Bupa Care Homes (CFHCare) Limited

Greenfield Care Home

Inspection report

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Date of inspection visit:
29 November 2016
30 November 2016
01 December 2016

Date of publication:
06 January 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out an unannounced inspection of Greenfield Nursing Home on 29 and 30 November and 01 December 2016. The first day was unannounced.

Greenfield Residential and Nursing 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 80 people living there at the time of our inspection.

The home did have a registered manager in post however they had not worked at the home for some time. An interim manager was providing cover and in the process of applying to be registered to become the registered manager. They were not present during inspection and the clinical service manager was present and providing management cover. The previous registered manager had left but had not yet applied to cancel their registration. 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.

At the last inspection on 15 and 16 March 2016 we found the provider was in breach of legal requirements of the Health and Social Care Act, 2008 (Regulated Activities) Regulations 2014, in respect of the need to seek consent when providing care and treatment. We issued a warning notice and asked the provider to be compliant with the regulation by June 2016. At this inspection, we found continued failures with this regulation which demonstrated that the provider was still not compliant.

Before this inspection we had received some concerning information in relation to medicines management, inadequate levels of care staff and nurses, inadequate training for nurses to provide specific clinical duties and poor care records. We looked into these areas during the inspection.

We found the service to be in breach of nine regulations under the Health and Social Care Act, 2008 (Regulated Activities) Regulations 2014. The breaches were in relation to, person centred care, seeking consent, safe care and treatment, failure to manage people's medicines effectively, failure to deploy sufficient numbers of suitably qualified, competent persons to deliver care, failure to ensure staff received appropriate support, training, professional development, supervision and appraisal, good governance, failure to manage complaints effectively and failure to undertake robust employment checks and failure to notify Care Quality Commission of significant events that affected the smooth running of the service. You can see what action we have told the provider to take at the back of the full version of the report

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

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

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

There was a variance in the quality and consistency of care and treatment between the five different units. We found people living in the two residential units received satisfactory standards of care. This included leadership; the response to people's needs and care records. However, the quality of care and treatment in the three nursing care units was inconsistent and did not always meet the fundamental standards of care people should expect. A lack of consistent, adequate numbers of suitably skilled staff had impacted on the quality of care and treatment and had impacted on one of the residential units which had been providing adequate levels of care.

The provider had not ensured there was the right mix of skills and competencies of staff on duty each day or the minimum number of staff. A single nurse had been left in charge of three nursing units in some instances which meant there had been only one nurse to look after 46 people requiring nursing care. One unit did not have care staff during night. We asked for care staff to be provided for this unit every night and the provider acted immediately.

We were informed that the provider was undertaking on-going recruitment of care staff and nurses to ensure the service was fully staffed.

During the inspection we observed staff responding to people's needs in a timely manner and there were always staff available for people when they asked for assistance, however, staff, people, relatives and visitors informed us this did not happen routinely and that people had to wait longer to receive support from care staff.

Safe recruitment practices were not always followed to help ensure only suitable people worked in the home. Not all staff had provided full employment histories and there was a lack of suitable references from previous employers.

We saw risk assessments in people's care files, the quality and accuracy varied between residential units and nursing units. Risks assessments in the two residential units had been completed and reviewed adequately when people's needs changed. However, in the nursing units people's risk assessments were not always completed nor were they accurate, reviewed or updated when people's needs changed. Staff did not monitor people's risks appropriately. We found similar inconsistencies with care plans.

We found staff did not always follow relevant recognised guidance in relation to skin care and pressure sore management. People were left at significant risk of developing skin sores as they had been left in bed for long periods of time.

Risk assessments for bed rails had been completed and reviewed regularly. Where necessary these have been replaced.

Staff had received training in safeguarding adults. They showed awareness of signs of abuse and what actions to take. There was a record of safeguarding incidents which showed how they had been investigated and analysed for trends and patterns. However, lessons learnt were not always put into action and recommendations from safeguarding incidents had not been acted on.

People's medicines had not been managed safely. Guidance for safe management of medicines had not been followed which included secure storage of medicines, excessive amounts of waste medicines and lack of robust recording for creams. Medicine were not always given on time and medicine rounds took longer to complete in nursing units, which had an impact on people who took medicines that required regular timing for pain management.

People were not effectively protected in the event of a fire. Building fire risk assessments were in place; however, personal emergency evacuation plans (PEEPS) that we found in people's care files did not provide sufficient guidance to enable safe evacuation of people in case of emergency.

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.

The provider had not met the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). They had failed to fully comply with a warning notice which was issued by the Care Quality Commission in June 2016.

We found people's care plans had not been written in line with the Mental Capacity Act, 2005 (MCA). Mental capacity assessments had been completed appropriately for people who lived in the residential houses or units. However, mental capacity assessment we found in the three nursing units were generic and not decision specific. People who could not communicate their decisions had not been supported through best interest processes.

We identified people who required DoLS authorisations who had not been considered for authorisation. The provider was undertaking work to improve staff's knowledge and practice in relation to mental capacity and supporting people to make decisions about their care and treatment.

There was shortfall in mandatory staff training for nurses to enable them to undertake key clinical tasks to ensure people's needs were adequately met. All nurses employed by the provider were untrained to take blood samples or to provide catheter care.

People using the service had access to healthcare professionals as required to meet their needs. We found that people's health care needs were assessed on admission to the service to ensure the home was able to meet their assessed needs. However, this was not always consistent as some people did not have pre-admission assessments in their records.

Care plans in nursing units were not consistently person centred, the information on people's needs was not accurate and provided conflicting information and they did not demonstrate people's involvement. People and their relatives told us they were consulted about their care however; they were not involved in the care planning and review of their care. The provider had sought people's opinions on the quality of care and treatment being provided. This was done through relatives and residents meetings and annual surveys.

People received adequate food and drinks throughout the day ensuring their nutritional needs were met. However, risks of weight loss were not managed in a robust manner because weight monitoring was inconsistent and not always accurate.

