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?	**Inadequate**
Is the service effective?	**Requires Improvement**
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 20, 21, and 22 June 2017. We last inspected Greenfield Care Home in December 2016. At that inspection, we found that people's safety was being compromised in a number of areas. This included how people's medicines were managed, a lack of person centred care, seeking consent, safe care and treatment and failure to deploy sufficient numbers of suitably qualified, competent persons to deliver care. There was also a failure to ensure staff received appropriate support, training, supervision and appraisal, a failure to provide good governance, failure to manage complaints effectively and a failure to undertake robust employment checks. We also found the provider had failed to notify Care Quality Commission (CQC) of significant events that affected the smooth running of the service. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

During this inspection we reviewed actions the provider told us they had taken to gain compliance against the breaches in regulations identified at the previous inspection in December 2016. We also looked to see if improvements had been made in respect of the breaches. During this inspection we saw that significant work had taken place since our last inspection to improve the safety, effectiveness and quality of the service.

However we found three continuing breaches of the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to the safe management of medicines, management of risks to receiving care and failure to ensure staff received appropriate support, and training. We made a recommendation in respect of system and processes for managing internal safeguarding investigations in the service. We also found that the work being done was still in its early stages and needed to be sustained to ensure a consistent delivery of safe care and treatment that could be evidenced in the longer term. 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 61 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 in 18 months ago. During our last inspection an interim manager was providing cover and was in the process of applying to be registered to become the registered manager. However during this inspection we were informed that they were leaving the service and an interim manager had not been identified. 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 medicines management, the management of risks to people such as wound care and the management of safeguarding concerns in the service. We looked into these areas during the inspection.

The overall rating for this service is 'Requires improvement'. The service has previously been placed in special measures and there will be no change to this situation following the outcomes from this inspection.

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.

People who lived at Greenfield Care Home told us that they felt safe in the home and that there was sufficient staff available to help them when they needed this. People who lived at the home and their visitors spoke highly of the care staff and told us they were happy with the care and treatment.

There had been an improvement in the quality of care and treatment across the four different units. This included the care records, care staff responses to people's needs, adequate numbers of staff and referrals to other professionals.

We observed staff communicating with people in a kind and respectful way. People told us staff respected their privacy and dignity and encouraged them to be independent.

Since our last inspection in December 2016 the provider had made improvements in relation to ensuring that there was the right mix of skills and competencies of staff on duty each day. In majority of the times they had ensured that a qualified nurse was in charge of the nursing units.

Training records indicated that all staff had received training in fire safety awareness and nurses had been provided with relevant training to meet the clinical needs of people in their care. Staff had also received training in safeguarding and knew the appropriate action to take if they believed someone was at risk of abuse. They were aware of the procedures for reporting bad practice or 'whistle blowing' within the organisation. However the internal safeguarding processes and procedures in the service were not robust.

People told us and we observed there had been an improvement in staff's response to people's needs. The level of staffing on the days of the inspection was sufficient to ensure that the current number of people living in the home had their needs met in a timely manner. The numbers of staff on shift during the day and night were seen to be consistent. Systems were in place for the recruitment of staff and to make sure the relevant checks were carried out before employment.

Since the last inspection the provider had been responsive and proactive in improving the systems used in the recording of information about people's needs and the planning of their care.

We looked at the risk assessments in place for people and these included risk assessments for skin and pressure area care, falls, moving and handling, mobility and nutrition and for the management of a different conditions or specific medication. However we found shortfalls in other areas of risk management, including wound care, and a failure to provide staff that were first aid trained on units that had people with high risk of choking.

We found some improvements had been made in relation to medicines management. Audits had been carried out and medicines had been stored safely. There was significant number of medicines related incidents since the last inspection in December 2016. People did not always get the medicines they were prescribed for. We found continuing concerns regarding the safe management of people's medicines.

Measures had been taken to reduce the risks associated with fire. Infection control measures were in place and standards of hygiene had been maintained. The premises and equipment had been maintained and serviced in line with regulations and manufacturer's recommendations.

Improvements had been made in relation to seeking consent. The service had taken appropriate action where people lacked the capacity to make decisions about their care and needed to be deprived of their liberty to keep them safe.

People using the service had access to healthcare professionals as required to meet their needs. However this was not always timely. There were systems in place to assess people's health care needs on admission to the service to ensure the home was able to meet their assessed needs.
Improvements had been made across the service to ensure care plans were accurate and written in a person centred manner.

The provider had sought people's opinions on the quality of care and treatment being provided.

People received adequate food and drinks throughout the day ensuring their nutritional needs were met. We saw that a range of organised activities were being made available to people. Staff had been actively involved in supporting people with activities that had been arranged. We noted that the environment within two units of the home had been developed to make it as enabling an environment as possible for people living with dementia.

Management and governance systems in the home had improved however they remained unstable. Further improvements were required to ensure stability in leadership and governance. The service had no registered manager and had not had one for 18 months. There had been five different managers since June 2015. Two house managers who had been recruited at the time of our last inspection had left the home. One unit did not have a manager. A service recovery team had been assisting with leadership and to help improve the service.

We noted an improvement in the systems designed to assess, monitor and improve the service. However, the number of shortfalls we found indicated the quality assurance and auditing processes had not been effective, as matters needing attention had not always been recognised and/or addressed in a timely manner.

The service had engaged with other health and social care stakeholders such as the local authority, Clinical Commission Groups, local health care professionals and the local Commissioning Support unit to improve the quality of care and treatment provided to people.

Staff and people told us morale had improved in the service and that they felt supported by management. People we spoke with and their relatives told us they had seen an improvement in the service.

There was a business contingency plan to demonstrate how the provider had planned for unplanned eventualities which may have an impact on the delivery of regulated activities.

