New Boundaries Community Services Limited

Greenacres

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Greenacres is a residential care home providing personal care to three people with learning disabilities and/or autistic people.

Greenacres is a small bungalow, with no communal space, where each person has their own individual flatlet. Staff have use of an onsite office within the building.

People's experience of using this service and what we found
Risks, including those posed by the environment, were not well managed. Some risks had not been sufficiently assessed and mitigated and continued to place people who used the service, staff, and others, at risk of harm.

Some safeguarding incidents had not been thoroughly investigated and the provider had not taken robust action to reduce future risk. Safeguarding incidents had not been reported to the Care Quality Commission (CQC.) This meant CQC had reduced overview of risks at the service and had been unable to monitor the provider's response to specific incidents.

There were not enough staff to meet people's complex needs. Bank and agency staff were used regularly but there was limited oversight of their training and some staff's excessive working hours. Permanent staff did not all have the training they needed to meet people's needs.

Rotas did not evidence that people's one to one commissioned hours were being provided in line with their local authority contract. This placed people at risk of unsafe care and treatment and had impacted negatively on one person who used the service.

Infection control was not robust. Staff who refused to take part in the COVID-19 testing programme or who failed to wear their masks correctly, placed people at risk. The provider had failed to take action to investigate and reduce this risk.

Oversight of the service was poor. In the absence of a registered manager, the provider had failed to monitor the safety and quality of the service. Systems and processes designed to monitor and improve the service, were not always in place or were not robust, although the new manager had begun to introduce some weekly auditing and checking procedures.

The manager demonstrated a good understanding of the areas for improvement, but they were working a large number of hours, some of which were on shift to cover for staff vacancies. They were not fully supported by the provider to address the multiple areas for improvement. The provider was reluctant to engage with us which meant we did not have full confidence that all the issues we raised would be addressed robustly and promptly.

Medicines were well managed.

People were not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

Based on our review of safe and well -led the service was not able to demonstrate they were meeting some of the underpinning principles of Right support, right care right culture.

Right support:
• The model of care and setting did not maximise people's choice, control and independence. People were included in decisions about their care and support, but staffing issues meant that they were not always able to achieve their goals. Some of people's specific support needs were not always clearly identified and met.

Right care and right culture:
• Records indicated that work needed to be completed to ensure that all staff understood the ethos, culture and values that underpinned the service. The language in care plans and staff records was not always inclusive and respectful. The provider's oversight of this issue was poor. Some individual staff were observed to treat people who used the service with respect in a way that upheld their dignity.

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

Rating at last inspection
The last rating for this service was Good (published 29 April 2019)

Why we inspected
We received concerns in relation to the management of risk. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

We looked at infection prevention and control measures under the safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

The overall rating for the service has changed from Good to Inadequate. This is based on the findings at this inspection.

We have found evidence that the provider needs to make significant improvement. Please see the safe and well-led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

Following our inspection the provider began to address some of the issues we had raised, in order to mitigate some immediate risks.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Greenacres on our website at www.cqc.org.uk.

Enforcement
For enforcement decisions taken during the period that the 'COVID-19 – Enforcement principles and decision-making framework' applies, add the following paragraph: We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safeguarding, the management of risk, infection control, staffing and governance at this inspection.

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

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led. Details are in our well-led findings below.

Greenacres

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors on the day of the site visit on 19 October 2021. The same inspectors carried out a feedback session on 26 October 2021, once the inspection process was concluded.

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

The service did not have a manager registered with the Care Quality Commission. Being a registered manager means that they, and the provider, are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from a relative, the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with

key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with the three people who used the service and one relative about their experience of the care provided. We spoke with five members of staff including the manager, care workers and agency staff.

We reviewed a range of records. This included two people's care records and medication records. We looked at two staff files in relation to recruitment and staff supervision. We also reviewed a variety of records relating to how the provider monitored the safety and quality of the service.

After the inspection
We continued to seek clarification from the provider to explore evidence we found and gain assurances. We contacted the provider on multiple occasions, but responses lacked the specific detail about how the provider would reduce known risks. We continued to seek clarification from the local authority, and we contacted the police for further details about a possible risk of financial abuse.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse; Assessing risk, safety monitoring and management

●Systems designed to safeguard people from the risk of abuse or improper treatment were not robust. People who used the service may have been at potential risk of financial abuse and no investigation had taken place into this.

● Significant safeguarding incidents, where people had come to harm, had not been reported to CQC, as is required. This meant these incidents could not be closely monitored by CQC to help ensure there was no repeat.