People in the residential units were supported with meaningful daytime activities. However, this was not consistent in the nursing units where we found people were not offered adequate stimulation or meaningful activities. There were two activities co-ordinators employed and a third one was due to be in post.

Management systems in the home were not robust. The provider had failed to provide staff with appropriate, support, training and professional development. They had failed to deploy sufficient numbers of suitably qualified competent staff.

There had been no registered manager for 12 months. There had been four different managers since June 2015. We found the provider had recruited a new clinical service manager and two new house managers who were in post at the time of the inspection. These managers showed knowledge, skills and understanding of people's care needs. After the inspection the provider informed us the Clinical Service Manager was going to be appointed as the registered manager.

There were systems designed to assess, monitor and improve the service were in place. 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 addressed. This meant the provider had not identified risks to make sure the service ran smoothly.

The service had several written plans for improvements in different areas of care and treatment. We found audit tools had identified a number of concerns and areas that required improvement however; plans that had been written on how these concerns were to be addressed had not been robustly followed to ensure the actions were completed.

We found there was low staff morale, a high level of staff sickness and high staff turnover. Staff reported feeling stressful and under pressure. All staff we spoke with told us they enjoyed their work and wanted to do their best to enhance the experience of people living at the home. They however, complained that there were consistently short staffed and felt that this was having a significant impact on people they support.

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 was not meeting the Care Quality Commission registration requirements. They did not send 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 instances where the provider had not worked in line with their own organisational policies. This included recruitment of staff, staff supervision, care planning, mental capacity, medicines and providing adequate levels of staff.

The majority of people felt they received a good service and spoke highly of their staff. They told us the staff were kind, caring and respectful but felt that the service was short staffed. Many people appreciated having their privacy respected and their independence supported.

We found the service had a policy on how people could raise complaints about care and treatment however, the provider had not responded to people's complaints 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 were not cared for by sufficient numbers of staff who had been carefully recruited and were suitably qualified. Staffing rotas showed there were at times insufficient numbers of staff available. Staff were not always recruited in line with safe procedures.

People's medicines were not managed in accordance with safe procedures and staff who administered medicines had not been competence tested when errors had occurred.

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.

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

Is the service effective?

Inadequate

The service was not effective

People were not cared for by staff who were trained and supervised and who were given enough information to care for the people they supported.

Where people lacked the capacity to consent to care and treatment, the principles and guidance around best interest decisions were not always followed under the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

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

Is the service caring?

Requires Improvement

The service was not always caring.

Staff were respectful to people, attentive to their needs and treated people with kindness in their day to day care.

People's views and values were not always considered when planning how their care was provided.

People's wishes on how they would like to be cared for in the event of serious illness or at the end of their life were considered.

Is the service responsive?

Inadequate

The service was not responsive.

People's care and support plans were not person centred. Information in care plans was inconsistent or inaccurate. There was a lack of sufficient detail to ensure people received consistent support from staff providing care.

People were not always provided with a range of appropriate social activities to provide them stimulation.

People had access to information about how to complain however, complaints and concerns were not always addressed in a timely way.

Is the service well-led?

Inadequate

The service was not well-led

People's comments about the management and leadership arrangements at the service were mixed. Leadership arrangements were unstable however the provider was addressing this.

Systems for assessing and monitoring the quality of the service and for seeking people's views and opinions about the running of the home were not effectively implemented to improve the care and treatment people received.

Staff morale was low and staff sickness was high.

Staff had access to a range of policies and procedures, job descriptions, staff handbook and contracts of employment to support them with their work and to help them understand their roles and responsibilities.

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 29, and 30 November and 01 December 2016, and the first day was unannounced. This meant the provider did not know we would be visiting to inspect.

The inspection team consisted of two adult social care inspectors and an expert 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 were also two specialist professional advisors, one had expertise in the care of older people and those living with dementia, the other had expertise in community and general nursing for adults. We also had a pharmacist who specialised in medicine management.

Before the inspection we had not asked the provider to complete a Provider Information Return (PIR) due to technical problems. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and 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 Nursing Home.

During the inspection, we used a number of different methods to help us understand the experiences of people who lived in the home. We spent time talking with people who lived at the home to gather their views

on their experience of the care and support provided by the service. We spoke with 13 people who lived at the home and six relatives. We also spoke with 26 staff and two visiting professionals, three unit managers, the clinical service manager for the service, the training officer, the regional director for the service and three clinical service managers from other services owned by the provider. We reviewed records and management systems and also undertook observations of care delivery.

We looked at samples of care records of 17 people 15 of which we pathway tracked. Pathway tracking is where we look in detail at how people's needs are assessed and care planned whilst they live at the home. We also looked at a variety of records relating to management of the service this included staff duty rosters, seven recruitment files, the accident and incident records, policies and procedures, service certificates, minutes of residents and staff meetings, reports from commissioners and the local authority, also quality assurance reports and action plans.

Inadequate

Is the service safe?

Our findings

We asked people and their relatives if they felt safe. People's views were mixed, their comments included: "I'm happy here they keep me safe.", "We need night staff on this unit, and it's difficult to get a carer when you need help in the in the night." Comments from relatives included, "I'm happy with the care they are giving him for now, as long as they don't keep him in bed all the time", "I'm happy with the care and staff are good but they don't seem to be same faces at all, they keep moving around." During the inspection we observed people were comfortable around staff and seemed happy when staff approached them.

We found there were not enough staff to meet people's needs. The system for assessing and monitoring staffing levels to meet people's needs had been introduced in October 2016. This system was not effective in ensuring adequate numbers of staff were deployed to meet people's needs. Staff on two nursing units told us of times when there were only two members of staff on duty looking after 21 people who required nursing care. In another nursing unit we found there were two staff instead of three during the night to look after 12 people. On one occasion a nurse was left on their own as the care staff had to accompany a person who lived on the unit to hospital. This meant that for a period of time the nurse had been left to support 12 people who lived with dementia and required nursing care.

Staff said, "There are not enough staff and there is not enough for people (who live here) to do. There were only two of us looking after 21 people, 14 people require help with eating. Staff are rushed and people don't get the care they need in good time."

