Care Quality Commission

Guinness Care and Support Limited

Greenhill Residential Home

Inspection report

Priscott Way
Kingsteignton
Newton Abbot
TQ12 3QT

Tel: 01626202642
Website: www.guinnesspartnership.com

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 4, 6 and 9 October 2017. The provider, Guinness Care and Support Limited also runs two other care homes in Devon with a head office in Exeter. Greenhill Residential Home is purpose built and registered to provide accommodation for up to 36 people who require personal care. Some people require nursing support and this is provided by the local district nurses. At the time we visited, 31 people were living at the home.

There was a registered manager employed at the home. 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 and associated Regulations about how the service is run. The registered manager had given notice and a new manager was due to commence employment shortly. The team leader had also given notice and there would soon be a vacancy.

In May 2015 our inspection found that the service was rated as 'Inadequate' overall. The domains of effective, caring and responsive 'required improvement'. There were concerns relating to people not being treated with dignity and respect, people not being protected from unsafe care and treatment, nutrition and hydration needs not being met and lack of action to ensure the quality and safety of the service improved. The service was put into special measures, meaning that we kept the service under review and inspected again in January 2016. At that inspection we found actions had been taken to address all the shortcomings identified at the May 2015 inspection. However, we were unable to judge well led domain as good because the actions taken to ensure people received well-led care had not been in place long enough to ensure they were applied consistently and over time.

At this inspection in October 2017 we found there were failings across all domains.

People were not safe at Greenhill Residential Home. There were not enough staff to ensure people's needs were met in a timely way or by staff who had the information they needed to meet people's needs. Many people at Greenhill had complex needs and high dependency levels requiring support and supervision to keep them safe. The staffing levels did not ensure they received the care they needed.

The organisation and leadership of each shift was poor. This meant that the registered manager and provider had not recognised that the staffing levels did not reflect people's dependency levels. The service was based on completing tasks for people with a routine focussing on staff rather than people's needs. Management had not listened to staff, who had raised the issue of inadequate staffing levels in supervisions and meetings. This meant that although staff were caring and worked hard to meet people's basic needs, they were physically unable to ensure people received person centred care in a timely way. This had led to very low staff morale and increasing sickness levels.

The lack of shift and effective staff deployment meant that people were not able to get up and go to bed

when they wanted. Personal care support continued into late morning on a regular basis, based on how much time staff had. Many people required two care staff for personal care and mobility support and a large number of people needed assistance with eating and drinking. There was not enough time for staff to meet these needs effectively. For example, 29 people at Greenhill were at high risk of falls which was increased due to lack of staff supervision. Continence management was also poor and people could not always get to the bathroom in time which further put people at risk.

Although people were supported by kind, caring and compassionate staff who tried to promote people's independence and treat them with dignity and respect, they were unable to ensure that people's dignity was maintained at all times. The atmosphere was chaotic, rushed and task orientated. There were call bells ringing constantly, door alarms beeping and noisy 'walkie talkie' radio communications between staff.

The provider and registered manager had audited people's weights and food and fluid records but had not recognised that in reality people were not receiving adequate nutrition, including those people identified as being at high risk. This meant people remained at risk of losing weight and not receiving enough food and fluids throughout the day and night.

People's health needs were not always managed well. The provider and registered manager did not ensure staff had the information they needed to meet people's needs. Staff relied on brief handover sheets and verbal handover rather than care plans or health care documents kept in the office. Records were not always completed meaning that health risks were not always identified, consistently recorded or managed to completion. This put people at risk of not having their health needs met effectively or identified. Particular areas of concern were catheter care and bowel management.

Following our findings on the second day of inspection, we were concerned about the safety of people living at the home. We contacted the provider and asked for reassurances that people would be safe over the weekend. The Service Manager for Older People and the Director of Independent Living who is also the Nominated Individual immediately assured us on the second day of our inspection they would be monitoring the service over the weekend and in the future. They confirmed that the service had already decided not to allow any further admissions. Extra care staff and a registered nurse on shifts over the weekend were put in place and the management team were considering people's dependency levels as a whole for the future. The visiting district nurse also contacted the local bowel and bladder nurse on the second day of our inspection to ensure one person received the treatment they needed.

Medication security was not safe. We also asked to be assured that the medication keys were stored in a safe place and not left unattended. There were not enough continence aids; staff were concerned that none had been ordered in time for the weekend. We asked to be assured more continence aids would be purchased for the weekend. We also asked that people at risk of losing weight were weighed and receiving adequate food and fluids and that people's bowel and bladder management improved as a priority. We also fed back our findings to the safeguarding team as part of the on-going safeguarding process.

On the third day of our inspection there were some improvements due to the additional staff. The service appeared calmer, people were not so late in getting up or having to wait as long for assistance but the organisation of the shift pattern, staff deployment, lack of adequate communication and person centred care remained a concern.

Although there were quality assurance systems in place to monitor all aspects of the home to identify areas for improvement, the provider had failed to identify the urgency of our concerns or identified the experience for people living at the home in reality.

We found that people's day to day life in the home was not always a positive experience. Despite an activity co-ordinator being employed, their input, although caring, was not effective and did not ensure each person had regular opportunity for stimulation and engagement. People were not facilitated to maintain regular social stimulation in a person centred way to maintain wellbeing. During our inspection many individuals were left for long periods alone, despite care plans identified specific need for engagement, such as depression, loneliness and anxiety. Staff did not have time to spend with people, chat or to have input into activities and social stimulation. This meant that people had little contact with staff other than for tasks. Some people with more complex needs such as living with dementia or other mental health needs were not consistently supported. Staff were unable to be pro-active in ensuring care was based on people's preferences and interests, join in and seek out activities in the wider community and consistently help people live a fulfilled life, individually and in groups.

