Bupa Care Homes (CFHCare) Limited

Greenfield Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced inspection took place on 10 and 11 October 2017. At our last inspection in June 2017, we found that the service was not safe and not consistently effective. There were shortfalls in the safe management of medicines and risks to receiving care were not effectively managed. There was also a failure to ensure staff received appropriate support, training, supervision and appraisal. These were breaches of Regulation 12 and Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to make improvements to the management of medicines, management of risks to people and staff training. Following the inspection, the provider sent us an action plan, which set out what action they intended to take to improve the service.

During this inspection, we reviewed the actions that the provider told us they had taken to gain compliance against the breaches in regulations identified at the previous inspection in June 2017. We saw that significant work had taken place since our last inspection to improve the safety, effectiveness and quality of the service. We found improvements had been made in order to meet the regulations in relation to medicines management, staff training and the provider was compliant in these areas.

However, we found a continuing breach of the regulations. These were in relation to the management of risks to receiving care. We also found the provider had failed to make statutory notifications of notifiable incidents to CQC. You can see what action we told the provider to take at the back of the full version of the report.

Greenfield Care Home is a purpose built care home, registered to accommodate up to 112 people, with varying needs, who require 24 hour nursing and/or personal care. The home is split into four units known as 'houses' for people with different levels of need, including people who are living with dementia. The home is located in Ingol, close to the city of Preston and is accessible by road and public transport. Ample car parking is available at the home. There were 57 people who lived there at the time of our inspection.

The home did not have a registered manager in post. The last registered manager had left two years ago. A new manager had been appointed however, they had not started working at the time of our inspection. The regional support manager was providing managerial cover supported by a team of 'service recovery' managers. 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.

Before this inspection, we had received some concerning information in relation to the lack of reporting of safeguarding incidents to the local safeguarding authority and the accuracy of people's care records. We looked into these areas during the inspection.

We spoke to people and their relatives and received positive feedback about the care provided at Greenfield

Care Home. Safeguarding adults' procedures were in place however staff did not always understand their responsibilities in relation to reporting incidents to safeguarding authorities.
In majority of the cases, we found risks associated with people's care were identified and assessed. However, this was not always consistent across all four units. There was a whistle-blowing procedure available and staff said they would use it if they needed to. There was a disciplinary procedure in place however, this had not always been operated effectively.

There had been a significant improvement in the management of people's medicines. People's medicines were managed appropriately and according to the records seen people received their medicines as prescribed by health care professionals.

The service had recruitment policies and procedures in place to help ensure safety in the recruitment of staff. These had been followed to ensure staff were recruited safely for the protection and wellbeing of people who used the service. Records we saw and conversations with staff showed the service had adequate care staff to ensure that people's needs were sufficiently met.

People were protected against the risk of fire. Building fire risk assessments were in place and firefighting equipment had been maintained.

Staff had completed an induction programme when they started work and they were up to date with the training that the provider had deemed necessary for the role. The service followed the requirements of the Mental Capacity Act 2005 Code of practice and Deprivation of Liberty Safeguards. This helped to protect the rights of people who were not able to make important decisions themselves. There were appropriate arrangements in place to support people to have a varied and healthy diet. People had access to a GP and other health care professionals when they needed them.

People told us that staff treated them in a respectful and dignified manner. We observed people were happy, comfortable and relaxed with staff. A significant number of people who had previously been confined to their beds or bedrooms had been encouraged and supported to sit in communal areas with other people on a regular basis. This was an improvement.

We noted ongoing improvements in care plans. The care plans and risk assessments provided guidance for staff on how to meet people's needs and were reviewed regularly. Care plans showed how people and their relatives were involved in discussion around their care. However, some improvement will be required to ensure care record plans are updated when a review shows significant changes in people's care needs. People were encouraged to share their opinions on the quality of care and service being provided. There were a variety of activities provided to keep people occupied.

The environment had been adapted to suit the needs of people who lived at Greenfield Care Home.

We observed that significant improvements had been made sustained in various areas of care. We received positive feedback from people, relatives and staff regarding management of the service. Staff morale had improved and care staff felt supported by management. There were established management systems at the service. The general manager had provided oversight of duties they delegated to other staff. However, improvements were required in respect of oversight on the management of safeguarding incidents.

Quality assurance systems were in place and various areas of people's care been audited regularly to identify areas that needed improvement. There was a business contingency plan to demonstrate how the provider had planned for unexpected eventualities, which may have an impact on the delivery of care and

treatment.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe

People received their medicines when they needed them and as prescribed.

Risks to the health, safety and wellbeing of people who used the service were assessed. However, improvements were required to reduce the risk of moving and handling related injuries.

Staff were aware of their duty and responsibility to protect people from abuse. However, internal processes for reporting accidents and incidents and reporting safeguarding concerns were not robust.

Staff disciplinary procedures were not robust.

Is the service effective?

Good

This service was effective.

