics. The call bell in the dining room had been repaired but the bathroom call bells were still not working. We asked for an update on this, once the work had been completed. We have not received any confirmation to evidence this has been completed.

On the third day of the inspection visit, we asked a member of staff to demonstrate what happened when the call bell was triggered. The member of staff pressed the alarm and we noted it was not always audible throughout the home. A staff member told us they had to be near to the alarm box to be alerted to any alarm going off. We found this was the case and the alarm could not be heard from the main lounge area.

Whilst undertaking a visual check of the call bell system we found call bells were not always in an accessible position. For example, call bells in communal bathrooms were placed so high, people using the toilets or who had fallen upon the floor would not be able to reach them. We pointed this out to a member of staff and asked them what arrangements were in place to manage this. They told us people who lived at the home were living with dementia and said people would not know or remember to ring the alarm even if they could reach. They told us the call bell system was so old that no additional technology could be added to the system to support people in an emergency.

We reviewed care records related to people who lived at the home and noted at least three people were at

risk of falls during the night. This lack of equipment placed people at risk of harm as they could not summon help in an emergency and no technology was in place to alert staff that people at risk of falls were mobile in their bedroom. One staff member said, "We can't keep an eye on people at all times, when they are in their bedrooms. We have monitors in place for a few people but you can only hear them in the office. If people fall there's no way of us knowing unless we find them when doing checks or we hear them shouting. There's no way of knowing. If we are on the opposite side of the building we won't hear a thing."

We spoke with the manager about the alarm system. They confirmed the call bell system needed updating but due to previous financial pressures the registered provider did not yet have the finances to update the system. Following the inspection visit we requested a full service and assessment of the call bell system was undertaken to ensure the call bell was fit or purpose.

As part of the inspection process we reviewed documentation relating to the health and safety of the home. We found not all equipment was suitably serviced and maintained. Whilst reviewing certification it was found the fire alarm had not been serviced since 2015. We noted there had been correspondence from the Fire and Rescue Service sent in September 2017 to the nominated individual highlighting this as a concern. We asked the nominated individual about this. They told us this had been an oversight and they were not aware of this and agreed to take immediate action. Following the inspection visit we received confirmation the fire system had been serviced and remedial work was required to make the alarm system fully functioning.

The above matters show the provider was not meeting legal requirements in relating to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because they had failed to ensure equipment was suitably maintained and fit for purpose in order to manage and assess risk. We made referrals to the health and safety department at the local authority and spoke to the Fire and Rescue Service to inform them of our findings.

We reviewed the standard of maintenance at the home. During the inspection process staff disclosed only one bathroom was in use for people who lived at the home. One staff member said, "We only have one bathroom to 21 people." We reviewed the main bathroom in use at the home and noted the space between the bath and radiator was limited. In addition the bath hoist was fixed and manoeuvred into the small space. This meant there was a risk of people catching their body on the radiator whilst being transferred. We spoke with the nominated individual about this. They told us a plumber was visiting to price up some work to make the main bathroom more accessible to people. We viewed the maintenance budget and noted there was no reference upon the maintenance budget for refurbishing of bathrooms and making them fit for purpose.

During the inspection process we found the home was not suitably maintained throughout the building. For example, we found two radiator covers were not secured to walls. Wallpaper in the dining room was missing and bare plaster was exposed. Flooring in the dining area was ripped and torn and posed a slips, trips and falls hazard. Holes were noted in the ceiling on the corridor where emergency lighting had been replaced. Flooring in communal toilets were split and raised. The bath panel in the main and sole bathing area had a large chunk out of it and posed as a risk. In addition, one toilet had a toilet seat missing.

Whilst assessing bedrooms at the home we found one bedroom was uncomfortably cold. We measured the temperature in this room on each visit and noted the temperature in this room was consistently 18c. On the second day of our inspection visit we raised concerns about the temperature in this room with the manager. They agreed the room felt cold and agreed to look into this. We found action had still not been taken by the third day. We spoke with a member of staff they told us this room was always cold. They said extra blankets

had been placed on the bed to counteract the cold. They said concerns about the room temperature had been reported in the communication book. As far as they were aware no action had been taken. We reviewed the communication book and noted concerns about the temperature had been raised by staff on two occasions. Despite being raised at least sixteen days ago there was no evidence this had been reviewed and actioned. We asked the nominated individual to make amendments in order for the room to be made fit for purpose. We have not received any confirmation to evidence this has been completed.

We spoke with the nominated individual about processes for ensuring the home was suitably maintained. They told us the cleaner would normally check bedrooms to ensure they were in good order. In addition staff had a responsibility to report any concerns in the communication book. Staff had followed process and reported maintenance concerns but there was no evidence to show that repairs were made in a timely manner.

The above matters show the provider was not meeting legal requirements in relating to Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because they had failed to ensure premises were suitably maintained to meet the needs of the people who lived at the home.

As part of the inspection process we looked to see how the registered provider managed and addressed individual risk. To do this we reviewed ten care records related to people who lived at the home. We found systems for managing risk were ineffective and inconsistent. We reviewed care records related to one person who lived at the home who displayed some behaviour which challenged the service. We found there was no written behaviour management guiding staff how they should manage the behaviours. Additionally, there was no information informing staff what factors triggered the behaviours so they could be prevented as much as reasonably practical from occurring. We looked at recorded incidents and noted there had been 24 incidents over four and a half months. On one occasion it had taken staff three hours to calm the person.

