Greystones Nursing Home Ltd

Greystones Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 26 January 2016 and was unannounced. At the last inspection on 20 June 2014 we found the service met the regulations.

Greystones Nursing Home provides nursing and personal care for up to 25 people, some of who are living with dementia or have mental health needs. Accommodation is provided in single and shared bedrooms over three floors. There is a passenger lift to the first floor and chair lift access to the second floor. There is a lounge, dining room and smoking room on the ground floor.

The home has 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.

People told us they felt safe and we saw staff were attentive and responsive to people's needs. Staff lacked understanding of what constituted abuse and we found safeguarding incidents had not been referred to the local authority safeguarding team. We found this was a breach in regulation as safeguarding incidents were not always recognised or reported appropriately. Risks to people were not always well managed which meant people were at risk of harm. We found this was a breach of regulation as people were not receiving safe care and treatment.

Some aspects of medicine management showed good practice, however other areas were not meeting requirements such as the lack of protocols for 'as required' medicines and the systems for checking medicines people brought in with them from home when admitted for respite care. We found this was a breach in regulation as people's medicines were not managed safely.

A refurbishment programme was underway and the lounge, dining room and reception areas had been redecorated, re-carpeted and refurnished. Some bedrooms had also been refurbished and the registered manager told us people had been involved in choosing the colour scheme. However, we found many areas of the home were not clean or well maintained. For example, windows which did not close fully causing a draught in some bedrooms and broken locks on doors. We found the lack of signage and adaptions in the environment meant people living with dementia were not supported in finding their way around the home. We found this was a breach in regulation as the premises were not clean or well maintained.

There was no tool used to calculate the staffing levels and no evidence to show that the layout of the building or people's dependencies had been taken into consideration. We found staffing levels were at a minimum level and although the registered manager told us additional staff were brought in to provide one to one support to people this was not reflected on the duty rotas. At weekends there were no ancillary staff which meant cleaning and laundry tasks were completed by the care staff. We found this was a breach in regulation as there were not enough staff to meet people's needs.

Staff recruitment processes were not robust as thorough checks had not been completed. We found this was a breach in regulation as staff's suitability to work in the care service had not been assured..

The legal framework relating to the Mental Capacity Act 2015 (MCA) and Deprivation of Liberty Safeguards (DoLS) had been followed as some people had DoLS authorisations in place and applications had been made for others. However, we found a lack of understanding around the principles of this legislation as one person who was assessed as having capacity had restrictions in place with no evidence to show they had agreed to these decisions. We found this was a breach in regulation as people's consent had not been determined.

Staff received the training and support they required to fulfil their roles. People had access to health care services. People enjoyed a range of activities in the home and community.

People told us they enjoyed the food and we saw there was plenty of choice available. However, food intake charts were not reviewed or monitored by staff to ensure people who were nutritionally at risk had received enough to eat. We found this was a breach in regulation as people's care needs were not being met.

People and relatives we met spoke highly of the staff and praised the care provided. We saw staff were kind, caring and patient with people and there was a relaxed and friendly atmosphere. However, we found some practices undermined people's privacy and dignity and showed a lack of respect. For example, no locks on two toilet doors, no plugs at wash hand basins meaning people could not fill their sinks to have a wash, dirty bed linen and mattresses which smelt of urine and smoke from the smoking room pervading other areas of the home. We found this was a breach in regulation as people's privacy and dignity was not maintained.

People's needs were not always assessed before admission to ensure that staff could meet them. People admitted for short stays had no care plans or risk assessments to guide staff in meeting their needs. Care documentation for people who lived permanently at the home was detailed but was not up to date. We found this was a breach in regulation as people's care needs were not being met.

The complaints procedure was displayed and we saw complaints were recorded and investigated. However, the outcome of the investigation and response to the complainant was not always clear or recorded. We found this was a breach in regulation as complaints were not being dealt with appropriately.

People, relatives and staff all praised the registered manager who was described as supportive. We found them to be open and committed to making improvements in the service. However, although some quality assurance systems were in place, the systems were not effective as they had failed to identify and rectify the issues we found at this inspection. We found this was a breach in regulation as there was not good governance.

Overall, we found significant shortfalls in the care and service provided to people. We identified ten breaches 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.

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

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.

Although people told us they felt safe, safeguarding incidents were not recognised or referred to the appropriate authorities which placed people at risk of harm. Risks to people were not well managed.

Staffing levels were not always sufficient as the layout of the building and dependencies of people using the service were not considered when determining numbers of staff required. Staff recruitment processes were not robust, which placed people at risk from unsuitable staff.