Staff had received training, induction and supervision to ensure they had the necessary skills and knowledge to carry out their roles safely.

Staff understood how to protect the rights of people who did not have capacity to consent to their care.

People were supported to have a sufficient amount to eat and drink. People received care and support which assisted them to maintain their health.

Is the service caring?

Good

The service was caring.

Relatives spoke highly of care staff and felt their family members were treated in a kind and caring manner.

People's personal information was managed in a way that protected their privacy and dignity.

Staff knew people and spoke respectfully of the people they supported.

There were some notable improvements in people's well-being.

Is the service responsive?

Requires Improvement

Is the service responsive?

The service was not consistently responsive.

Assessments of individual needs and risks had been undertaken to identify people's care and support needs. However, care plans had not always been changed where there were significant changes to care needs.

People were provided with a range of social activities. The provider sought feedback from people living at the home, their relatives and staff and used the feedback received to improve the service.

People and their relatives had access to information about how to complain and were confident that any complaints would be listened to and acted upon.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

There was no registered manager in post at the time of the inspection. Interim management cover was provided. People felt the service was well managed.

Management oversight had been provided to care staff and the overall running of the service. Improvements were required.

Incidents and accidents had been recorded. However they were not always reported to appropriate agencies. The Care Quality Commission had not been notified of certain incidents in the home.

Systems for assessing and monitoring the quality of the service and for seeking people's views and opinions about the running of the service were implemented to improve the care and treatment people received.

Greenfield Care 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 10 and 11 October 2017, and was unannounced. The inspection team consisted of five adult social care inspectors including the lead inspector for the service. We had two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. The experts involved in this inspection had expertise in the care of older people and people living with dementia. There were also two specialist professional advisors who had expertise in community and general nursing for adults and dementia nursing. We also had a pharmacy inspector who specialised in medicine management.

We did not ask the provider to complete 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.

Before the inspection, we gained feedback from health and social care professionals who worked alongside the service. We also reviewed the information we held about the service and the provider. This included safeguarding alerts and statutory notifications sent to us by the manager about incidents and events that had occurred at the service. A notification is information about important events, which the provider is required to send us by law.

During the inspection, we used a number of different methods to help us understand the experiences of people who used the service. We reviewed records of care and management systems used by the service for care delivery. We observed the environment and staff supporting people. We spoke to 22 people and six relatives. We spoke with six professionals. We also spoke with the clinical service manager, three house managers, the interim general manager (recovery support manager) regional service recovery director, the maintenance officer, 11 care staff and one nurse.

We looked at the care records of 18 people of which nine records were pathway tracked. Pathway tracking is where we look in detail at how people's needs are assessed and care planned whilst they use the service. We also looked at a variety of records relating to management of the service. This included staff duty rosters, four recruitment files, the accident and incident records, policies and procedures, service certificates, minutes of staff meetings, reports from safeguarding professionals and also quality assurance reports, audits, and medicine records.

Requires Improvement

Is the service safe?

Our findings

At our last comprehensive inspection of Greenfield Care Home in June 2017, we found the provider's arrangements for managing medicines did not protect people against the risks associated with medicines. There were failings in the assessment of the risks to the health and safety of people and measures to mitigate any such risks were not robust. These were multiple breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.The provider sent us a report telling us what actions they were going to take to meet the requirements of regulations.

During this inspection, we found the necessary improvements had been made in respect of medicines management. We also found that some improvements had been made in respect of managing risks associated with skin and wound care. However, there were ongoing concerns in the reporting of deterioration to wounds to the safeguarding authorities, the identification and reporting of accident and incidents to the local safeguarding authority and shortfalls in the risk management plans.

We looked at how risks to people's individual safety and well-being were assessed and managed. We found individual risks had been identified in people's care records and were kept under review. The risk assessments included; skin integrity, nutrition and falls. Strategies had been drawn up to guide staff on how to monitor and respond to identified risks. The assessments were kept under review monthly or earlier if there was a change in the level of risk. However, we found instances where risks had not been adequately assessed and planned for. For example, one person had experienced a choking episode however, no incident records, risk assessments or a review of their plan had been carried out. The information had not been shared with other staff members for example through a handover to ensure that precautions could be undertaken for this person.

In another example, we found a person had experienced a fall with some significant injuries however their risk assessments had not been updated to demonstrate the increase in risk and if any further actions could be taken to reduce the risks. We also found two people's care records in relation to skin care had not been updated when a risk to their skin integrity had been identified. Although adequate care and treatment had been provided to the two people, the records to demonstrate the level of risks had not been updated to guide care staff appropriately. Regardless of the improvements, we noted in relation to wound care, there were shortfalls and inconsistent approach which meant people could be exposed to risk.

