Cumbria Care

Greengarth

Inspection report

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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

Overall summary

We visited the home on 23 and 28 April 2015 and met with the provider on 2 June 2015. The inspection was unannounced and in response to concerns and information received by the Care Quality Commission (CQC). Greengarth is registered to provide accommodation for people who require personal care. The home can accommodate up to 39 older people, some of whom are living with dementia. The home is operated by Cumbria Care, a unit of Cumbria County Council.

Accommodation is provided over two floors, with the upper floor accessible via stairs or passenger lift. There is a separate unit at the home that provides accommodation for people living with dementia.

The home is required to have a registered manager. 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.

Summary of findings

The person registered in respect of this home has been absent for more than six months. The management of the home has been overseen by registered managers from other Cumbria Care homes during this time period.

The provider is required to tell us when registered managers are absent from the home for a period of 28 days or more, including the reasons for the absence. The provider failed to tell us about this matter.

This is a breach of Regulation 14 of the Care Quality Commission (Registration) Regulations 2009 because the provider failed to give assurances that the service would continue to be properly managed during the registered manager's absence. You can see what action we told the provider to take at the back of the full version of the report.

It is a requirement of the Care Quality Commission (Registration) Regulations 2009, that the provider must notify the Commission without delay of allegations of abuse, accidents or incidents that had involved people who used this service. This is so that we can monitor services effectively and carry out our regulatory responsibilities. The sample of people's care records that we looked at recorded examples of incidents and accidents that should have been reported to CQC. Our systems showed that we had not received any notifications. This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of the report.

We also found that the provider did not meet the requirements of the Mental Capacity Act 2005 (MCA) and associated Deprivation of Liberty Safeguards (DoLS). Appropriate assessments of people's capacity to make decisions had not been carried out. People who lived in the dementia unit had their liberty restricted because they were not freely able to leave that part of the home if they wished. Where people lack the ability to make decisions about their lifestyle, the MCA and DoLS require providers to submit applications to a 'supervisory body' for authority to restrict people's liberty.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people who used this service were deprived of their liberty and were not protected from abuse or improper treatment. You can see what action we told the provider to take at the back of the full version of the report.

We observed at the time of our inspection visits, that there were sufficient numbers of staff on duty to meet the needs and expectations of the people that used this service. However, this was not the case during the night. The night shift was covered by only two members of staff. There were not enough staff on duty during the night to safely meet the needs of the people that used this service.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not have a robust system in place to ensure sufficient numbers of staff were available at all times in order to safely meet the needs of the people that used this service. You can see what action we told the provider to take at the back of the full version of the report.

We looked at the way in which people's medicines were handled and managed at the home. Although we saw some elements of good practice, for example staff explained to people whether they needed to chew, swallow or let the tablet dissolve, we found that medicines were not managed safely. There were discrepancies between the medicines records and the medicines in stock. There were no records or care plans with regards to the administration of topical medicines such as creams and ointments.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people did not receive their medicines in a safe way or as prescribed. You can see what action we told the provider to take at the back of the full version of the report.

The home was generally clean, tidy and fresh smelling. We did identify some gaps in the control and prevention of infection practises at the home. For example staff did not always wear protective clothing when dealing with contaminated items and the laundry area was not clean or well organised.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider did not have robust processes for

Summary of findings

detecting and controlling the risks of cross contamination and the spread of infection. You can see what action we told the provider to take at the back of the full version of the report.

Care plans and records had not been maintained to provide an accurate and up to date account of people's care and support needs. We saw examples of personal records that had not been appropriately and securely stored.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were placed at risk of receiving inappropriate and unsafe care because information about their care needs was out of date. People's private and personal information was compromised because of the lack of security. You can see what action we told the provider to take at the back of the full version of the report.

The sample of care plans we looked at also contained DNACPR (do not attempt cardiopulmonary resuscitation) forms. We found no evidence to confirm that these decisions had been made in the best interests, or with consent or proper consultation with the people they related to.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People had not been properly consulted about their wishes with regard to their end of life care and support. You can see what action we told the provider to take at the back of the full version of the report.