There was a shortage of nursing staff on duty to provide clinical care to people. On one of the nursing units which had 12 people who lived with dementia we found that for a period of 21 days between the 04 November and 24 November 2016 on 13 occasions there was no nurse on duty from morning till 8 p.m. On 13 occasions, there were two care staff instead of 3 on duty in the night. On the last weekend of November 2016 there was one nurse throughout the service providing clinical care to 46 people with nursing needs.

Staff told us this situation had happened regularly. One staff member told us, "Residents are waiting too long to be changed and turned. There are no incidents reported, however manual handling procedures are not being followed causing a risk to residents." And; "On more than one occasion there has been nobody available at all, even in other units, to help out with [people who need two staff to assist them] on Maple unit."

Throughout our inspection we continued to monitor the staffing levels and the impact on people. We noticed that adequate levels of staff had been provided on the days we were present at the home. Staff however, appeared rushed and did not have adequate time to sit and speak with people. Staff tried their best to ensure people were attended to promptly however, this was not always possible. This meant that people could not be assured they would receive consistent and timely care and treatment that met their assessed needs.

We found one residential unit did not have care staff to provide support during the night. We were informed

this was routine practice and that cover was provided by care staff from the next door unit. However, evidence we obtained through speaking to residents and from minutes of residents meetings showed that this lack of night care staff had a negative impact on people's care and treatment. One person had raised their concerns that they are being left waiting for too long to receive personal care support and could not get their medicines on time as they could not locate care staff from the neighbouring unit. This person had resorted to suggesting if they could use walkie talkies to alert and locate care staff when he needed them to provide care.

We asked the clinical manager and the regional director how they determine the levels of staff in the home. They informed us that they used a dependency tool to calculate the number of staff needed. We looked at the documentation however; this was not an effective tool to determine staffing needs and had not been accurately completed. They also informed us that maintaining staffing levels and staff recruitment had been their biggest challenge at the home. They said that they had recruited a number of nurses and carers and were waiting for employment checks to be completed. They also informed us that a high level of staff sickness had affected the smooth running of the service and that they were attempting to address this.

There was a failure to deploy sufficient numbers of suitably qualified, competent, skilled and experienced persons in order to meet people's needs. This was a breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014.

Staff did not monitor people's risks appropriately and consistently in the various units which made up the home. There were risk assessments in people's care files which included risk of malnutrition, food and fluid intake, mobility and personal care. Care files we checked in the residential units demonstrated that people's risks had been assessed, documented and reviewed regularly when there was a change. However, care records we reviewed in the nursing units showed that risk assessments had been written but, the information they contained did not always reflect the people's needs. In some instances they were not being monitored or reviewed regularly to make sure people were safe. For example one person had recently been discharged from hospital after a significant operation. This had affected their mobility and the way they were assisted to move from bed to chair or to the toilet, however no review had been completed.

We found their care plan had not been updated to reflect this change nor was there guidance for care staff on how to support this person when moving them. We saw evidence which showed care staff had reported that they were finding it difficult to assist this person with moving around.

In another example we looked at the care plan and risk assessment for someone who was using bed rails on one of the dementia nursing units. The care plan stated that checks should be carried out on the bed rails every hour when the person was in bed. Staff confirmed this was not being done due to shortage of staff. We found that the assessment showed that bed rails were not suitable for this person and some areas of the assessment had been incorrectly completed. This meant that the provider could not demonstrate that the safety of the resident was protected.

We found one person was at risk of skin breakdown and infections. The person was bedbound and had a contracted posture which restricted access to some parts of their lower body. This person's room was malodorous, we asked staff the reason for this smell and they informed us that it was because they could not access this person to provide intimate care. There was no care plan in place for this, or evidence to demonstrate that any action was being taken to ensure this person's needs were being met or that advice had been sought from other health care professional. We raised a safeguarding alert with the local authority in relation to this person.

In another care file we found a skin care risk assessment. The risk assessment stated that this person was not at risk of skin damage when clearly this was the case. We looked at the 'waterlow score' for this person. A 'waterlow score' is a tool used by health care professionals to estimate the risk for development of pressure sores in patients. This person's waterlow score was assessed as very high risk. Which meant their skin could break or get damaged easily

We found they had been assessed as very high risk of developing pressure sores/ulcers. We noted a body map had been recently completed showing this person had a wound, it stated that the person required turning or changing positions every four hours, however, there was no records to show whether this had occurred. This meant that people could not be assured that risks to health and safe safety of receiving the care or treatment would be managed effectively.

There was a lack of robust risk assessment and management. This was a breach of regulation 12 (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014.

We looked at a sample of people's medicines across the home. Medicines were stored securely in locked treatment rooms and access was restricted to authorised staff. Controlled drugs were stored in suitable controlled drugs cupboards and access to them was restricted with appropriate checks in place.

Medicines audits (checks) were in place and we saw daily, weekly and monthly checks carried out by staff and managers. These had identified a number of concerns and some action had been taken to make the necessary improvements. However, we found a number of errors that the audits had not identified or action had not been taken. For example, over the previous three months we saw numerous days when the fridge temperature had not been checked and recorded. One fridge was not checked for 12 consecutive days. This meant there was a risk that medicines kept in the fridge would not be stored safely and be unfit for use. Topical medicines, such as creams, were not accurately recorded after they had been applied; several audits had identified this issue but accurate records of cream administration were not routinely made so we could not be sure that people were having them applied properly.

Medicines disposal was recorded appropriately. However, staff told us that all medicines were cleared out and disposed of at the end of the month and replaced with new stock even if they were still in use; this meant some medicines were being unnecessarily being disposed of. We also saw that medicines awaiting collection for disposal were not locked away in the medicines store room as per national guidance.

We observed part of a morning medicines round which began at approximately 9:15am and finished at 11:40am. Records showed that medicines rounds varied in length but routinely finished near lunchtime. Nursing staff told us this was often due to the complexity of people's medicines, the expectation of carrying out other tasks and being interrupted. The medicines optimisation team from the Clinical Commissioning Group (CCG) had also identified concerns about the length of the medicines rounds in their support visits. Records showed that this had impacted on when medicines were being administered to people.