We looked at how people were supported in the event of serious incident or accident, which resulted from the provision of care. We found in all cases that we reviewed people were supported appropriately after an incident such as a fall. Medical attention was sought in a timely manner where required. However, we found incidents that had not been reported to the local safeguarding authority in line with established safeguarding protocols, guidance and regulations. These included two incidents where people had suffered injuries while being supported with their transfers and one incident where a person had suffered significant injuries from a fall. We discussed the concerns with the general manager and the clinical service manager and they raised a safeguarding alert during the inspection.

During our last inspection in June 2017, we found people had been exposed to risks as a result of the poor moving and handling practices in the service. During this inspection, we found some improvements had been made. For instance, all people who required support with their transfers had personal equipment allocated for their own personal use and staff had received training in the safe moving and handling of people. However, we found ongoing concerns.

Before the inspection, we had received concerns from the local safeguarding team that records for one person did not provide staff with accurate and consistent guidance on how they needed to be supported with their moving and handling. Staff spoken with gave conflicting information on how the person was supported with their transfers. This exposed people to the risk of inconsistent and unsafe care. We spoke to the general manager who informed us that they had reviewed the care record in question and provided correct guidance. They also added that they would ensure that all staff received moving and handling competence checks to ensure care staff were competent in this area.

We looked at the disciplinary procedures that were in place to support the organisation in taking action against staff in the event of any misconduct or failure to follow company policies and procedures. We noted that contractual arrangements and a disciplinary policy were in place. However, we found an instance where the provider had failed to follow their organisational procedures effectively in regards to one staff member. Recommendations made following the provider's internal investigations had not been followed before the staff member was incorporated back into the service. This meant that the provider had failed to follow their own policies and people could not be assured that robust action would be taken to address concerns of misconduct or unprofessional behaviour.

There were failings in the assessment of the risks to the health and safety of people and measures to mitigate any such risks were not robust. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people who used the service whether they felt safe receiving care from the service. All people we spoke with told us they felt safe. Examples of comments included, "I've loved every minute of being here, I don't regret coming here. The attitude of the staff makes me feel safe. If I didn't I'd speak to [Unit manager]." And; "It's nice here.", "I feel safe because I ring and they come." If I didn't feel safe I could tell my visitors." A relative we spoke with told us, "[my family member] is safe because there are people here if she does fall."

Feedback from professionals was equally positive. Comments included, "The home has a different feel now and you can tell people are receiving the care they need."

We looked at how the service protected people from abuse and the risk of abuse. Staff spoken with expressed a good understanding of safeguarding and protection matters. They were aware of the various signs and indicators of abuse. They were clear about what action they would take if they witnessed or suspected any abusive practice. Staff confirmed they had received training and guidance on safeguarding and protecting adults.

We looked at the risk assessments in place concerning fire safety and how people would be supported in the event of an emergency. We saw the service had contingency plans in place and a building evacuation plan. There was an overall fire risk assessment for the service in place. We saw there were clear notices within the premises for fire procedures and fire exits were kept clear. Records showed that staff had been involved in fire safety practice drills.

Maintenance records showed safety checks and servicing in the home including the emergency equipment,

fire alarm, call bells and electrical systems testing had been undertaken. Maintenance checks had been done regularly and records had been kept. Faults and repairs had been highlighted and addressed. These measures helped to make sure people were cared for in a safe and well maintained environment.

We found there were plans in place to respond to any emergencies that might arise and these were understood by staff. The provider had devised a continuity plan. This set out emergency plans for the continuity of the service in the event of adverse events such as loss of power, accommodation or severe weather.

We looked at the arrangements in place for managing people's medicines. Concerns about medicines identified at our previous inspections of December 2016 and June 2017 meant that the home was in breach of regulation 12, the proper and safe management of medicines. During this inspection in October 2017, we found significant improvements had been made which demonstrated that medicines were handled safely. People and their relatives were satisfied with the way medicines were managed. Staff designated to administer medicines had completed a safe handling of medicines course and undertook competency tests to ensure they were competent at this task. Staff had access to a set of policies and procedures, which were readily available for reference. We saw staff administered medicines safely, by checking each person's medicines with their individual records before administering them. This ensured the right person got the right medicine.

As part of the inspection, we checked the procedures and records for the storage, receipt, administration and disposal of medicines. Records were kept for medicines that were awaiting disposal and medicines for disposal were kept securely. Arrangements had been put in place to ensure unwanted medicines were disposed of on a monthly basis. Staff had monitored the temperatures in the medicines storage rooms and fridges and kept records of these checks. This ensured that temperatures were kept at the recommended levels to prevent medicines from being compromised.

We observed the medicines administration rounds in the morning and at lunch time. We saw staff administered medicines safely and at the right times. We observed procedures for people who were given their medicines via a percutaneous endoscopic gastrostomy tube (PEG). The procedures had improved and staff followed best practice and nationally recognised guidance. This was a noticeable improvement.