The provider had sent notifications to CQC for notifiable incidents, such as allegations and incidents of abuse and significant events that affected the smooth delivery of services.

We found the service had a policy on how people could raise complaints about care and treatment and improvements had been made to ensure people's complaints were dealt with in a timely manner.

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

People's medicines were not managed in accordance with safe procedures and staff had not always been given guidance on how to administer certain medicines.

Risks to the health, safety and wellbeing of people who used the service were not always adequately assessed and appropriately managed.

Staff were aware of their duty and responsibility to protect people from abuse and were aware of the procedure to follow if they suspected any abusive or neglectful practice. However internal processes for investigating safeguarding concerns were not robust.

Is the service effective?

Requires Improvement

The service was not consistently effective

Staff had received some training and supervision however appraisal had not been undertaken for care staff. First aid training or basic life support training had not been provided to all staff.

People's mental capacity was assessed when appropriate and relatives were involved in best interests decisions. Where people needed to be deprived of their liberty to keep them safe, appropriate applications were submitted to the local authority.

People were supported to have sufficient to eat and drink and to maintain a balanced diet.

Is the service caring?

Good

The service was caring.

People and their relatives told us staff were caring. Staff knew people at the home well and treated them with kindness and respect.

People told us staff respected their privacy and dignity and we saw examples of this during out inspection.

People told us they were encouraged to be independent. We noted that equipment was available which supported people to be as independent as possible.

Is the service responsive?

Requires Improvement

The service was being responsive but the improvements made in this respect need to fully embed and continue to evidence that the improvements can be sustained and consistently achieved.

Care plans had been improved in detailing individual care needs and assessing risk. Assessments of individual needs and risks had been undertaken to identify people's care and support needs.

People were supported by staff to take part in a variety of activities within the home. Most people living at the home and relatives told us they were happy with the activities available.

The provider sought feedback from people living at the home, their relatives and staff and used the feedback received to improve the service.
People had access to information about how to complain and complaints had been addressed in a timely manner.

Is the service well-led?

Requires Improvement

The service was not consistently well-led

There was no registered manager employed. There was interim leadership to support the recovery of the service. However, leadership and governance in the service remained unstable due to high turnover of managers.

Staff told us they felt supported and listened to by the manager. Morale had improved.

The recruitment of nursing staff remained a challenge and improvements were required. The provider was actively recruiting.

Incidents and accidents had been recorded and followed up with appropriate agencies or individuals and, if required, CQC had been notified. However this was not consistent. Internal processes for investigation incidents had not always been followed.

A considerable amount of work and monitoring had been done to meet the regulations and measurable systems were being used to assess the quality of the service provided.

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 20, 21 and 22 June 2017, and the first day was unannounced. The inspection team consisted of five adult social care inspectors and 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. There was also one specialist professional advisor who had expertise in community and general nursing for adults. We also had a pharmacy inspector and a regional medicines manager who both specialised in medicine management.

Before the inspection we had asked the provider to complete a Provider Information Return (PIR). 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. They completed the PIR which we reviewed and took into account when we made the judgements in this report.

Before the inspection we gained feedback from health and social care professionals who visited 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 registered provider, about significant incidents and events that had occurred at the service. A notification is information about important events which the service is required to send us by law. We reviewed information from the local commissioning group and the local authority, also information that had been shared with us from other professionals and comments and feedback that we had received from staff, relatives and visitors of people who lived at Greenfield Care Home.

During the inspection we spoke with 11 people who lived at the service and 14 visitors. We spoke with 16 care staff, two regional support managers, the clinical support manager, a regional director, the activities co-ordinator, maintenance staff, the trainer and three house managers. We observed staff providing care and support to people over the three days of the inspection and reviewed in detail the care records of 18 people who lived at the home.

We carried out observations of staff interactions, walked around the building to see if it was safe and clean for people who lived there. We also looked at service records including eight staff recruitment files, supervision and training records, policies and procedures, complaints and compliments records, records of quality and safety audits completed and fire safety and environmental health records.

Inadequate

Is the service safe?

Our findings

At our last comprehensive inspection of Greenfield Care Home in December 2016, we found there was a failure to ensure that people's medicines were managed safely, a failure to provide safe care and treatment, failure to deploy sufficient numbers of suitably qualified, competent persons to deliver care. There was a shortage of nursing staff on duty to provide clinical care to people, a failure to ensure staff received appropriate support, training and professional development. There was also a lack of robust risk monitoring and management, a lack of reporting incidents or concern under safeguarding procedures. We also found there were failings in implementing effective plans for emergency and contingency planning and a failure to undertake robust safe staff recruitment practices.

These were multiple breaches of Regulation 12, breaches of Regulation 18 and Regulation 19 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 reviewed requirements outlined in their action plan sent to us following the inspection of the service in December 2016. We reviewed compliance against regulations 12, 18 and 19 of the Health and Social Care Act, 2008 (Regulated Activities) Regulations 2014. We found that improvements had been made in respect of safe recruitment of care staff and the service was compliant. Some improvements had also been made in respect of managing risks to fire, ensuring enough staff were on duty and providing nurses with clinical skills. Although some improvement had been made in respect of medicines management and the management of risks we found there were continuing concerns that the provider had not met the required standards and was in breach of Regulation 12.

We received positive responses to questions we asked people who lived at Greenfield Care Home about safety. All the people we spoke with told us that they felt safe in the home. Comments from people included: "I feel safe, my daughters made the right decision", "My brother put me here, I am glad he did", "There are plenty of people here. You always know where you're going" and "I feel safe but I don't know why."

Relatives and visitors were also positive about the quality of care and people's safety. Comments included: "We look around its secure there no open doors leaving the building. We've never seen any bullying and I've never seen anybody being unkind", "Every time I come there's always somebody there, she's not isolated. She's rarely left in her bedroom unless she's in bed", "I feel comfortable with the staff, the girls are amazing, but they move them round the units."