Assessments, planning and delivery of care were not based on risk assessment and people's choices. Arrangements were not in place to enable staff to respond appropriately to people's changing needs.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

We found that the home had an auditing process in place and systems for obtaining feedback and comments from people who used the service. The systems were not robust. Gaps in the systems meant that the provider was not able to effectively evaluate the service to make improvements.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

We observed that chickens from a nearby neighbour were able to access the home. We were concerned about the health and hygiene issues and contacted the local authority environmental health officer about this.

We recommended that the provider reviewed their policies and procedure regarding animals in care homes, particularly with regard to the prevention and control of infections.

We have made a recommendation about training for staff in relation to assessing and supporting people with their nutritional needs. This is because nutritional assessments had not been accurately completed. Additionally, staff had not consistently followed instructions for supporting people identified as being at risk of poor nutrition.

However in the course of finalising and analysing the information, we revisited the service on 10 and 13 July to judge if actions had been taken since our visits in April. Following the feedback that we had provided on 2 June, we found that no progress had been made.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special Measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin

Summary of findings

the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

The service will 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 we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate 

The service was not safe.

There was not enough staff on duty at night to keep people safe

Social workers we spoke to were concerned that the service did not always act appropriately when allegations of abuse arose. The safeguarding systems and processes in place at the home were not effective. People were not protected from the risks of harm or abuse.

People were not protected against the risks associated with unsafe use and management of medicines.

Gaps in risk assessments meant that people who used this service were not adequately protected or supported to make choices.

Is the service effective?

Inadequate 

The service was not effective.

Staff did not understand the Deprivation of Liberty Safeguards or the key requirements of the Mental Capacity Act 2005. This meant that people's human and legal rights were not respected.

People's nutritional needs were not consistently monitored and managed appropriately. However, the people we spoke to during our visit to the home told us that they were very satisfied with the standard of food provided.

Staff training programmes were in development but some training had already been updated. However, fire evacuation and safety training had not been completed by staff.

Is the service caring?

Requires improvement 

The service was caring, but there were inconsistencies in the caring approach.

We observed that staff treated people with kindness and dignity. We saw and heard some very nice examples of staff supporting people who used this service.

People we spoke to told us that staff were "friendly and helpful." People said that they felt "well cared for."

Staff had limited input into the care planning system and did not always read

the care plans.

Personal and confidential information did not always reflect people's current care needs and confidential information had not been kept secure. People were not always appropriately consulted about their end of life care wishes. People's rights, privacy, dignity and confidentiality was compromised.

Summary of findings

Is the service responsive?

Requires improvement 

The service was not always responsive.

We found that care plans did not contain up to date information about people's care and support needs.

Health and social care professionals voiced concerns that the service was "resistant" to the involvement of external people such as social workers, occupational therapists and the community psychiatric nurse. People were placed at risk of receiving inappropriate support.

Is the service well-led?

Inadequate 

The service was not well led.

People were not protected against the risk of harm because the systems used to assess the quality of the service were limited and not effective.

The culture at the home was not open and transparent. Senior managers had failed to ensure effective and open partnership working with relevant agencies such as CQC and the local social work team.

There has not been a registered manager in post, full time at the home for over six months. Staff told us that different people had been covering the manager's post and this had resulted in lots of changes and inconsistencies.

Greengarth

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 on 23 and 28 April 2015 and was unannounced. We also met with the provider as part of this inspection on 2 June 2015.

The inspection was carried out by an adult social care inspector.

Prior to our inspection we checked all of the information we held about the home. We contacted health and social care professionals, such as social workers and community nurses, to obtain their views and experiences of this service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During our visit to the service we spoke with five people who lived at Greengarth, three relatives who were visiting the home at the time of our inspection, five members of staff as well as the acting manager at the home and the provider's operations manager.

We reviewed a sample of four people's care plans in depth and we observed staff working with people who used the service. We looked at a sample of the records that had been maintained with regards to the running and maintenance of the home. We looked at the fire safety records, infection control processes, staff and service user meeting minutes and we looked at the way staff had been supported in their roles.

We spoke to staff about medicines management. We observed part of the lunchtime medicines administration round. We saw medicines being checked, handled and medicine records being completed during this observation.

We also looked at a sample of the policies and procedures that were in place at the home.

Inadequate

Is the service safe?

Our findings

The service was not safe.