People, relatives, staff and external professionals did not have confidence in the registered manager and provider. Staff were visibly upset about the lack of time to provide a good service to people they cared about. They did not feel valued, listened to or part of a team, despite regular supervision session with more senior staff or management. All staff had received appropriate induction and training but felt they could not put this into practice.

The home was not always clean and free from offensive odours. There was no attention to detail and domestic shift patterns meant at times care staff had to provide cleaning which they did not have time to do.

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 time frame. 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.

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.

We found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to staffing, safe care and treatment, premises and equipment, person centred care, dignity and respect and good governance.

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.

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.

There were not enough skilled and experienced staff to ensure people remained safe and receive individualised care in a timely way.

Risks were not well managed to ensure that people were safe.

People were at risk of not receiving adequate nutrition and hydration to maintain their health and wellbeing.

People did not always receive their medicines when they needed them as there were not enough staff.

Systems were in place to protect people from the risk of abuse.

Is the service effective?

Inadequate

The service was not effective in ensuring people's needs were met.

Staff had received training but did not have the information about people's needs to be able to meet them.

Staff understood their legal obligations including how to support people who could not consent to their own care and treatment but did not always have time to ensure people's rights were protected.

Is the service caring?

Inadequate

The service was not caring.

Although the staff were caring, the people they provided support for, the lack of care staff did not ensure people's dignity and respect were always maintained.

People received an uncaring service because staff were rushed and had insufficient time to provide support in a manner that respected people's privacy and dignity.

The provider had failed to ensure people received a personalised service from staff who were kind, caring and compassionate at all times.

End of life care planning was lacking and did not ensure people's needs were known and met.

People and their relatives, where required, were involved in making decisions about their care but their concerns were not always acted upon.

Is the service responsive?

Inadequate

The service was not responsive.

People's social needs had not been assessed and people were not supported to lead interesting or fulfilling lives.

People did not receive a service that was responsive to their changing health and wellbeing needs.

Staff were not able to provide individualised care to people to maintain their quality of life and wellbeing due to the lack of knowledgeable staff.

People's individual care needs and preferences had been assessed and basic needs were being met but not to a good standard and staff did not have the time or information to provide stimulation and engagement to meet people's social and leisure needs.

People could not be confident complaints and concerns were taken seriously and dealt with to promote improvement. Response to concerns about lack of staffing had not happened.

Is the service well-led?

Inadequate

The service was not well-led.

People and staff did not benefit from an open, inclusive culture within the home.

Good leadership, openness, support and visibility were not demonstrated by the registered manager and senior staff team to ensure staff felt supported and valued.

The provider's oversight and quality assurance systems failed to ensure people received a good quality service driven by responsive improvement in a timely way.

Care Quality Commission

Greenhill Residential 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.There had also been a safeguarding concern raised relating to possible poor care for one individual and multiple medication errors. During our inspection further concerns were raised by visiting health professionals and registered nurses working over that weekend.

This inspection took place on 4, 6 and 9 October 2017 and was unannounced on the first day. The inspection team consisted of one adult social care inspector and a pharmacy inspector.

We reviewed information that we held about the service. Providers are required to notify the Care Quality Commission about events and incidents that occur including unexpected deaths, injuries to people receiving care and safeguarding matters. We reviewed the notifications the provider had sent us. We also looked at the safeguarding concerns information as part of the on-going safeguarding process.

During the inspection, we spent time with all 31 people living at Greenhill Residential Home. We spoke individually with 11 people and as some people could not tell us about their experiences directly due to medical conditions, we spent time with people observing their care in the communal areas. We also took lunch with people in the dining room on the first day.

We spoke with three visiting relatives, two visiting health professionals, the registered manager, team leader, the provider Nominated Individual who was also the Director of Independent Living and the Service Manager for Older People. We spoke with the administrator, two domestics, the cook, activity co-ordinator and kitchen porter. We also spoke with three senior care workers, eight care workers and two agency care workers and a bank care worker.

The records we looked at included six people's care records and daily records, 17 people's medicine records, health care records and other records relating to people's care. We looked at three staff recruitment files and staff training and supervision records. We also observed a medicine round. We also looked at

records relating to how the provider monitored the quality of the service such as complaints, audits and quality assurance surveys.

Inadequate

Is the service safe?

Our findings

People were not receiving safe care. There were not enough staff to deliver effective, safe or person centred care. People and relatives all told us there were not enough staff. One person said, "I do lots of waiting here. I wait for a cigarette, now I'm waiting for yoghurt." All staff we spoke to told us there were not enough staff saying, "It's always busy, hectic", "It's the provider, it's a daily thing. The PM shift is horrendous". One agency care worker said, "When I've been here I feel I've run a marathon." Another agency care worker said, "It's the only home I've been in where there's no time, you just have to get tasks done." There were two senior care workers on duty in the morning with six care staff. The seniors spent the morning administering medication leaving six care workers to assist people to get up and have breakfast. On the first day of our inspection the senior had been administering medication for an hour and still only managed to see three people due to interruptions. Care staff said seniors didn't have time to help with care.

Staffing levels had not been arranged with a view to people's dependencies. We went through the handover sheet with staff who told us there were 14 people who they were giving assistance, prompting or full assistance, with eating and drinking. The Head of Quality Assurance and Compliance and the Registered Manager said following the inspection they thought this was eight people but staff identified they were assisting 14 people during our inspection. Two people we sat with took an hour to eat their lunch with two care workers. Night staff said they did not have time to do a full drinks round in the morning which was reflected by food and fluid charts for those at risk of losing weight. The Head of Compliance and the Registered Manager said following the inspection there was a drinks round in the evening but on 25 occasions over a week the six people's food and fluid charts we looked at did not show a drink had been offered.