Medicines management systems were not always safe.

Some areas of the building were not well maintained or clean.

Is the service effective?

Requires Improvement

The service was not always effective.

Mental Capacity Act 2015 (MCA) and Deprivation of Liberty Safeguards (DoLS) applications had been made and some authorisations were in place. Yet there was no evidence of informed consent to decisions where people had capacity.

Staff received the training and support they required to fulfil their roles.

People enjoyed the meals and were provided with a choice of different foods. Snacks and drinks were available at all times. However, the food intake of people who were nutritionally at risk was not monitored or reviewed by staff to ensure they had received sufficient.

People had access to healthcare services. Adaptations were needed to help people living with dementia find their way around the home.

Is the service caring?

Requires Improvement

The service was not always caring.

People's privacy and dignity was not always respected. Appropriate arrangements were not in place to protect people who did not smoke from the smoking fumes of those who did.

People and relatives praised the care they received and the kindness of the staff. Staff were caring, compassionate and attentive and there was a relaxed and friendly atmosphere in the home.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Assessment processes for people admitted for short stays did not ensure the person's needs could be met by the service and there were no care plans or risk assessments to guide staff in care delivery. Although some care plans and risk assessments were well recorded for people who lived in the service permanently, many were not up to date.

People enjoyed a range of activities in the home and out in the community.

The complaints procedure was accessible to people. Complaints were recorded and investigated, however the outcome and response to the complainant was not always clear.

Is the service well-led?

Inadequate

The service was not well led.

Although we found the registered manager was open and committed to making improvements to the service and people, staff and relatives spoke positively about the registered manager, there were significant shortfalls in the governance arrangements which failed to identify and rectify the issues we found at this inspection. This included monthly monitoring visits by the registered provider.

There had been a failure to submit the required notifications to the Commission without reasonable cause.

Greystones Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. 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 26 January 2016 and was unannounced. Two inspectors attended, a member of the inspector's business support team and an expert by experience with experience of mental health services. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the home. This included looking at information we had received about the service and statutory notifications we had received from the home. We also contacted the local authority commissioners and the safeguarding team.

We usually send the provider a Provider Information Return (PIR) before the inspection. 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. We did not send a PIR on this occasion.

We spoke with 12 people who were using the service, two relatives, one nurse, four care staff, the cook, the deputy manager and the registered manager.

We looked at six people's care records, two staff files, medicine records and the training matrix as well as records relating to the management of the service. We looked round the building and saw people's bedrooms, bathrooms and communal areas.

Inadequate

Is the service safe?

Our findings

Although staff told us they had received safeguarding training, we found staff we spoke with lacked understanding of what constituted abuse. Staff gave examples of abuse such as physical, financial and psychological, yet when we gave staff scenarios of people who lived at the home shouting and being verbally abusive to each other, staff did not recognise this as abuse as they felt it was to be expected of people living with mental health problems. They said if staff were to shout at service users this would be safeguarding and they would have no hesitation in reporting it. Staff knew they could raise safeguarding alerts themselves and showed us information about the local safeguarding team, including telephone numbers, displayed in the nurse station. We saw safeguarding records which showed some incidents had been referred to the local safeguarding team. However, other incident, accident and complaint records showed several occasions where abuse was alleged or suspected. Although the police and other agencies had been involved in some of these incidents, there was no evidence to show referrals had been made to the local authority safeguarding team. When we discussed this with the registered manager they offered no explanation as to why this had not been done. The failure to recognise incidents as abuse and make appropriate referrals meant people were not protected from abuse. We made referrals to the local authority safeguarding team following the inspection. This was a breach of the Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe in the home. When we asked one person if they felt safe they replied, "Safe? Yes I do." However, we had concerns about how risks to people's health and safety were identified and managed. For example, records showed one person had gone missing on a group outing and after several hours was located by the police unharmed. When we spoke with the registered manager about this incident they told us the person required one to one support from staff while out in the community. Yet the risk assessments for this person gave conflicting advice about the level of support they required. One risk assessment dated 26 October 2013 stated the person required one to one support from staff. A second risk assessment with the same date said the person was to be 'accompanied by two staff members to ensure the safety of staff, public and (person's name).' A further risk assessment dated 30 May 2014 said 'to ensure the correct amount of staff are available to go on outing, either one to one or one to two depending on the outing.' Care files we looked at contained personal emergency evacuation plans (PEEPS) to inform staff of the support people would need if they had to evacuate the home in an emergency. However, one PEEP had been written in 2014 and had not been updated to reflect the deterioration in the person's mobility as described within their care plan. This was a breach of the Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the systems in place for managing medicines and although we found some areas of good practice, we also identified shortfalls. Medicine stocks were stored in a locked treatment room, however storage cupboards were not locked and some medicines were out on the counter. The deputy manager said they did not have keys for the cupboards and the medicines on the counter were waiting to be destroyed. A record was maintained of medicines destroyed in the home, yet although a witness signature was required, there were entries with only one signature. Daily temperatures of the medicine fridge were recorded but the treatment room temperature had not been recorded since April 2014, although the thermometer in the