We visited all four units in the home and looked at sixteen people's medication administration records (MARs). Records were completed clearly and there were no 'gaps' in administration records. One person was prescribed a medicine to thicken their drinks. Instructions for making drinks of the right consistency were written on the MAR. Use of the thickener was recorded on the MAR. Handwritten medicines administration records had been checked and verified by two people to ensure the information had been copied correctly from the prescription. This meant that actions had been taken to prevent prescription errors.

Medicines audits (checks) were in place and we saw daily and monthly checks carried out by the senior staff and management. Concerns and errors had been identified during the audits and actions had been taken to ensure people continued to receive their medicines safely. Where errors had been found, staff had been provided with support to improve their practice. For example on one of the four units, we saw that recent checks by the unit manager had found that some medicines had been signed for but not administered by staff over a two day period. The manager had made checks with the pharmacy about this and we were satisfied that people were not put at risk. We noted that the staff member responsible had been spoken with about the errors and additional training and supervision was provided. No further instances of non-administration of medicines were noted but we were told that additional precautions remained in place until the manager could satisfy themselves that the staff member was competent to administer medicines.

There were appropriate arrangements in place for the management of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). They were stored in a controlled drugs cupboard or secure safe, access to them was restricted and the keys held securely. There were protocols for giving 'as required' (PRN) medicines and when these medicines had been given, it had been clearly recorded. This helped to make sure that people received the medicines they needed appropriately.

We found there were suitable arrangements for the management and storage of creams such as topical creams. Cream charts and body maps were in place. This guided care staff on where to apply the creams. Staff had recorded and signed when they had applied the creams. We noted in two units the provider had installed lockable storage cupboards for topical creams to prevent risks of people misusing topical medicines stored in their bedrooms.

We looked at how the provider managed staffing levels and the deployment of staff. On the day of the inspection, there were adequate staff to meet people's needs. We saw people's requests for support being responded to in a prompt and timely manner. We requested a month's staffing rotas including the week of the inspection. We found the rotas indicated there were sufficient staff available for the people who lived at the home. One person told us, "There is enough staff; they're always in and out. At night they look in every hour." We had continued to monitor the staffing levels in the service since our inspection in December 2016. Ongoing concerns regarding the recruitment of nurses were being dealt with. We saw arrangements had been made to recruit more nurses and regular agency nurses had been used to provide interim cover.

A staff dependency tool was being used to determine the number of staff required to meet people's needs. We noted that staff numbers had been kept at the same level even at the time when the number of people living in the home had reduced. The manager told us that the staffing levels were kept under review and were flexible in response to the needs and requirements of the people who lived at the home. This monitoring of staffing against dependency would be essential when people's needs changed and more staff were needed to meet people's individual needs.

We looked at the records of five staff members employed at the service. We saw that all the checks and information required by law had been obtained before staff had been offered employment in the home. Staff files were well organised, which made information easy to find. All the files we looked at contained evidence that application forms had been completed by people and interviews had taken place before an offer of employment was made. At least two forms of identification, one of which was photographic, had also been retained on people's files. Staff members we spoke with confirmed they had been checked as being fit to work with vulnerable people through the Disclosure and Barring Service (DBS). This meant the provider had taken appropriate steps to ensure only suitable staff were employed to work in the home.

We looked at how the service minimised the risk of infections and found staff had undertaken training in infection prevention and control and food hygiene. The building was clean with hand sanitising gel and hand washing facilities available around the premises. We observed staff making appropriate use of personal protective equipment such as disposable gloves and aprons. There were domestic staff who were responsible for cleaning the premises. We found equipment had been serviced and maintained as required. For example, safety certificates confirmed gas appliances and electrical equipment complied with statutory requirements and were safe for use.

Good

Is the service effective?

Our findings

At our previous inspection of Greenfield Care Home in June 2017, we found the provider had failed to ensure that all staff had received appropriate support, training, professional development, as is necessary to enable them to carry out the duties they are employed to perform. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014. Following the inspection, the provider sent us an action plan, which set out the actions they intended to take to improve the service. During this inspection, we found the necessary improvements had been made.

People and their relatives told us they felt the staff were appropriately trained and had the necessary skills and abilities to meet their needs. Comments included; "They always ask for your consent, they're nice and friendly.", "If I don't feel well I just press the buzzer and sometimes they'll get the doctor if needed.", "The food is getting better. Staff feed me and they're respectful. If I don't want it they don't give it me." Comments from relatives included, "If anything happens they always call us." And, "The home is okay now and it's very pleasant here."

We received positive feedback from two visiting professionals. They told us, "The staff are very good and try to encourage independence" and "They work well with professionals and take recommendations on board."

We looked at how the provider trained and supported their staff. We found all staff completed induction training when they commenced work in the home. This included an initial orientation induction, training in the organisation's policies and procedures, and training that the provider deemed necessary for the role. We reviewed the training records for the whole service and found a number of training courses had been provided to care staff. Shortfalls that we identified in our last inspection had been rectified. For example, we found first aid training had been rolled out including basic life support training. We also found arrangements had been made for staff to attend training on wound care management. Staff in the home had also been encouraged to join regional forums and meetings conducted by the local Clinical Commissioning Group to enhance their knowledge and skills and share best practice.