Visiting professionals were positive about people's safety and acknowledged that steps had been taken to improve people's safety. Two professionals however commented that there is evidence further improvements are required to ensure people's safety is maintained in the long run.

At the last inspection in December 2016, there were a number of issues relating to medicines which breached Regulation 12 of the Health and Social care Act 2008. These included poor monitoring and record keeping for medicine fridges, not recording when a person's topical medicines had been applied and not

recording when someone had received thickener to assist them to drink. There were also issues regarding the storage of unwanted medicines and concerns about the timeliness of administration due to lengthy medicine rounds.

Since January 2017, eleven concerns had been raised about medicine related errors. There have been six incidents where residents' pain relieving patches had either not been applied or were the wrong strength. The other problems included people missing essential medication.

At this inspection we saw that the provider had made changes to improve the safety of people using medicines. We looked at how medicines were managed for 22 people living in the home. Audit checks were done daily, weekly and monthly, and we saw improvements across all the units in the home. Action plans were devised following the findings and we saw that changes had been made.

Medicines were stored securely in locked treatment rooms and temperature sensitive medicines were stored in locked fridges. There was evidence of daily monitoring and all fridges were within the recommended temperature range. Medicines that are controlled drugs (medicines subject to stricter legal control because they are liable to be misused) were stored and recorded in the right way. We saw evidence of regular balance checks of controlled drugs. There was still some unwanted medicine waiting return to the pharmacy that was not locked away as national guidance states. Improvements had been made to the management of people's topical preparations, such as creams and ointments. Administration records were in place to record the application of these medicines, as well as body maps to show staff where they should be applied. However, creams were not stored securely and we saw one person's cream in other person's room, which if used would be an infection risk.

All the medicine administration records (MAR's) we inspected had residents photographs and allergy details completed; this helps to prevent medicines being given to the wrong person or to a person with an allergy. All the MARs we reviewed had been completed fully and accurately. Where necessary, we saw two staff signatures on the records on handwritten records. We saw time sensitive medicine administered properly in all but one person's record. Some people were prescribed medicines to be taken when required. There was written guidance in place to guide care staff how to administer these medicines, and details of the time and amount given was recorded. However, some of the guidance was not personalised and needed further information to ensure medicines would be given safely. Some were prescribed with a choice of dose and there was no information to guide staff when to give the upper or lower doses meaning people may not be given the right dose of their medication. We asked a registered nurse about this and they were unable to explain a decision they had made.

There were several examples of errors with medicine administration. A resident had a patch applied to the wrong place, which made the patch ineffective. Another resident's patch strength had increased but the new patch was not applied for three days even though the new strength was available to use. A third resident was prescribed an essential medicine used for preventing blood clots was not being managed properly.

We looked at records for two residents who were given their medicines straight into their stomach via a percutaneous endoscopic gastrostomy (PEG) tube. There was no clear guidance available for staff to administer these medicines safely, for example if it was acceptable to crush or dissolve the tablet and some medicines were available in liquid form but were prescribed as tablets. There was no recorded pharmacist or GP intervention regarding appropriate administration of these medicines. This meant there was a risk these medicines might not be given to people safely.

Changes in people's medicines had not always been followed which had led to people missing their

medicines. For example one person had been prescribed new medicines by their GP and although the medicines had been delivered and were in stock in the home, the person had not been offered the new medicines for 19 days. Another person had medicines which had been discontinued following an episode of hospital admission, on return to the service staff had continued to give the medicines and were not aware the medicines had been discontinued. This had been documented on the hospital discharge documents that the person brought with them from hospital. This meant that people could not be assured to receive their medicines as prescribed.

There were continuing failings in medicines management and administration systems at the home because the provider could not always demonstrate that medicines were being safely handled. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how risks to people's individual safety and well-being were assessed and managed. At our last inspection we found individual risk assessments were not properly recorded and regularly reviewed. At this inspection we noted sufficient improvements had been made. 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.

There was a 'comprehensive risk assessment' around mental wellbeing and behaviours. This incorporated an initial risk screening tool and an in-depth risk assessment process. The domains covered included; risk to others and vulnerability, exploitation or self-neglect. The domains provided scope for evidence of the identified risks to be included.

Despite the improvements noted, we discovered evidence which demonstrated that people were not adequately protected from risks of harm. We found that some improvements had been made in respect of managing risks associated with skin and wound care however there was a failure to adequately manage or recognise risks associated with the deterioration of wounds. Two of the care records that we reviewed demonstrated that staff had managed wounds appropriately and followed the care plans in the majority of the times. However records of care and reports from other professionals demonstrated that on two occasions staff had failed to recognise when wounds had deteriorated and needed to be escalated to specialist professionals such as podiatrists. In one instance a recommendation had been made to refer one person to a podiatrist however this had not been acted on in a timely manner. There had been a delay of up to six week before the service had made the recommended referral. Professionals who attended advised that the staff should have referred for support an early stage to avoid further deterioration.

We found another case where signs of wound deterioration such as onset of infection had not been spotted by staff. A specialist professional had also commented that staff should have noticed the deterioration and informed the specialists sooner. These concerns were reported to the local safeguarding teams and recommendations were made to the service to ensure people were protected from harm. Specialist professionals are now regularly visiting the service to monitor people's care around wound management.

We looked at how people would be supported in the event of emergencies such as falls, choking or accidental injuries. There was a protocol to support staff in relation to summoning emergency medical assistance and staff were aware of the procedure and had followed it when needed. However; we found a significant shortfall in the training and development on emergency techniques such as first aid awareness and/or basis life support.