There were 15 people who required assistance with continence and pressure relieving at regular intervals, some two hourly, others four hourly and assistance with continence management after meals. 12 of these people required assistance from two care workers together for personal care. Care workers were managing to ensure people were turned and their position moved regularly but continence management was lacking. This resulted in people being wet in bed or in their chair before care workers could get to them. 18 people could not use the call bell independently due to living with dementia or physical restrictions. People did not receive care in a timely way. People were still receiving assistance to get up after 11am, not due to their choice, although if people wanted a lie in this was accommodated. Breakfast was then taken near to lunch time and people were not able to enjoy any social or leisure time in the mornings. After the lunch finished at 3pm people were assisted with continence management so staff were busy. This routine was followed on each day of our inspection. Staff felt de-moralised and said they did not feel they had done a good job when they went home.

Care staff were given a list of tasks which failed to recognise people as individuals, or refer to people in a respectful and dignified manner. Staff were allocated room numbers and tasks each day. Care staff also had morning duties such as replacing all jugs, room numbers to feed (meaning people), tea trolley at 11, trays and to 'push downstairs fluids', meaning to encourage people at risk to drink. They were to 'help with doubles' and supervise numbered rooms and complete all 'turns and stands'. The handover sheet told staff

to ensure they filled out all charts and daily notes at the time of task. However, most staff stayed on after their shift to complete records, meaning records were not always up to date during the shift. The handover sheet said records would be spot checked throughout the shift. This did not happen. Staff said they simply did not have time to complete what was required each day, and during our inspection we saw this was the case.

There was also the registered manager and team leader during the week supported by an administrator, laundry person, cook and kitchen porter. The activity co-ordinator worked as a breakfast assistant from 8-11am. They and the kitchen porter assisted with breakfast trays and breakfast in the dining room. Neither were given a handover sheet and so could not be sure of people's needs. The breakfast assistant devised the breakfast menu list without up to date information about each person's dietary needs and any changes to those needs. This put people having breakfast at risk of not receiving appropriate food and drink safely.

Staff were not effectively deployed or in sufficient numbers to ensure people's needs were met safely and in line with their wishes and preferences. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The handover process in the morning was not effective. The registered manager and team leader were not present and relied on a 24 hour report (shift leaders completed a 24 hour report which was a daily summary for the managers), the handover being given by the shift leader. Daily records only reflected tasks completed. A night senior care worker handed over to the day senior care worker. This was scheduled to happen at 7.45am but staff said this was often late as they were busy. The day care workers then sat waiting in the foyer leaving the lounge unsupervised until after 8.20am. We saw this on two days of our inspection. The day senior care worker then spent time handing over again to those day care staff. Therefore, day staff did not begin providing care until after 08.20 when most people had still not been assisted to get up, dressed or had a drink.

People were at risk of falling because despite their care plans saying people required monitoring, the lounge was often not supervised and people were not monitored. 29 people living at Greenhill were assessed as being at high risk of falling and two people did not have a risk assessment for falls in their care file. During our inspection we saw at least 12 people left unsupervised in the lounge on the first day at 8am and at other times on all days. There was no means for them to call for staff. Sometimes people were calling out or attempting to mobilise unaided. Their care plans said they should be monitored when mobilising. They were not. This put people at high risk of falls. One person was stated as being independent with their walking frame on the handover sheet. Their falls risk assessment noted they were high risk of falls. Their contact sheet in the 'working folder' said they had recently fallen twice in one week and 'to monitor' with no further detail.

The district nurse told us how one person had recently been found outside alone and this person had recently fallen sustaining a head wound. Although staff knew about this person's Deprivation of Liberty Safeguards (DoLS), they were not always following instructions. For example, this person's DoLS recommendations stated, 'not safe to be left unattended'. They were unattended most of the day throughout our inspection .Another person had recently fallen unwitnessed in their bathroom at 05.25. They had then not been checked again until 8am. The care plan noted they liked to be independent, reluctant to use the call bell and had declined a pressure alarm mat. Staff told us the person had become more frail recently but the handover sheet only noted "independent mobile with frame and slow".

Risk assessments relating to the environment, and to people's health and wellbeing had been completed but not monitored or communicated to staff to ensure actions were taken. For example, one manual

handling risk assessment said the person had a motion sensitive fall management system for their bed. Two staff said they did not know this and said they had had no input into the person's care plan. Care plans had good information about people's backgrounds, interests and needs although not communicated to care staff. Short term health needs were poorly recorded and did not ensure they were met to completion. Accidents and incidents were recorded individually with actions recorded but actions were not always taken from findings, putting people at risk. For example, if someone had fallen, an action would be to monitor and we did not see any meaningful or effective 'monitoring' in practice. The shift leader communication report on 1 October 2017 said one person had fallen in another person's room and there was no further explanation about how they got there.