We saw evidence to demonstrate that staff had received coaching in various areas to help them improve their practice. There were new ways of working such as peer to peer reviews for medicines which helped staff to learn from each other. Staff spoken with told us about the training they had received and confirmed that there was an ongoing programme of learning and development. This included moving and handling, first aid awareness, palliative care, fire safety, food safety, infection control, dementia awareness and challenging behaviours awareness training. We looked at records, which showed processes were in place to identify and plan for the delivery of suitable training.

Staff spoken with said they had received one to one supervision and ongoing support from the management team. This had provided staff with the opportunity to discuss their responsibilities and the care of people who used the service. We saw records were kept of the supervision sessions held and we noted plans were in place and scheduled supervision meetings. Staff received an annual appraisal of their work performance, which included a review of their training and development needs. The general manager informed us that

some of the training being provided was a result of feedback from staff during their supervision conversations. This meant that staff were supported to identify their learning needs and the provider had taken action to meet the needs.

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 make 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. People's records showed that the provider had applied to relevant supervisory authorities for deprivation of liberty authorisations for people. These authorisations had been requested when it had been necessary to restrict people for their own safety and these were as least restrictive as possible. Follow ups had been done to check the progress of the applications that had been submitted to the local authority.

We reviewed how the service gained people's consent to care and treatment in line with the MCA. We looked at people's care records and found that mental capacity assessments had been completed to identify whether people could make their own decisions regarding their care and treatment. Best interests' processes had been followed. We found consent records had been completed to demonstrate whether people could consent to having their medicines managed by staff and to having their photographs taken. In one example, we found one person had been fully supported to take part in a meeting with professionals during their medicines review. Regardless of the communication difficulties, staff had provided significant support to ensure the person's views were heard and respected. We saw evidence showing how this had enhanced this person's well-being. This was evidence of good practice.

We looked at how people's nutrition was supported and managed. We found the provider had suitable arrangements for ensuring people who used the service were protected against the risks of inadequate nutrition and hydration. Systems and processes for monitoring people's nutritional needs were in place. Where people required their diet to be monitored, staff had completed monitoring records showing whether the minimum targets were met each day. People's records showed people's preferences and risks associated with poor nutrition had been identified and specialist professionals had been involved where appropriate.

People were actively consulted about their meals. The catering manager had monthly meetings with people in the home to discuss their needs and preferences. We also found catering audits had been undertaken monthly to identify areas of improvement in people's diet and the menus.

We observed staff supported people to eat their meals. The atmosphere was calm and caring and people were not rushed with their meals. All people appeared to enjoy their meal. Staff offered a choice of drinks. Two additional staff members called hostesses were employed in the nursing units to assist people who required support with their eating and drinking. They encouraged individuals with their meals and checked they had enough to eat. We observed staff gave people an alternative choice if they did not like the meals on offer. Comments about the food were positive. The comments included, "The food is getting better. Staff feed me and they're respectful. If I don't want it they don't give it me." and "They give you a drink when you want, the meals are very good and staff always ask you where you want to sit."

The weight records we checked showed some people who we had identified to have been significant risks of weight loss and malnutrition during our inspection in December 2016 and June 2017 had gained substantial weight which was a sign of improvement on the people's welfare and well-being.

We found information in the service had been written in different formats to ensure people in the service were able to read and understand it. Staff also used aids such as picture boards or whiteboards to support people who had difficulty with their speech. This meant that information had been made accessible to people.

We found people had been encouraged and supported to personalise their rooms with their own belongings. This had helped to create a sense of 'home' and ownership. One person showed us their bedroom and told us, "I have the best room around here, they clean it for me." We were also shown the improvements to the garden; ramps had been provided and pathways were kept clear to help with access.

People's healthcare needs were considered as part of the care planning process. We noted assessments had been completed of physical and mental health and there was a detailed section in each person's care plan covering people's medical conditions. Regular health checks visits were carried out by various health professionals. This helped identify any signs of deterioration in people's health. There were links with the local primary health services and professionals such as local doctors; district nurses teams, tissue viability nurses and the local Clinical Commissioning Group. This meant that staff had access to professional help and advice if they ever needed it.

Good

Is the service caring?

Our findings

We received positive comments about the care staff and the service delivered to people. We also observed several caring and appropriate interactions between staff and people who lived in the home especially when assisting them to sit down or moving around the home Comments from people included, "They're kind and they treat me with respect.", "They're very good and kind." If there's anything you want you can talk to anyone", "The staff are very good and polite.", "They are kind and caring. I like the girls, they treat you as they find you.", "You have a chat if they come to you, and they'll ask if you're OK." And , "Staff are kind, they just get on with it, they do whatever you want doing and it makes you feel you're at home."