Staff told us they were concerned about the safety of other people living at the home when the person started being aggressive. One staff member said they had witnessed the person assaulting other people who lived at the home. We reviewed accidents and incidents that had occurred and noted there had been two documented occasions when the person had threatened or tried to harm other people who lived at the home. This demonstrated people who lived at the home were at risk of harm from the person's behaviour and the registered provider had not put in place management plans to safeguard people.

We spoke with staff and asked them how they successfully supported the person when they were displaying behaviours which challenged the service. Staff told us they could not always manage these behaviours appropriately. They said they had not been appropriately supported by the registered provider to manage these behaviours. One staff member said, "We never know what the rules are. We have been told we need to go in three's at all times but we get told different things. We have had no training to deal with this." In addition, staff told us they had been physically assaulted by the person. One staff member said, "You need to protect yourself. I have been hit around the face twice by [person]; you get to learn when it's coming."

We looked at how the registered provider supported people with specific health conditions. One person who lived at the home had a medical condition whereby blood sugars needed to be monitored and the person's required a specific diet. Because of the persons health condition there was a risk the person may require additional support in an emergency. We asked a member of staff about the management plan in place for supporting the person in an emergency. The member of staff could not provide us with a suitable solution as to how they would manage the condition. They told us they had received no training to manage this.

When risks were identified; processes to manage the risk were not consistently carried out. For example,

one person who lived at the home required medicine to help them with their breathing. It was recorded the person had short term memory loss and required staff assistance with this. However, staff told us the person self-administered the medicine. This conflicted with information in the persons care plan and risk assessment. Another person who lived at the home was highlighted as being at risk of dehydration. There was no evidence within the person's care records to show that staff practice took this into consideration and monitored the amount of fluids the person drank. We spoke with the nominated individual about this. They were unaware of the risk and said the manager would be too as the incident had occurred before they were managing the home. This information was documented within the person's care record but had not been acted upon. This demonstrated systems for monitoring risk were ineffective.

One person who lived at the home had a behavioural monitoring chart in place. Behavioural monitoring charts allow staff to track and reflect upon people's behaviours so patterns and themes can be identified in order for action to be taken to reduce negative behaviours. The care plan for this person instructed staff to review the behaviour chart every three months so behaviour could be assessed. There was no evidence within the care record to demonstrate this had happened. We spoke to the manager who confirmed no assessment of behaviours had taken place. This meant incidents had not been reviewed to look for trends and themes as a means to reduce the frequency of incidents from occurring.

We looked at how the service managed the risk of people falling. During the inspection process we noted one person was documented at high risk of falls. The person had fallen seven times in seven months. Five of the seven documented falls had been unwitnessed and had occurred during the night in their bedroom. A risk assessment had been carried out instructing staff to observe the person when mobile and informing night staff to ensure monitoring equipment was switched on when the person was in their bedroom. We viewed the person's room and found no monitoring equipment was in place. We asked staff about this and they told us as far as they were aware there was no monitoring equipment in use for the person. This conflicted with information documented within the persons care records. We spoke with a senior member of staff to check processes for monitoring the person's movements in their bedroom. They confirmed no technology was in place for the person. This demonstrated that risks had been identified but no consistent processes had been implemented to manage the risk.

The above matters show the provider was not meeting legal requirements in relating to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because they had failed to ensure risk was suitably identified, managed and addressed to ensure people received safe care and treatment. We raised a safeguarding alert with the local authority to inform them of our findings.

We reviewed systems and processes to protect people from harm. We asked people who lived at the home and relatives whether or not people were safe at the home. Although two people told us they felt safe, a further four people told us they had some concerns about their safety. Two people who lived at the home told us they did not feel safe during the night. One person said, "Every night there's another lady shouting the odds; she walks in my bedroom and walks around. I really don't like that." Another person told us they felt threatened as a person of the opposite sex came into their bedroom at night time. They told us they did not like this.

We spoke with staff to ensure they could identify and respond appropriately to abuse. Staff were able to identify abuse and were aware of the internal processes for reporting abuse. One member of staff said they questioned the efficiency of the organisations process. They said, "I have raised concerns with seniors and trainee managers but they never seem to be sorted out."

We reviewed incident reports completed by the registered provider and identified four incidents where

people who lived at the home had been placed at risk of harm. We asked the nominated individual if these incidents had been reported as safeguarding concerns to the local authority safeguarding team. The nominated individual said they were unsure if they had as this would have been the responsibility of the registered manager. They confirmed no processes were in place. This demonstrated that the lack of processes for the monitoring incidents were ineffective. Safeguarding concerns were not raised in accordance with organisational policy and good practice guidelines.

We spoke with a relative of a person who lived at the home. They expressed concerns as an allegation had been made with regard to a member of staffs conduct. The relative said they were unsure as to whether or not action had been taken as agreed. We spoke with the nominated individual who confirmed there had been an alleged incident involving a member of staff. The nominated individual said they had investigated this but had not informed the Commission or the Local Authority safeguarding team about the incident. We looked at the organisations policy for managing safeguarding matters and noted this policy stated all allegations would be reported to the Local Authority and the Commission. This demonstrated that safeguarding processes were weak and inconsistent as the organisational safeguarding policy was not followed on this occasion.

The above matters show the provider was not meeting legal requirements in relating to Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the registered provider had failed to ensure all safeguarding processes were implemented and acted upon to ensure people who lived at the home were not placed at risk of harm.

As part of the inspection process we reviewed staffing levels at the home. We did this to ensure staff were suitably deployed to meet the needs of people who lived at the home. We reviewed staff rotas and noted staffing levels ranged from four staff during the day to two staff at night.