One person that required a long acting pain killer to be given 12 hours apart so it worked properly was not consistently given this at the right time; records showed it was administered between eight and 16 hours over the last month. Another person was prescribed Paracetamol to be given every four hours but the timing of the medicines rounds meant that this could not always safely achieved; the exact times of administration of Paracetamol were not recorded for this person so it was not possible to demonstrate this was being managed safely. A third person was prescribed a medicine for Parkinson's but it was not clear from the records whether this person was receiving them at the right times.

Records of thickeners used to thicken fluids for people with swallowing problems were not clearly recorded when they had been used. Information was available to care workers about how to use them for individual people but the records did not demonstrate when they were being given so we could not be sure they were being handled safely.

Senior care workers and nursing staff that administered medicines received medicines handling training however, their competencies had not been assessed to make sure they had the necessary skills.

There were 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(1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how risks around the premises were managed and found the premises had been well maintained, building and fire risk assessments had also been undertaken. We found fire safety equipment had been serviced in line with related regulations. Fire alarms had been tested regularly. However, fire evacuation drills were not undertaken regularly to ensure staff and people were familiar with what to do in the event of a fire. For example there were shortfalls in fire safety training and there was a lack of fire drills within the service.

Agency staff did not receive induction to the home and did not know the fire procedures and evacuation procedures in place at the service. We spoke to the clinical service manager and the regional director and they showed us documentation for inducting agency staff that were meant to be used however, these had not been put into practice. This meant care staff could not effectively support people in the event of a fire at the home which has a potential of exposing people to harm.

We looked at how people would be supported in the event of emergencies. We found some people did not have personal emergency evacuation plans (PEEPS) in place for staff to follow should there be an emergency. The few PEEPs that we saw in people's files were very basic and did not provide sufficient information to guide staff. This meant that the home had not put sufficient measures in place to establish what assistance each individual required and people could not be assured they could be evacuated in a safe and timely manner during an emergency.

There were failings in implementing effective plans for emergency and contingency planning effect. This was a breach of Regulation 12(2) (a) (e) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the service had not consistently followed safe recruitment practices. Staff recruitment records we saw showed three care staff members had been employed without satisfactory employment references. Therefore evidence of their conduct in previous employment had not been obtained. The organisation's recruitment policies states that a minimum of two written references are obtained before appointment is confirmed. This confirmed that the organisation had failed to follow its own recruitment policies.

In three care staff files we found employment checks did not cover prospective employee's full employment history. In another file we found the provider had not ensured they requested appropriate references for one person to establish why they had left their previous employer. Regulations require that where a person has been previously employed in a position whose duties involved work with children or vulnerable adults, satisfactory verification, so far as reasonably practicable, of the reason why the person's employment in that position ended. This meant the provider had not followed safe recruitment procedures consistently to help to protect vulnerable adults.

There was a failure to undertake robust safe staff recruitment practices. This was a breach of Regulation 19 (2) (a) (b) (3) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Four out of five staff files that we checked demonstrated an attempt had been made to ensure safe recruitment had been implemented. They contained evidence that application forms had been completed by people and interviews had taken place before an offer of employment was made. At least two forms of identification, one of which was photographic, had also been retained on staff's files. Staff members we spoke with confirmed they had been checked as being fit to work with vulnerable people through the Disclosure and Barring Service (DBS).

The majority of care staff we spoke with knew how to keep people safe and how to recognise safeguarding concerns. We saw evidence and documentation that showed how staff had raised concerns to the local safeguarding authority. They had received training in safeguarding adults. Policies and procedures for people to raise concerns about their own care and treatment were in place. We found staff had raised concerns regarding the people's welfare for example when the service was short staffed and when an act or omission or neglect had happened. Internal investigations had been undertaken and recommendations shared with staff. In majority of the cases the provider had acted in line with local and national safeguarding procedures. This meant people could be assured care staff would raise safeguarding concerns to allow independent investigations by relevant authorities.

Processes for the reporting and recording of accidents /incidents had been implemented and staff had recorded the support they had provided for people after the incidents. We saw that support had been sought from emergency services and health professionals after incidents. The home had recorded falls, accidents and incidents and looked at the causes and actions to reduce the risks. However, risk reduction measures had not always been shared with staff or used to update people's care records.

The provider had systems for the management of risks associated with infections and outbreaks. We found risk assessments had been put in place for areas of known risks of infection and there was guidance for staff. Regular infection control audits had been carried out and action plans had been devised which were monitored and updated when actions had been completed. The service worked collaboratively with other local agencies to ensure infections and risks of infections were managed effectively. We also found the service had employed cleaners who worked in all units. Most parts of the home smelt clean and fresh and furniture and décor looked clean. There was a malodorous smell evident in the nursing unit where people living with dementia were accommodated. We were told the smell was coming from floors and we were assured that plans were in place to replace them.

A range of certificates demonstrating that facilities and equipment within the home, such as fire safety equipment and lifting equipment, water testing were regularly checked. Current gas certificates were available to show these facilities had been checked by external contractors. We found the provider had carried out maintenance checks.

Inadequate

Is the service effective?

Our findings

At our previous inspection of Greenfield Nursing Home in March 2016 we found the service had not taken effective action to ensure people's rights were always protected. This was because consent had not been obtained through best interest decision making processes before the provision of specific care delivery and the provider had failed to demonstrate how they had assessed people's mental capacity to make their own decisions about their care.

The mental capacity documentation contained conflicting information regarding people's capacity to consent to care and mental capacity assessments were generic and not decision specific. As a result of our findings we issued the provider with a warning notice for breaching regulation 11 of the Health and Social Care Act, 2008 (Regulated Activities) Regulations 2014. We asked the provider to ensure they were compliant with the regulation by 12 June 2016.

During this inspection we checked to see what improvements had been made to ensure compliance with regulation 11 of the Health and Social Care Act, 2008 (Regulated Activities) Regulations 2014. Improvements made by the service were not sufficient to demonstrate that they had met the requirements of the regulation.