room showed the temperature was within the safe range.

One person had been admitted for a period of respite the day before our visit and had brought their medicines in with them in a monitored dosage system (MDS). The tablets prescribed to be taken the previous evening were not in the MDS and the daily records showed these had been given by staff, but a medicine administration record (MAR) had not been put in place until the morning of our visit. This meant the medicines had not been booked in and had been administered but not signed for. We asked the deputy manager if they had checked the medicines brought in were correct for the person's current prescription. The deputy manager said this had not been done. However, when the deputy manager noticed one of the tablets supplied in the MDS did not have a description, they checked with the supplying pharmacist before administering the tablet.

One person's MAR showed their medicines had already been signed as administered. The deputy manager told us this was clearly a recording error from the previous day as the tablets were still in the monitored dose system (MDS).

There were no protocols for medicines prescribed on an 'as required' basis. The absence of a protocol falls short of the guidance given by the National Institute for Health and Care Excellence (NICE) and increases the risk of inconsistencies in administration. The registered manager printed a protocol from their computer, which included sections for staff to complete about what the medicine was prescribed for and how the person liked to take it. However it did not include a place for staff to record why the medicine had been given and whether it had had the desired effect. The registered manager said they would adapt the protocols and make sure they were used. The home's copy of the BNF (British National Formulary) was dated March to September 2014. This reference book is updated annually. It is important the service has an up to date BNF so they can check current information about medicines used in the home. We saw the first aid kit in the clinical room was missing a number of items. The deputy manager told us there were no records relating to the checking of the kit.

We saw a record of a medication error which had occurred when a person had been given a prescribed flu jab by the practice nurse from the GP surgery and was then given it again by one of the home's staff who did not know it had already been given. Whilst this had been followed up and advice had been taken from the GP, it had not been reported to the Care Quality Commission. This was a breach of the Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were safe systems in place for the ordering and receipt of medicines. Prescriptions were copied and retained until the medicines had been received and checked, which proved effective as errors made by the dispensing pharmacy had been identified and acted on. A balance sheet was in place for all medicines supplied in boxes and where medicines had been prescribed with the instruction to take one or two, the amount given had been recorded. A 'Hypo box' for use if people became hypo-glycaemic was in place with all components included and in date.

We observed the morning medicine round. Medicines prescribed to be taken before food had been given by the night staff to make sure people received their medicines as prescribed and were not delayed in having breakfast. The deputy manager demonstrated good practice in medicine administration. For example, they asked people if they were ready for their medicines, particularly those which had to be chewed and might have affected people's enjoyment of their breakfast. When a tablet was accidently dropped on the floor by a person and they went to pick it up and take it, the deputy manager told them they would destroy it and get them another one.The deputy manager told us one person could be given their medicines covertly (disguised in food or drink). We saw a letter from the person's GP saying they had agreed this with the

independent mental capacity assessor (IMCA) as the person had been assessed as lacking the capacity to make decisions about taking their medicines.

We looked round the home with the registered manager and saw all areas including bedrooms, apart from three where people were either asleep or receiving care. The registered manager told us there was an ongoing refurbishment programme and we saw evidence of improvements made. For example, the lounge, dining room and reception area had been redecorated and refurbished which included new carpets. Some bedrooms had also been upgraded. However, we found some areas of the home were in a poor state of repair and required attention. For example, broken locks on one bedroom and two toilet doors, no screens in one shared room, broken drawers in two bedrooms and no cold water from a bath tap. We found the lino flooring in two bedrooms was split in several places. The registered manager told us new flooring had been ordered for these rooms and would be fitted in February 2016. The windows in some of the bedrooms on the first and second floors did not close fully into the frame and there was a noticeable draught in these rooms. We saw in one room the curtains were water damaged on the inside which suggested rain had come through the windows. Additional heaters had been provided in some of these rooms but the temperature was markedly colder than elsewhere in the home. The registered manager told us the provider had received quotes to replace the windows but was not able to confirm when this work would be completed. A monitoring visit carried out by the Clinical Commissioning Group (CCG) and Local Authority in March 2015 had raised concerns about bedroom temperatures and the action plan submitted by the provider in response stated they had contacted heating engineers and would be putting additional radiators into these bedrooms. Our inspection found this work had not been completed.