People who were at risk of constipation or who could not communication their toileting needs verbally, for example due to living with dementia, could not be confident their needs would be met safely. One person unable to communicate these needs easily had minimal recording of bowel movement or type. They were unable to tell us directly due to their condition meaning they relied on care workers to monitor this. We saw the last recording in their bowel record of a bowel action was on 18 September 2017 and there was no description of stool type which is good practice. The district nurse arranged for the Bowel and Bladder Nurse to visit during our inspection and perform a bowel ultrasound. This found a high level of constipated, impacted bowel that would be unresolved by an enema as it was so high, therefore requiring regular oral medication. The laxative previously prescribed was still by their bed not taken at 11.15 on that day having been left at 8am. The medicines administration chart and medicine cupboard showed only 14 sachets of laxative had been given since July 2017 with an unopened 30 sachet packet. Therefore, this had not been monitored or laxative offered regularly. This put this person at high risk of ill health and discomfort.

On all three days we found two people's catheter bags extremely full. This is poor practice and can cause discomfort and urine to back track up the tube and a risk of infection. One person told us this often happened and the catheter then leaked over them. On 8 October 2017 the night staff had recorded at 10pm, 'possibly bypassing'. Previous daily records on 23 September 2017 said the catheter bag had been not open to allow flow and the bag was kinked. There was no further comment about any action taken. The day staff did not know this and the person's catheter bag was full again. Another entry on 8 October said the catheter bag had torn as not put on stand properly. The handover sheet did not mention the person had a catheter at all. The district nurse also had concerns about catheter care management. They had also found catheter bags extremely full and un-emptied. They had previously instructed carers to tie on a leg bag in a certain way due to a person's sore skin but had found it not done in that way again on 9 October 2017.

We looked at the medicines administration records (MAR) for 17 people. We also looked at three records for the administration of topical medicines , the care plans relating to medicines for five people and spoke to two staff members involved in the administration of medicines.

We found that the records for oral medicines had been completed and there were no gaps in administration recording. However, we found that the information recorded on the front of the records conflicted with the information recorded on the rear of the chart. We found that when people were prescribed a variable dose of a medicine to be given that the record of the amount administered on the front of the chart recorded one quantity whilst a different quantity was recorded on the rear of the chart. This meant that it was not possible to identify if a person was receiving a safe or effective dose of the prescribed medicine. We also found that the records made for the application of topical medicines such as creams, ointments and protective sprays were incomplete. This meant it was not possible to say that people were receiving these medicines as prescribed, which could lead to discomfort or skin sore or broken skin.

When people were prescribed medicines to be taken "when required" there was no information available to

guide staff on how to make the decision about when the medicine was to be given. No record was made of the reason for administrations when they had been recorded. This meant that the prescriber could not be kept informed about the effectiveness of the medicine and people may not be offered 'as required' medicines when they needed them. For example, the safeguarding concern relating to medication included poor communication about health professional advice to offer pain relief for one person prior to mobilising. This had not consistently happened, meaning the person may have been in pain.

The service held a stock of homely remedies (medicines that can be purchased over the counter). However, we found that some of the medicines contained in this stock were prescription only medicines. The provider removed these during the inspection and made arrangements to replace them with appropriate stock as stated in the home's homely remedy policy.

The provider had made arrangements to store medicines in lockable trolleys but these were observed during the inspection to be left unattended with the key in the lock. Temperature records for the medicine fridge last been completed on the 11th March 2017. We asked a member of staff to confirm the current temperature but they were not able to as the thermometer was not working. When medicines are not stored at the correct temperature, they may not work properly.

The member of staff contacted the supplying pharmacy for advice, which was to dispose of the medicines in the fridge and request a replacement supply urgently, which the registered manager assured us they would do. This meant that people may have been at risk of receiving ineffective medicines from the fridge.

Risks associated with people's care were not assessed, identified or managed effectively to ensure they were supported safely. People's medicines were not always managed safely. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service was not kept clean and tidy or free from offensive odours to promote a pleasant living space. There was no attention to detail and domestic shift patterns meant at times care staff had to provide cleaning which they did not have time to do. On day one of the inspection there were three domestics on duty and one of these was until 6pm.On day two there were two, and on day three there were four until 3pm. We saw in the mornings that the accommodation areas were untidy as care workers were busy delivering care. We found a full catheter night bag in a toilet, bags lying around with soiled pads waiting for disposal, surfaces were not clean such as tables and window sills. Some commodes were dirty with faeces and left for at least two hours which created an odour in people's bedrooms and in the corridors. A relative told us they were not happy with the cleanliness, saying they had put up some pictures in their loved ones room three weeks ago and the drill dust was still there. At 3pm after lunch on each day of the inspection the dining room floor was dirty and covered with food crumbs. The district nurse had also noticed areas of dirty, soiled bags waiting for disposal in the corridors. We saw that the domestics finished their shift at 3pm each day and care staff did not have time to attend to any cleaning duties.

People's environment was not clean and free from offensive odour. This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff files showed that the relevant checks had taken place before a staff member commenced their employment. This included criminal record checks (DBS), gaps in employment and the service asked for at least two references including previous employer. This was to make sure potential new staff were safe to work with vulnerable people.

Inadequate

Is the service effective?

Our findings

The service was not providing effective care and put people at risk.

Although people had care plans detailing their needs, we did not see any care workers using them. The daily record was kept separately in people's rooms or with them in the lounge. This meant that care workers were writing their daily records with no reference to people's on-going needs. Care workers said they were not encouraged to enter the office and told to knock and wait. All daily records we looked at described tasks only. Care workers all told us they relied on their handover sheets. These were short summaries of each person printed out for each care worker. These did not give sufficient information to enable care workers to meet people's needs, putting them at risk. For example, the handover sheet did not include one person was receiving medication for nausea which was also not in their care plan. Another person was on an anti-depressive medication, also not recorded in their care plan or handover sheet. Another person was on a fork mashable diet to enable them to eat safely. The handover sheet said they just had their food cut up. Two people were described as anxious, one also had had a bereavement. There were no details as to how to manage this in the handover sheet, therefore no actions were recorded on their daily records about anxiety despite there being instructions in their care plan for regular chats with staff. These were not happening and we did not see staff with these people other than for tasks. Both spent most of the day in their rooms alone.