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.

The provider had suitable policies and procedures in place to guide staff practice and staff had been trained to improve their understanding of the principles of the MCA. During the inspection we observed staff gained people's consent before undertaking care tasks. Staff showed a good understanding of gaining consent in practice. However, we found mental capacity assessments completed were generic and not decision specific and where people could not express their own decisions verbally, there was no evidence to demonstrate how staff had facilitated people to take part in the process by way of different communication methods. Out of 17 files that we looked at, eight contained incomplete information or mental capacity assessments that had not been completed in line with the principles of the Act.

In one example we found a person who could not speak had been assessed as unable to make their own decisions and having fluctuating mental capacity. This was generic assessment and did not specify what decision this person was unable to make. The records indicated that this person required their family member to assist in the best interest decision making process. However, there was no evidence to

demonstrate how the family had been consulted even though they visited the home regularly. We also found the person who suffered from chest infections, had refused to have immunisation. There was no evidence how staff had ensured that this person had mental capacity to make this important decision. There was no evidence to demonstrate how the service had involved family and other professionals in this decision.

In another example we found one person who had been asking to go home. The person was admitted into the service in April 2016 however, we were told that the DoLS authorisation application had been made in October 2016. This meant the person had been unlawfully deprived of their liberties for five months. We looked at this person's pre-admission assessment. The section on mental capacity and deprivation of liberty were not completed. We saw that a best interest decision was recorded for the use of bedrails. However, no capacity assessment had been completed before this decision and neither the person nor their next of kin, had signed in agreement with the use of bedrails.

We saw that one mental capacity assessment had been completed during the inspection. This record was only partially completed and was unclear around the decision that was being assessed. This assessment recorded that the person had 'variable capacity', however we found evidence in the care notes that stated the person had capacity to make day to day decisions about their care.

We looked at the care records for a person that staff told us periodically asked to go home. A capacity assessment had been completed on August 2016. This assessment was generic and not decision specific as required by the Mental Capacity Act. We saw that a best interest decision form was in place. However, it did not specify what specific area it covered and was dated June 2016. This meant that a best interest decision had been made before a capacity assessment had been recorded. This did not ensure that care was delivered with the consent of the person involved. The Unit Manager told us a DoLS application had been applied for however; this had not yet been approved.

We spoke to the clinical service manager and the regional director regarding the warning notice that that we issued in June 2016 and our findings above. They informed us that 137 staff had received mental capacity training and 60 percent of the care files had been reviewed. They said another clinical service manager from another region had been visiting to review files and coach staff on mental capacity. We saw workbooks that were due to be given to staff to complete in order to improve their knowledge and understanding of MCA. However, processes on two of the nursing units had not been reviewed, in these units we found people who required DoLS authorisation who had not been appropriately referred.

Although staff had received training we found staff in some of the units lacked knowledge and understanding of what DoLS meant and which service users required DoLS and why. However staff in the residential units showed awareness of the principles and the records we saw in the residential units showed assessments had been completed appropriately and met the required standards. The Clinical Service Manager informed us that high staff turnover had also impacted the service's ability to have this training and knowledge embedded in staff's daily practice.

The service provider had failed to ensure that staff obtained consent lawfully and act within the principles and codes of conduct associated with the Mental Capacity Act, 2005.Therefore this is a repeated breach of Regulation 11 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014.

Records we saw showed that some applications had been made to deprive people of their liberties in some of the units however; there were three people we identified who had not been referred. Records we saw showed the clinical service manager had identified this issue and asked for this to be completed more than

once. This had not been completed at the time of out inspection. We therefore asked the service to ensure that this was completed.

We found the provider had provided training to care staff in various areas of care delivery. Staff informed us they were provided comprehensive induction to prepare them for their role. We saw records which showed staff had completed training which included safeguarding adults, MCA and DoLS, moving and handling, medicine management, fire safety and food handling. However, there were some shortfalls in training and staff had not been competence tested to ensure they continue to practice and deliver care safely.

Before the inspection we had received information from visiting health professionals expressing concerns that nurses employed by the provider were unable to undertake some essential clinical tasks, such as taking blood samples and catheterisation and managing percutaneous endoscopic gastrostomy PEGs. (PEG) is an endoscopic medical procedure in which a tube (PEG tube) is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate.

The service had relied on the community health service, if people required support with these health care needs. Services that are registered to provide nursing care are expected to have their nurses trained to deliver healthcare and treatment. All nine registered nurses who were employed by the service had not been trained to take blood samples and undertake catheterisation procedures. We saw evidence nurses had recently undertaken training on maintaining PEGs and there were plans to train the nurses to undertake the other clinical tasks above. Systems to support nurses to maintain their continuous professional development were not robust as they relied on staff supervisions to identify learning needs, however the supervisions had not taken place which meant learning and development needs could not be identified.

The organisation' supervision policy states that staff should receive a minimum of six sessions of supervision and one appraisal per year if working full time. We spoke to care staff who informed us that they had not received supervision for a long time, but used to have this regularly. This meant that the provider had not provided staff with supervision to enable them to carry out the duties they are employed to perform. They had also failed to follow their own policies on staff supervision.

There were shortfalls in staff training and supervision. This was a breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014.

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. We found snacks and drinks were readily available throughout the home and people were offered drinks regularly. People who required assistance with eating were adequately supported. The provider employed hostesses who ensured people had adequate snacks and drinks throughout the day. We observed the chef working together with care staff, checking whether the food they had sent for people with special dietary needs to the right specifications. They showed knowledge of people who were on special diets such as soft diet.

Nutritional care records we looked at showed people had been assessed to ensure their nutritional needs were met. The clinical service manager informed us they had adopted a 'hydration kit' which was used to monitor people who were at risk of dehydration or not drinking enough fluids.

There was a system for monitoring and managing people who were at risk of unintentional weight loss. We saw people had been weighed regularly however; concerns had been raised about the accuracy of the scales as the weights had been fluctuating significantly over very short periods of time. For example in one

person's care files, records showed that they had lost a significant amount of weight in one week however the following week they had gained a significant amount of weight which was not possible. We spoke to the clinical service manager who explained to us how the scales had lost calibration while being transferred between the units. They informed us they were to buy additional scales for each unit to avoid this. However; they had been aware of this issue and had not provided additional scales for each house when they became aware of this.