We spoke to some of the people who lived at Greengarth and to three people who were visiting the home at the time of our inspection. They told us that they were "satisfied" with the home. One person told us, "I feel safe here and wouldn't stop here if I didn't like it."

We spoke to social workers and community nurses who visited the home regularly.

The community nurse told us that staff had always acted on any concerns. The nurse said that any concerns had been escalated to the district nursing team in a timely way.

The social work team we spoke with were not positive in their views and experience of this service. They were concerned about the staffing ratios and the lack of reporting incidents and potential safeguarding concerns.

We checked the information we held about this service. We found that the home had notified CQC of three incidents, accidents and one potential safeguarding incident that had occurred at Greengarth since our last inspection in June 2014. We were aware that further matters had occurred at the home from the information we held about the service and because the local social work team had alerted CQC about them. This meant that the provider had failed to keep CQC informed of events at the home.

We spoke to staff about safeguarding and abuse. Staff told us that they had or were in the process of receiving training updates on these topics. Staff could give us an overview of abusive practices and of their responsibilities to report any suspicions to their line manager.

We looked at a sample of people's care and support records and daily notes. We found examples of incidents that should have been notified to CQC and/or the local safeguarding team. For example; five people had suffered falls and needed treatment from the doctor or at the hospital; one person had two occasions of unexplained bruising recorded in their daily notes, but no action had been taken by the home to ensure this person was safe and the cause of the bruising investigated.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people who used this service were not protected from abuse or improper treatment.

People's care records included some element of risk assessments but these were not up dated to reflect people's changing needs and had not been reviewed following incidents. For example; where people had suffered falls or required the use of equipment, such as bed rails, to help keep them safe. People were placed at risk of receiving inappropriate and unsafe care.

At the time of our visit there were sufficient numbers of staff on duty to meet the needs of people who used this service. We observed that call bells were answered promptly and people were supported when necessary. The staff we spoke with told us that they thought that there were enough staff to meet people's needs. People who used the service told us that staff attended them quickly if they needed help. Two people told us that the staff took them out to the shops "if they had time."

We looked at the staff rotas. Whilst there were enough staff on duty during the day, there were only two members of staff covering the night shift. We spoke to the manager, the operations manager and the provider about the night time staffing levels and how these levels had been determined. The operations manager told us that the night staffing levels were going to be reviewed and that the numbers had been based on "historical information." We judged that night staffing levels were inadequate and did not take into account the layout of the home and the needs of the people that lived at Greengarth.

We spoke with daytime staff during our visit to the home. Two members of staff told us that the home "could do with more staff". One of them told us that they didn't have time to read people's care plans and daily diaries and another said, "It's hard because not only do we provide care but are also responsible for some of the cleaning (bedrooms) and cover of the laundry in the afternoon and at weekends." We spoke to the operations manager about staffing levels during this visit to the home. We asked them how these had been determined. The home did not have a dependency tool to help them calculate the correct numbers of staff needed in order to meet people's needs appropriately.

Inadequate

Is the service safe?

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

As part of this inspection we looked at the way in which medicines were managed and administered. We also looked for care plans relating to the use of medicines. The provider had policies and procedures relating to the administration of medicines. We saw that staff had not followed these procedures. We found that medicines were not managed safely.

We found that the administration records for people taking oral medicines had been completed appropriately and the sample of stocks checked against these records were accurate.

We looked at the records for the handling of Controlled Drugs at the home. The Controlled Drugs record book was in a poor condition and the binding was falling apart. Controlled Drugs records should be securely maintained in a bound register with numbered pages.

When we checked the stock of one person's Controlled Drugs, we found a discrepancy with the stock recorded in the Controlled Drugs register. We asked the senior care worker and the manager about this matter. They checked the general medication administration record (MAR). This showed that the Controlled Drug had been administered as prescribed but this had not been recorded, as required, in the Controlled Drug register.

We found that the recording of creams and topical medications was poor. MAR records stated that this type of medicine was "administered by care staff". The MAR's had not been signed to indicate that this medicine had been administered. We asked the senior care worker and manager whether the administration of this type of medicine was recorded elsewhere. We were told that this would be noted in people's daily records, but when we checked these this was not the case.