● Some staff were overdue their safeguarding refresher training and one member of bank staff had no record of this training. Staff were not all clear about how to raise safeguarding concerns outside of the organisation.

Systems and processes did not ensure people were kept safe from harm. This was a breach of regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Two people had care plans and risk assessments which were designed to meet their complex support needs. Information for staff relating to these was not clear and not understood by all staff. This placed the people who used the service, staff, and potentially others, at risk. Following our inspection, the manager reviewed all the records and produced new care plans and risk assessments.

● Risk assessments were not reviewed regularly or reviewed following a change. One person had moved from another service in August 2021. They still had some of the risk assessments from that service in place weeks later. The care plan and risk assessments had not been reviewed in the light of a significant change to this person's care provision.

● There was no risk assessment regarding staff lone working at night. There was no expectation for staff to check in with colleagues to confirm all was well and no clear procedure for staff to follow in the event of an emergency.

● Risks from the environment had not been fully considered and, if required, mitigated. There were no window restrictors, cool touch hobs or kettles. Potential risks from cleaning products and razors had not been considered and documented.

Systems were either not in place or robust enough to demonstrate safety was effectively managed. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

●Some people who used the service had been commissioned to receive one to one hours during the day. Rotas demonstrated that these hours were not always provided. Staff and people who used the service confirmed this. One staff member commented, "There are not always three people on – staffing is a disaster." The failure to ensure these hours were consistently provided may have contributed to a serious incident involving one of the people who used the service.

● A new person was recently admitted to the service in an emergency. There should have been three staff on duty but there were only two. Neither of these was a permanent member of staff, with one being an agency staff member and the other bank staff.

● Staffing reduced to one waking night staff. The reduction to this level of staffing had not been risk assessed and staff were not confident that this level of staffing would keep people, including themselves, safe.

●The service had four vacant staff positions and the provider tried to cover the hours with bank staff and agency staff. We found that some of these staff were routinely working excessively long hours and noted reports of a member of staff sleeping on duty. There was no record of any investigation into this incident.

● New staff had not completed an induction. They had also not met with their manager or the provider to review their progress and receive support during the first weeks and months of their employment. The new manager had remedied this and had met with them once, although one had been in post almost a year by the time this meeting took place.

● Staff lacked some specific training to meet people's complex needs. Records for some agency staff indicated that they also lacked this training. One agency member's training record documented that all her training was incomplete. The provider had not identified this as an issue.

● The lack of consistent staffing, and the fact that the vehicle was shared with the sister service meant that people's access to the community was restricted.

There were not enough staff skilled and experienced staff to meet people's needs promptly. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Permanent staff were recruited safely using a structured recruitment process.

Preventing and controlling infection

● We were not assured that the provider was using PPE effectively and safely. Staff were not all wearing masks in accordance with government guidelines and where staff had declared themselves exempt from wearing a mask, their right to do this was not investigated and documented.

● We were assured that the provider was accessing testing for people using the service but not for all staff. Following a staff member testing positive for COVID-19 the day after our inspection, we became aware that some staff had been refusing to carry out PCR tests. Records of regular lateral flow tests for staff were also not complete.

● We were not assured that the provider was preventing visitors from catching and spreading infections or making sure infection outbreaks could be effectively prevented or managed. They were not ensuring all staff worked in accordance with government guidance.

● We were not fully assured that the provider was promoting safety through the layout and hygiene practices of the premises. Although some enhanced cleaning practices were in place, audits showed these were not routinely carried out by all staff.

● We were not assured that the provider was meeting shielding and social distancing rules within a small home environment. The service was small and social distancing was not always possible. Staff also increased risks by failing to follow government guidance regarding regular testing and mask wearing.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider's infection prevention and control policy was up to date. Staff were not always working in accordance with this policy.
● The service appeared clean and the people who used the service helped keep their own flatlets clean. Some areas of the service, such as one person's bathroom required upgrading as the current state made it more difficult to keep clean. We observed mould on the ceiling of one person's shower room.

Systems and processes did not fully protect people from the risk and spread of infection, including Covid-19. This was a further breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Learning lessons when things go wrong
● There were no effective systems in place designed to monitor and analyse incidents and accidents and reduce any future risks. Trends were not identified, and staff were not kept fully informed of the progress of any investigation into an incident.
●The new manager, who had only been in post for a matter of weeks, had begun to address this by devising an incident tracker, but this had not been put in place at the time of our inspection.