Comments from relatives included, "They're lovely and caring, as soon as I arrive, they call [my family member] to me.", "Yes, they are kind and caring. If you ask the girls to do anything, they're there for you and I'm very happy with that."

Staff spoken with and the unit managers had a sound knowledge and understanding of the needs of people they cared for. Staff members told us how they enjoyed working at the service. Comments from staff included, "We care for people like they are our family really" and "I like to treat people the same way I would like to be treated by them."

Our observations showed that there had been a significant improvement in the atmosphere in the home. People told us staff were much happier and supported them to the best of their ability. We also observed people were supported to join others in communal areas on a regular basis and rather than being confined to their bedrooms. This was a remarkable improvement, which had resulted in the enhancement of a number of people's well-being especially in the nursing units.

Staff had a good understanding of protecting and respecting people's human rights. Some of the care staff had received training, which included guidance in dignity and respect and equality and diversity. We discussed this with staff; they described the importance of promoting each individual's uniqueness. There was a sensitive and caring approach, underpinned by awareness of the Equality Act 2010. The Equality Act 2010 legally protects people from discrimination in the work place and in wider society.

We considered how people's dignity was maintained and promoted. We noted people's daily records and care plans had been written in a way that took account of their choices and preferences. People had been asked about their likes and dislikes and this had been included in their daily support. Staff we spoke with talked about people in a respectful, confidential and friendly way.

People's privacy was respected. One person chose to spend time alone in their room and this choice was respected by the staff. Staff described how they upheld people's privacy, by sensitively supporting people with their personal care needs and maintaining confidentiality of information. We observed staff knocked on bedroom doors before entering and ensured doors were closed when people were being supported with personal care.

We also observed improvement for one person who we had found on previous inspections staff were unable to provide them with personal care and were constrained to their bed. During this inspection we found a specialist seat had been acquired to ensure the person could get out of bed and sit with others. In addition specialist bathing equipment had been provided which meant the person was regularly getting showered.

There was information available about advocacy. One person who lived at the service had access to an advocate who were supporting them regularly. Advocates support people to access information and make informed choices about various areas in their lives. Due to their communication needs some people could not remember whether they had been involved in their care plans. However, our conversation with the manager and records of residents and relatives meetings demonstrated that people were given the opportunity to take part in their care planning wherever possible and the manager had asked relatives other ways that could enhance their ability to be part of the care planning. We noted improvements had been made in this regard in all the care files we reviewed. The care staff we spoke with displayed a real passion in relation to the care of people and it was evident that the ethos of the service was based on the care and compassion of the people using the service.

Requires Improvement

Is the service responsive?

Our findings

People and their relatives made positive comments about the way staff responded to people's needs and preferences. People we spoke with who used the service told us they thought their care was tailored to their needs. Comments included, "I can sit here (in the lounge) or in the garden. I can read and there are games to play. They get some singers in and a magician but not a lot of trips out.", "Staff are very kind and responsive. I only had one that was nasty everything I was doing it was always, "Hurry up … be quicker. I told Nurse four or five months ago and she's gone now. Staff that are left now are great, I can ask them anything and they'll do it.", "I sit in here and join in the activities when I can. They give me a printed sheet, but I can't read it. I like to try and do the keep fit." and, "It depends if there's anything on TV, but usually not a lot. I think they're doing reminiscence this afternoon. I don't get bored" and "I usually go out with my family, I go to Blackpool and have an ice cream when I get there" And, "You get taken out, I'm looking forward to going to Blackpool illuminations, and my sisters visit."

Relatives felt that staff were approachable and had a good understanding of people's individual needs. One relative said, "If I wasn't happy I'd tell them. I've no complaints. [Family member] is always up (out of bed) when I come, I'm pleased about that."

Similarly, we received positive comments from professionals. One professional commented, "I find the care home very cooperative in my work." Another professional told us, "The home is in a different place now; it has never felt like this for a long time, it has improved and people are much happier."

We reviewed how the service aimed to provide personalised care. We looked at the way the service assessed and planned for people's needs, choices and abilities. We saw examples of the assessments carried out before people moved into the service. The assessment involved gathering information from the person and others, such as their families, social workers and health care professionals. All care records contained a pre-admission assessment. This helped the general manager determine if the service and the care staff would be able to meet the person's needs.

We looked at what arrangements the service had in place to ensure people received care that had been appropriately assessed, planned and reviewed. We looked at 18 people's care files. The majority of the files were organised, detailed and clearly written. They also included people's personal preferences, life histories, and objectives and achievements. Care staff had full access to this information. People's care plans were supported by a series of risk assessments. The plans were split into sections according to people's needs and were easy to follow and read. Wound management care plans had improved significantly. The care plans contained a range of strategies which not only focussed on the individual's needs, but also included ways to ensure the people had access to things that were important to them. Although we noted improvements in the way care records were written and the frequency of reviews, we also found care records did not always contain accurate information about people's current needs.

