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 up to three people with a learning disability and/or autistic people. At the time of our inspection there were three people using the service. Greenacres is a small bungalow divided into three individual flatlets with no communal space. Staff have use of an onsite office within the building.

People's experience of using this service and what we found
We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

Right Support:
The model of care did not maximise people's choice, control and independence.

People were not supported to have maximum choice and control of their lives and staff did not 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. Where people's freedoms to make choices had been restricted, these decisions were not appropriately reviewed, or alternatives considered.

The provider identified and recorded people's interests, goals and aspirations but appropriate staffing was not always available to support people to achieve these. This meant people were not supported to increase their independence and ensure a good quality of life, in line with their stated goals.

Right Care:
Care needed to be more person centred and increase people's leisure opportunities and access to the wider community. People led restricted lives and spent a lot of time at the service or at the provider's own activity hub located in another of the provider's services. Staff mostly treated people with kindness and respect, but systems and processes did not enable staff to help people develop. People were frequently supported by staff who did not know them well and staff were often monitoring people rather than encouraging them to develop.

The provider had failed to ensure people were fully safeguarded from abuse as measures and procedures were in place but not followed. This placed people, and others, at risk of harm.

Right Culture:
The ethos, values, attitudes and behaviours of leaders and care staff did not ensure people using services led confident, inclusive and empowered lives. The provider did not have systems in place to support people

to lead their best lives. Oversight of care delivery and the culture at the service was poor. This placed people at risk of receiving unsafe care and treatment. Care did not meet people's complex needs and the provider did not have oversight of the failings of the service.

The values of the service, as set out in its policies and procedures, were not evident in practice. People were not supported to develop and grow their skills and independence. The provider did not ensure staff had the training, skills and experience they needed to deliver the care people needed. Staff were demotivated and the culture of the service was not inclusive and progressive. Action plans and monthly updates shared with the Care Quality Commission (CQC) did not drive improvement and did not demonstrate a cohesive culture.

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

Rating at last inspection and update – The last rating for this service was inadequate (published 10 March 2022.) Conditions were imposed on the provider's registration and they submitted monthly improvement plans documenting how they were bringing about improvements. At this inspection we found the provider remained in breach of regulations.

Why we inspected
We carried out an unannounced focused inspection of this service on 19 and 26 October 2021. Breaches of legal requirements were found. We imposed additional conditions on the provider's registration and required them to send us a monthly action plan documenting actions taken to improve safe care and treatment, safeguarding, staffing and good governance at the service.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the key questions safe and well-led which contain those requirements. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service remains inadequate. This is based on the findings at this inspection.

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
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 monitor the service and will take further action if needed.

We have identified breaches in relation to assessing people's needs, treating people with respect and maintaining their dignity, safe care and treatment, safeguarding, good governance and ensuring there were enough skilled and experienced staff.

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

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service remains 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? The service was not safe.	**Inadequate**
Is the service well-led? The service was not well-led.	**Inadequate**

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 Health and Social Care Act 2008.

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
This inspection was carried out by two inspectors on the first day and one inspector on the following day.

Service and service type
Greenacres is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Greenacres is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations. At the time of our inspection there was no registered manager in post.

Notice of inspection
This inspection was unannounced on the first day and we told the provider we would be returning the following day. Inspection activity started on 15 September 2022 and ended with a feedback session on 10 October 2022.

What we did before the inspection
We reviewed the provider's monthly action plan updates which had been shared with us. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service.

During the inspection
We spoke with all three people who used the service and two relatives. We also spoke with the provider, the regional operations manager, the manager and ten care staff, one of whom was a team leader, one a night staff member and three who were agency staff. We received feedback from the local authority quality monitoring team.

We reviewed a range of records. This included three people's care plans, three sets of medication records, agency staff recruitment information and other records relating to the quality and safety of the service.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question inadequate. At this inspection the rating for this key question has remained 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

At our last inspection the provider had failed to operate an effective system to identify, monitor and report safeguarding concerns. This was a breach of regulation 13 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There had not been enough improvement at this inspection and the provider remained in breach of regulation 13.