The registered manager told us there had been a leak from the flat roof into the smoking lounge and we saw the ceiling coving by the external door was hanging down. The registered manager told us the leak had been repaired by a builder who had confirmed the ceiling was safe. This room was being used constantly by people who used the service. We asked the registered manager to provide us with written confirmation from the builder that the ceiling was safe and to remove the seating from directly below the damaged ceiling. We received confirmation from the manager that the builder had repaired the ceiling two days after our inspection

We saw certificates which showed maintenance checks for gas safety, fire equipment and portable appliance tests were up-to-date. The electrical installation certificate dated 22 October 2014 showed the test results were 'unsatisfactory' and identified works to be completed. The registered manager was unable to provide us with evidence to show these issues had been rectified.

We found standards of cleanliness were poor in some areas of the home. For example, we turned back the covers on three beds and found a strong odour of urine, which the registered manager told us was coming from the mattresses. They told us two new mattresses had been ordered for the beds in one room and said they would arrange for a new mattress on the other bed. The downstairs toilet opposite the smoking room was dirty with faecal stains on the woodwork by the door and cobwebs on the ceiling. The door lock was broken and there was no handle on the inside of the door which made it hard to close. The registered manager told us the cleaner had been in to clean the floor but could not explain why the rest of the room had not been cleaned. In one bedroom the seat cushions on the settee were marked and stained and the bed table was dirty. In the ensuite of another room there was a bucket on the shower floor which contained the shower head, a doll and a broken drawer front which was missing from the chest of drawers in the bedroom. The ensuite was dirty and cold. The registered manager told us the radiator was switched off because the person kept breaking the radiator cover. They said the shower room was not used and was due for refurbishment. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us the usual staffing levels were one nurse and three care staff from 8am to 8pm and one nurse and one care staff member from 8pm to 8am. We looked at the duty rotas for the three weeks leading up to the inspection which reflected these levels. However, we noted one staff member had two roles, one of which was working as a care staff member, yet the rota did not reflect the actual hours spent in each role. The registered manager told us additional staff were brought in every day to provide one-to-one support with people taking them out into the community or accompanying them on appointments. These hours were not reflected on the duty rotas, although we saw an additional member of care staff arrived on duty during the morning of our inspection.

We considered the staffing was at a minimum level taking into consideration the layout of the building with the accommodation spread over three floors and the dependencies of the people who used the service. Staff said they thought there were enough of them available to meet people's needs. However, they said they would be able do more with people if they had more time. Staff told us two people were nursed in bed throughout the day and night and two other people walked around at night and often went into other people's rooms. The registered manager told us they had spoken with the provider about increasing the night staffing levels but no action had been taken as a result of these discussions.

We saw the care staff were assigned to other tasks in addition to providing care and support to people. For example, the rotas showed there were no cleaners or laundry staff employed at the weekend. When ancillary staff were not working these tasks were undertaken by the care staff. Care staff were also responsible for providing activities. Although we did not observe any shortfalls in care during the time we were present in the home, we recognised there were two cleaners, a laundry staff member, an administrator and the registered manager on duty which meant the care staff could concentrate on providing care and support to people. We concluded that on days when there were no additional staff to undertake laundry, cleaning, administrative and management tasks, the care staff would have less time to provide the care and support people needed. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff recruitment files we reviewed showed robust processes were not in place to ensure applicants were suitable to work in the care service. We looked at recruitment files for two nurses. Although both files included references, none were from the applicant's previous employer but appeared to be from colleagues. With one of the references was a letter from the applicant to a person asking them to complete the 'enclosed reference' and either send it to the registered manager or give it back to them via a relative and they would hand it in themselves. This meant references may not give a detailed review of the applicant's work record, their abilities and suitability for work from an employer's point of view. Only one of the files included evidence to show the registered manager had seen the applicant's Disclosure and Barring Scheme (DBS) disclosure. This criminal record check is carried out to ensure the applicant suitability to work with vulnerable adults. Neither of the files included confirmation to show the applicant's nursing registration, Personal Identification Number (PIN), with the Nursing and Midwifery Council (NMC) had been checked to make sure it was current. One of the files did not include any detail of the applicant's employment history prior to 2014. Neither file included any detail of the applicant's induction. Following the inspection the registered manager confirmed they had checked both applicants' PINs and they were current and confirmed one applicant had completed an induction. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (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. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). 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.