We checked whether staff had been given guidance about the administration of creams and ointments. There was no information recorded in people's care plans, nor were there body maps identifying where and when creams should be applied. There was no way of checking and confirming that people had received this type of medicine as their doctor had intended or that the treatment was effective. People were at risk of receiving inappropriate treatment.

We looked for care plans relating to medicines associated with medical conditions such as Diabetes and for people prescribed "when required" (PRN) painkillers. There were no care plans in place for either of these situations.

We asked staff how people with limited communication skills would access pain relief when required. Staff told us that they would observe their facial expressions or behaviours. Information about behaviours and facial expressions were not recorded in people's individual care plans to help guide staff. This meant that people were placed at risk of suffering unnecessary pain.

There were no care plans to help staff manage people with diabetes safely. There was no guidance as to how staff should monitor people with diabetes or to help them recognise a hyper or hypo-glycaemic event. A recent safeguarding meeting had identified shortfalls in the support of one service user with diabetes. Although the provider had said during the meeting that record keeping would be changed, this had not happened at the time of our inspection.

This meant that staff did not have clear guidance available to them to make sure people received appropriate and safe support with their medical conditions.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that the provider had policies and procedures in place regarding the control and prevention of infection. The staff that we spoke to during our inspection confirmed that they had received training with regard to infection prevention and control. We observed staff wearing protective clothing and following good infection prevention processes. These practises were not carried out with any consistency and we spoke to the manager and the operations manager about our observations.

We viewed the laundry area during our inspection of the home and we spoke with laundry staff about their work. They told us that they had received training about infection control and prevention but that they had not undertaken recent health and safety training or training to help ensure they handled hazardous substances safely (COSHH).

We noted that the laundry was not clean or well organised. The areas behind the washing machines required thorough

Inadequate

Is the service safe?

cleaning, waste bins were open topped and there was no system in place to ensure laundry progressed safely from dirty areas to clean areas to help reduce the risks of cross contamination and infection.

We were told, and we observed, that staff frequently used the laundry as a short cut to the designated staff smoking area. This also raised the risks of cross contamination and infection. We spoke to the managers about this matter at the time of our visit and during our meeting with the provider.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On our first visit date we observed that chickens belonging to a near-by neighbour of Greengarth entered the home via the conservatory doors. Although the therapeutic value of animals in care homes was appreciated, we were concerned about health and hygiene issues. We contacted the local authority environmental health officer about this matter. They supplied guidance for the provider regarding health, safety and animals in care homes.

We recommend that the service review their policies and processes regarding animals in care homes in relation to reducing the risks associated with infection prevention and control.

Inadequate

Is the service effective?

Our findings

The service was not effective.

The people we spoke to during our visit to the home told us that they were happy with the standard of food provided. One person told us; "We have plenty to drink. I can have a cup of tea whenever I like and the girls (care staff) will make tea for my visitors too." Another said; "The food is great. I can't eat it all sometimes but I do have a small appetite."

One of the people who lived at Greengarth said; "I would like my breakfast earlier. It is a long time between getting up and breakfast. You have to wait until they (the staff) have got everyone up."

A relative told us; "The staff are very patient when helping my relative with eating and drinking. Staff make an effort and if there is something my relative doesn't like they always bring something else. I am offered drinks when I visit and if I like I could have a meal with my relative."

The managers told us of some problems that had been experienced by the service with regards to the accuracy of the staff training and supervision records. However, when we looked at a sample of these records and spoke to staff, we found that these matters had started to be addressed.

The provider told us of the induction training that was provided to new members of staff. They also gave us details of the staff training plan for the coming year. Planned staff training updates included safeguarding processes (we noted that this had already commenced), safe handling of medicines and training with regard to dignity and respect. The operations manager told us that a training plan in relation to care planning was under development in conjunction with Kendal college and that this would be implemented within this financial year.

We noted that the fire evacuation and safety training for staff at the home had not been completed and we brought this to the attention of the manager at the time of our inspection as it needed to be addressed quickly.

The staff that we spoke to during our inspection of the service told us of some of the training they had received including safeguarding, dementia care training and infection control training. Staff told us that they tried to, "Book onto training courses when they became available." Staff also confirmed that they received regular supervision from their line managers. We sampled staff records, which confirmed this to be the case. We saw that performance had been discussed during supervision meetings. Where issues had been identified, we found evidence of further discussions and meetings being held in order to work out individual support plans for staff.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act 2005 (MCA). The Mental Capacity Act (MCA) and DoLS provide legal safeguards for people who may be unable to make decisions about their care. The records and care plans in place showed that the principles of the Mental Capacity Act 2005 Code of Practice had not been followed when assessing an individual's ability to make a particular decision.