● Systems designed to safeguard people from the risk of abuse or improper treatment were not fit for purpose. Known risks had not been robustly assessed and action taken to reduce them. Staff were not sufficiently clear about safeguarding risks which left people, including staff and the public, at potential risk of harm.
● A safeguarding incident had been reported to CQC and the local authority before our inspection. Risks relating to this incident had not been fully assessed and robustly managed. The service had exposed people who used the service to the risk of harm.
●The provider had not reported all safeguarding concerns to the local authority and CQC, as required. This meant CQC and the local authority were not able to take action to investigate and monitor ongoing concerns.
● Failure to assess, report and manage significant safeguarding concerns was also identified at our last inspection in October 2021.

The provider did not operate an effective system to identify, monitor and report safeguarding concerns and did not ensure care was provided in a way that ensured people were not controlled. This was a continued breach of regulation 13 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to operate an effective system to keep people safe. This was a breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There had not been enough improvement at this inspection and the provider remained in breach of regulation 12.

● Care plans and risk assessments, designed to meet people's complex needs, were not clearly written or

fully updated when people's needs changed. Agency staff, including those who had worked several shifts in recent weeks, were unaware of some key information needed to keep people safe. This placed people at risk of harm and had been an issue at our previous inspection in October 2021.
●There was a lone worker policy for staff. However, night staff were not aware of actions to keep themselves and others safe. There was no formal on-call arrangement with management should an incident occur and help or advice be needed.
● The risks relating to people's distressed reactions had not been fully assessed and actions put in place to reduce them.
● Risks from the environment were not always well managed. One person was documented to behave in a way which could potentially put themselves and others at risk of harm. This risk had not been fully assessed and reduced.

The provider did not ensure risks were assessed and mitigated. This was a continued breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

● We found the service did not always act within the principles of the MCA. Decision making in some cases needed to be more clearly documented to demonstrate people's rights were always upheld. Some decisions had not followed the MCA process. Appropriate legal authorisations were in place to deprive a person of their liberty and conditions related to DoLS authorisations were being met.

Staffing and recruitment

At our last inspection the provider had failed to ensure there were enough skilled and experienced staff to meet people's needs. This was a breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There had not been enough improvement at this inspection and the provider remained in breach of regulation 18.

●The service relied heavily on agency staff due to a significant number of vacant posts. On the first day of our inspection two agency staff and one permanent staff member were on duty. Neither of the agency staff had received a structured induction and demonstrated an incomplete understanding of people's needs. One had received no handover from the previous shift and was completely unaware of some critical information about the person they were supporting. This placed people at risk and was a concern at our last inspection.
● Feedback about agency staff from relatives, care staff and the manager was negative. A typical comment from staff was, "[There are] too many agency staff…. [They] don't know what they're doing. Residents feel safe with core staff." One relative told us, "[They] use a lot of agency and [my relative] doesn't get the

continuity [they] need. [They] need consistent messaging which [they] don't receive."
● Permanent staff did not receive all the training they needed to carry out their role safely and effectively. Some key specialist training had not been provided and staff also told us they wished they could have some face to face training as all their training had been online. Online training did not enable them to ask questions and explore wider issues around their learning.
● Rotas showed there were enough staff on duty. However, staff told us sometimes, due to a lack of medicines trained staff, they had to leave the service and administer medicines in another of the provider's services next door. This reduced staffing for approximately 30 minutes. All three people who used the service had been assessed and funded for one to one staffing during the day. This reduction in staffing was unsafe and meant there was a risk of people's needs not being met during this 30 minute period.
● Staff told us they had ad hoc arrangements to ensure staffing was in place to support people without placing either themselves or those they supported at risk. This arrangement was not formalised, and we were not assured the deployment of staff was always appropriate.
● Although permanent staff were safely recruited, there were minimal checks in place for new agency staff. The regional operations manager was not able to assure us agency staff, including all those we met during our inspection, had received the appropriate training, had the right to work in the UK and had a completed check from the Disclosure and Barring Service (DBS). DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
●The manager, who had been in post since January 2022, was responsible for three services, one of which was a 20 minute drive away. All staff and all relatives stated they thought the manager was spread too thinly. One staff member commented, "The current manager is very good [and] fast acting but most of the time involved in the other units [which is] the provider's decision."