The registered manager told us seven people had DoLS authorisations in place and applications had been made for 12 other people. We looked at the DoLS authorisation for one person. An agreement was in place for the person to receive their medicines covertly which had involved an independent mental capacity assessor (IMCA) as the person was assessed as not having capacity to make decisions about their medicines. There was no reference to the person having a DoLS authorisation in any of their risk assessments or support plans.

We looked at the care records for a person who did not have a DoLS authorisation. Records showed a previous application for DoLS had not been upheld but another application had been made. Despite the lack of DoLS the support plan for this person said they were aware of the locked door policy but could ask if they wanted to go out. The support plan said if they did go out, they would always be accompanied by a member of staff. There was also reference in the support plan to the person having allocated amounts of cigarettes every day as this was in their best interests. We did not see any evidence of an agreement being reached with the person in relation to these decisions. We saw written in the support plan 'Staff to consider locking door to room if (name) is exposing self to increased danger of falls.' We asked the registered manager who had signed this entry, what it was about. They said it should not be there. These practices indicated an unlawful deprivation of the person's liberty as there was no DoLS authorisation in place. This demonstrated staff were not working in line with the requirements of the MCA and DoLS.

We saw staff asked people for their consent before assisting them or providing support. However the records we reviewed did not show how consent had been obtained. For example, one person, who was assessed to have capacity, had signed consent to their care and treatment yet this was dated 2013 and although their care plans and risk assessments had been reviewed since this date there was no evidence to show consent or agreement to these changes. In the other care records we reviewed there was no evidence of consent or agreement to support plans or risk assessments from the individuals concerned or their representatives. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us the training they received was good. We looked at the staff training matrix which showed staff were up to date and listed dates when refresher training was due. We saw systems were in place to ensure

staff received support through regular supervisions and appraisals. Staff we spoke with confirmed these sessions took place and said they felt supported by the registered manager.

People were complimentary about the food and the cook. One person said, "Food is very good – you have a choice."

We observed both the breakfast and lunchtime meals. People could choose where to have their meals and most chose to eat in the dining room where tables were set with tablecloths and condiments. At breakfast people were asked what they would like as they came into the room. Staff told us people could have whatever they liked. We saw the majority of people had cereal or porridge followed by toast and hard boiled eggs.

At lunchtime the main meal was lamb stew with alternatives of ham omelette, corned beef, salad and sandwiches also available. Seconds were available and additional homemade samosas were brought round which were well received. There was a range of desserts including sponge and custard, yogurts, fresh fruit, jelly, ice cream and rice pudding. There was a relaxed atmosphere with people and staff laughing and joking and the cook came in to see if all was well. Staff gave support to those who needed it. Fresh fruit, snacks and drinks were available to people throughout the day and we saw people helping themselves to fruit. One person who had been out over lunchtime arrived back and the cook had made them curry, samosas, salad and plenty of fresh fruit, which met their cultural needs.

Staff told us people chose their main meals either the previous day or during the morning if they had had problems remembering their choices. Staff said if people changed their minds this would be catered for. Although we found there was plenty of choice the meals arrived pre-plated which meant people were not given the opportunity to choose if they wanted all the components of the meal or the portion size. The menu was not displayed in the dining room as staff told us it had been taken down when the room was decorated and had not been replaced.

We looked at the care records of a person who had lost 5kg in weight in the last two months. This person was prescribed dietary supplements and their food and fluid intake was being recorded. However we saw the intake records did not always show the amount of food the person had taken. We reviewed the records over a six week period and found only two records of the person being offered something to eat at supper. On the two occasions it had been recorded, the record said the person had eaten biscuits; however the person's care records said they needed a pureed diet. We asked the deputy and the registered manager what process they had in place for intake records to be checked and analysed to make sure people were receiving adequate nutrition. Both said it was the job of the nurse in charge on each shift. We did not see any evidence of this being done. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the cook and a senior care assistant about fortifying meals for people who were at risk nutritionally. Neither recognised the term but showed us boxes of double cream which they said was used in drinks and food and used to make smoothies.

We saw from care records that people had access to healthcare professionals as needed. This included the GP, dentist, chiropodist, community psychiatric nurse, social worker and care home liaison team.

