Greenfield Care Homes Limited

Greenfield Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This unannounced inspection took place on 19 and 21 April 2016. At the last inspection on 8 and 11 December 2014 we found three breaches of regulations and rated the service as 'Requires Improvement.' The breaches of regulations were in relation to ensuring that the care and treatment of people was appropriate and met their needs, the provision of care to people in a safe way in terms of assessing the risk of, preventing, detecting and controlling the spread of infections and the provider had not taken the correct actions to ensure that the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were followed. The provider sent us an action plan and told us they would make the necessary improvements by the end of August 2015. We have given the provider time to embed their changes before returning to complete a comprehensive inspection.

Greenfield Care Home provides accommodation for up to nine people who require personal care and support on a daily basis in a care home setting. The home specialises in caring for adults with a learning disability. At the time of our visit, there were nine people using the service. The provider is also registered to provide personal care from Greenfield Care Home to people living in their own homes but at the time of the inspection, there were no people using that service.

The home had a registered manager at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. At the time of this unannounced inspection the registered manager was on leave and we spoke with and were assisted by the deputy manager.

At this inspection we found the provider did not have effective systems to assess, review and manage risks to ensure the safety of people and others. For example, there were inaccuracies in people's nutritional risk plans which meant people's dietary needs may not be met and staff may not adequately support those at risk of choking. People did not have up to date personal emergency evacuation plans (PEEPS) which meant staff may not have all the information required to safely support people evacuate from the building if necessary.

We found the provider did not have effective systems to ensure the cleanliness of the building and ensure people were protected from the risks of the spread of infection. People did not have adequate resources to maintain personal hygiene. Toilet paper and paper towels for drying hands after washing them were not available in every toilet/bathroom. The showerheads in two bathrooms were encrusted with lime scale and could pose a risk of water borne infections. Some areas of the home were not as clean as they could be.

The call bell system that people or staff could use to call if they needed help or assistance was not working. We checked and found that none of the available call bells were working. The lack of an adequate call bell system meant that people and staff would not be able to call for assistance when they required it. There

were no assessments of any associated risks to people or staff so these could be mitigated against.

In one bedroom a sharp hook, used to attach the curtains to the curtain rail had become detached and was lying on the window ledge. This could cause harm to the person using the room or could be used to harm others. A window in the top floor bathroom was wide open and did not have a window restrictor in place. Both of these hazards were pointed out immediately to the deputy manager and they took action to mitigate the risks. However, there were no risk assessments in respect of the risks of people falling from a height such as from windows that could be fully opened.

We found out of date food items that had not been disposed of in one of the kitchens. These could have been given to people to consume increasing the risks of them eating unsafe items of food. In the same kitchen we saw a risk of some items of food becoming contaminated because the food was stored in the cupboard under the sink that also contained cleaning products such as cleaning sprays and bleach.

Most people were supported by staff to take their medicines when they needed them, but we also found one instance when one person was given a medicine at a different time to the time advised by their doctor. Medicines were stored securely and staff received annual medicines training to ensure that medicines administration was managed safely.

We observed and we received feedback from staff and relatives that there were insufficient numbers of staff to care for and support people to meet their needs. We looked at the staff rotas for the time between January and May 2016 and on most days only two staff were on duty during the day and only two staff on duty at night to care for the nine people who use the service. Four people needed two staff to help them with personal care and another two needed to be transferred using a hoist and two members of staff. This meant that there were no staff supervising other people when two staff attended to the people who needed two staff.

The provider did not have suitable staffing levels to make sure people had the opportunity to participate in a range of social and recreational activities that met their individual needs. Records showed that in the previous four months apart from going out to the day centre or with family, most people had rarely left the house except for a short walk to the local shops, because there were not enough staff to take them out. The home was not as well led as it could have been because the registered manager had not recognised the various breaches of regulations so these could be addressed. They had also not submitted to CQC notifications of relevant events and changes as required by law. People, relatives and staff were not asked for their opinions about the service. One of the directors of the Greenfield Care Homes Limited conducted a monthly health and safety check of the home. Although we saw a one page report of what had been looked, we did not see an action plan with time scales of how any areas for improvements would be addressed. This meant that errors might not have been rectified in a timely manner.