The provider told us that there was no one at the home subjected to authorisation under the Deprivation of Liberty Safeguards (DoLS). On the day of our visit we checked this information again with the home manager. They confirmed that there was no one at the home subjected to DoLS.

However, we found that there were nine people living with dementia who lived in the dementia unit of the home. These people were unable to leave that unit if they wished as the door was secured with a numerical key pad.

We found people had bed rails in use on their beds. There were no risk assessments, no evidence of best interest meetings or mental capacity assessments regarding the use of this type of restrictive equipment. The correct procedures had not been followed to demonstrate how these decisions had been made and if these were the least restrictive methods of keeping people safe.

We spoke to the manager about our concerns regarding the people at the home who had their rights, liberties and choices restricted.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also observed that one person was given their medicine in a drink. We asked the senior carer and the manager about this and checked this person's records. The senior carer was not aware that this method of administration was carried out in a covert way, but we could find no evidence to confirm the person had given consent for their medicine to be administered in this way. We checked this person's care plan and risk assessments but there was no evidence

Is the service effective?

of a mental capacity assessment, a best interest assessment or confirmation from the doctor or pharmacy that this was a safe and appropriate way of administering this person's medicines.

We looked at care plans to see how decisions had been made around people's treatment choices and 'do not attempt cardio pulmonary resuscitation' (DNACPR). In the sample of care records we looked at during our visit, we found that people had DNACPR (do not attempt cardiopulmonary resuscitation) forms. We did not see anything to confirm that the correct decision making processes had been followed with regard to the DNACPR's. This meant that people may not have been properly consulted about their wishes regarding the care and support they would like at the end of their life.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed the serving of breakfast in the dementia care unit. People were able to choose what they would like for breakfast. We saw staff supporting people with their nutritional needs. The support included verbal encouragement to help promote independence and physical assistance. Where people needed more support to eat their meal, staff sat down with them on a one to one basis and helped them eat in a dignified and well-paced manner.

At lunchtime people were able to sit outside in the garden, in the sunshine for their meal if they chose. Staff were very attentive even though everyone was not in the dining room. We observed some very good interactions and practices between staff and service users during mealtimes.

Staff were aware of people who had been identified as being at risk of malnutrition and of who needed to have fortified diets, extra snacks and food diaries completed. One care worker shared their ideas for making pureed diets more attractive; for example the use of food moulds and special plates.

We checked the nutritional records of four people who lived at the home. However, whilst people were physically supported with eating and drinking, nutritional records were not well maintained.

Although we saw evidence that people had received an assessment of their nutritional needs, it was not clear from the records that assessments had been thoroughly carried out by staff that understood the process of assessment and evaluation.

The records of one person identified weight loss and recorded that they should be weighed every three days. Their dietary assessment had not been reviewed and their body weight had not been monitored as recorded. Staff had also been instructed to monitor this person's food intake but when we asked to see the food diary records they had not been maintained.

Another person's dietary assessment recorded that they did not have any specific dietary requirements. However, other records showed that they were at risk from malnutrition and had been prescribed dietary supplements to take throughout the day. Their dietary assessment had not been reviewed following a period of weight loss or following the use of the prescribed food supplements.

We recommend that the service finds out more about training for staff, based on current good practice in relation to assessing and supporting people with their nutritional needs.

We looked at the general environment of the home during our inspection visits. We found that the home was in need of some redecoration and repair. For example, paintwork was chipped, wall paper was peeling, walls and ceilings had cracks, some due to water ingress.

We asked the provider about the refurbishment programme for the home and the ongoing maintenance plan. The provider told us that there was no refurbishment plans but that an amount of money had been set aside for any outstanding redecoration improvements.

The issues regarding the general environment of the home had also been identified in the internal audit carried out by the provider in January 2015.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the home had not been properly maintained.

Requires improvement

Is the service caring?

Our findings

We spoke to some of the people who lived at Greengarth and to some of their visitors.