We asked four people who lived at the home their views on staffing levels. All four people expressed some concern about the levels of staff available. Feedback included, "There just aren't enough staff on sometimes; the [carers] get very tired." And, "There are always enough staff on duty in the day; I'm not sure about night time and weekends." Another person who lived at the home told us that due to the size and layout of the home two staff during the night was insufficient to meet people's needs. They said, "That's not enough for all of the people they need to look after, and it's a big place."

We asked staff their opinion of staffing levels. Feedback included, "I don't think there are enough staff. There is only two on at night time. Staff constantly don't have time." Also, "Some days are terrible. Some days I feel I need to split myself into three people to get everything done." In addition, staff told us they did not feel they could guarantee people would be safe due to low staffing levels resulting in poor oversight of communal areas. Staff told us, "We can't guarantee people are going to be safe. We can't be in all areas of the building at all times. If another staff is in the dining room and one in one of the lounges that leaves no one else on the floor." And, "We have a lot of people who wander up the stairs. There are not always enough staff on duty to keep an eye on them."

We reviewed the number of accidents which had occurred at the home over a seven week period and noted there had been 17 recorded incidents. Of these, 11 incidents had occurred and had not been witnessed by staff and six had occurred within the communal areas. This demonstrated oversight of people was inconsistent.

We noted there was reliance upon senior managers to support the staff team to ensure tasks were completed. For example, the nominated individual supported staff at lunch time to serve meals and was

also observed carrying out cleaning tasks. We pointed this out to the nominated individual and asked how staff were supported at weekends when no senior managers were on duty. They told us they had previously scheduled an additional carer at weekend by recruiting a weekend carer. This had however not worked out. We saw no other evidence of staffing levels being reviewed and increased following the absence of the weekend carer.

There was no evidence to demonstrate staffing levels had been reviewed to take into consideration the needs of people who lived at the home or the lack of effective equipment. Two staff were deployed at night time despite the nominated individual's assessment that one person who lived at the home had been assessed as requiring three staff to support them when they were displaying behaviours which challenged the service. Staff informed us only one person who lived at the home was fully independent and required no support with personal care. One staff member told us "Five or six people need the support of two staff" for all personal care. There was no evidence to show this had been taken into consideration when reviewing staffing levels. In addition, staff told us they carried out nightly checks in pairs. This meant half of the building was at times unoccupied by staff. As such there was a risk people could not be heard and responded to in an emergency.

We looked at arrangements for carrying out the cleaning duties in the absence of the cleaner. The nominated individual told us a senior member of the management team carried out the cleaning tasks in the absence of the cleaner. They showed us a rota which indicated some cleaning tasks were carried out. However, the nominated individual was unable to evidence these tasks had taken place as there were no completed cleaning schedules available. Staff told us they were expected to carry out the cleaning tasks in addition to their own tasks. They told us however they did not always have time to do this. We found this was reflected in the cleanliness of the home.

The above matters show the registered provider was not meeting legal requirements in relating to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because they had failed to ensure staff were effectively deployed at all times.

We looked at recruitment procedures to ensure people were supported by suitably qualified and experienced staff. To do this we reviewed staff records for four staff employed at the home. We found suitable processes were not in place. Three of the four files we reviewed did not have full employment checks in place. Also, one person was documented as starting employment without any written references being received. This meant the registered provider could not be fully assured staff employed were suitable to work with people who may be vulnerable.

We looked at processes to ensure staff were not able to work without a valid Disclosure and Barring Service check (DBS). A valid DBS check is a statutory requirement for staff providing a personal care service supporting people who may be vulnerable. Whilst reviewing DBS records we were unable to locate a DBS check for one member of staff. We asked the nominated individual about this and they told us they were sure one had taken place but they were unsure as to where the registered manager would have stored this. We asked the nominated individual to forward a copy of this when it was located. We never received this.

In addition, when staff had previous convictions recorded upon their certificate; systems were not fully implemented to ensure additional checks were in place to assess people's suitability for working with vulnerable people. There was no evidence within personal records to evidence discussions had taken place about the convictions and risks assessed.

The above matters show the registered provider was not meeting legal requirements in relating to

Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because they had failed to ensure systems for recruiting staff were robust and ensured risks were fully assessed and decisions documented to ensure the suitability of staff employed.

Inadequate

Is the service effective?

Our findings

We looked at how people's health care needs were met to ensure people received effective care. Feedback included, "I see a doctor when I ask; he's recently changed my tablets." And, "I've been to an appointment because of my hearing loss."

We saw evidence of health professional input from doctors, dietitians, district nursing teams and opticians. However, when advice and guidance for care and support was required from health professionals we found this was not always sought in a timely manner. For example one person's care plan stated the person's doctor should be instructed of episodes of challenging behaviour. We noted support from a doctor to review such behaviours was requested once in April 2017 and once in October 2017. We identified 12 incidents which had occurred in between these dates. There was no evidence to show other advice and guidance in relation to management of challenging behaviour had been sought from the GP. In addition, a referral to a mental health team for advice and guidance was made in April 2017; the person was assessed as not requiring support at that time. The mental health team advised staff to go back to the doctor for a referral if further support was required. We saw no evidence of this occurring, despite there being 24 reported incidents of behaviours which challenged. This included two counts of physical assault upon staff and one physical assault upon a person who lived at the home.