Whilst we observed staff were caring for and supporting people appropriately and noted they received training in a range of subjects, we found that they did not receive specialist training in understanding the needs of people with a learning disability and in ways to communicate better with people, such as learning Makaton. This is a language programme using signs and symbols to help people to communicate. Staff spoke about the training they had received and how it had helped them to understand the needs of people they cared for.

The provider had a complaints procedure which was accessible to all and also available in an easy read format for people using the service. The arrangements in place to respond to people's concerns and complaints were not very effective in that the complaints, investigations and responses to complainants

were not recorded to ensure learning took place.

Training records showed staff had received training in safeguarding adults at risk of harm. Staff knew and explained to us what constituted abuse and the action they would take to protect people if they had a concern.

The service had taken appropriate action to ensure the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were followed. DoLS were in place to protect people where they did not have capacity to make decisions and where it is deemed necessary to restrict their freedom in some way to protect them. We saw and heard staff encouraging people to make their own decisions and giving them the time and support to do so.

Detailed records of the care and support people received were kept. People had access to healthcare professionals when they needed them. People were supported to eat and drink sufficient amounts to meet their needs.

People were supported by caring staff and we observed people were relaxed with staff who knew and cared for them. Throughout the two days of our inspection we heard staff speaking and helping people in a kind, gentle and respectful way. Staff showed people care, support and respect when engaging with them.

We found a number of breaches of regulations during this inspection. You can see what action we have told the provider to take at the back of this report for the breaches in relation to premises and equipment, sending notifications and receiving and acting on complaints.

We are taking further action against the provider for breaches of regulations in relation to safe care and treatment of people, good governance and a lack of staff. We shall report on this when our action is completed.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe. The provider did not have suitable arrangements to assess risks so these could be identified for appropriate action to be taken to manage them. For example risk assessments were not undertaken to identify risks in relation to people's choking risks and other aspects of their safety so appropriate plans could be put in place to manage these risks.

The premises were not cleaned and maintained adequately. The emergency call bell system did not work so people or staff could summon help and hazards in the home had not been managed to lessen the risks to people.

There were insufficient numbers of skilled staff deployed to ensure that people had their needs met in an appropriate and timely way, according to their preferences.

The recruitment practices were safe and ensured staff were suitable for their roles.

Staff were knowledgeable in recognising signs of potential abuse and the action they needed to take. The provider had systems in place to protect people against risks associated with the management of medicines, but in one case a person did not receive a medicine as prescribed.□

Is the service effective?

Requires Improvement

The service was not always effective. The provider ensured people received meals to meet their nutritional needs. Where people needed support, staff supported then to eat and drink sufficient amounts of their choice to meet their needs.

Whilst, the provider ensured staff received training and supervision to support them in their roles, they did not received specific training in regards to understanding the needs of people with a learning disability or to communicate with them.

Staff took appropriate action to ensure people received the care and support they needed from healthcare professionals.

The service had taken the correct actions to ensure that the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were followed.□

Is the service caring?

Requires Improvement

The service was not always caring. Whilst staff treated people with dignity, respect and kindness, the provider had not ensured that people were always cared for in a way that was respectful and which promoted their dignity. For example, people who might require urgent personal care at a particular time needed to wait if staff were busy with other people before they were attended to as there were not enough staff on duty.

People and their relatives were supported to make choices about their care in ways that were appropriate to their individual communication needs.

Is the service responsive?

Requires Improvement

The service was not as responsive as it could be.

Assessments were undertaken to identify people's needs and these were used to develop care plans for people. Changes in people's health and care needs were acted upon to help protect people's wellbeing.

Relatives we spoke with told us they felt able to raise concerns and would complain if they needed to. The system to manage complaints was however not effective because there was no evidence that learning took place when the provider received complaints.

Is the service well-led?

Inadequate

The service was not well-led.

The provider carried out a range of checks and audits to monitor the quality of the service. However, these were not effective as the provider had not identified the various areas for improvement that we found during our inspection.

The registered manager did not have a clear understanding of their roles and responsibilities with regard to the requirements for submission of notifications of relevant events and changes to CQC.