The provider had failed to recognise the risk of having on duty care staff who were not trained in providing

first aid when the service provided care and support to people who were at risk of choking. We found a record showing an instance where staff had not adequately supported one person who had a choking episode. The initial actions taken by care staff demonstrated a lack of awareness and understanding on how to support or rescue people in these circumstances, which had a potential of exposing the person to harm. We noted that the care staff were not first aid trained. Records we saw in the service demonstrated that there were people living with dementia who were at risk of choking. 107 out of approximately 112 care staff had not received first aid or basic life support training. Health and safety regulations require that if training in emergency techniques would be appropriate to control or mitigate risk, for example if residents are known to be at serious risk of choking, then such training may be required.

We noted that the service had carried out a risk assessment in May 2017 and identified the shortfall in training in emergency techniques. However there was no documented evidence to demonstrate how this had been prioritised. We spoke to the regional support manager in charge, who informed us that the training had not been provided due to other clinical related training they had been previously identified as required. We discussed the importance of ensuring that suitably skilled staff were provided on each shift to ensure emergencies are adequately responded to. We were assured that this training would be provided as priority.

Following our last inspection in December 2016, we received concerns regarding risks of injuries during moving and handling. The service had informed us that a person had sustained some injuries due to the use of an unfitting hoist sling. We recommended that people were assessed and provided with appropriately sized slings to meet their needs and we were assured that this had been done and staff were aware of the risks. During this inspection we checked whether these risks had been managed and whether staff had followed the safe practice of using one individually matched sling per person. However on the first day of the inspection we found on the two nursing units staff were using two same size slings for six people. This meant people did not have individual slings to use.

We spoke to five care staff regarding this practice; staff told us they had not been aware of the need to use individualised slings. We reviewed accident and incident records and identified another person had sustained unexplained injuries, that care staff had attributed to injuries during hoist transfers. We spoke to the regional support manager and raised our concerns. On the second day separate slings were provided for each individual on Beech Unit. Staff on Maple unit had been provided with disposable slings however these were one size and staff informed us they were not appropriate for the majority of people on that unit. This meant that measures to mitigate risks associated with moving and handling of people had not been effectively managed.

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

We looked at the risk assessments in place concerning fire safety and how people would be moved in the event of an emergency. Improvements had been made to ensure that care staff could effectively support people in the event of a fire. We found people's records contained personal emergency evacuation plans (PEEPS) which provided guidance to staff should there be an emergency. Fire safety training had been provided to care staff and agency staff had been provided with induction to familiarise themselves with the environment and evacuation procedures. This helped to ensure staff were aware of what needed to be done to keep the home a safe place to live. 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.

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

water temperatures, fire alarm, call bells and electrical systems testing. Maintenance checks were being done regularly and records had been kept. We could see that any repairs or faults had been highlighted and addressed. These measures helped to make sure people were cared for in a safe and well maintained environment.

We looked at how the provider managed staffing levels and the deployment of staff. People their relatives and staff told us there had been adequate numbers of staff to ensure people's needs were met in a timely manner. We observed staff were responding to people's needs promptly and call bells were being answered quickly when people requested assistance. We noted there had been an improvement in the staffing levels for all the units including the provision of qualified nurses on each unit that required a nurse on duty. The provider had made efforts to recruit nurses however this had been a challenge and they had struggled to fill the nurse vacancies. Arrangements had been put in place to ensure cover was provided through the use of agency staff. We found instances where the use of agency staff had affected the consistence of care provided. For example there were important information about people's care was not effectively shared as in the unit where there was frequent use of agency nurses. There were incidents that had resulted due to some agency staff's lack of familiarity with people.The regional manager told us that if agency staff were needed they would request the same workers to provide continuity of care for the people who lived at Greenfield Care Home. They also informed us that staffing levels were kept under review and were flexible in response to the needs and requirements of the people using the service. This continuous monitoring of staffing against dependency would be essential when occupancy increased and more staff were needed to meet people's individual needs.

After our inspection in December 2016 we had continued to monitor the staffing arrangements at Greenfield Care Home. The provider had sent us their weekly staffing rotas since December 2016. We also reviewed recent staffing rotas including the week of the inspection. Rotas indicated there were sufficient staff available for the 61 people who lived there. The regional support manager and two other members of the organisation's service recovery team were on duty five days a week to oversee care and senior managers were on day shift across the week.

Several new staff had been appointed since we last visited the service. We looked at the records of eight staff members employed at the service since December 2016. 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 prior to them being offered employment. We found in one staff member's recruitment file, one employment reference had been requested from an employer who was not their most recent employer. However all other files had appropriate references.We discussed with the regional support manager the importance of ensuring reference requests were made to previous employers and most recent employers to ensure the value of information provided.

All the staff we spoke with knew the appropriate action to take if they believed someone was at risk of abuse. They were also aware of the procedures for reporting bad practice or 'whistle blowing 'within the organisation. All the staff we spoke with expressed confidence in the management team to follow up any concerns they might raise and that prompt action would be taken to make sure people were kept safe. The records and notifications to CQC indicated that in most cases referrals were being made to the relevant agencies where there had been incidents that might put people at risk. However before the inspection concerns had been raised by the local safeguarding authority regarding the accuracy and transparency of internal safeguarding processes in the service. We also identified incidents and concerns that had not been internally investigated or reported to the local safeguarding team. We spoke to the safeguarding

professionals who informed us that they had met with the managers at the service and that internal processes had started to improve. This meant people could be assured care staff would raise safeguarding concerns to allow independent investigations by relevant authorities.
We recommend the provider to follow appropriate guidance and best in respect of managing and undertaking safeguarding investigations.

We noted during the inspection that contractual arrangements were in place for staff. These included disciplinary procedures to support the organisation in taking immediate action against staff in the event of any misconduct or failure to follow company policies and procedures.