Using medicines safely
● Medicines were well managed. Medicines which are only required occasionally, such as those to help manage people's distress, had clear protocols to guide staff and were not excessively used. One tablet was unaccounted for in the medicines administration record and we reported this to staff. Information about medicines was good.
● The new manager had introduced weekly medicines audits, and these were of good quality. Staff has received training in administering medicines and staff told us their competency to administer medicines had been spot checked.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

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

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements;

●There had been no registered manager in place since October 2020. The newly appointed manager had taken up their post a few weeks before our inspection, having moved over from another of the provider's services. The manager told us it was their intention to register to manage the service.

● The provider was not proactive about assessing risk. Significant safeguarding risks had not been assessed and reduced. The provider had failed to report these incidents to CQC which meant there was reduced external oversight of risk. Opportunities had been missed to identify ways of preventing future incidents, and exposed people to the risk of continued distress or harm.

● The lack of trained and experienced staff and insufficient management oversight had impacted negatively on the quality and consistency of the care provided. A member of staff explained, "A lot of staff don't understand the needs of the people here. [We] all need extra training." The provider had not identified this as a concern.

● The provider had not identified and mitigated any risk from staff, including the manager, working excessively long hours. The manager was also expected to be on call all the time for this service and others. This was not sustainable.

● Incomplete and conflicting records also posed a threat to consistent and safe care. There was no rationale for some recording staff were doing and some records were documented in multiple locations.

● Some records were out of date and it was not clear where staff, especially new and agency staff, needed to go to find key information. One staff member told us, "We run on agency. It's so difficult to run with new staff. There is so much to tell them,….for them to sit and read [the care plan] is pretty impossible. They can't take it all in. They're huge. There is no crib sheet with basic stuff really. There is some information they really do need to know."

●Following our inspection visit we invited the provider to attend a feedback session to discuss our findings, but they did not attend. We raised the serious concerns outlined in this report in a series of e mails to them, but they did not respond to us by any of the deadlines set. The responses we received did not fully address all the issues we had raised and gave us continued cause for concern.

Continuous learning and improving care

●With no registered manager in post, the oversight of the service becomes the responsibility of the provider or their delegated deputy. The provider had no management staff below them and our expectation is that, in those circumstances, they would monitor the safety and quality of the service themselves. This had not happened.

● We identified that audits monitoring the safety and quality of the service had not taken place this year. The only comprehensive audit on record for 2021 was deemed, by the manager, to be of too poor quality to show us. Incidents and accidents were not robustly recorded, investigated, analysed and reviewed.

Systems and processes did not effectively assess, monitor and improve the safety and quality of the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The manager had introduced a series of weekly checks for health and safety and was planning to build this into a full audit programme

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Although there were regular meetings with the people who used the service about their care, care was not always person centred. People were not always supported to achieve the goals they set in these meetings. The staffing pressures in recent months and the lack of consistent access to a vehicle meant people had not been accessing the community in a meaningful way. People were not empowered and were spending most of their time within the service.

● People did not have a clear structure to their days. However, some staff clearly had good relationships with people and worked to increase their independent living skills.

● Staff told us they did not feel supported in their roles, although all were positive about the manager. Some staff told us they did not feel they could raise issues with the provider. This was a concern, given the amount of time the service had been without a registered manager.

● Staff attended staff meetings and were positive about the opportunities for supervision sessions the manager had given them.

● Relatives and staff were not routinely asked to provide feedback on the service via survey or occasional meetings. Staff, however, could provide feedback in their supervision sessions.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● Where serious incidents had taken place, the provider had not always been open and honest about it. One relative told us they did not feel they had been appropriately informed about a significant incident involving their family member.

● Information about the potential for financial abuse by a former staff member had not been shared with the people who used the service or their relatives.

Working in partnership with others

● Following our feedback, the manager began to address the issues we raised. However, the provider was not proactive, even in some matters of health and safety.

● Records demonstrated that the service worked in partnership with other health and social care professionals. We saw evidence of good communication with professional colleagues following a recent incident. However, information was not always well documented and clearly shared with staff.

● Since our inspection the service has been working closely with quality officers from the local authority to improve the quality and safety of the service.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure there were systems in place to assess and mitigate risks, including the risk of infection. Regulation 12 (1) (2) (a) (b) and (h).

The enforcement action we took:

We imposed a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to ensure there were effective systems in place to prevent abuse or to investigate allegations of abuse. Regulation 13 (2) and (3).

The enforcement action we took:

We imposed a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to operate an effective system to assess, monitor and improve the quality and safety of the service. Regulation 17 (1) (2) (a).

The enforcement action we took:

We imposed a condition on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure there were enough competent, skilled and experienced staff to meet people's needs. Regulation 18 (1) and (2) (a).

The enforcement action we took:

We imposed a condition on the provider's registration.