We asked the nominated individual if any further referrals had been made to the mental health team. They told us no further referrals had been made and said it would be the doctor's decision as to whether or not a referral would be made. We asked the nominated individual if the doctor was fully aware of the nature and frequency of all incidents which had occurred. The nominated individual was unable to confirm if this was the case. This demonstrated people's health needs were not consistently met in a timely manner by the registered provider.

We looked at records maintained when there had been health professional input. Records were maintained to show the action and outcome of each health professional's visit. This was to allow staff to have an oversight of all health professional involvement. Although recording systems were in place, we found oversight of health professionals actions were inconsistently recorded. On the first day of our inspection visit, we noted within one person's healthcare records it was documented the person had received two of the same vaccinations fifteen days apart. Only one vaccination was required. We highlighted this to the nominated individual; they were not aware of this and agreed to investigate. On the second day of the inspection the nominated individual confirmed no other member of staff had identified this as a concern. No staff had therefore identified this as a risk to the person's health and wellbeing. We requested this was investigated and followed up with the person's doctor to ensure the person was not at risk of harm and asked for an update upon this matter.

The above matters show the provider was not meeting legal requirements in relating to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the registered provider had failed to ensure timely care planning took place to ensure the health, safety and welfare of the service users.

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

We reviewed care records to ensure consent for people who could not make decisions for themselves, due to lack of capacity was completed in line with the principles. We found principles were not consistently followed. For example, we saw relatives had been consulted with regards to seeking consent for vaccinations against flu. However, when we reviewed care records we found two people had been vaccinated against additional illnesses for which consent had not been achieved. In addition, another person had been given the same vaccination twice.

We reviewed care records and risk assessments maintained by the registered provider and noted consent for care and treatment was not always sought. For example, care plans had not been reviewed and updated and signed for by people who lived at the home or their family members.

We asked a relative if they were included in making decisions on behalf of their family member. They told us sometimes they would be involved in best interest decisions but said this was not consistent. They said, "Discussions [about best interest] are ad hoc really – when something's gone wrong usually."

The above matters show the registered provider was not meeting legal requirements in relating to breach of Regulation 11 of the Health and Social Care Act 2014. This was because processes were not consistently implemented to ensure care and treatment of service users was provided with the consent of the relevant person.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We looked at processes to ensure people were lawfully deprived of their liberty. During a visual inspection of the home, we noted some restrictions were in place to deprive people of their liberty. Monitoring equipment was placed in two people's bedrooms and a bed rail was in place on one bed. We reviewed completed DoLS applications and noted these did not always accurately reflect restrictions in place. The monitoring equipment and bed rail had not been incorporated onto the DoLS applications. The nominated individual could not explain why these restrictions had been omitted from the applications. In addition, we were unable to find any evidence to demonstrate best interest's processes had been followed to make the decisions to place these restrictions in people's lives.

This was a Breach of Regulation 13 of the Health and Social Care Act 2014 because the registered provider had failed to ensure people were deprived of their liberty for the purpose of receiving care and treatment with lawful authority.

We asked people who lived at the home and relatives about their views on the quality and availability of food at the home. We received mixed feedback. Feedback included, "Breakfast is the best, I have porridge. The toast is out of this world." And, "The food – it really is awful." Also, "The quality is okay – you can live off it well enough – but there isn't enough." And, "It all tastes the same." Also, "I've found food is often served which I would not eat myself."

On the first two days of our inspection visit we observed lunch being served. We found organisation and deployment of staffing was poor. We observed people being taken into the dining area twenty five minutes before lunch was due to be served. People were left sitting at tables with no appropriate stimulus. For example, tables were bare, with the exception of a tablecloth. There was no cutlery or condiments on the table, all of which would have acted as visual prompts for people living with dementia to remind them lunch was about to be observed. We observed people attempting to leave the dining area whilst they were waiting to be served. Staff guided people back to their seats and encouraged them to wait for their meal.

We asked a member of staff why the tables had not been set. They told us care staff were responsible for washing pots after meals and on this occasion it may have been possible cutlery was not readily available before lunch. They said there was not always enough cutlery at the home for people to use. We spoke with the nominated individual about this. They told us extra cutlery was on order.

People were offered choices as to what they would like to eat. We observed staff making a sandwich for one person when they expressed dissatisfaction at the cooked meals offered. Drinks were provided whilst people ate their meals and throughout the day. We noted drinks during the day were accompanied by home-made biscuits and cake. We observed no healthy snacks being offered, such as fresh fruit.

We asked staff their opinion on the food provided. Two staff raised concerns about the quality and availability of foods. They told us people were not routinely offered healthy snacks such as fruit and were encouraged to eat sugary snacks such as cake.

We spoke with the cook and they were aware of people's individual dietary needs. We reviewed the set menu which detailed meals provided at the home and noted meals were not always nutritionally balanced. For example, one evening meal consisted of fruit loaf and crumpets. We asked the cook if they were aware of the eatwell guidance. The eatwell guide is a policy tool used to define government recommendations on eating healthily and achieving a well-balanced diet. The cook told us they were not aware of this but said they would look at the menus and discuss them with the nominated individual.

We recommend the registered provider consults with good practice guidelines to promote effective nutrition at the home.

We looked at staff training to check staff were given the opportunity to develop skills to enable them to give effective care. We asked three people who lived at the home if they considered the staff well equipped to meet their needs. Two of the three people we spoke with said staff did not always have the correct skills. One person said, "I feel they haven't been trained to handle people who lash out at them. I've seen one or two people lash out and can understand the carers' frustrations; but they don't seem to understand dementia patients."