People, relatives and staff were not asked for their opinions about the quality of the service for the provider to identify areas where they could improve the service.

People, relatives and staff fed back that they were happy with the management.

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 unannounced inspection took place on 19 and 21 April 2016. This inspection was carried out to follow on from our inspection on 8 and 11 December 2014 2015 when we rated the service 'Requires Improvement' and to check that improvements the provider told us they would make in relation to the breaches of regulations had been met. This inspection was carried out by one inspector.

We reviewed the information we had about the service prior to our visit and we looked at notifications that the provider is legally required to send us about certain events such as serious injuries and deaths.

We gathered information by speaking with four people living at Greenfield Care Home, but they were not able to fully share their experiences of using the service because of their complex needs. We spoke with four family members on the second day of the inspection and with the deputy manager.

We observed staff supporting people in the communal areas. We looked at five care records and four staff records and reviewed records relating to the management of the service.

After the inspection we telephoned and spoke with five relatives and four members of staff.

Inadequate

Is the service safe?

Our findings

On the 8 and 11 December 2014 we inspected the service and identified a breach of the regulation in relation to people not being protected through adequate risk management systems. The provider sent us an action plan and told us they would make the necessary improvements by the end of August 2015.

At this inspection, we found the provider was not meeting the legal requirements in relation to ensuring the safe care of people and the safety of others by making sure the risk assessments and management plans relating to people were up to date. A management plan for one person relating to a risk of choking stated in separate areas the type and texture of food the person needed to eat. The information was not consistent and varied in each area of the record. The eating chart for this person stated they had eaten food that was not consistent with their nutritional risk assessment. Another care plan stated 'no bread to be given,' but the eating chart for this person stated they had eaten bread in the form of sandwiches. We spoke with the deputy manager about these two concerns and she said that the risk assessments and management plan would be amended immediately and staff informed about the type of food these two people require. The inaccuracies we saw in people's nutritional risk management plans meant people were at risk of not receiving the correct type of food and the risk of choking had not been mitigated.

At the inspection on the 8 and 11 December 2014 we identified a breach of the regulation in relation to parts of the building needing cleaning, and that there was no toilet paper or soap available in some of the bathrooms. The provider sent us an action plan and told us they would make the necessary improvements by the end of July 2015.

At this inspection we found the provider was not meeting the legal requirements in relation to making sure people were receiving safe care and support. The provider did not have effective systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of people and others. The provider did not ensure the cleanliness of the premises and people were protected from the risks of the spread of infection. People did not have adequate resources to maintain personal hygiene. We saw that the only toilet or bathroom in the home that had toilet paper was on the ground floor but no paper towels were available in this room for drying the hands after washing them. Other bathrooms/toilets we looked at did not have plugs for the sinks or bath, there was no toilet paper available in any of the rooms, hand wash or soap and hand towels were also not available. Although we saw there were adequate supplies of paper towels, soap and toilet paper in a storeroom. We spoke with the deputy manager about the lack of toilet paper and hand towels and they told us that two people would eat the paper and this was why it was not available in the toilets and bathrooms. The lack of hygiene products for people and staff to use presented an infection control risk. There were no risk assessments in place to assess the risks relating to the above issues and for management plans to be put in place to manage any identified risks.

Staff were aware of the steps to take to keep people safe should a fire occur but people did not have an up to date personal emergency evacuation plan (PEEP). Records showed the PEEP's had last been updated in 2012. Records showed that fire drills were held every six months during the daytime, no night fire drills or simulated fire drills were recorded. We saw that the service had contracts for the maintenance of fire

equipment used in the home, including fire extinguishers, fire blankets and emergency lighting. People were not being kept safe because of the lack of up to date information about the risks to a person should an evacuation be required.

We saw the top floor bathroom window was wide open and did not have a window restrictor in place. We pointed this out immediately to the deputy manager and they found the key for the window and locked it. However, there were no window restrictors should the windows need to be opened such as in summer when the weather is warmer. There was therefore nothing in place to prevent the window from opening widely to prevent people falling from a height. There were no risk assessments either generally for the premises or individually to identify and to manage the risks of people falling from a height, such as from windows.