We observed lunch time experiences during the first two days of the inspection. Staff were polite, smiled, engaged with people and had time for them. People were offered choices and were encouraged to eat. The atmosphere during lunch time was relaxed and people enjoyed their meals. The care staff offered people food with respect, in an effective and efficient manner. People were not rushed and staff had time to talk with residents. We received positive comments about food. Comments included: "Meals are very good"; "I have a poached eggs made for me especially."

We looked at the premises and people's bedrooms and found they were clean, warm, well presented and people had personalised their bedrooms with their own possessions. One of the nursing units had been decorated to suit the needs of people living with dementia. People had plenty of space to walk around safely if they wanted a moment to themselves. People's independence was promoted especially during meal times. People were encouraged to eat independently wherever possible.

We looked at how people were supported to maintain good health, access community health care services and receive on going health care support. There were links with the local primary health services and professionals such as district nurses, dieticians, doctors, and community mental health practitioners came into the service to offer support regularly. People we spoke with told us they were able to access health care services as required. One relative told us, "Any concerns and I tell staff and they get the Doctor for him."

Requires Improvement

Is the service caring?

Our findings

We asked people if the staff team were caring. Comments included, "Staff here look after me very good I can't complain" and "I thoroughly enjoyed my first few months here, I enjoyed meeting people and I still enjoy it", "The girls treat you like a human being", "Staff always knock on my door no one comes straight in. My wishes are always respected. Overall I am very happy"

Similarly relatives told us, "Staff very helpful." And; "I have been in a few homes recently, this is the best." However, another visitor told us, their relative had experienced falls and fractured their hip and had been in bed for six weeks. They were unhappy that she had not been supported to get out of bed.

We found the concerns with staffing levels and availability of regular staff had caused a negative impact on people who used the service. We saw evidence from residents meetings showing two people had raised concerns regarding lack of night staff on their unit and how this had impacted on their welfare. Staff we spoke with also raised concerns that they felt people were being left longer waiting while staff were supporting other people. However, staff showed commitment to providing compassionate and safe care regardless.

During the inspection, we observed some warm and genuine interactions between people and staff. Conversations showed kindness and compassion. Care spoken with were passionate about their job. They told us regardless of the difficulties with staffing levels they did their job to their best. People appeared to be very comfortable in staff presence and staff knew people well. We saw members of staff working, providing consistent care and support to people. We noted that care workers approached people in a kind and respectful manner and responded to their requests for assistance promptly. Where people were unwell and required assurance, staff took time and sat with them. People were referred to by their preferred names.

We spoke to professionals who visited the home and they informed us they felt staff were caring and witnessed warm relationships between carers and people when they visited. They however commented that staff had struggled at times to spend enough time with people due to staff shortages.

The provider had not always demonstrated how people were involved in reviewing their written plans of care to ensure their preferences and wishes were taken into consideration. We looked at how the service supported people to express their views and how people were actively involved in decisions about their care, treatment and support. We saw evidence to support that people who lived in the residential units had been actively involved in the planning of their care. However, this was not the case in the three nursing units.

We found people had requested to be part of the assessment and review of their care; however no evidence of involvement had been recorded in the care files. Care files did not show how people or their relatives had taken part in planning their own care. We spoke to relatives who confirmed they had not been formally involved in reviewing their relatives 'care. They however, informed us they had been kept informed of any changes to their relatives care needs.

We looked at how people's privacy and dignity was respected and promoted. People we spoke with told us they could get up and go to bed when they wished and they said their privacy and dignity was respected by the staff team. One person, living on the residential unit, told us that staff respected their privacy. A staff member we spoke with told us how they would respect people's dignity. For example, they told us they would knock before entering people's bedrooms and ensured people go to bed when they want to.

During the inspection we saw evidence of involvement of an advocate for one person who lacked mental capacity to make decisions for themselves and wanted to return to their own home. We have previously recommended the provider to explore how best to signpost people to, or involve advocacy services when appropriate, in order to support people with decisions relating to their care and treatment.

We found evidence of end of life care plans in people's records. Plans were in place to provide staff with end of life training; however we noted it had been cancelled due to staff shortages. We were assured that this was to be provided in due course. This meant that people could be assured they would receive end of life care in line with their wishes.

Inadequate

Is the service responsive?

Our findings

We asked people who lived at the service if they felt their needs and wishes were responded to timely and appropriately. One person told us, "There is not enough for us to do" and: "They are short of staff and you can never find anyone when you need them"; "I have to wait for an hour to get a cup of tea and wait long periods of time for medicines."

Care planning documentation was not adequate and did not always reflect the care which was being provided to people. Care plans we reviewed from the nursing units either had conflicting information, lacked detail around current needs, or in some instances did not consider people's needs at all. We found care was not assessed, planned or delivered in a person centred way. Person centred care means ensuring the person is at the centre of everything which is done for or with them. This involves taking into account people's individual wishes and needs. Some of the care plans were difficult to follow and did not contain detailed information to enable care staff to know how the person should be supported.

Care plans did not always reflect the person's current needs and we could not see evidence of regular reviews or updates to care plans. Care plans should have been evaluated and updated monthly, or sooner, depending on people's changing needs. However, we saw a number of care plans across the three nursing units which had not been evaluated for four months between April and September 2016 and therefore did not reflect people's current care needs. For example one person's oral care plan stated that they did not have dentures, however we saw professional visits indicating this person had been visited by the dentist as their dentures had not been fitting properly and needed fixing. There were no instructions on how to support this person with their mouth care.

In another person's care plan we found multiple entries by visiting health care professionals mentioning the person's pain; however this person did not have a care plan for pain management or a pain chart, to guide staff on what signs to look for to identify if the person is in pain and what to do to support them. We noted a service quality audit carried out by a clinical development manager in one nursing unit included the following comment, "This residents care plans are very poor and not reflective of his current care needs." However, we noted that care plans in the residential units were well organised and had been reviewed regularly when people's needs changed.