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 premises were kept clean and maintained to a good standard. There were policies and procedures for the management of risks associated with infections. People told us staff wore their uniforms and gloves and disposed of used gloves appropriately. Staff told us how incidents of outbreaks had been dealt with to protect people.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection of Greenfield Care Home in December 2016, we found the service had not taken effective action to ensure people's capacity to consent to care was taken into consideration. This was because mental capacity documentation contained conflicting information regarding people's capacity to consent to care and mental capacity assessments were generic and not decision specific. We also found best interests decisions had not been considered for some people who lacked mental capacity and people who required DoLS authorisation who had not been appropriately referred to the local authority in line with the principles of the Mental Capacity Act, 2005 (MCA). There were also shortfalls in staff training and supervision. These were breaches of Regulation 11 and Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection we reviewed what actions the provider had completed to achieve compliance with the regulations. We could see that significant and productive work had been done by the management and staff to improve care planning, care practices and the recording and monitoring of practices to show they had met the breaches found at the last inspection. The registered provider now needed to demonstrate that this was sustainable over the long term. We also found improvements had been made in respect of staff training and supervision. However we found shortfalls which demonstrated that not all staff had received training and that is deemed essential for their role and were competence checked. Supervisions had been started however care staff had not received appraisals. Improvements made by the service were not sufficient to demonstrate that they had met the requirements of Regulation 18.

At the inspection in December 2016 a significant shortfall in the training that the provider required staff to complete in order to fulfil their roles had been found. At this inspection we saw there was a training matrix in place recording the training staff had done and what they needed and this indicated systematic approach was being taken to identifying training needs. We spoke with a staff trainer and one of the regional support managers. They explained a training analysis had been completed and training had been prioritised to ensure staff delivering care were competent in their work. Training needs were being identified and training was being organised and records were being kept of the training done. Records showed that nurses employed by the provider had received essential training in specific clinical skills where we had found shortfalls during the last inspection. Support had also been sought from the local Clinical Commission Group to provide some of the training.

Although training had been provided in a number of areas and continued to be reviewed, we found a significant shortfall in the training in emergency techniques such as First Aid or basic life support skills. Five of the current care staff out of 112 had received emergency training. This lack of training meant that the provider could not be assured that staff would respond appropriately to an emergency or risks involving other staff members or people who lived at the home.

We also found shortfalls in staff knowledge and competence in the safe moving and handling of people. We spoke to five care staff regarding the use of moving and handling equipment such as slings. They were unaware of the guidance around the use of slings and informed us they routinely used one sling for all

people. This demonstrated a lack of awareness and knowledge on the risks associated with this practice. Staff informed us they had not been competence tested to see whether they transferred people safely after their moving and handling training. This meant that the provider had failed to show how they had supervised staff to demonstrate they had the required or acceptable levels of competence to carry out their role unsupervised.

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; "Yes they always ask for my opinion if I need help" Comments from relatives included, "I think the ones who have been here longer are competent. When staff are new, no they don't look competent, but you see an improvement after a month", "[Relative] had a fit and she fell and they rang us. We get calls if there's anything wrong.", "Outside its well laid out, well-kept gardens. It's as good as you're going to get in this area."

Staff had started to receive supervision and they told us that they found this helpful. The purpose of supervision was explained to staff and recorded on their supervision record. We could see issues around staff performance was being identified and addressed through supervision and actions had been discussed to improve staff performance. We looked at records of appraisals and found that not all staff who had been employed for more than a year had received an appraisal. We spoke to the regional support manager who informed us that they planning to start appraisals in the coming months and that a new approach to appraisals had been introduced in March 2017 however none of the care staff had received this. They informed us that appraisals had been undertaken for the three house managers. Staff should receive regular appraisal of their performance in their role from an appropriately skilled and experienced person and any training, learning and development needs should be identified, planned for and supported.

There was a failure to ensure that all staff had received such appropriate support, training, professional development, supervision and appraisal 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.

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.

At this inspection June 2017 we looked at people's records and saw 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 noted a significant improvement in the documentation recorded to demonstrate how people's capacity to make decision had been reached. We saw in care records that people who had capacity to make decisions about their care and treatment had been supported to do so. Mental capacity assessments were decision specific and demonstrated how the person had been supported during the assessment in line with

the principles of the MCA. Some people were not able to make some important decisions about their care or lives due to living with dementia. We looked at care plans to see how decisions had been made around their treatment choices and 'do not attempt cardio pulmonary resuscitation' (DNACPR). The records in place showed that the principles of the Mental Capacity Act 2005 Code of Practice were being used when assessing a person's ability to make a particular decision.

The service had improved the procedures for assessing a person's decision making capacity and for making sure that any decisions that needed to be taken on their behalf were only made in their best interests. The records on the process that had been followed showed how relatives, health professionals and senior care staff had been involved when needed to make sure decisions were only being made in that person's best interest. The house managers we spoke with showed a clear understanding of the principles of the MCA and records indicated they were applying them in practice. Staff had received training on the MCA and however those we spoke with were not clear about obtaining valid consent however we saw them seeking people's consent during the inspection.

We noted that the information around who held Power of Attorney for a person was being recorded so staff knew who had this in place. Powers of Attorney show who has legal authority to make decisions on a person's behalf when they cannot do so themselves and may be for financial and/or care and welfare needs.

We looked at how people's nutrition was 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. All of the care plans we looked at contained information on specific dietary needs, preferences and any intolerances. All the people who lived at Greenfield Care Home had an individual nutritional assessment and people had their weight regularly monitored for changes so appropriate action could be taken if needed. There was also information on people's dietary needs such as diabetic diets and soft meals. We saw evidence of checks being completed in regard to staff completing dietary intake charts, positional changes and weight monitoring. We could see that a nutritional assessment tool was being used and was reviewed when people's needs changed.