We noted that the call bell system for people or staff to use to call for help was not operational. The provider had not carried out appropriate risk assessments in relation to how people could call for help if they needed to call a member of staff, for example if they had fallen in their room. This meant that people were not able to alert staff to receive the help they needed if they were at risk of harm or injury.

Risks related to the premises were also not managed appropriately. In one bedroom a sharp hook, used to attach the curtains to the curtain rail had become detached and was lying on the window ledge. This could pose a risk of harm to the person using the room or others. We pointed it out to the deputy manager and it was removed.

During our tour of the premises we saw that people's clothes were being dried on a rack in front of the radiator in the second lounge, where people were sitting and sometimes passing through when going to or coming from their bedrooms. This meant that not only did the provider not have appropriate arrangements to dry people's clothes after they had been washed, but this practice could also pose a risk of trips and falls to people.

People were not protected against the risks associated with the unsafe arrangements for the provision of food. During this inspection we checked the storage of food in both kitchens and in the second smaller kitchen found several items of out of date food that had not been disposed of, and which could have been given to people to consume increasing the risks of them eating unsafe items of food. In this smaller kitchen we also saw food was stored in the cupboard under the sink that also contained cleaning products such as cleaning sprays and bleach. Three apples in the fruit bowl had bite marks in them and had been partially eaten, but were still on display. Records showed that only the roast joint of meat on a Sunday was temperature checked, no other meat was checked to ensure it had been cooked at the right temperature.

Whilst medicines were overall administered to people appropriately, we saw that where people were prescribed to take a certain medicine at night this was being given at 6pm. One of the side effects of the medicine was to cause increase in the length of sleep The majority of staff had received training in medicine administration in 2015. We asked staff about this but they were unable to explain why the medicine was given early apart from the fact people went to bed early. The early administration of medicines meant that people were not receiving their medicines within the time frame that the GP had prescribed the medicine and might not have received the full benefit of these medicines. The above paragraphs show there was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not ensure that the premises were cleaned and maintained to an adequate standard. The showerheads in two bathrooms were encrusted with lime scale and could pose a risk of water borne infections. The stairs and the wall were dirty and dusty and the inside window ledges and the windows in the

stair areas were dirty. We saw two places on the stairs where the carpet was not adequately secured and which could pose a trip hazard. We did see dated invoices for the deep cleaning of carpets for April and July 2015 and March 2016. Although the carpets had been deep cleaned we saw this level of cleanliness was not being maintained by weekly hoovering and checking for trip hazards. One of the bedrooms we looked at was overall clean but the window ledge was dirty.

We saw there was a cleaning checklist in place and staff were expected to check bathrooms were clean at various times of the day and tick the checklist. We saw that two of the cleaning checks list had been ticked as actioned for the afternoon before noon. Therefore this task of checking the cleanliness of various areas of the home was a ticking exercise as opposed to making sure people benefitted from clean premises.

The call bell system had not worked for some time as confirmed by staff but they were unable to give accurate dates as to when it stopped working. There were no evidence of any repair or maintenance of the system to ensure it was operating appropriately. The lack of an adequate alarm system meant that people and staff were at risk of not being able to call for assistance when they required it.

The paragraphs above show a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed that there were insufficient numbers of staff to care for and support people to meet their needs. We looked at the staff rotas between January and May 2016 and on most days only two staff were on duty during the day and only two staff on duty at night. We were told that the provider employs a cleaner for four hours a week and the caring staff were expected to keep the home clean outside of these four hours. This meant care staff were being taken away from caring duties to attend to ancillary tasks.

The staff handbook dated June 2013 which we were shown stated staff should take a minimum 11 hour rest between shifts. The staff rotas showed in February and April 2016 staff had worked a night shift and then a late shift which only gave them a five and a half hour break between shifts. In March 2016 the same staff member had worked a continuous shift of 18½ hours. In April there were eight occasions when staff worked a late shift followed by a night shift a total of 18½ hours on duty and five occasions where staff worked an early shift and then a night shift on the same day, this only gave them a break of five hours between shifts. There were therefore risks to people as staff were not given adequate time between shifts to rest so they could care for people appropriately and safely. We spoke with the registered manager after the inspection and pointed out our findings of staff shift patterns they told us they were not aware that staff were working long shifts and were not having adequate rest between shifts.