One visitor told us that they were "very pleased" with the home. They said; "The staff are lovely and are aware of my relative's personal care needs. They (staff) always let me know of any concerns about my relative. It is a friendly, warm environment and I get the impression that my relative is ok here."

One person who lived at the home told us; "The lasses (staff) are very good and helpful. They go round and make sure everyone is alright." Another person said; "Staff look after me very well, nothing is too much trouble. I am quite happy here."

We noted that people who used this service were given choices about day to day events such as meal choices, activities or where they wanted to spend their time. People who had limited communication skills were not properly consulted about their choices and wished because there were no alternative communication methods in place. For example the use of pictures or large print.

The home had displayed information about advocacy services on the main notice board in a communal lounge. However, this information was not within easy reach or eyesight of people who may have been wheelchair users or lived in the dementia care unit.

On the days of our visits there were no people receiving end of life care. We looked at a sample of four care records in detail. We found that some people had instructions in their records stating that they did not wish to be resuscitated in the event of a cardiac or respiratory arrest. However, these had not been developed in line with current guidance and legislation. Staff were not clear and lacked understanding of the Mental Capacity Act 2005 in relation to decision making processes.

We observed on the day of our visit that staff were attentive, responded quickly to requests from the people they were supporting and that call bells were answered promptly. During our visit to the home we observed and overheard very good and pleasant interactions between staff and service users. We heard one member of staff helping someone to get out of bed. Staff asked the person about their clothing choices and discussed what was on offer for breakfast that day.

We observed, and people told us that staff treated them with respect and kindness.

We spoke to care staff at the home about their work. They were able to give a verbal account of the personal needs of the people they supported. We spent a large part of our time in the dementia care unit at the home. We observed staff supporting people in this part of the home and noted that support was provided in a caring, gentle and friendly manner.

Requires improvement

Is the service responsive?

Our findings

A visitor to the home said that the staff caring for their relative knew about their personal needs and preferences. The visitor told us that their relative's admission to living at the home was a "smooth transition" because they had first attended the day care service operated from the home and used the respite services.

One of the people that lived at Greengarth showed us their room. They told us that they had been able to bring some of their own furniture and possessions into the home with them. This had helped to make it "more personal and like home" for them.

None of the visitors or service users we spoke to had ever made a complaint about the service they received. One person told us, "If there were any problems I would just speak to the girls (staff) and I know they would get it sorted out."

Staff told us that they had recently been allocated to work on specific units at the home. Previously they had been working in all areas. Staff told us that they saw this as "an improvement". For example, one care worker said; "This is a better way of working. It helps us to get to know service users better especially with regards to their communication and care needs."

Another member of the care team said; "Communication between the girls (staff) is very good. We all used to attend the formal handover when we came on shift. This has changed recently and only the seniors attend but they do pass on the information about people's care needs to us."

Staff told us that they were supposed to read people's individual daily diaries when they came on shift. This was to help ensure they were familiar to any changes to people's individual care needs. However, staff also told us that they "didn't always have the time" to read these updates to care needs. This meant that people were placed at risk of receiving care that was not always centred around their current, individual needs.

Social workers, occupational therapists and the community mental health team told us that they had concerns about the way in which support was "planned and delivered." They told us that people's care plans were not fully followed and that people "only receive very basic care." The low staffing levels were attributed to this.

We found that some people were provided with equipment such as bed rails for example. One person's care file recorded that they had become "confused" and had tried to climb over the bed rails. We checked their records and found that the use of this equipment had not been reviewed. Risk assessments had not been undertaken to make sure this was the most appropriate and safest method of keeping people safe.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

Staff that we spoke to during our inspection of the home told us of "lots of different people" that had been in to manage the service. They said it had been "confusing" because people had different ways of working and different expectations of staff. During our inspection of the home we heard a conversation between a member of staff and the acting manager with regards to completion of people's daily diaries. There was confusion between the staff and manager as to what exactly should be recorded in these documents.

All of the people we spoke to who were visiting or lived at Greengarth told us that they had never had to make a complaint about the service. They told us that they knew who to speak to should they have any concerns and were confident that "they (the staff) would sort it out". People told us that they felt able to raise issues or suggestions at any time with staff but that there were also resident and relatives meetings frequently held. This meant that people who used this service were able to contribute to the running of the service if they wished.