We observed lunch time experiences during the three days of the inspection. People told us they enjoyed the food and were given a choice of meals and drinks. There were pictorial menus that could be used to help people choose their meals for the day. Comments from people included, "We get a lot of chicken but I'm never hungry.", "The food is alright we get a couple of choices and if there is nothing I like there's sandwiches." A visitor told us "[relative] has put on one and half of a stone. At home we thought she had eaten but she hadn't, now she eats well and looks like mum."

Refreshments and snacks were observed being offered throughout the day. These consisted of a mixture of hot and cold drinks and a variety of biscuits and fruits. There were designated staff who ensured that people were provided with drinks and snacks on the nursing units. This helped to relieve care staff to undertake personal care duties. Staff had received training on nutrition and food safety to help them understand their responsibilities and the risks to people.

The care plans and records that we looked at showed that in majority of the cases people were being seen by appropriate professionals to meet their needs. For example, referrals had been made to the dietician and the speech and language therapist (SALT). One person had been assessed as at risk of choking had been seen by the speech and language therapist (SALT) and a plan was in place to help mitigate the risk. This included the requirements about thickened liquids and pureed food for people and for those who chose not to eat meat.

We could see in people's care plans that improvements had been made in relation to partnership working with other agencies. These included health care professionals and support agencies involved in people's care such as local GPs, community nursing teams, community mental health teams, podiatrists, opticians and social services. However we observed that further improvements were required to ensure vital information about people's care needs and any changes is shared chased up. This would include ensuring that referrals were made promptly where possible by the service to ensure people received effective support.

Good

Is the service caring?

Our findings

We 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. Some staff initiated the interactions easily. For example whilst people were sitting in the dining room waiting for other people sit down, then lunch could be served. We also saw examples of staff giving people their full attention and offering reassurance especially in the units where people lived with dementia.

We spoke with people who lived at Greenfield Care Home and their relatives about how they felt the staff approached them and cared for people. They told us that staff treated them with "kindness" and "consideration". Comments included; "The staff are very good in every way. They're kind and they care about me the way they treat me", "It's nice and quiet on this unit, staff treat me with respect and I treat them with respect. No-one tells me when to go to bed. Night staff are as good as the day staff.", "I'm an independent lady, I have to be up for breakfast, dinner and tea. They will bring meals for me if poorly." Comments from visitors and relatives were also positive. The comments included; "There had been a changeover of staff and they're kind, caring and they understand [relative]", "I would say their attitude is helpful, but there's an awful lot of changes" And; "They're lovely and it's got better, they've got rid of agency."

During our last inspection we found evidence which demonstrated that the poor staffing levels and unavailability of regular staff had caused a negative impact on people who used the service. Staff we spoke with also raised concerns that they felt people were being left longer waiting while staff were supporting other people. During this inspection in June 2017, we found there had been an improvement in the staffing levels which had resulted in people getting the support they needed in a timely manner. Care staff commented on how they felt the improvements in staff levels had contributed to better care for the people in their care.

We found all the units at Greenfield Care Home to have a friendly and welcoming atmosphere. We observed staff engaging with people in a warm and friendly manner. We also received positive comments about the caring nature of staff from healthcare professionals. One professional told us "The house manager is knowledgeable and will act on any concerns; she is genuine and cares for the people and her staff."

We saw people were treated with respect and dignity. For example, staff addressed people with their preferred name and spoke in a kind way. In addition to responding to people's requests for support, staff spent time chatting with people and interacting socially. People appeared comfortable in the company of staff and had developed positive relationships with them. At lunch time we saw that staff sat and spoke with people. Staff assisted people and ensured they were using their mobility aids safely. Staff spoken with understood their role in providing people with compassionate care and support. We discussed the importance of ensuring that all toilet and bathrooms in the home have facilities to allow people to lock the door if they wish to do so to maintain their privacy. The maintenance person acted on this immediately.

We looked at people's care files and identified that there had been an improvement in involving people and

their relatives in the planning of their care. People across the home had been supported to express their views in decisions about their care, treatment and support. People told us they chose where to spend their time, where to see their visitors and how they wanted their care to be provided. For example one person said they wanted their bath at 11.00am. Staff acknowledged this and supported them at their preferred time. We also noted that people were able to say when they wanted to be woken up in the morning. Our observations during the inspection showed that people had not been woken up against their will.

All bedrooms at the home were being used for single occupancy. This meant that people were able to spend time in private if they wished to and could see their doctors, family and friends in private.

Relatives of people who lived at Greenfield Care Home told us they could visit anytime of the day or week, there were no restrictions and they felt welcomed. This meant that people were able to continue maintaining important relationship in their lives. We saw that staff knocked on the doors to private areas before entering and ensured doors to bedrooms were closed when people were receiving personal care. We spoke with some people in their bedrooms and saw these had been made personal places with people's own belongings, such as photographs and ornaments to help them to feel at home with their familiar and valued things.

Staff had a good understanding of protecting and respecting people's human rights. Some staff had received training which included guidance in 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.

People had been supported to have access to advocacy service if they needed them. We spoke with the manager about access to advocacy services should people require their guidance and support. They had information details that could be provided to people and their families if this was required. We also found one person had been referred to advocacy services. This ensured people's interests would be represented and they could access appropriate services outside of the service to act on their behalf if needed.

We found evidence of end of life care plans in people's records. This meant that people could be assured they would receive end of life care in line with their wishes.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection of Greenfield Care Home in December 2016, we found the service had failed to design care or treatment with a view to achieve service user's preferences and ensuring their needs were met in a person centred manner. Care records did not always contain accurate details to reflect people's needs and the care they required. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found there was a failure to take appropriate action without delay, to respond, to operate an effectively and accessible system for identifying, receiving, recording, handling and responding to complaints. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. After the inspection the provider sent us a report telling us the actions they had taken to ensure that complaints were dealt with effectively and people's care records reflected their needs.