We saw staff were very busy and did not always have the time to spend with people. Staff and relatives we spoke with felt there was an inadequate number of staff to meet the sometimes challenging needs of the people at Greenfield Care Home. We observed two people who had behaviours which were challenging the staff. We noted that whilst the two members of staff spent time with them and helped them to calm down and relax, there were no staff available to support the other seven people using the service, if they needed care or support. This meant people might not have received care in a timely manner if they needed support such as with personal care.

When speaking with staff they told us the night staff started to get people up at 6am in the morning. Staff explained the buses for taking people to the day centre came between 8am and 8.30am and as there were only two night staff they had to start early in order to get everyone up and dressed, to administer medicines and to help people with their breakfast before the buses arrived. Records showed four people needed the help of two staff with their personal care, such as washing, toileting and dressing. Staff told us the registered

manager came on duty at 7.30 but did not assist with personal care and day staff did not start until 8am. Until April 2016 day staff had started at 8.30am. This meant that only two staff were available to get nine people up in the morning and there were no staff to supervise people in the lounge or garden areas. In addition, we observed and were told that four people needed the help of two staff to assist them with personal care and two other people needed to use a hoist for transfers. This meant that other people were left unattended when staff were caring for one of the individual who needed two members of staff.

The provider did not have enough staff on duty to make sure people had the opportunity to participate in a range of social and recreational activities that met their individual needs. Activities were not provided according to people's preferences, likes and dislikes. Peoples care plans noted the activities people liked doing, such as swimming, horse riding, bowling and helping with household chores. One relative said "They [their relative] gets very bored, there is nothing to do, so they want to go to bed." Other relatives commented, "There's not enough for people to do," and "my relative likes to chat but there isn't enough staff to spend time with them." Staff said, "If we had more staff we could do more with people." Records showed that in the previous four months apart from going out to the day centre or with family, most people had rarely left the house except for a short walk to the local shops.

Staff explained that one member of staff would take two people out in the morning and two people out in the afternoon. They were unable to take out more people because of the physical support people needed when traveling in the community. This meant that not everyone had the opportunity to engage in an activity of their choosing because of the insufficient staff and lack of planning around staffing levels.

This lack of attention to the staffing levels and analysis in regards to whether these were sufficient to meet people's needs was putting people's health and wellbeing at risk. The paragraphs above show there was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at four staff files and saw that recruitment processes had been followed to ensure that staff were checked appropriately before they were assessed as suitable to work with people using the service

There were policies and procedures available to staff which set out how they should protect people from abuse, neglect or harm. Training records showed that the majority of staff had received recent training in safeguarding adults at risk. Staff we spoke with were aware of what constitutes abuse and the action they should take to report it.

The provider had a medicines policy which was kept in the front of the medicines administration records (MAR) folder and staff had signed to say they had read it. The policy was due to be updated in June 2016. We noted that medicines were delivered from the pharmacy in blister packs and these did not state whether a person had an allergy. We pointed this out to the deputy manager who said they would contact the pharmacy and ensure allergies were clearly stated on the blister packs. We saw that any allergies a person had were noted in their care plan. The majority of staff had received training in medicine administration in 2015.

Requires Improvement

Is the service effective?

Our findings

Whilst we observed staff cared for and supported people appropriately we found they were not fully supported to fulfil their roles. Records showed staff had attended recent training in moving and handling, first aid and fire safety. Specialist training had also been completed in epilepsy awareness. However, records showed that supporting people with learning disabilities was an available training course, but no staff had completed this. This meant that people were not supported as well as they could have been by staff who were knowledgeable in understanding the needs of people with a learning disability.

Staff told us those people who could not communicate verbally or who had limited verbal skills communicated through one word answers, body language and Makaton signing. Makaton is a language programme using signs and symbols to help people to communicate. Records showed that staff had not received training in Makaton signing. We saw one person who was anxious signing to staff their needs. We saw staff struggled to understand the person and to communicate better with them to allay the person's anxiety. One person had been reviewed by the speech and language therapist [SALT] and they had given staff a list of signs to help the person communicate. Staff had put these in the person's care file but were not actively using these so staff could quickly recognise what the person was communicating. We spoke with the deputy manager about this and they said that training could be organised and the Makaton signs displayed to help staff communicate effectively.