The provider and registered manager had failed to ensure people's continence was well managed. This had been raised recently in a safeguarding concern and the service had booked further training for care workers in catheter care and manual handling. The recent safeguarding concern had highlighted the incorrect securing of a catheter leg strap resulting in a sore area for one person. However, there were still concerns. Due to lack of staff care workers told us people were often found to be wet when they went to them. There was a lack of continence pads. Staff said they had not been ordered in time and now they did not have many. They said people could be sat on a wet pad for at least an hour at times. We asked the registered manager to go out and purchase some pads, which they did.

One person had a sore area noted on the handover sheet. Care workers told us the person was usually faecally incontinent on each transfer causing distress and embarrassment to the person. The handover sheet only said the person had cancer of the bowel which could cause incontinence and did not inform staff how to minimise distress. We found the bowel recording sheet had 14 day and 19 day gaps between recording and did not specify what type of bowel movement using the Bristol Bowel type chart. This was recommended by the Bowel and Bladder Nurse. The Bowel and Bladder Nurse told us they had recently trained care workers in this area. There was another chart with more recent dates completed but no type of bowel movement recorded. Therefore staff could not be sure of the bowel actions for this person to ensure they were receiving the appropriate care. By the third day of our inspection Bristol Bowel charts had been re-introduced to daily record folders for people who required monitoring.

There had been concerns about manual handling technique by care workers raised in the recent safeguarding concern showing that slide sheets had not been used to move a person. This had caused skin shearing. The district nurse said they had also had to ask for an urgent occupational health visit for another

person who had sustained a skin tear due to standaid use. The person was now using a hoist. They said staff had not related the skin tear to standaid use. Some people had frail skin prone to accidental skin tears. As there were not enough staff to monitor people at risk, we saw one person, mobilising unsupervised with a walking frame sustain a skin tear on their hand on a door during our inspection.

We could not be sure that health concerns identified were managed to completion. Short term health concerns were not commented on in the handover sheets. Care plans included 'prone to chest infections' and 'urine infections' and stated that care workers should ensure people were sat up or 'push fluids'. However, care workers did not read these. Health concerns were recorded in a separate 'working folder' in the office. However, these did not always record outcomes such as whether the chest infection or urine infection had resolved. One person had indigestion and their family had to bring in some medication. Staff did not know the person suffered from this. Care workers did not know what medication anyone was on if they were not involved in administering. One person had a fall recently and sustained a head wound. Night staff had called 111 for advice and placed a dressing over the wound. However, when the district nurse visited later they found the wound required suturing which staff had not identified.

Care workers provided regular assistance to people to change position and to reduce the risk of potential skin pressure damage. Fifteen people required regular assistance to enable them to change their position. Four people had a pressure sore and the district nurse said these seemed to be healing. However, where people had pressure sores and were receiving regular dressing and treatment from the district nurse, staff did not know the details of how to effectively manage these wounds. The district nurse had noticed that one person's foot was not always kept elevated. This was now on the handover sheet but care staff did not have any information about the wound under the dressing or how it was progressing. People had pressure relieving equipment in place but those using special mattresses required the settings to be monitored. The monitoring forms were incomplete and we could not be sure they were on the correct settings to minimise pressure damage. Staff said they used their judgement as the person's weight, which the mattress setting was based on. The correct setting was not recorded in the daily record folders and care workers did not have time to go to the office and check the person's care plan. One person told us they had asked staff to change their mattress setting as it was not hard enough.

People did not receive effective oral care, which put them at risk of developing related oral health problems. We looked at people's toothbrushes in all the rooms upstairs and found the people who required assistance with personal care either did not have a toothbrush or it was very dry and hard. When we asked two staff, they said they had been telling other staff that oral care was not being done and listed at least six people who had bad breath. We saw three people with particularly unpleasant mouths who had clearly not received oral care over our inspection. The district nurse also commented on this.

People were at a high risk of losing weight and not receiving sufficient nutrition. We identified at least 12 people at risk, due to their medical condition, mental health status or had already lost weight since admission to Greenhill. We looked at food and fluid charts for seven people in detail. These showed failings to ensure people received enough nutrition. Although fluids had been totalled by senior staff these figures were often below 1000mls in 24 hours and there was no guidance for staff showing people's optimum fluid target or what action they should take if they were concerned about the fluid intake. There was no analysis of food intake.

Nutrition records were lacking. Some people were not offered any food from 5pm until 10 or 11am the next day despite being identified as losing weight. Where people declined their meal there were no records of staff returning to offer food later meaning at times people had their last meal at 1pm. Staff said if it was not recorded then the person had not been offered. The July monthly quality and compliance monitoring audit

tool stated about one person, "[Person's name] is not having three meals a day and if they are asleep they are not being given any second chance to have food". This person had had a sudden weight loss and had been identified as being at risk of malnutrition. In the August audit tool it stated, "the eating and drinking care plan showed no change to this recognised need."

The chef made individual main meals and handed them to each care worker to give to people. They had a list and knew who was on what diet. However, there was no additional high calorie food available in between meals, snacks in the evening or finger food to encourage people, especially those at risk and living with dementia, to eat. There were also no lists of people's likes and dislikes in care plans or in the kitchen. The chef said they knew some items but would like more communication from care staff.