The registered manager told us 15 people who used the service were living with dementia. When looking round the home we found there was a lack of signage to help people find their way around. For example, although bathroom and toilet doors had signs with a picture and words to help people recognise these

facilities, people's bedrooms doors often only had a number. Some bedroom doors had people's names on but these signs were small and as all doors were the same colour there was nothing else to distinguish one person's room from another. Staff told us people used to have memory boxes to help with identification but said these were not used anymore. We considered improvements were needed to help people living with dementia find their way around the home. For example, by the use of appropriate signage, floor, lighting and colour schemes. We recommend that the service explores the National Institute for Health and Care Excellence (NICE) quality standards for people living with dementia under Quality Standard 30 (QS30: Supporting people to live well with dementia) and Quality Statement 7 (design and adaptation of housing) on how premises can be designed or adapted in a way that helps people with dementia manage their surroundings, retain their independence, and reduce feelings of confusion and anxiety.

Requires Improvement

Is the service caring?

Our findings

Although we observed staff were respectful in their interactions with people, we found some practices demonstrated a lack of respect and undermined people's dignity. For example, we saw some beds had been made and the bedding was dirty and there was a strong odour of urine, some pillows were mis-shapen and lumpy, one pillow had no pillowcase and the plastic covering was split. One person's mattress was too big for the bed base and was hanging over the edge. Some wash hand basins in people's bedrooms had no plugs. When we asked the registered manager how people managed to have a wash if they could not fill the sink they said they did not know, agreed it was unacceptable and said they would address this. The broken locks on toilet doors meant people's privacy could not be ensured when they were using these facilities. The registered manager told us four people's clothes were not kept in their rooms due to behaviour triggered by their mental illness. We saw these people's clothing was piled up on shelves in the laundry. The registered manager told us there were plans in place to upgrade the laundry facilities and this would include providing wardrobes for these people's clothes.

Some people did not have keys to their rooms. We heard one person, who had come to the home for a period of respite care the day before our inspection, asking staff for a key for their room on several occasions during the day of our visit. We asked the registered manager about this late in the afternoon as the person was still asking about it. They asked a staff member to check if there was a key for them and told us if there wasn't they would get one the next day. This person wishes with regard to having a key to their room should have been known to staff and arrangements put in place prior to their admission.

The smoking room was located on the ground floor and was used constantly by many of the people who used the service. The door was kept open which meant the smoke permeated to all areas of the home including the lounge and dining room. We raised this with the registered manager who agreed with us and closed the door to the smoking room area but this was soon opened again and remained open for the rest of the day. The deputy manager told us 11 of the 24 people living in the home did not smoke. We saw six of these people had bedrooms on the ground floor which meant the smell of smoke would affect their rooms, their clothing and their personal possessions. Government guidelines on smoking state individual smoking rooms can be provided for people living in care homes but they must be well ventilated and smoke must not get into other rooms. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we met during the inspection spoke highly of the staff and praised the care they received. One person said, "Are you in charge of this inspection because I want you to know how good it is here." Another person told us, "I'm happy, I like the company." A further person said they were 'over the moon' with the care. One person who had been to other care homes for respite care told us they liked Greystones much better because it was 'clean, good food and everyone's pleasant."

Relatives were equally positive. One relative said, "Don't know where we would be without this place. The staff are caring, the cook is great with an adapted diet for swallowing. She even adapts Friday fish and chips night for (my relative) and the manager is so good." Another person told us, "I'm happy with my relative's

care."

We saw people were comfortable around staff and there was a pleasant, relaxed atmosphere. We saw staff knew people well and interacted kindly and compassionately with them. For example, we saw one person was distressed on two occasions and each time staff dealt with them calmly and swiftly. We saw another staff member supporting a person at their preferred pace as they walked along the corridor. The staff member chatted to the person reassuring them and telling them how well they were doing and the person was smiling. We saw staff took time to listen to what people had to say and responded promptly to requests for assistance.

We saw people were offered choices such as where they would like to eat their meals and we heard staff asking people for their consent before carrying out any tasks. One person told us they preferred the quietness of their own room rather than the lounge and this choice was respected by staff. The registered manager told us where bedrooms had been refurbished, people had been involved in choosing the colour schemes. We saw some people's rooms were personalised with furniture they had brought in and possessions such as photographs and other memorabilia. Other people's rooms were stark in comparison with few personal effects.