We found in four care records people's needs had significantly changed. Although reviews had been completed in two of the records, the care plan had not been updated which meant that the guidance

available to care staff about people's needs was not accurate which could expose people to risk of receiving inappropriate care. For example, changes in how people were assisted with their movement or transfers, changes in pain management and the development of new risks to people such as choking and falls. The same concerns had been raised by the local safeguarding professionals before our inspection. We spoke to the general manager who informed us that they would now ensure old care plans were removed and replaced with new care plans and guidance as soon as a significant change was noted instead of waiting until the end of the month. Although care records had been audited and areas of improvements noted, we found that further improvements were required across the service to ensure that care records were accurate and reflected people's needs.

Daily reports provided evidence to show people had received care and support in line with their care plan. We noted the records were detailed and people's needs were described in respectful and sensitive terms. We also noted records were completed as necessary for people who required any aspect of their care monitoring, for example, weight, falls, fluids and behaviour. This was a significant improvement since our last inspection; however this needed further improvement to show that the staff in the service can imbed this in their daily practice and show consistence.

During our visit, we observed people were routinely encouraged to make choices and that staff responded to their requests. There were ongoing residents and relatives meetings. In one of the meetings, we saw discussion about the Care Quality Commission inspection and how the manager intended to resolve shortfalls identified. The minutes showed an honest and transparent dialogue between people, relatives and the manager about the challenges at the home and people's experiences.

Residents' surveys had been issued to people and were due to be returned during the month of October. This provided the opportunity for people to be consulted and make shared decisions. We saw a few questionaries' that had been completed by people. Responses were mixed with one person saying they felt they were waiting longer for help, another person expressed satisfaction with the support they received. One relative commented that staff were kind, courteous and worked hard. The general manager informed us that once they received all the survey questionnaires they would analyse the feedback from people and respond to any suggestions.

People had access to various activities to occupy their time. People indicated they were mostly satisfied with the range of activities provided at the service. We noted a schedule of activities had been set for people including arts and craft, physical exercises and day trips. During the inspection, we observed staff supporting people with various activities of their choice. One person told us, "At Christmas the church people come in occasionally and sing in the lounge in an afternoon." Furthermore we observed the local vicar visited to give communion and pray with people.

We saw one person had requested to visit a local neighbourhood where they used to live. Staff supported them and arranged a day out which allowed the person to meet with their former neighbours and friends. The person told us they felt this was a special thing to do and appreciated the support that staff had offered. We saw arrangements had been made for another visit in the community. In another example, we saw one person had requested a trumpeter to visit the home and play them, 'The last post'. Staff had actively sought help from local school music clubs to help and ensure they fulfil this person's wishes. We also saw that the general manager had taken people who lived in the nursing units on day trips such as Blackpool. This helped people to have a social life and maintain community links.

We saw a significant number of compliments had been received from people and their relatives on the care and treatment. For example care staff on the Beech unit and Oak unit were praised by relatives for the care

they provided to one person. Comments included; "Thank you for the care, love and skill you showed to [relative], he was totally happy during his time with you."

The service had a complaints procedure in place. The procedure provided directions on making a complaint and how it would be managed. This included timescales for responses. We saw complaints and compliments guidance was provided to people when they joined the service and was easily accessible. Staff we spoke with confirmed they knew what action to take should someone in their care, or a relative approach them with a complaint. There were two complaints that had been received at the time of our inspection. We noted that the complaints were acknowledged when they received and action was taken to address the concerns in a timely manner.

All of the relatives we spoke with confirmed they were aware of the complaints procedure and how to access any information around making a complaint. They told us they were confident should they have any issues that these would be dealt with appropriately. Comments from people included; "I've never been unhappy about anything." And; "They'd soon know, but I don't think I've got any complaints."

Requires Improvement

Is the service well-led?

Our findings

We received positive feedback about the management and leadership at Greenfield Care Home. People told us, "The manager, comes every morning and asks me how I am.", "The manager comes in to see me about twice a week he listens to me, it's generally got better since he's been here." "Yes I know the manager, I'll speak to him, but not about the home, we have a laugh", "The manager is approachable and I feel he would listen to any concerns if I have any." Similarly, comments from relatives about management of the home were positive. Comments included; "He's ok, approachable, he listens if he's not dashing about.", When you come in you don't smell urine, it's a calm and Ok atmosphere and some staff are really jolly and that's good."

Throughout the inspection, we observed people who used the service and staff frequently approached the general manager and unit managers who responded to them in a professional and courteous manner. All the staff spoken with described the manager as approachable. We also observed that there was a happy and calm atmosphere in the service. Staff informed us that moral was high and that they were proud of their achievements and were keen to ensure people received the best support they could give. This was a marked improvement from our last inspections in December 2016 and June 2017.