Before the inspection we had received concerns from a local hospital regarding the care of two people who were admitted from Greenfield Nursing Home who were PEG fed. People who were supported with PEG require assistance with maintenance of their PEG as well as mouth care. During the inspection we looked at care records for three people who were PEG fed. We found for all three records there were records of feeding regimes however, there was no PEG care plan or risk assessment to guide staff on how to care for the person on PEG and the precautions to take. We also found there were no care plans for oral care and no records of mouth care being delivered.

The clinical manager informed us that they were aware of the concerns and that nurses employed at the service had recently been trained to be able to manage people who require PEG feed. We saw evidence to

demonstrate staff had been trained. They also informed us that they had faced challenges with staffing levels which they anticipated to improve and aid in the quality of the care plans. We saw evidence to show that systems were in place to check the quality of the care plans and examples of these were seen in action. However, actions were not always taken to take corrective measures.

There was a failure 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. This was a breach of Regulation 9 (3) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014.

There was a complaints policy and procedure advising people how to make a complaint; this included the contact details for external organisations including social services and the local government ombudsman and the Care Quality Commission. It also contained guidance for staff on how to support people to make a complaint about their care and treatment. Information about how to raise concerns, complaints and compliments was displayed in the entrance hall. We saw people had made complimentary comments about the service.

However, during the inspection we noted that the provider had failed to establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying of the regulated activity.

For example we found two complaints received in April 2016 and May 2016 had not been concluded to show how the provider had responded to people's concerns. In another complaint a relative had requested for someone from the service to respond to their emails and concerns on several occasions. We looked at the provider's policy which stated that, "All formal complaints should be responded to in writing within a maximum of 21 calendar days." This meant the provider had failed to follow their own policy.

We also noted two complaints had been received in October 2016 and November 2016 from relatives who were unhappy that their family members had been left in bed till late in the day. These two complaints had been recorded however, they had not been acknowledged or a responded to. Two people living at the service had raised concerns about the lack of staff during the night on one of the residential units which was not staffed at night. They had expressed concerns from July 2016 to November 2016 at every residents meeting how this was impacting on their welfare, especially delays in receiving medicines on time and receiving personal care. However, these concerns had not been formally acknowledged, or addressed as complaints. This meant complaints and concerns had not be identified, taken seriously and responded to proactively.

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 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014.

There were two activity co-ordinators employed by the provider to facilitate activities and offer people with stimulation and meaningful day time activities. We saw activity plans which included day trips, crafts and board games. People had suggested their own activities and these were considered. We however noted that there was a lack of stimulation within the nursing units.

We observed that activities were mainly provided in the residential units. People in the nursing units were at risk of being isolated as majority of them spent time in their bedrooms. We discussed this with the clinical manager and the regional director. They acknowledged our observations and informed us they would

address this and also informed us they had recruited one of the care staff to co-ordinate activities.

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. On the second day of the inspection we saw one person had been visited by the local priest and had received communion. Staff told us this was a regular arrangement. This had helped to ensure that people continued to have their 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.

Inadequate

Is the service well-led?

Our findings

People's views about management were mixed. Comments from people included; "The Manager is wonderful", "She's brilliant, absolutely great, she's the best ever" and "I don't know who the manager is."

We asked staff their views on leadership and whether they felt supported. Views were varied. Staff comments included, "I like caring for people here but management don't care about us", "It's been better since the new unit manager started", "We are severely short-staffed, and I feel anxious to come to work because I may be working on my own on the unit" and "I would not put my nana here."

During the inspection we noticed there was low morale and staffing records showed a high level of staff sickness among some of the care staff at the service. Six out of the 17 staff we spoke with felt morale was low due to staff shortages. We also noted some of the comments in the staff meetings which showed the staff team had struggled to maintain a positive approach.

Seven staff members did not feel they were listened to or supported and felt their views were not taken into consideration. They told us staff meetings were not regular. They said they were often not given their work rota until the week before, or the day before in some instances. Four staff told us they felt that 'the BUPA system of documentation was not robust enough and was a "tick box" exercise'. They told us the care files were hard to use and it was difficult to find information. Staff pointed out how some of the information in the care plans was contradictory to people's needs.

These verbal comments and sentiments we received from staff were reflected in minutes of staff meetings and comments made in records by one clinical service manager who had visited to support the service in September 2016. They expressed that, 'I feel that staff are not coping clinically and there are areas where I have real concerns that the home is not safe." They had suggested a restriction of the admissions to allow staff to catch up and for recruitment of nurses. However, we were informed this had not been agreed by the external leadership of the service.

Staff had contacted the CQC and the local safeguarding team sharing the same views. The main concern raised was the shortage of staff which was impacting on the care delivery. However, we observed that regardless of the low morale, all staff that we spoke with showed a commitment to people living at the home. They told us they would do their best to ensure people are comfortable and safe regardless of the difficulties they faced. However we found that despite the care staff trying to do their best that peoples' care was being affected

Following our last inspection in March 2016, the service received significant support from the local authority and the local health commissioning authority (Clinical Commissioning Group) to ensure they improved the quality of care and treatment and comply with their contractual agreements. This included medicines management, infection control, staff training and safeguarding people. However we found recommendations and suggested changes had not been sustained and embedded into the service to improve the quality of care and experiences for people living at the home.

At the time of our inspection the service had a registered manager who had left at the beginning of 2016 but not involved in the running of the service. Since this time the service had been managed by an interim manager who had not yet been registered with the Care Quality Commission but has started the process of registering. Since June 2015 there have been five different clinical service managers. At the time of our inspection the current clinical service manager had been in post for 10 weeks. We also noted that the provider had employed two new house managers for the nursing units.

After the inspection we were informed the clinical service manager will be the taking the registered manager role and applying for registration with the Commission.