On 8 and 11 December 2014 we inspected the service and identified a breach of the regulation in relation to the provider not taking the correct actions to ensure that the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were followed. The provider sent us an action plan and told us they would make the necessary improvements by the end of August 2015.

At this inspection we found the provider was meeting the legal requirements in relation to the MCA and DoLS. We saw that each person had been assessed through a mental capacity assessment and the provider had applied to the local authority to verify their findings. Each person had a time specific DoLS authorisation and this was clearly displayed in the person care plan. The Mental Capacity Act 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. DoLS protects people when they are being cared for or treated in ways that deprive them of their liberty. People can only be deprived of their liberty to receive care and treatment when it 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.

Training records showed staff had received training on the MCA in August 2014. Staff we spoke with had an understanding of how they should help people to make decisions and what to do if the person was unable to decide. However, in the action plan the provider sent us they stated they would organise refresher training for staff on the MCA. We could not find any evidence that this refresher training had taken place.

Staff told us they were fully supported by the registered manager. Staff received one to one supervision every two months plus an annual appraisal, although the staff handbook and the staff contracts we looked at stated one to one supervision would be monthly. Staff said they were happy meeting with the manager every two months and because they were a small staff team of eight they had the opportunity to meet with the manager more often if required. Staff records showed that they received an annual appraisal and this covered competencies in various areas, scored by the member of staff and the appraiser. This was used to identify areas for further training and development and goals were set for the next year. Records confirmed that staff meetings were held every three months. The most recent agenda and minutes included topics on fire procedures, cleaning and staff competence.

People were supported to eat and drink sufficient amounts to meet their needs and staff monitored people's weight, as a way of checking a person's nutritional health. People nodded and smiled when we asked them if they enjoyed the food offered. One person was able to tell us what they had eaten and that they had enjoyed the meal. Meals were planned on a four week rota and care plans contained information on people's food preferences their likes, dislikes, the food consistency and type of drinks they preferred so staff had the necessary information to support them appropriately with their nutrition. This information should help to ensure people were supported appropriately with their nutrition, but we saw for two people the recommended nutrition plan was not being followed and we have addressed this issue under the 'safe' domain.

One person told us that they had helped prepare the evening meal by peeling the potatoes; staff said they enjoyed doing this and they encouraged them to join in with the preparation of meals. People could chose to sit together at a dining table in the main lounge dining area or they could chose to eat in their rooms or at the table in the smaller lounge. Staff told us family and friends were welcome to join people for a meal. Cold drinks were available throughout the day which people could help themselves to. Staff also prepared hot drinks for people regularly throughout the day. We saw that staff recorded what each person had to eat and drink, to monitor their intake so action could be taken if they were not eating or drinking enough.

People were supported to maintain good health and have appropriate access to healthcare services. Care files we inspected confirmed that all the people were registered with a GP and their health care needs were well documented in their care plans. We could see that all appointments people had with health care professionals such as dentists or chiropodists were always recorded in their health care plan. Each person had a hospital passport. A hospital passport assists people with learning disabilities to provide hospital staff with important information about them and their health when they are admitted to hospital. Staff would accompany and support people with any medical appointments. This showed that people were supported to have their health needs met.

Requires Improvement

Is the service caring?

Our findings

People were supported by caring staff. One person nodded their head when asked if the staff were good, to affirm they were. Other people we asked said "Yes" and smiled. Relatives we spoke with commented, "Our relative is unbelievably happy here, it takes a great worry off our minds," "staff know and understand my relative," "they look after my relative very well, I can't find fault with it [the home]," "we are more than pleased with the care our relative receives" and "staff are dedicated to people, they are very good." Another relative said, "I go by how my relative reacts, if they are chatty and talking about staff, I know everything is ok."

Whilst staff were individually caring to people, the provider was not that caring. They had not ensured that people were always cared for in a way that was respectful and which promoted their dignity. For example, people who might require urgent personal care at a particular time needed to wait if staff were busy with other people before they were attended to as there were not enough staff on duty.