One person was unable to be weighed and had their weight calculated using arm measurements weekly. There were no instructions for staff to ensure this was done correctly or the same each time making the results ineffective. The GP had been informed of the person's low weight in March 2017 and advised to continue with the high calorie diet. However, the provider and registered manager had not audited these food and fluid records to ensure people were receiving sufficient nutrition or fluids in reality. We saw some people had not received sufficient nutrition and were at risk of malnutrition. For example, one person's weight records stated 'continue with high calorie diet' in March and again in June but their records showed their diet was minimal with just 'squash' after 5pm. On the first two days of our inspection, this person did not receive breakfast until 11 am or later. This was the same person with an impacted bowel. Some records showed staff offered regular drinks but some days showed large gaps between offers of drinks. Another person with diet controlled diabetes did not receive breakfast until 11am. Staff said the person had not had anything else to eat or been offered since the previous day. One staff member told us they had told the care staff this person needed to be assisted to get up earlier and the late breakfast had happened before.

The mealtime routine overall and how people received drinks was not effective due to lack of staff and organisation. Some people, especially those who required two care workers to assist them, or assistance with eating and drinking did not receive a drink until late morning. People were not able to have a drink or food when they wanted due to lack of adequate staffing levels. There was no early morning drinks round done by the night staff. This was confirmed by staff and people . Breakfast continued on the first two days until 11.45am. People were started being assisted to sit ready for lunch at 12.30. We took lunch with most people in the dining room. Meals were served at 1.15pm. This meant some people were left sitting at the dining tables for at least 45 minutes before receiving their meal, just waiting.

Due to people requiring assistance and support, lunch continued until nearly 3pm on the first two days of our inspection. This meant there was a lot of waiting for people, with minimal staff interaction as they were busy. At 3pm there was a tea round with cake when people had just finished their lunch and pudding. The last meal was at 5pm. There was a risk some people may refuse meals because they had only recently eaten and were not ready for their next meal. Failure to offer sufficient food and drinks at regular times throughout the day placed people at risk of malnutrition, dehydration, weight loss and other health related illnesses. Then night staff offered people drinks at random so some people got a drink and some did not.

People's risks associated with their health care were not managed effectively. People were at risk of not receiving adequate nutrition and hydration. This meant people were at risk of not having their needs met safely. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff training and induction was up to date and good but not always put into practice. Staff underwent a comprehensive induction process, including shadowing more experienced staff and classroom training.

Training was on-going and included refresher training following training in a wide range of topics which the provider felt were important. For example, safeguarding, health and safety, dementia care and manual handling.

We checked whether the provider was working within the principles of the Mental Capacity Act 2005 (MCA). The 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 take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). Staff clearly understood the importance of seeking people's consent and offering them choice about the care they received. Where people lacked capacity to make some decisions, the staff were clear about their responsibilities to follow the principles of the MCA when making decisions for people in their best interests.

People were not able to get up or go to bed when they wanted due to lack of adequate staffing. People were given simple choices such as what they would like to drink or what clothes to wear or where to sit. Therefore, although staff understood about enabling people's choice providing care in people's best interests they could not meet people's preferences due to lack of adequate staffing levels. Records showed that people's ability to consent to certain decisions had been assessed and best interest decisions made. These had involved the relevant individuals such as the person's family or a healthcare professional. There was clear information within these records to give staff guidance on how they needed to support people to make a number of different decisions about their daily lives. For example, bed rails and pressure alarm mats were used appropriately but staff did not read care plan information.

The premises were purpose built providing large spaces and communal areas. There was potential for the service to be a pleasant place to live if it was clean and utilised fully. Although few people were facilitated to use the garden, this was a secure, circular area with raised beds and a pond.

Inadequate

Is the service caring?

Our findings

The service was not caring. Although care staff were kind and chatted to people during tasks, people did not experience person centred, caring support. People and relatives said staff were lovely when they saw them but had to wait a lot. The management team mainly stayed in the office by the entrance and communicated with care staff by walkie talkie. These could be heard throughout the home and referred to people by room number. The team leader said this was for confidentiality but this did not create a caring atmosphere. Staff spoke of people in terms of numbers, 'doubles', feeds' and 'turns'. The shift leader 24 hour communication report also referred to people as 'rooms', "Rm 12 fall in Rm 14". Much of the communication was from walkie talkies loudly sounding whilst care staff were delivering care, often from their pocket at people's head height. There was also constant noise from call bells ringing or the walkie talkie telling staff to answer calls bells that had been ringing for at least 15 minutes at times. Care staff said they felt stressed as they were usually in the middle of assisting someone so they just turned off the call bell and said they would be back later. We witnessed this a number of times over the three days.

People had to wait long periods for any support depending on the routine of the home and where staff were up to with their tasks. People waited a long time for assistance with continence management for example. There was no way for people to alert or contact staff if they required support in the lounge. If a person declined assistance when asked, they could not rely on care staff to assist them later. We saw two people become incontinent in the lounge for this reason during the inspection.

People felt rushed or had to wait until staff were ready to help them. On all three days we heard people who did not want to/could not use the call bell, calling out for assistance. Most staff did not have a name badge so people did not know who to call for or who was on duty. One person was in bed wanting to get up and another on the toilet with the door open waiting for assistance. Another door was also open revealing a person with no lower half clothes on. The registered manager said this was the person's choice which is why they were upstairs at the end of the corridor so less people walking past the door. However, this person could have used a privacy screen or other methods to ensure they were warm and comfortable. Their daily records and food and fluid chart showed they were often 'left till last' by staff in the mornings for support.