The registered manager told us they looked after the personal monies for many of the people living in the home. We saw systems were in place to keep the money safe with access limited to the registered provider and registered manager and all transactions were recorded. Although the registered manager told us people could access their money at weekends we saw an incident form which was undated which showed a person had requested money at the weekend and had been told by staff they could not access the money until Monday when the registered manager was on duty. This resulted in the person becoming verbally and physically aggressive.

Requires Improvement

Is the service responsive?

Our findings

We were concerned people's needs were not fully assessed by the service before admission, particularly in the case of people admitted for respite or emergency care. For example, we found one person had been admitted to the service in October 2015 as an emergency placement. The registered manager told us there had been no assessment information and they had accepted the person as they had been in the home a few months previously. However, following admission it became clear the person's needs had changed and the registered manager told us staff struggled to support this person and keep other people in the home safe. Eventually, the person was transferred to another service but their time at Greystones had a detrimental effect on the health and safety of other people living in the home and the staff. We looked at the care records for this person and found there were no care plans or risk assessments in place to show the support and care this person required.

Similarly there was no recent assessment information for another person who had been admitted for respite care. Although records showed this person had been coming to the home for periods of respite care since 2014, there were no care plans or risk assessments in place to guide staff in how to support this person. An assessment provided by the Local Authority in 2014 was the only record which gave some information about this person's needs. We discussed both these people with the registered manager who acknowledged there was no process in place to determine if people's needs had changed between respite visits or to check if medication they brought in with them was current and correct.

The registered manager told us they were in the process of transferring all the care documentation onto an electronic care management system. They said this was not yet fully operational and staff were currently using the care files to plan and deliver people's care. Support plans we reviewed covered activities of daily living and had been developed with a person centred approach and contained good detail of people's abilities, preferences and support needs. However there was no evidence to show people had been involved in the development or review of their support plans. Whilst the majority of support plans were clear and detailed, we saw the plans for people's mental health needs contained medical terms which non-clinical staff might not understand. We showed one of these care plans to a senior care assistant and asked if they understood it. They said they didn't. We saw care files contained assessments of people's needs. However these had not always been fully completed. For example, the risk assessments in relation to falls, mental health and dietary intake in one person's file had not been dated and where the level of risk and the residual risk should have been recorded it was blank.

We found care plans and risk assessment were not up to date and this was acknowledged by the registered manager. We saw an audit dated 1 October 2015 in one person's file which identified all the care plans and risk assessments needed updating. When we looked at this file we found the care plans and risk assessments had not been updated and monthly reviews consisted of the same phrases indicating there were no changes over several months. Care records showed one person had started to experience painful arthritis in 2014 yet there was no support plan in place.
We saw daily record entries were almost exactly the same each day and did not reflect how the person had spent their time or how they had been feeling or behaving. People had hospital passports in their care files

but these had not been completed. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with expressed satisfaction with the care and support they received. One relative told us they visited regularly and said they knew everything that was going on with their relative's care and said staff involved them.

We saw staff spent time with people individually playing dominoes and cards. People told us about activities they had done which included picnics in the grounds, walks in the local park, karaoke, board games, visits to the nearby Monkey Café for tea and cake, trips to Subway, shopping at Sainsburys, birthday buffets, barbecues, bowls, planting in pots and cake baking. People told us they had been on trips to Bradford, the Trafford Centre, Tropical World and Blackpool Illuminations. Activity records we saw showed people were involved in a range of activities.

The home had a computer for people who lived in the home. Staff told us this used to be in the lounge but said it had been moved. We saw the computer was stored in the visitors' room and was not set up. The visitors' room was kept locked and therefore not accessible to people who lived in the home unless they asked staff to unlock the door. One staff member told us they wanted to introduce a Nintendo Wii so people could have fun and keep fit.

In the reception area there was a TV screen and music played on a loop continually throughout our visit. The screen showed photographs of people enjoying activities, including Music for Health sessions where people were singing and dancing along with tambourines, maracas and streamers.

The complaints procedure was displayed in the home. We looked at the complaints log and saw six complaints had been received in the last 12 months. Records we saw provided details of the complaints and showed what action had been taken to investigate, however only one of the six showed what the outcome was and how this had been fed back to the complainant. We also found four of the six complaints raised safeguarding issues yet when we asked the registered manager they confirmed these had not been referred to safeguarding. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

Although we received positive feedback from people and relatives about the care provided we found systems and processes in place to ensure people received safe and appropriate care were not always being followed. For example, as detailed in other sections of this report we found shortfalls in the way medicines and risks were managed, safeguarding incidents were not always identified or reported, parts of the premises were not well maintained or clean, care records were not up-to-date or accurate, staff recruitment process were not robust, insufficient staffing and there was a lack of understanding around consent and decision making.