We asked staff about training provided. Staff told us they did not think they received appropriate training to meet the needs of people who lived at the home. Feedback included, "I have had no training to deal with [service user.] I've asked for moving and handling training. I have been here [no of years] and I still have not had this. I have mentioned it to management but it's not been dealt with." And, "I have done some training. There are still times when I don't feel as if I have the skills – some people don't have the understanding. Some training is definitely required how you handle people and their approach."

We spoke with the nominated individual about the service's training and development plan for staff. They told us this was the same across both homes. Staff training was planned every year following staff appraisals. The services policy was that safeguarding of vulnerable adults, infection control and first aid

training should be refreshed every three years.

We reviewed documentation maintained by the registered provider in relation to training completed and planned. We were unable to have a true and accurate picture of this as the registered provider had three separate means of recording training, all of which had conflicting information. For example, the nominated individual said they used the National Minimum Dataset for Social Care (NMDS) to record all training but when we viewed records these had not been updated since June 2017. In addition they had a training matrix which we were informed by the nominated individual was not fully up to date. Also, the nominated individual had a separate planning document which we found did not reflect all required training needs. For example, some staff had been booked onto a course which was cancelled. This had not been taken into consideration and they had not been identified as needing to complete the training which had been cancelled.

Evidence upon the training matrix and upon the NMDS system showed gaps within training. For example, 14 staff had not received any health and safety training, eleven staff had not received any basic food hygiene training, 17 staff had not received any safeguarding or dementia training. No staff had received any training to manage behaviours which challenged.

We noted the registered provider had planned dementia training to take place the week after our inspection visit. They told us two sessions were planned. They said they were providing this training using a training resource from a reputable charity.

We asked the nominated individual how staff were supported to manage behaviours which challenged the service. They confirmed no training had yet been provided to staff. They told us they recognised staff needed this training but nothing was planned. They said they would look at providing this in the on-coming year. This demonstrated the nominated individual had failed to ensure staff had received the appropriate training and professional development necessary for them to carry out their roles.

The above matters show the registered provider was not meeting legal requirements in relating to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because they had failed to ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons were employed to meet the needs of people who lived at the home.

We spoke with staff about supervision. Supervision is a one to one meeting between the staff member and a senior member of the staff team to discuss any concerns and training needs. Staff confirmed they received supervision on a six monthly basis.

We asked staff about the induction process. One staff member confirmed they received a formal induction with a senior manager at the start of their employment. They said following a short induction, they got "thrown in at the deep end." They said however, they were happy with this arrangement.

Requires Improvement

Is the service caring?

Our findings

People who lived at the home provided us with positive feedback about the caring nature of staff who worked at the home. Feedback included, "Most of the time they're all right." And, "They are all very nice, with everybody." Also, "They are very caring." And, "Absolutely brilliant; you couldn't get better; 110%."

We spoke with relatives about staff attitude and personality and received different responses. Feedback included, "Some carers are so kind: they'll hug the residents, dance with them. But there are one or two with a different attitude who can't wait to go home." And, "I am happy with the care [my relative] gets. The staff have got better since last year." One relative praised the caring attitude of staff and the way they promoted people's voice. The relative said, "They do fight the corner of people who live at the home."

Although we received positive feedback about the caring nature of staff, we found dignity was not consistently considered at the home. On the second day of the inspection visit, whilst carrying out a visual inspection of the home, we found faeces upon the carpet, door and wall of one person's bedroom. The manager told us this was a common problem due to the person's behaviour. There was no reference to this within the person's care record to instruct staff to how to appropriately maintain the person's room to keep it clean. We instructed this to be cleaned up immediately. When we returned two days later we found the faeces was still upon the persons carpet. This compromised the person's human rights as the registered provider failed to respect and protect the person's right to live with dignity. They were not supported sensitively and appropriately, as they were expected to stay in a bedroom which was not appropriately cleaned.

We looked at how equality and diversity was achieved at the home. We asked a senior member of the care team if they addressed people's sexual orientation when planning care for individuals. The senior member of staff said they would have discussions with people about this if people felt comfortable doing so. They were aware someone who lived at the home may have unmet needs but said the person was likely to be uncomfortable talking about this. We discussed this with the manager, they said they had had a discussion with the person but nothing had been documented to show the outcome of the discussion.

In addition, we asked how people's spiritual beliefs were met. The senior member of the care team said they asked people their beliefs as part of the admission process. They said no one had asked for support to have their spiritual needs met but if they did they would support them to meet the need. The senior member of staff said a priest used to visit the home but this no longer happens, they told us no-one at the home currently had any religious requirements. We spoke to the nominated individual. They told us they had spoken with the local church and they did not have enough volunteers to carryout visits to the home.

We observed staff responding to people when they were in need. We observed staff bringing a person a blanket when they said they were feeling cold. The person thanked the staff saying, "Thank you darling, thank you a million times." Staff provided reassurance and comfort to people when they were distressed. For example, one person was missing their family member. Staff took time to sit with the person offering comfort and stroking their hand. This calmed the person and they looked more comforted at this

interaction.

Although we observed staff taking time out to sit with people, people and relatives told us positive relationships were sometimes hindered by the lack of staff available. Feedback included, "No, none of them have time to listen, they say, 'I'll talk to you later' but they never do." And, "You don't really see them sitting and chatting with the residents much." Also, "It depends on the staff [on duty]; some interact well and in a caring way."