All staff told us a regular list of people who were 'left till last' to get up because they required two staff to assist. Staff told us the same people often arrived in the dining room for breakfast at past 11 am. People were got up and 'brought' to the lounge. Staff gave breakfast when they had 'got people up' so people had to wait for staff to be available to assist with personal care before they were given breakfast. There was no formal drinks round in the morning so people received drinks randomly or if they asked. No-one was offered breakfast in bed or enabled to sit up in their rooms in the morning unless they had mental capacity to ask. Therefore, the routine was based on staffing levels and tasks to make it easier for staff not people's preferences. One care worker said, "It all goes wrong if someone wants to get up at the 'wrong' time." One person was lying unable to move in their bed at 9.30am. They told us they didn't want us to 'make a fuss' and ring the bell, staff would come eventually. The handover sheet said they liked to get up between 7 and 8am. Their food and fluid chart showed breakfast regularly between 9 and 10.30. They told us they often went to bed later than they wished as well. One person told us, "I say I don't want to go down but I go

anyway."

People who were able told us they often had to wait for a drink. We waited with one person for half an hour for their first morning drink at 9.30am. When it came with the kitchen porter who was allocated to assist with breakfast trays, the porter did not have help and did not ask care staff to assist the person either so could not assist the person to sit up so they ate their cereal almost lying down spilling milk. Staff told us there was a shortage of cups, mugs and saucers. This meant that people were using staff mugs from the kitchen and mugs advertising care agencies.

People had to wait for assistance to the toilet. One person and later their relative separately told us that they were very anxious, especially at night in case they needed help because they would have to wait. The handover sheet just said the person was continent with pads for comfort. The contact sheet in the 'working folder' said the person had bladder issues. On the third day of our inspection the person's relative said they were going to see the bladder nurse as the person always felt they wanted the toilet. Care workers told us they often found people wet with urine when they did their checks.

People often looked unkempt without their hair brushed or clothes kept clean. Staff said they did not have time to do a good job. One person had a 'crusty' eye after their wash. One relative was taking their loved one to change their skirt and said they often had stains on their clothes. Another person was left for an hour at breakfast with porridge down their clothes protector. Another relative said the staff did not always cover the person up and left food remains on their top.

Most people sat in the lounge/dining room where the TV was on. However, no-one appeared to be watching it or had been asked if they wanted to watch anything particular. The seating was not conducive to seeing or hearing the screen or was too far away and there were no subtitles. On many occasions staff were using the hoist or left wheelchairs and high tables in front of the screen.

People were not treated with dignity and respect. People's independence and autonomy was not always prompted. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person was receiving end of life care. Although, the registered manager said they were able to add additional staff to the shift to be with this person we saw the person left alone for long periods. End of life care plans were sparse and stated 'ensure [person's name]'s wishes are met but did not describe the wishes or any detail. Staff would not know people's end of life wishes or who had a treatment escalation plan (TEP) plan as they did not look in the care plans. This meant they would not know who wished to be resuscitated or not or how they wished to be cared for at the end of their life. The registered manager said they had organised training in the past by the local hospice but we could not see where this learning had been put into practice. The person's handover sheet said 'confirmed end of life care' with no further details.

People's end of life wishes were not always recorded. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

People did not receive a responsive service or receive care in a timely or person centred way. The routine each day was based on staff and task routines. Staff said if anything different happened such as someone wanting to get up at a different time, this put the routine back and so they were always playing 'catch up'. One person told us, "I don't get a shower regularly, staff get pinched. I'm still waiting, there's not enough time."

We did not see staff spending any time with people other than for tasks. Staff said they did not have time to sit or chat with people and clearly they found this upsetting. They told us, "I can't remember the last time I properly talked to someone. We can only write tasks in the daily records as that's all we do", "There's a big activity gap, the carers have no input, there is nothing after 4pm, weekends or holidays. [Person's name] loves a walk but there is no time." There were various communal areas in the home but only the lounge and dining room was used and people's bedrooms. Some people were able to choose to stay in their rooms but staff said most people were 'brought to' the lounge for staff convenience so they could see where people were. However, this was also not effective. Staff said there were lots of people who could be offered breakfast or time in their rooms and this had been fed back to the registered manager. However, the routine had remained the same and staff did not offer choices other than where would people like to sit.

Due to the inadequate staffing levels and poor daily organisation people were not able to enjoy regular social and leisure time. The activity co-ordinator worked 18 hours a week but in practice this was 8-11.30am assisting with breakfast and then an hour doing activities before lunch. They tried to provide some activities and had organised flower arranging, bingo and games, word quizzes, a gardening club, cooking and cake decorating in the past. During our inspection we saw a word game and flower arranging. However, this only was able to include around five people for a short amount of time. Records were not kept individually of activities people took part in. Daily records showed very little evidence of any activities.

Care plans contained useful information about people's lives and hobbies but these were not used to inform the provision of activities. One person had a pile of their own books with them but no-one else had access to any reading material. Two comfortable communal areas, a lounge upstairs and a downstairs activity room with a piano were available. However, these books and activity items were not used by staff. The downstairs lounge looking onto the garden was used for staff meetings and storage. The tea tray from the second day of our inspection was still present in this room on two days later. We saw people using the lovely garden and seating area but only with relatives or visitors or if one person was able to find a free staff member to have a cigarette with. Otherwise people went from room to lounge/diner, toilet and back again without any meaningful stimulation.