Some people were woken up early in the morning, irrespective of their preferences so they would be ready for the day centre. Records showed that because of the lack of staff, some people got up at 6am. We asked staff what time people went to bed and we were told between 6.30 pm and 8pm. When we asked relatives what time the people would usually go to bed two relatives said, "No when they are at home they stay up late 10 or 11pm," "no they like to watch DVD's and stay up talking." Care plans did not detail if people or their relatives had been asked about their preferences for what time they got up and went to bed. Relatives we spoke with confirm they had not been asked about the person preferences in regards to the time they went to bed or got up.

The general practice of not providing toilet paper and paper towels in the toilets and bathrooms did not promote people's dignity and independence. This meant that some people who were independent could not use the toilets they wanted and could only use the ground floor toilet where there was toilet paper and then could not dry their hands after they had used the toilet because there were no paper towels. Others would have to ask staff before they could use the toilet even though they were living in their own home and might have been independent in using the toilet.

We observed that staff knew people well and this was evident in the way they and people spoke and communicated together. This knowledge of people gave staff the opportunity to support people in the most effective way. We could see staff knew people's behaviour patterns and the best way to help a person. The help people needed from staff when they were upset or anxious was also documented in their care plans so this was provided in a consistent manner.

People were not rushed by staff in what they needed to do when they were attended by staff, but this did mean that other people had to wait for staff help. Where staff attended people to provide personal care, this was carried out discreetly and in a way to respect people privacy. We saw other instances where staff respected people's privacy. For example staff knocked on people's bedroom doors before they went in and spoke quietly to people.

Throughout the two days of our inspection, we heard staff speaking and helping people in a kind, gentle and respectful way. Staff showed people care, support and respect when engaging with them.

Relatives told us they had been involved in discussions about people's care preferences where they were not able to express themselves verbally. Most of the relatives we spoke with said they were kept up to date with any concerns or appointments their family members had and were happy with the communication between them and the home.

Requires Improvement

Is the service responsive?

Our findings

Relatives told us they were happy to speak up if they had a concern or complaint, and one relative felt their concerns were not always actioned promptly or taken seriously. Three relatives told us about concerns they had had with the laundering of their relatives clothes, such as dark and light fabric being mixed together during washing so white items came out grey, jumpers being washed at the wrong temperature and either shrinking or stretching and clothes smelling musty because they had been dried indoors. They said they had complained to the manager but they felt that things had not improved a great deal. We looked at the complaints and compliments book and saw the complaints relatives told us about had not been documented. There were no documented complaints in this book since February 2013. This showed that the provider was not operating an effective system for identifying, receiving, recording, handling and responding to complaints and did not use complaints as a way of improving the quality of the service people received. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A complaints and suggestion box was displayed in the main lounge area, where people and relatives could leave a message, if staff were unable to speak to them immediately. An easy read version of the complaints procedure was also on display to help people using the service understand the complaints process.

People's needs were assessed before they moved into the home and support was planned in response to their needs. Assessments detailed the support requirements of a person for daily living, including general health, medicines, and dietary and communication needs. People's records included information on the person's background which enabled staff to understand them as an individual and to support them appropriately.

On the first day staff were in the garden with four people playing catch and football which we could see people were enjoying. On the second day an activities provider came to the home for one hour with games and art materials for people to use. Although not everyone was able to join in with this activity within that hour because their disability meant they needed more help. An activities book from 2015 included pictures of outings and events that people had been involved in such as bowling, visiting the local farm and garden centre, birthday and Christmas parties.

People's care plans were developed using the information gathered at the person's initial assessment, they were organised and accessible to staff. Each person had a personal page which gave information about family and friends and a communications guide, to help staff communicate effectively with the person. The plans were easy to read and where these were well completed gave staff a good understanding of who a person was and how they wanted to be supported. Relatives when asked said they were aware of the care plan for their relative and had been involved in developing the support the person required. Eight people had also had a review of their care by the local authority in early 2016. Reviews of care were also held at the day centre that people attended and relatives confirmed they were invited to this review.

Inadequate

Is the service well-led?