During our inspection visit, staff spoke fondly about the people who lived at the home. Two staff became visibly upset when talking about the concerns they had identified in regards to the management of the home.

We made observations of the care and treatment provided and noted staff were kind and caring. For example, we observed one person smiling at a member of staff. The staff member interacted by giving the person a kiss. This made the person smile further and remarked, "She is a little love."

We observed staff promoting and encouraging independence. For example, people were encouraged to choose what they would like to eat at meal times. Staff brought people different foods to act as a visual prompt so people could choose what they would like to eat. Staff were patient when people could not make up their minds what they would like.

We observed staff supporting people to mobilise. Staff were patient and provided encouragement to people when they were finding it difficult to walk. Staff offered clear and short instructions when supporting people to be independent. For example, "I'm just putting my hand on your back to support you'; And, "Come on, this way...around this corner then we're going to turn left."

There was a light hearted atmosphere at the home, where care staff and people who lived at the home positively interacted together. We spoke with one person who was living at the home temporarily, they told us, "The staff are great, we have a joke. I would give this place 95 out of 50 marks." Observations made during the visits demonstrated that people who lived at the home looked comfortable and relaxed in their surroundings. We observed one person lying on a settee having an afternoon nap.

Requires Improvement

Is the service responsive?

Our findings

We asked people who lived at the home if they were provided with person centred care. People told us, "They know me well enough; if I get a bit in their face, they know not to take it the wrong way." And, "They've got used to us and us to them."

Staff told us the quality of person centred care depended upon their being an appropriate number of staff on duty to carry out care. One staff member said, "If we are fully staffed people get person centred care. We do our best. If we are understaffed or under pressure we rush."

At the last inspection visit carried out in December 2016, the registered manager had started working with the local authority to review care plans to make them more person centred. They told us the plan was to move all care plans into the new format to improve the standard of the care plan and to increase person centred support. At this inspection visit carried out In October 2017, we found the registered provider had stopped using the new format and had reverted to the old format for care planning.

We spoke with the nominated individual about their plans for making records more person centred. They told us the registered manager had not completed all care plans in the new template before their departure. They said no one else at the home had been trained to use the new format. They told us the manager at their other home had started liaising with the local authority to develop a new care plan record and risk assessment template which would enable them to make the care records more person centred. They said in the future they hoped to equip the manager with the necessary skills to develop the care plans at Greenfield House.

Care plans addressed a number of topics including personal care, diet and nutrition needs and personal safety. Although care plans sometimes detailed people's likes, dislikes and preferences we found this information was not routinely implemented into delivery of care. For example, it was reported in one person's care record the person liked fresh air and walking outside. This information was not reflected in the care plan so the person could be encouraged to pursue their interest.

We looked to see if people were consulted during the care planning process. Whilst we saw some evidence of people's likes, dislikes and preferences being addressed, people were not always aware whether or not they had a care plan and what it involved. Two people told us they did have care plans but said they were not routinely involved in developing them. One relative told us, "They [staff] do ask us things but they don't go through the care plan with us, no." Another relative told us they had made suggestions to improve the care provided to their relative but told us they felt they were not listened to.

We recommend the registered provider consults with good practice guidelines to develop and implement person centred care.

We asked four people who lived at the home their thoughts upon activities provided. All four people commented upon the lack of activities at the home. Feedback included, "Other than the musician, once a

month, there's television, which is nonsense in itself. I read my paper and [related activity]. It's left to individual carers, no set procedure. Sometimes they bring a ball out and start throwing it round a group, or skittles." And, "I haven't seen anything much going on while I've been here." Also, "There's not a great deal going on but there aren't many who can take part if they do organise anything. Most just want to sit quietly and be looked after." Also, "I do get bored a lot of the time."

Whilst walking around the home we noted there was an activities schedule upon the wall which detailed four separate activities per day. On the first day of the inspection this was not consistently followed and activities did not take place as planned. During our inspection visit we observed some activity taking place, we observed one person playing dominoes and a ball activity taking place. In addition, we observed the nominated individual offering people pens and paper to colour with to keep them occupied.

We asked staff their views on activities. They told us they did not always have time to carry out activities and interact with people who lived at the home. One staff member said, "I just wish there was more I could do. There is not enough entertainment for people." Another staff member expressed concern about the lack of opportunity for people to go outside. They said staff had offered to take people out to local garden centres and community facilities but they had not been given permission to do so.

We recommend the registered provider consults with good practice guidelines and reviews the deployment of staffing to ensure people who live at the home are offered activities to promote their mind and well-being.

We spoke with people who lived at the home and their relatives to ensure they felt their concerns were responded to in a timely manner. No one who lived at the home said they had any complaints at the time of our inspection visits.

We received mixed feedback about the responsiveness of the registered provider when dealing with complaints. One person who lived at the home told us they had raised a complaint and were happy with the action taken following the concern being raised. In addition, two relatives told us they had raised complaints and were happy with the response given. However, one relative told us they had raised a complaint with the nominated individual and they had not as yet received an appropriate response. They said they were unhappy with how their complaint was being handled.

We spoke with staff; one member of staff told us they had raised a complaint with the manager in regards to staffing arrangements at the home. They told us they had not yet received a response and did not know the outcome of their complaint. We reviewed the complaints log and noted this complaint had not been formally documented. The manager told us they were unaware of the complaint. We noted however other complaints had been recorded and responded to in a timely manner.

We recommend the registered manager consults with good practice and reviews their complaints policy to ensure all concerns and complaints are captured in an appropriate manner.