Comments from professionals included, "It's getting to be one of the best homes around here, and its good really.", "They have responded and are acting on concerns promptly and the atmosphere had improved."

We checked to see if the provider was informing the Care Quality Commission (CQC) of key events in the service and related to people who used the service. We found that in majority of the cases, the registered provider had fulfilled their regulatory responsibilities and statutory notifications had been submitted. However, we found three incidents where staff had failed to notify the Care Quality Commission about significant incidents in line with guidance and regulations. This included significant injuries, injuries incurred during the delivery of care and deterioration in a wound. Providers should notify CQC of certain incidents. The intention of this regulation is to ensure CQC is notified of specific changes in the running of the service, incidents involving people using the service and allegations of abuse, among other things. This is so CQC can be assured the provider has taken appropriate action. This also helps to ensure CQC is able to undertake its regulatory activities effectively.

The provider had failed to make statutory notifications of notifiable incidents to CQC. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

During this inspection, we found that the provider and staff had continued to make improvements to quality of care and treatment provided to people who lived at the home. We saw some evidence to demonstrate that they had managed to sustain the changes that they had introduced following out inspections in December 2016 and June 2017. There continued to be a systematic approach to identifying and addressing shortfalls in the service. The service recovery team that had been introduced by the provider had continued to work with staff and people to improve the quality of the care provided.

Management at the home had actively engaged in dialogue with stakeholders such as the local authority the local clinical commissioning group. They took part in a quality improvement programme led by the local authority and cooperated with the improvement plans and targets set up for them. We observed that the quality of the care provided had significantly improved and outcomes for individual people who were at risk of receiving poor care had also improved.

However, during this inspection we found ongoing concerns in relation to the provision of safe care and treatment. This included risk management, shortfalls in safe moving and handling and concerns in relation to reporting safeguarding concerns. We found two breaches of regulation in relation to risk management and a failure to notify CQC of certain incidents in the service. This meant that the quality assurance processes operated at the home required further improvements to ensure care and treatment could be provided safely and that any changes introduced can be sustained in the long term.

There was no registered manager employed at Greenfield Care Home. The service was led by a regional service recovery manager who was preparing to register with the Care Quality Commission as an interim registered manager. The service recovery manager had responsibility for the day to day operation of the service. They were supported by another regional service recovery manager and a regional service recovery director. Each unit was managed by a house manager who was responsible for the care staff on their units. This provided a clear leadership structure in the service.

All staff we spoke with were aware of their roles and responsibilities as well as the lines of accountability and who to contact in the event of any emergency or concern. There were up to date policies and procedures relating to the running of the service. Staff were made aware of the policies at the time of their induction and when any changes came into place.

We spoke with service recovery manager and the house managers about the daily operations of the service. It was clear they understood their roles and responsibilities and had an understanding of the operation of the service. This included what was working well, areas for improvement and plans for the future. They had an action plan in place to record things that they needed to work on to improve the service.

The registered provider used various ways to monitor the quality of the service. There were audits of the systems to manage medicines, health and safety, care files and fire safety equipment. The audits and checks were designed to ensure different aspects of the service were meeting the required standards. We saw daily and weekly clinical risk management meetings had been undertaken to discuss any emerging or ongoing risks to people's care.

We saw completed audits during the inspection and noted action plans were drawn up to address any shortfalls. There was an ongoing action plan, which was completed following our last two inspections. We found the action plan had been followed and monitored for progress and a significant number of the actions such as staff training, work on consent, and improvements in medicines management had been successfully completed while some were in progress such as the provision of further training on wound care and improvements in care files.

There were quality assurance consultation systems and tools in place. We saw there were policies on undertaking surveys to seek people and their relatives' views and opinions about the care they received. People and their relatives we spoke with informed us that they could share their views anytime.

We looked at how staff worked as a team and how effective communication between staff members was maintained. Communication about people's needs and about the service was robust. We found handover

meetings, were used to keep staff informed of people's daily needs and any changes to people's care. For example, information relating to changes in people's needs. We found this system needed to be embedded to be effective as some risks had not been picked up and discussed. Staff had been invited to contribute to the meetings.

We found the organisation had maintained links with other organisations to enhance the services they delivered, this included affiliations with organisations such as local health care agencies and local commissioning group, pharmacies, and local GPs. Challenges associated with working with other agencies had been identified and the service had engaged other services effectively to ensure safe and effective provision of care service.

There was evidence of how the staff and management had sought best practice to improve their practice and people's outcomes. For example, we found some staff had been appointed as champions in various areas of care such as safeguarding, mental capacity infection control. They were responsible for attending multi agency meetings to improve their skills and knowledge and share best practice with others.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to establish effective systems for assessing the risks to the health and safety of service users of receiving the care or treatment and doing all that is reasonably practicable to mitigate any such risks. Regulation 12(2)(a)(b)- Safe care and treatment