Our findings

People who lived at Greenfield Care Home knew who the deputy manager and staff were by name and could freely communicate with them at any time. Relatives were positive about the registered manager, deputy manager and staff. Relatives said, "Staff are very caring, "the new management is good" and "the manager is good, people miss him when he's away." Relatives also said about the staff, "They work well together, a real team." Staff confirmed they did work well together and said they worked hard to ensure people were happy, well cared for and safe.

Despite these comments, we found the service was not well led. This was because the provider did not have effective arrangements to assess, monitor and improve the quality of the service. In this report we have addressed some of the concerns we found in regards to a breach of the regulation regarding person centred care under the regulation about the safe care and treatment of people. However, the provider had still not addressed the concerns we identified at our last inspection under those two regulations despite them sending an action plan and telling us they would do so. During this inspection, we found evidence that the provider was breaching additional legal requirements, which further increased the risks of people receiving unsafe and inappropriate care and support. The provider's quality assurance systems were ineffective in that these had failed to identify the areas where improvements were required so they could take the necessary action to address the concerns we found.

We identified a number of areas where the provider had failed to assess risks to people and the quality of care they were receiving and to take appropriate remedial action. For example although care plans were audited monthly and any omissions found were actioned and signed and dated as completed, the provider had not identified the inconsistencies we found in relation to the management of risks and carrying out the actions identified in care plans to meet people recreational and social needs. The service also provided a service for people with a learning disability but the provider had not taken action to make sure staff were appropriately supported in their role by making sure they received relevant training to increase their knowledge of the needs of people with a learning disability.

One of the directors of the Greenfield Care Homes Limited conducted a monthly health and safety check of the home. This included checking the home was safe and secure, the health and safety file and the daily records were up to date, petty cash and people monies were correct and safe and checked that people's annual reviews had occurred. Although we saw a one page report of what had been looked at each month for the previous five months we did not see an action plan with time scales of how any areas identified for improvements would be addressed and errors would be corrected.

Systems were not in place to gather the views of people, relatives and staff to help improve the quality of the service. We asked staff and relatives if they were asked for their opinion about the service through a questionnaire or survey. None of the staff or relatives had received a questionnaire or survey to complete and give feedback on the quality of the service. There was no evidence that people who used the service were asked for their opinion on how the service was run.

Relatives and staff confirmed that resident or family meetings did not take place at the home. Four relatives told us the only time they met with other relatives was on a Thursday when all the people at the home did not attend the day centre. Relatives would visit and speak together and voice any concerns they had but they did not have chance to meet as a group to hear about any news from the home. Residents meetings were not held so that people could have an input into any outings, activities, or menu planning. The above shows there was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had not submitted to CQC the notifications of relevant events and changes so the CQC could monitor how these had been dealt with. They had not sent CQC notifications about the outcomes of the DoLS applications they made in 2015, as they are required to do by law. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Although the attempts by the provider to monitor the quality of the service were largely ineffective, there were a few positive attempts. For example the registered manager conducted daily, weekly and monthly audits of the fire alarm system and equipment used in the home. We saw records of the monthly medicines audits that were undertaken. These showed medicines were being administered and recorded correctly. The supplying pharmacy conducted an audit in October 2015 and found areas where improvements could be made. We saw that action had been taken to improve the recording of medicines. These improvements had been signed off and dated as completed.

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 Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered person had not submitted to CQC the notifications of relevant events as required 18(1)(4)(a)(b)(c)(d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The registered person did not ensure the premises and equipment were adequately maintained and clean. Regulation 15(1)(a)(e)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered person did not ensure there were systems to receive and act on complaints. 16(1)(2)

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 Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not ensure that care and treatment was provided in a safe way for service users by having a robust system to assess risks and doing all that is reasonably practicable to mitigate any such risks as part of the delivery of care. Regulation 12 (1)(2)(a) (b)(d)(e)(g)(h)

The enforcement action we took:

Issued a warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not have effective systems to assess, monitor and improve the quality of services provided to people and to assess, monitor and mitigate risks relating to the health safety and welfare of service users and others. 17(1)(2)(a)(b)(c)(f)(3)

The enforcement action we took:

Issued warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person did not ensure there were sufficient numbers of staff deployed in order to meet the needs of the service users 18(1)

The enforcement action we took:

Issued a warning notice