We found the provider had not submitted all required notifications to the Commission. Records showed police and safeguarding incidents dating back to January 2015. Although we were satisfied that appropriate action was taken to keep people safe, these incidents had not been reported to the Commission which is a legal requirement. This meant we did not have accurate information on the number of incidents which occurred in the service. We discussed this with the registered manager who said they were not aware they had to notify us of these incidents and said they would ensure all notifications were reported to us in the future.

We asked the registered manager for copies of the quality audits they carried out. We were given a laundry audit, health and safety audit, catering and dining room audit and a building audit but found these were limited in their scope. For example, we saw a laundry audit had been completed in October 2015 and there was a list of seven actions to be completed, but no evidence to show these had been done. The building audit had been completed in September 2015 and included actions and completion dates and the registered manager told us these audits were completed three monthly and the next one was due in January 2016. Yet we were concerned the environmental issues we identified during the inspection had not been picked up or rectified by this audit system. The registered manager told us minor maintenance works were not recorded but reported verbally by staff and completed by the laundry staff member who carried out the 'handyman' role. We saw a medication audit had been completed by a pharmacist from the supplying pharmacy in June 2015 which did not highlight any problems. The last recorded internal medications audit had been completed in October 2015. This had highlighted some low level issues and an action plan had been put in place to address them.

We saw reports of quality monitoring visits carried out by the provider in October, November and December 2015. These reports were detailed and showed discussions with people who lived in the home and staff as well as scrutiny of records. However, the reports did not identify any actions or reflect any of the issues we found at this inspection.

We saw accidents and incident reports were reviewed monthly by the registered manager. However, the audit system only identified the number which had occurred during the month and there was no analysis of the information to identify trends or themes or look at 'lessons learnt' to prevent recurrences. The registered manager told us they had an analysis tool which would address this and said they would put this in place.

We found there were no systems in place to determine whether staffing levels were sufficient to meet people's needs and keep them safe. The registered manager said there was no tool used to calculate staffing levels although they said they had plans to introduce one. They said dependency levels were taken into consideration, yet acknowledged there were no recorded assessments of people's dependencies. This was a breach of the Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had a registered manager who had been in post for over two years. People who lived in the home spoke highly of the registered manager and said they liked her. One person told us, "The manager is very good, does a good job. In fact she's superb." Staff described the registered manager as supportive and told us she worked with them as part of the team. We observed the registered manager provided leadership and support to the staff team and was committed to making improvements for people who used the service.

We saw staff meetings were held monthly and minutes from the last one in December 2015 showed a range of topics were discussed. Staff told us meetings were held regularly and they were able to raise any issues. We saw residents meetings had been held in February, June and September 2015. These were chaired by the registered manager and people in the home were given an opportunity to air their views.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Service users were not treated with dignity and respect and their privacy was not ensured. Regulation 10 (1) (2) (a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered person had not ensured that they had obtained the consent of the relevant person to care and treatment, and where the service user was 16 or over and was unable to give such consent because they lacked capacity to do so, had not acted in accordance with the Mental Capacity Act 2005. Regulation 11 (1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints An accessible system was not established or operated for recording, handling and responding to complaints. Regulation 16 (1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures were not established and operated effectively to ensure that persons

Treatment of disease, disorder or injury	employed were of good character and have the qualifications, competence, skills and experience which are necessary for the work to be performed by them. Regulation 19 (1) (a) (b) (2) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed. Regulation 18 (1)

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The care and treatment of service users was not appropriate and did not meet their needs or reflect their preferences. Regulation 9 (1) (a) (b) (c) (3) (b) (i)

The enforcement action we took:

Warning notioce

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Service users were not provided with care and treatment in a safe way as the management of medicines was not safe and proper; and the risks to the health and safety of service users were not assessed or mitigated. Regulation 12 (1) (2) (a) (b) (g)

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Service users were not protected from abuse and improper treatment as systems and processes were not established and operated effectively to investigate any allegation or evidence of abuse. Regulation 13 (2) & (3).

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 15 HSCA RA Regulations 2014 Premises

personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	and equipment All premises used by the service provider were not clean or properly maintained. Regulation 15 (1) (a) (e).

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not established or operated effectively to assess, monitor and improve the quality of the services provided or to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. Regulation 17 (1) (2) (a) (b)

The enforcement action we took:

Warning notice