We found that the provider had not acted in an open and transparent way. For example, the registered manager at the home had been absent since August 2014. The provider failed to notify CQC of the absence until January 2015. When CQC were notified, the provider gave no clear information as to the circumstances surrounding the absence or how long the absence would last. Furthermore there were no plans provided as to how the service would be managed effectively and safely during this period of the registered manager's absence.

The provider did not give assurances that the service would be properly managed during the absence of the registered manager.

This is a breach of Regulation 14 of the Care Quality Commission (Registration) Regulations 2009

We checked the information we held about the service and contacted health and social care professionals about the service. We also checked a sample of records during our visit to the home. These included care plans, accident and incident records. We found that the provider had not been reporting allegations of abuse, accidents or incidents that had involved people who used this service, to social workers or to CQC.

This is a breach of Regulation 18 of Care Quality Commission (Registration) regulations 2009.

We found that the home had general risk assessments in place for example the fire risk assessment, Legionella tests and water temperature checks. We noted that regular checks and tests were carried out to ensure fire detection and protection systems worked effectively. However, we found that staff training with regards to fire safety and evacuation was out of date. The provider told us that this training was planned over the year from April 2015 to March 2016.

We saw that some internal auditing had taken place. The audits had identified some of the issues identified during our inspection of this service. For example gaps in care plans, medication records and protocols for PRN medicines. The auditing process was not robust as the shortfalls identified had not been rechecked by the auditor.

CQC attended three safeguarding strategy meetings in March 2015 regarding the care and welfare of three people who had lived at Greengarth. Some of the concerns raised at these meetings were with regard to record keeping and monitoring the well-being of people who used the service. One of the actions from the meeting was that the manager would make sure staff were completing care records with all the details of personal care. We found during our inspection that the actions agreed by the acting manager during the strategy meetings had not been put in place.

We saw some evidence of risk assessments in people's care records but these had not routinely been reviewed and updated as people's needs changed. Care plans were not up to date and did not provide an accurate account of people's care and support needs. Gaps in care records included records relating to decision making processes and consent.

We found personal records relating to the care and support of people who used this service that had not been stored securely. The personal care records of eight service users had been stored in an unlocked filing cabinet. Further records belonging to numerous service users had been left out on a work surface on one of the ground floor units. The unit was not in use but was unlocked and accessible to any visitor to the home. We spoke to the senior carer on duty at the time of our inspection about this matter. The records had been removed by the time we left the home on the first day of our visit.

Inadequate

Is the service well-led?

The lack of care with regards to the management and accuracy of personal information compromised service user's privacy, confidentiality and wellbeing.

We asked about the arrangements in place with regards to people at risk of falling and how such incidents were monitored and managed to help reduce risks. The acting manager told us that although falls were recorded there were no formal processes for auditing to help look for trends and patterns.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 14 CQC (Registration) Regulations 2009 Notifications – notice of absence The provider failed to tell us about the extended absence of the registered manager and failed to provide adequate assurances that the service would be properly managed. Regulation 14(1)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The provider failed to notify CQC of incidents occurring at the home as specified in paragraph 2 of this regulation. Regulation 18(1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Decisions regarding people's wishes with regard to the management of their medicines, their end of life care and support had been made without proper consultation and consent. Regulation 11

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People did not receive their medicines in a safe way or as their doctor intended. Regulation 12(2)(g)

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People were not protected from the risks associated with the prevention, control and spread of infection because robust processes were not in place. Regulation 12(2)(h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Assessments, planning and delivery of care were not based on risk assessment and people's choices. Regulation 12

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 People who used this service were deprived of their liberty and were not protected from abuse or improper treatment. Regulation 13(5)

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 People were not protected from the risks of abuse or improper treatment because effective systems and processes were not in place. Regulation 13

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance. Regulation 15 (1) (c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have systems in place to effectively evaluate the service and make improvements. Regulation 17(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance People were placed at risk of receiving inappropriate and unsafe care because information about their care needs was out of date. People's private and personal information was compromised because of the lack of security. Regulation 17(2)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider did not have a robust system in place to ensure sufficient numbers of staff were available at all times in order to safely meet the needs of the people that used this service. Regulation 18(1)