There were not enough trained, skilled and experienced staff to meet people's needs. Staff did not receive the support they needed to carry out their roles. This was a continued breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● Staff told us there is no structured process to review incidents and learn from them. One staff member said, "[There is] no lessons learned or debrief because it's difficult when on a one to one with no support [or] time to yourselves to catch up on other things."
● Lessons had not been learned following our previous inspections. Issues raised previously remained a concern at this inspection. A particular area of support for one person had been very poorly managed at our previous inspection in October 2021. We noted the same inadequate management at this inspection which continued to place the person and others at risk of harm.

Using medicines safely
● Medicines were stored securely and there was information to guide staff when giving medicines which were only given on an as required basis (PRN). One person was prescribed a medicine to relieve anxiety, but the PRN protocol was not clear as to exactly when it should be administered.
●The same person had recently had a change in medication which had had a significant effect on them. Guidance relating to this change and how to support the person was not clear. However, other guidance was in place for staff to refer to and was of an acceptable quality.
● Staff who administered medicines had received training and had their competence to administer them safely checked.

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection. People had received their COVID-19 boosters on the day of our inspection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
Relatives told us they had been able to visit the service in line with government guidance throughout the COVID-19 pandemic and were now free to visit their relatives as and when they wished.

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 our last inspection we rated this key question inadequate. At this inspection the rating has remained 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;

At our last inspection the provider had failed to ensure there were governance arrangements in place to drive improvement at the service. This was a breach of regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There had not been enough improvement at this inspection and the provider remained in breach of regulation 17.

●There had been no registered manager in post since October 2020. The provider had moved the current manager from another of their services, where they had had only a few months experience in a care role. The provider had engaged them to manage three registered services and had not ensured they had a structured induction, key training or effective ongoing support. The provider demonstrated a poor understanding of the demands of the role of registered manager. This placed people at risk of receiving unsafe care and treatment.

● The senior management team did not work well together and important information was not appropriately shared within this team. For example, the manager had not been present during our inspection visits. When we spoke with the manager several days after our inspection, they were unaware of the serious concerns we had shared with the provider as these had not been relayed to them. This meant they had taken no initial action to begin to address these concerns.

● The provider's auditing systems were not robust and did not identify and address the safety and quality concerns we found at this inspection, some of which were longstanding. Night auditing and monitoring were supposed to take place, but staff told us these did not happen.

● There were minimal checks, training and induction for agency staff. The provider failed to put a system in place to ensure agency staff were safe to work at the service and had the required skills and experience. Staff were not deployed in a way which ensured they, and others were safe. This placed people at risk.

● Information systems were not robust. Handovers were not effective and were not held privately so sensitive information was difficult to share. Pen pictures containing key details about people's care needs and preferences, were not routinely used and information was confusing. Care plans, which agency staff relied upon, were not always updated with the latest information and staff were not aware of important information relating to people's welfare. This meant there was a risk of people's needs not being met.

The provider had failed to ensure there were governance arrangements in place to assess, monitor and improve the quality and safety of the service. This was a continued breach of regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's needs were not robustly assessed by the service before they were placed there. This meant we were not assured the service had fully considered whether a person's needs could be met. Some key information about people's needs was gathered informally from family following their placement. This lack of a structured assessment process placed people at potential risk of harm.

People who used the service did not always receive a comprehensive assessment of their needs before moving in. This was a breach of regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care; Working in partnership with others

● Both the provider, regional operations manager and manager demonstrated an awareness the service needed major improvement. They did not work as a cohesive team to bring about this improvement. Morale had become so low that we noted an acceptance of poor standards and an unwillingness to change. The provider and manager acknowledged they had identified problems relating to agency staff but had taken no effective action. The regional manager was not clear about their role and demonstrated an inability to drive improvement. There was a significant blame culture at all levels which hindered progress.