Inadequate

Is the service well-led?

Our findings

At the inspection carried out in December 2016, we found a breach to Regulation 18 of the Care Quality Commission Registration Regulations 2009. This was due to the registered provider failing to notify us of an incident which threatened their ability to carry on the regulated activity safely. The registered manager completed an action plan to demonstrate how they would make the improvements. They told us the necessary improvements would be in place by February 2017.

At this inspection carried out in October 2017, we found not all improvements had been made. During the course of the inspection process we identified five incidents where people had been placed at risk of harm. The registered provider had a legal responsibility to report these incidents to the Commission but had not done so.

We asked the nominated individual about reporting processes to ensure notifications were submitted to the commission in a timely manner. They told us this would have been the responsibility of the registered manager. They confirmed they had no oversight of these incidents and had no means of monitoring them.

The above matters show the provider was not meeting legal requirements in relating to breach of Regulation 18 of the Care Quality Commission Registration Regulations 2009. This was because processes were not consistently implemented to statutory notifications were submitted in a timely manner.

We reviewed the quality of care records maintained by the registered provider. We found records were not consistently and accurately completed in a timely manner. For example, documentation in relation to training records were inconsistent in their detail. Behavioural monitoring charts had not been completed as required after each episode of behaviours which challenged the service. Peoples weight assessments and risk calculators had been incorrectly documented and measured. Risk assessments failed to capture all relevant risk for people who lived at the home. Care records were not always updated to accurately reflect the needs of people who lived at the home when their needs increased.

Information within care records conflicted with care practices. For example, staff were instructed to support a person with their medicine but staff told us the person self-administered their own medicine. Another person's documentation instructed staff to use monitoring equipment when the person was in their room. This was not in place. Also, review dates for reassessments of people's needs were documented within care records but action was not taken to reassess people's needs as instructed.

Documentation at the home was not always effectively stored and easily accessible. The nominated individual was unable to source documents when required. Copies of investigation minutes, cleaning schedules and DBS certificates were not readily available when requested. The nominated individual said copies of annual satisfaction surveys had been carried out since the last inspection visit but was unable to locate these.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 (Good

governance) as the registered provider had failed to ensure records maintained were accurate.

We looked at auditing systems to monitor the effectiveness of care provided. We found audit systems were incomplete, missing and ineffective. Following the inspection visit in March 2016, we referred the registered provider to the Local Authority infection prevention and control team. (IPC) The IPC team supported the registered manager to develop an auditing system to enable suitable standards of hygiene to be monitored at the home. At this inspection visit we found the registered provider was not routinely completing these audits. This was reflected in the standard of hygiene around the home. We asked the nominated individual about this. They confirmed no formal IPC audits had taken place since the registered manager had left.

The medicines audit failed to ensure all medicines were suitably managed. For example, processes for managing stock balances were not accurate and failed to identify the concerns we found in relation to unexplained stock levels.

No formal audits of the environment took place. This meant that oversight of works which were required was inconsistent and had failed to identify the concerns we found in relation to the environment.

We spoke with the manager about auditing systems. They told us they had carried out an audit of care records in September 2017. Whilst this audit had taken place it had failed to identify the concerns we found in relation to the poor quality paperwork and documentation. For example, the audit had failed to identify out of date review dates and inaccurate recordings.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 (Good governance) as the registered provider had failed to evaluate practice to ensure fundamental standards were consistently addressed.

The registered manager had terminated their contract with the registered provider in July 2017. At the time of the inspection visit a manager was in place to oversee the running of the home. We were informed the manager had not yet decided as to whether or not they wished to become the registered manager with the overall responsibility of managing the home. In the interim the manager was being supported in their role by the nominated individual. During the inspection process we found oversight of the home was inconsistent. The nominated individual had no formal means of ensuring the service was operating to a suitable standard. Processes for ensuring the maintenance and upkeep of the building had not been reviewed when the staff member with key responsibility for this had left the service. When staff had identified and reported concerns within the environment, action was not always taken in a timely manner. This meant concerns identified in relation to the environment during the inspection process were not always picked up and actioned.

We found communication between managers had been poor, with the new manager not being aware of relevant information related to the safe management of the home. For example, they were not aware of all relevant risks related to people who lived at the home. We found risk was not always assessed and mitigated. Risks were managed reactively rather than proactively. For example, one person was identified at risk of falls. A risk assessment had been carried out to manage the risk but processes had not been implemented to reduce the risk of falls. Oversight at the home was poor and there was a lack of systems to ensure fundamental standards were achieved and maintained.

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

We spoke with people who lived at the home and relatives to gain their views on how the home was managed. We received mixed feedback. Two relatives spoke positively about the management at the home. One relative told us they had confidence in the skills of the nominated individual. Another relative said they thought the new manager was searching for solutions and had a good manner with people. However a third relative told us they found it difficult to work with the nominated individual. They said they had offered guidance and support to make improvements but were not taken up on the offer. They said the nominated individual was unwilling to listen.

People who lived at the home, relatives and staff spoke fondly of the new manager. Feedback included, "[Manager] has done loads. They are brilliant." And, "He's a very nice chap. I've no complaints about him. I usually see [nominated individual] if any wider concerns." Although we received positive feedback one person said they felt the manager was somewhat inexperienced and said this led them to being easily manipulated. Whilst staff spoke positively about the manager, staff said the manager was limited in what decisions they could make as all decisions had to be approved by the nominated individual. Staff said this restricted change from occurring.