At this inspection we reviewed compliance against the breach of Regulation 9 and 16 of the Health and Social Care Act, 2008 (Regulated Activities) Regulations 2014. We found significant improvements had been made to the care files. The way the majority of the files we reviewed had been written had reflected a person centred approach. All complaints before our last inspection in December 2016 and after the inspection had been dealt with in a timely manner.

People made positive comments about the way staff responded to their needs and preferences. Comments included, "I'm encouraged to do what I like, and sometimes I join in activities. We had a singer this week. I asked activities co-ordinator for a trip to Lytham, I didn't like Blackpool Lights", "I read the paper, watch TV play bingo and I've had my nails painted." Comments from relatives included; "They look after my [relative] very well. They involve me in the care and support planning. The unit manager is brilliant and I can't thank them enough."

There was an improvement in people's care plans since our last inspection. We looked at 18 people's care plans. The care plans were organised, detailed and clearly written. They also included people's personal preferences, life histories, and aspirations. Care staff told us they had full access to this information. Majority of the people had newly written care plans, which 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. All files contained details about people's life history and their likes and dislikes. The profile set out what was important to each person and how they could best be supported. We saw evidence to indicate the care plans had been reviewed and updated on a monthly basis or in line with changing needs. The shortfalls regarding people who required PEG feeding had been rectified and all care plans required to meet people's needs were in place. We found staff on all units had been proactive in ensuring that people's records were accurate and had ensured that they followed the care plans in majority of the cases.

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 charts were completed as necessary for people who required any aspect of their care monitoring, for example, personal hygiene, food and fluid intake, falls and behaviour. Staff had been

reminded the importance of ensuring that people's records were completed in a person centred manner and not in a task oriented manner. The quality manager who audited the care records had provided staff feedback where they felt records did not meet the standards. We noted that this was checked again to identify if the recording had improved. Evidence we saw showed that the records had improved following these checks.

There were ongoing discussions about people's needs and well-being; this included regular staff 'handover' meetings and daily meetings between the regional manager, clinical service manager senior care staff and the house managers. We noted further improvements were required to ensure all records were consistently reflecting people's needs and any changes.

People confirmed they had been involved in the development of their care plan and we noted some people had signed their reviews to indicate their participation and agreement. A relative also confirmed they had been consulted about their family member's care. The relative said, "They look after my wife very well. They involve me in the care and support planning. The unit manager is brilliant and I can't thank them enough."

We found examples of proactive practices on Maple, Acorn and Elm Units. We spoke to the House Managers on these units and we discovered that they were following best practice and acting promptly to ensure people's needs were met. For example on Elm unit the staff had identified an individual who required a special chair. To avoid unnecessary delay while waiting for the chair to be purchased they sourced an unused chair from another service to ensure the risks were mitigated.

People who lived at the home told us staff came when they needed them. Comments included, "If I ring the buzzer staff will attend to me quickly." We observed that staff provided support to people where and when they needed it. Call bells were answered quickly and support with tasks such as and moving around the home was provided in a timely manner. We also checked historic records for the call bells and found no concerns with the response times. People seemed comfortable and relaxed in the home environment. They could move around the home freely and choose where they sat in the lounges and at mealtimes.

Majority of the people we spoke with told us they had access to various activities and that there were things to do to occupy their time. The provider had employed three activities co-ordinators and we noted a schedule of activities was posted on the wall in each area of the home. The activities included baking, pet therapy, arts and craft, tea with friends, group sing and gardening. On the second day of the inspection, we observed people baking cakes in one part of the home and people doing arts and crafts in another part.

We observed the activities co-ordinator working and engaging with people in an encouraging and passionate manner. They varied their approach for those who were less interested in group activities and supported them on a one to one basis. The engagement we saw in the unit where people lived with dementia was exemplary and skilful. One person told us "[Activities co-ordinator] likes to try new things that can stimulate people living with dementia." Although improvements had been made in this area, three people we spoke with felt that more activities should be offered and that the activities coordinators had not been given enough time to cover all the units in the home. There were systems in place to encourage people to give feedback about the care and treatment. This included, residents meetings, surveys and suggestion boxes. We saw examples of surveys that had been completed and how the service had responded to people's feedback.

We looked at how people were supported to maintain local connections and take part in social activities. We found people were encouraged to maintain local community links. People and their relatives told us they were fully supported with this involvement. Arrangements had been made for people's cultural and

religious needs to be met. We saw examples where people were supported to have their cultural meals and to read books and materials linked to their cultural and religious backgrounds. This had helped to ensure that people continued to have their cultural and religious needs met. People were facilitated to maintain contact with their families. People told us they could visit their family and friends whenever they wanted. This ensured that people could visit and spend time with their relatives and maintain family links.

We looked at how people were assured they would receive consistent, co-ordinated, person centred care when they used, or moved between different services. We found evidence of information that had been completed to facilitate information sharing when people moved between services. However we found further improvements were required to ensure that information shared from other services such as hospital discharge letters and/or people's health check results from primary health services were reviewed. This would ensure that any changes required were promptly made to ensure people received seamless support.

The service had a policy and procedure for dealing with any complaints or concerns, which included the relevant time scales. We noted there was a complaints procedure displayed in the home and information about the procedure in the service user guide.

We looked at how the service managed complaints. There have been improvements made to ensure senior management in the service were aware of complaints and how they had been dealt with. We saw examples of two complaints and how they had been resolved. We saw there were systems in place to investigate complaints. Records seen indicated the matters had been investigated and resolved to the satisfaction of the complainant. This meant people could be confident in raising concerns and having these acknowledged and addressed. People and their relatives told us they would feel confident talking to a member of staff or the managers if they had a concern or wished to raise a complaint. Staff confirmed they knew what action to take should someone in their care want to make a complaint. Comments from relatives were positive, they included; "If I had something to complain about I would say and I wouldn't hold back from ringing the chairman of Bupa if I had to."