●The provider has not taken on board the findings of the last inspection and use them to build on. Care has not improved significantly since we last inspected and the process of improving the service had not been consistent. Following the last inspection, the provider had engaged a consultant. However, new systems were only partially implemented and those which were in place were not fully embedded.

● Following our last inspection, the local authority quality monitoring team had paid regular visits to the service and given the provider considerable advice and guidance. These visits had ceased in recent months, but the provider had not reached out for further assistance and guidance when needed.

●The provider had not reviewed the service as a whole and considered its wider failings. They had concentrated at times on addressing some very individual elements of the service in isolation. Given the widespread concerns we identified this represented poor oversight and a lack of effective monitoring.

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

● People's wishes, aspirations and preferences were captured in their care records but were not always demonstrated in the care delivered. An inconsistent staffing picture, lack of drivers and lack of appropriately skilled staff reduced people's ability to access the local community.

● People were not empowered and were not treated as equal partners in their care. One person's access to sweets and biscuits was restricted as part of a diet management programme. They had not agreed to this by signing their care plan and it was not clear why this was in place. Staff 'allowed' the person to have a few biscuits a week and to have a 'treat day' where they could buy a comic and a can of drink. This was a restrictive regime and did not appear to inspectors to have a solid therapeutic basis or be age appropriate.

● Spoken language used by staff and written in care plans was not always respectful and inclusive. Care plans judged whether a person had had a 'normal day' without making clear what 'normal' was supposed to be. Staff talked openly about people's reactions to being stressed or upset as "It's behaviours" or the person "Kicking off". One staff member told us they felt people should apologise to staff for their distressed reactions and related actions. Some staff demonstrated a punitive culture was beginning to develop, unchecked by the provider.

● The provider did not achieve a balance between promoting people's rights to privacy and dignity and the responsibility to keep people safe. Staff were observed entering one person's flat without knocking or asking to come in. However, staff also told us they did not check on the person overnight as they did not like this. The person could act in ways which placed themselves and potentially others at risk and it was not clear why this decision had been made.

People who used the service were not always treated with dignity and respect. This was a breach of regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff meetings were not held regularly. Staff had limited opportunity for peer support or to raise issues and make suggestions to improve the service. Staff told us the manager was supportive and received supervision sessions from them. All staff stated the manager had too much responsibility and was not able to be at the service as much as was needed. Staff felt unappreciated by the provider and morale was very low.

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
● The provider failed to fully understand their legal responsibilities and accountability as a registered provider to make it clear when things had gone wrong. This was a finding at the previous inspection.
● One relative told us the staff keep in touch and let them know if anything was wrong. Another said the manager had met with them to increase the knowledge about one person's background and past life history. The manager had done this because the service had sourced very little information when the person was placed there.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to carry out a collaborative assessment of people's needs to ensure these needs could be fully met. Regulation 9 (1) (b).

The enforcement action we took:

We issued a notice of decision to remove this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to ensure people who used the service were treated with dignity and respect. Regulation 10 (1) (b).

The enforcement action we took:

We issued a notice of decision to remove this location.

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 risks were assessed and mitigated. Regulation 12 (1) (2) (a) (b).

The enforcement action we took:

We issued a notice of decision to remove this location.

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 operate an effective system to identify, monitor and report safeguarding concerns and ensure care was provided in a way which meant people were not controlled. Regulation 13 (1) (2) (3) (4) (b) and (c).

The enforcement action we took:

We issued a notice of decision to remove this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure there were governance arrangements in place to assess, monitor and improve the quality and safety of the service. Regulation 17 (1) (2) (a).

The enforcement action we took:

We issued a notice of decision to remove this location.

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 trained, skilled and experienced staff to meet people's needs. Regulation 18 (1) (a).

The enforcement action we took:

We issued a notice of decision to remove this location.