There were unclear management arrangements which had led to a lack of effective leadership and management and oversight of the service. During the inspection process, we found it difficult to obtain key pieces of information which we would expect the management team to know or have access to. For example, the outcome of complaints and records to confirm statutory notifications had been sent to the Care Quality Commission.

At the last comprehensive inspection in March 2016, we identified the service was not meeting regulations in relation to seeking consent and working in line with the Mental Capacity Act 2005 principle. At this inspection, we identified the improvements made to address the shortfalls, were not sufficient. There continued to be a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which did not demonstrate a well-led effectively managed service.

We observed that actions to improve the service had been considered and some had started to be put in place. For example the recruitment of unit managers had been undertaken and they were starting to settle in their posts. Two nurses had been recruited with some evidence of on-going recruitment. However, we found a considerable number of other actions that required to be completed that were outstanding and which were impacting on the quality of the care provided in the home.

Staff had not been competence tested in a number of care practices. Competence checks would ensure that staff were assessed to see if they continue to be able to deliver care to the required standards. We found staff who had made errors in medicines administration had not been retrained or had their competence checked, to ensure they had developed adequate skills and knowledge to provide people with safe support.

The provider had failed to ensure the service had adequate levels of staff with the right skills to deliver safe care and treatment. We noted a number of times the nursing units had been without qualified nurses to deliver and oversee the care being delivered. There were shortfalls in the training and key skills required to ensure the nurses employed at the home could safely undertake clinical tasks that were required to meet the needs of people with nursing and healthcare needs. Nurses had not been effectively supported to maintain their registrations through continuous professional development and clinical supervision. The clinical service manager informed us that systems for supporting them were in place; however these had not been put into action.

We identified a number of breaches of regulations during this inspection, several of which related to areas of safety such as: safe care and treatment, seeking consent, care planning, lack of statutory notifications for significant incidents, maintaining adequate levels staff with the right qualifications, staff recruitment, training and supervision and receiving and responding to complaints. Some of these issues had not been identified by the provider. For example delays in responding to complaints and shortcomings in the employment checks. This demonstrated that the arrangements for assessing quality and safety were not effective.

Consultation surveys or relatives and residents meetings had been carried out to seek people's views on the quality of the service. However, some of the concerns raised in these meetings had not been addressed to ensure people are aware the provider was listening. For example the absence of night staff on one unit.

We looked at how staff worked as a team and how effective communication between staff members was maintained. We observed the clinical service manager undertaking 'clinical walk around' every morning collecting updates on any clinical concerns from the unit managers and offering them guidance on how to respond to any concerns they had. Staff had been kept informed through shift handover meetings and by speaking to manager directly if they had concerns, however there were no regular staff meetings. We were assured that regular staff meetings were to be arranged.

There were a significant number of quality assurance systems and tools for auditing the service. This included internal support from within the service and support from other managers from the provider's other services. A number of action plans from the local authority contracts monitoring team and from the local health commissioning group were also in place. However, quality assurance systems were not operated robustly to drive change and improvement in service delivery and quality of care and treatment. We found a number of concerns in people's files that could have been identified by robust quality assurance and governance systems.

We found audits had been undertaken for various aspects of care delivery including care plans, infection control, premises, care quality audits, medicines and clinical audits. Infection control audits were adequately addressed with actions plans that were monitored. However, all other audits had not been sufficiently supported by action plans which meant that the identified issues or concerns had not been monitored to ensure they were completed. We noted that this could have been as a result of instability with staffing and high turnover of care staff, nurses and unit managers which we noted to have been resolved.

We found the provider had systems in place to enable them to learn from significant incidents such as accidents, or safeguarding concerns. When a safeguarding alert had been raised a full investigation had been undertaken and recommendations were made. However, these were not always followed up to ensure they had been acted on. Accidents and incidents were recorded in people's individual files and analysed during clinical leadership meetings to identify trends and patterns and ways to reduce the accidents. Local safeguarding board protocols for reporting incidents had been followed.

There was a lack of robust oversight to ensure that policies and procedures had been followed robustly and that action had been taken to all concerns raised in the numerous audits that were undertaken.

The provider failed to establish and operate effective systems that enabled them to assess, monitor and improve the quality of the service and experience of service users. This was a breach of Regulation 17 (1) (2) (a) (b) (c) (e) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014.

We checked to see if the provider was meeting Care Quality Commission (CQC) registration requirements, including the submission of notifications and any other legal obligations. We found the registered provider had sent a number of notifications however this was not consistent. They had not always submitted statutory notifications to CQC. For example, a fire incident had occurred in one of the units resulting in the evacuation of 17 people into other units. This was a major incident affecting the service which had not been reported to the Commission. There had been a number of instances when the service had one qualified nurse supporting 46 people requiring nursing care and occasions when units were significantly short staffed. The Commission has not been notified of these instances in the failure to provide adequate staff at the home.

We also found allegations of abuse that had not been reported to the Commission. These incidents should have been reported to CQC. Regulations require providers to notify CQC of certain incidents and events. The intention of this regulation is to ensure CQC is notified of specific changes in the running of the service, incidents involving people using the service and allegations of abuse, among other things. This is so CQC can be assured the provider has taken appropriate action to keep people safe. This also helps to ensure CQC is able to undertake its regulatory activities effectively.

The provider had failed to make statutory notifications of notifiable incidents. This was a breach of Regulation 18 (1) (2) (b) (ii) (e) (g) (i) (ii) (iii) of the Care Quality Commission (Registration) Regulations 2009.

There were areas of good practice within the home, especially in the residential units. Where we found the care, systems and processes were run effectively and there was stable and consistent leadership. We saw attempts had been made to share this good practice through management meetings. However we also found that staff were often moved from the residential units to assist where there were staff shortages in other areas of the home. This was beginning to affect the staff morale and stability in the residential units.

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

We found the organisation had maintained links with other organisations to enhance the services they delivered, this included affiliations with organisations such as 'Investors in People' and 'Local commissioning groups, pharmacies, and local doctors.

Following the inspection, the provider sent us an action plan showing how they had responded to the concerns that we raised during the inspection. They also informed us they were not going to admit new residents into the service to ensure they can work to address the concerns we found.