Requires Improvement

Is the service well-led?

Our findings

At the last inspection, we found the provider had failed to operate effective governance and quality assurance systems to monitor and improve the quality of the care and treatment provided. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had also 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. Following the inspection, the provider sent us an action plan which set out the actions they intended to take to improve the service.

At this inspection in June 2017 we found that improvements had been made to the quality monitoring and auditing systems. We saw the quality monitoring systems were being effective in identifying areas of the service that needed to continue to improve. Shortfalls identified at the last inspection had been systematically addressed by the registered provider and manager and monitored to help make sure they could be sustained. The registered providers had introduced a service recovery team who were supporting the home to monitor and improve service provision.

Although there had been improvements; during this inspection we identified three breaches of regulations relating to safe care and treatment and staff training. This demonstrated that the arrangements for assessing quality and safety required further improvements to ensure they were effective and robust in identifying concerns.

People, visitors and relatives spoken with made positive comments about the leadership and management of the home however some people informed us they were not aware who manages the service. Comments included, "In my opinion the unit manager appears very open and responsive when issues are bought to light.", "The home is managed well and the staff seem to work well together.", A relative spoken with also told us, "Based on my experience I have seen the good, bad and indifferent however I'm happy with the current leadership.", "Yes I know who the manager is, he comes and talks to me and asks me how I am." And "I don't know (the manager) but there has been that many here."

Comments from staff regarding the leadership in the home were positive. We noted from speaking to staff and visiting professionals that staff moral had improved. One unit manager told us; we have very good support from the recovery team and the home manager and I have learnt a lot. Staff comments included, "[Name] is a brilliant boss. He knows everyone and always checks with the residents", "[name is a good unit manager and she gives us supervision and gets things done." Three care staff told us they appreciated the actions taken by the local authority, CQC and the local Clinical Commissioning Group (CCG) to improve the quality of the care in the home.

Professionals who visited the service shared positive feedback and informed us they had noticed some positive improvements in the service. They praised the competence of the three house managers for Maple, Elm and Oak units.

The provider had also continued to work collaboratively with stakeholders including the local authority's

quality improvement team, safeguarding professionals and the Care Quality Commission. This had helped to ensure the service improved the quality of care and treatment and comply with regulations and their contractual agreements. Although progress had been made and the quality of care had started to improved, we noted that a significant number of improvements were required in order to ensure that people receive safe care and treatment and to ensure the changes made can be sustained.

Leadership and governance arrangements at the service remained unstable. There was no registered manager in post at the time of the inspection. The service had not had a registered manager since January 2016. At our inspection in December 2016 an interim manager who was in the process of applying for registration with Care Quality Commission had left. A new manager had been recruited and had started the process of applying for registration with Care Quality Commission. However before this inspection in June 2017, we were informed that the manager was leaving the service. One of the regional support managers who had worked at the service previously was providing managerial support in collaboration with the service recovery team.

Although there had been some improvements in relation to staffing, we noted that the service continued to experience high staff turnover. Two house managers who had been employed at the time of our last inspection had left and 71 staff had left in the last 12 months. A recruitment drive for care staff and nurses had been undertaken and was ongoing. However there continued to be a significant shortage of nurses. The instability in the management and the high staff turnover had an impact on the improvement programme and the ability for the service to sustain and embed the changes that were required to improve the quality of the care provided to people.

We found improvements had been made to the auditing systems in the service. For example we saw audits carried out which were related to medicines administration records, care records, cleaning, infection control audits and health and safety checks. There were also catering audits as well as clinical audits. Managers from other services owned by the provider had visited to carry out quality checks and to monitor progress. These showed actions taken when concerns had been identified. We saw examples where audits carried out had been re-audited to ensure issues had been addressed. Where suggestions had been made to improve documentation or practice, action had been taken to follow up and monitor that this had been done in a timely manner.

Medicine audits had identified areas of concern and attempts had been made to ensure the concerns were rectified. We found the majority of the concerns relating to medicines were repeated and had been going on since the last inspection. We also found concerns to the safe moving and handling of people had not been identified and effectively dealt with before the inspection. This meant that the quality assurance processes operated at the home were not robust and required further improvements.

We looked at how staff worked as a team and how effective communication between staff members was maintained. Communication was described by staff as being "excellent", with regular staff meetings, handover every day, a communication book and notice board. We looked at the minutes of a recent staff meeting. Topics discussed included reminders for staff to ensure people were offered their medicines; bedrooms kept clean and signing medicines administration records appropriately.

People were actively encouraged to be involved in the running of the home. We saw residents meetings were held and minutes of recent meetings showed a range of issues had been discussed. People commented on the quality of the service, food and their environment. We saw changes that were made following suggestions by people.

The provider had systems in place to enable them to learn from significant incidents such as accidents, or safeguarding concerns. Local safeguarding board protocols for reporting incidents had been followed in majority of the cases. However the concerns had been raised by other professionals regarding the effectiveness and robustness of the internal processes for investigating and learning from safeguarding incidents. We found safeguarding incidents that had not been reported to the local authority.

The service had a business contingency plan to show how they would deal with unplanned events that affect the delivery of regulated services.

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 There was a failure to provide safe care and treatment. This was because the provider had failed to ensure that that there was a proper and safe management of medicines Regulation 12(2)(g)- 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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure that persons employed by the service provider in the provision of a regulated activity received such appropriate support, training, professional development and appraisal as is necessary to enable them to carry out the duties they are employed to perform. -Regulation 18(2)(a) - Staffing