We asked staff about their experience of working at the home. Five staff said morale was low. Feedback included, "Since [nominated individual] has taken over, it not the place I want to come to work in. Morale of staff is not very good. " And, "Morale is up and down, At the moment it's a little bit down." Also, "Staff get fed up of feeling underappreciated."

Staff responsible for providing direct care told us they did not feel valued and said they were not suitably consulted with. One staff member said, "Sometimes I feel I am listened to. It depends on who I am talking to. I do feel like I am banging my head against a brick wall. I am made to feel as I don't know what I am talking about when I am talking to [nominated individual.] [Manager] is more likely to listen." Also, "Everyone is so frustrated. Staff have been in tears."

We asked staff their views on how the service was managed. All staff said improvements were required in the way the home was managed. Staff acknowledged the need for a review of staffing levels, staff training, food provided to people who lived at the home, security and safety of the premises. Although staff noted concerns in the way the home was managed, all staff responsible for providing direct care said teamwork between care staff was good. They told us people got the best possible care they could with the resources provided. One staff member said, "They are a good bunch of girls. People get good care."

We spoke with relatives to see if they were consulted with regarding the ways in which the home was managed. Relatives told us they were invited to relatives meetings to discuss matters in relation to the management of the home. We reviewed minutes of relatives meetings and noted relatives were able to pass comments on standards of care and areas for improvement. We saw that matters discussed within the relatives meeting was fed back to staff during a staff meeting so improvements could be made.

We asked the nominated individual about quality assurance processes. The nominated individual provided us with copies of completed staff questionnaires. However they were unable to provide evidence to show people who lived at the home and relatives had been consulted with. The nominated individual told us they were sure they had been completed by the previous manager but could not locate them. Following the inspection visit we received two completed questionnaires which the new manager had asked relatives to complete. There was no information of concern upon the questionnaires.

We looked at compliments received by the service. We saw positive feedback had been received in relation to the quality of the care provided. One relative described staff as, 'caring, warm and amazing,' and thanked

staff for looking after their family member.

As part of the inspection process we looked to ensure the registered provider had their performance assessment on view as set out in the 2008 Health and Social Care Act. We saw the performance assessment was on view as required.

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 18 Registration Regulations 2009 Notifications of other incidents The registered provider failed to ensure suitable systems were in place and effectively operated to ensure statutory notifications were submitted to the Commission in a timely manner. 18 (1) (2) (e)

The enforcement action we took:

Under Section 28 of the Health and Social Care Act 2008 we varied the service providers registration. They are no longer authorised to carry on regulated activities from Greenfield House, White Lund Road, Morecambe, LA3 3NL

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered provider failed to ensure systems were in place to ensure consent for care and treatment was lawfully achieved. 11 (1) (2) (3) (4)

The enforcement action we took:

Under Section 28 of the Health and Social Care Act 2008 we varied the service providers registration. They are no longer authorised to carry on regulated activities from Greenfield House, White Lund Road, Morecambe, LA3 3NL

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had failed to assess the risks to the health and safety of people and do all that was reasonably practicable to mitigate risks to ensure care and treatment was provided in a safe way. 12 (1) (2) (a) (b) (c) (d) (e) (f) (g) (h) (I)

The enforcement action we took:

Under Section 28 of the Health and Social Care Act 2008 we varied the service providers

registration. They are no longer authorised to carry on regulated activities from Greenfield House, White Lund Road, Morecambe, LA3 3NL

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered provider failed to ensure systems were in place to ensure consent for care and treatment was lawfully achieved. 11 (1) (2) (3) (4)

The enforcement action we took:

Under Section 28 of the Health and Social Care Act 2008 we varied the service providers registration. They are no longer authorised to carry on regulated activities from Greenfield House, White Lund Road, Morecambe, LA3 3NL

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The registered provider had failed to ensure premises and equipment used by the service provider were suitable for the purpose being used and properly maintained. 15 (1) (e)

The enforcement action we took:

Under Section 28 of the Health and Social Care Act 2008 we varied the service providers registration. They are no longer authorised to carry on regulated activities from Greenfield House, White Lund Road, Morecambe, LA3 3NL

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had failed to assess, monitor and improve the quality and safety of the service provided in the carrying on of the regulated activity. 17 (1) (2) (a) The registered provider had failed to assess, monitor and mitigate the risks relating to the health and safety and welfare of people who lived at the home.

17 (1) (2) (b)

The registered provider had failed to maintain an accurate, complete and contemporaneous record in respect to each person who lived at the home

17 (1) (2) (c)

The enforcement action we took:

Under Section 28 of the Health and Social Care Act 2008 we varied the service providers registration. They are no longer authorised to carry on regulated activities from Greenfield House, White Lund Road, Morecambe, LA3 3NL

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered provider failed to ensure recruitment procedures were established to ensure people employed for the purposes of carrying out the regulated activity were of good character and had the skills and experience necessary for the role to be performed by them. 19 (1) (2) (3)

The enforcement action we took:

Under Section 28 of the Health and Social Care Act 2008 we varied the service providers registration. They are no longer authorised to carry on regulated activities from Greenfield House, White Lund Road, Morecambe, LA3 3NL

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider failed to ensure sufficient staff were deployed to meet the needs of the people who lived at the home at all times. 18 (1)

The enforcement action we took:

Under Section 28 of the Health and Social Care Act 2008 we varied the service providers registration. They are no longer authorised to carry on regulated activities from Greenfield House, White Lund Road, Morecambe, LA3 3NL