The activities co-ordinator said they did not get a break most days so by the time lunch had finished it was 3pm and then went home by 4 or a bit earlier if no break. This gave no time for meeting people's social and leisure needs or ensured people received regular stimulation and engagement. One relative told us their loved one had been alone in the dining room at 7.30pm the night before which had upset their son. We had also seen this person sat alone at a dining table for at least an hour. They had no stimulation and some

degree of dementia, unable to mobilise independently in their wheelchair. They were touching the tablecloth and place mats as sensory aids. At lunch time, people did not know what meal was being served. There were no condiments offered until we asked for some. The pictorial menu board remained the same breakfast pictures throughout our inspection. Staff said this had been the same for many months. There were no menus on the table or written anywhere.

Throughout the inspection we saw people sitting in the same chair all day, sat at tables alone for long periods or in their rooms alone for long periods. Two people in their rooms had particular needs shown in their care plans under 'emotional needs'. They were assessed as needing regular visits form staff due to anxiety and a bereavement. One care plan said, "A chat and a hot chocolate is all it takes to make me feel myself." We saw they sometimes had a hot chocolate but they told us no-one came to chat to them. One senior care worker found this upsetting as they knew their bereavement anniversary was coming up. Their daily record showed no evidence of any staff chats. The other person was known to be anxious and becoming breathless. We sat with them for half an hour. They said they were lonely. They sat in their room with the door shut for a long time with no stimulation in a chair that did not face the television and the television did not work. Their automatic door closer was faulty and did not enable the door to remain open if the person wanted this. This meant the person was isolated in their room as they were unable to see staff or other people passing their door The closer gave off a regular alarm which indicated the battery was flat. Another person said they felt guilty going out with their family as they knew the other person was lonely so they sat with them at lunchtime.

The handover sheet said one person 'suffers with anxiety and requires lots of company and TLC'. We sat with this person for some time and they said they had had no real company all day. Another person living with dementia sat in their chair in the lounge from 10am until at least 3pm. They appeared anxious during our inspection. Staff were unable to spend time with them despite their care plan stating, "Loves arts and crafts and loves to paint which often calms her down when she is anxious." Their care plan also said they got agitated when there was too much noise and being rushed could be upsetting. Two people were shouting out next to them for help in an unsupervised lounge on day two of our inspection. The records showed that this person often tried to leave the area to find somewhere quieter. This placed them at risk of falls if staff were unavailable to help them. This person was found outside unsupervised at night recently.

People's care records did not always record how their needs should be met, and did not always detail people's wishes and preferences or encourage staff to use this information in practice. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The operational monthly meeting noted that formal complaints were low and there was a policy to follow. However, relatives said they had raised issues verbally about staffing and cleanliness but nothing had happened. We asked for a summary of recent complaints but did not receive one.

Inadequate

Is the service well-led?

Our findings

The service was not well led. Guinness Care and Support is part of the Guinness Partnership whose main business is building and managing homes and housing services . Their vision set out on their website states: We define ourselves as a customer service business. Building homes that meet a range of housing need is still fundamental to our purpose, but the experience our housing and care customers have is just as important. Greenhill is described as having excellent facilities and standards of care; "Our care homes are comfortable places to live and each have 24-hour support and personal care. Greenhill was purpose built to meet the needs of older people. It's been designed with larger corridors and doorways to ensure it is fully accessible for the residents who live there".

We found significant failings across all domains during our inspection and that the provider had failed to deliver "an amazing service to our customers" as part of the Guinness vision. In May 2015 our inspection found that the service was rated as 'Inadequate' overall. The domains of effective, caring and responsive 'required improvement'. There were concerns relating to people not being treated with dignity and respect, people not being protected from unsafe care and treatment, nutrition and hydration needs not being met and lack of action to ensure the quality and safety of the service improved. The service was put into special measures, meaning that we kept the service under review and inspected again in January 2016. At that inspection we found actions had been taken to address all the shortcomings identified at the May 2015 inspection. However, we were unable to judge well led domain as good because the actions taken to ensure people received well-led care had not been in place long enough to ensure they were applied consistently and over time. During this inspection in October 2017 we found that improvements had not been sustained over time and that some areas of failings were as found in 2015.

Staff told there was very low staff morale. They all said they really cared about the people in their care. They said, "We just want some support, there is so much to do", "We are spoken to like nothing" and "I would love to see the registered manager and team leader do a shift on the floor. We have said we need more staff at every meeting." Other staff said, "I've stopped care work as it's too much", "The team leader is not supportive and abrupt, it's not nice in the office. I'm sweating, office staff get coffee and don't help". One care worker was visibly upset and said, "[Person's name] wanted to go out today. I had no time. The management just crack the whip. We do what we can." Another care worker was also visibly upset and said, "It's the worst two years of my life. No break yesterday and 20 minutes today. I needed to change a shift but the team leader had no time for me." We saw no evidence of community links or outings for people other than external entertainers booked regularly.

There was a high level of sickness. This was being managed using the company policy with return to work interviews. However, we heard from staff who told us they felt they could not keep on working at the service much longer as they did not feel cared for and were not going off sick on purpose. The activity co-ordinator said they had commented in the safeguarding section during their supervision that there was a risk in the lounge/dining room because they could not supervise people safely on their own. We saw this recorded but no actions taken.

Staff said communication was poor and they did not feel listened to by the management team. They did not read care plans and said they had been told to come in on their days off to read them so they did not. Few staff had signed to say they had read the care plans and those that had were some time ago. Care staff said they had had training recently about how to write records but this was not useful as they could only write tasks and daily records did not reflect any identified individual care plan needs. For example, for people at risk of pressure damage, recurrent chest or urine infection or isolation there was no mention of this in their daily records.

Staff felt they were not encouraged to go in the office. One care worker said they had been made to wait a long time, another said they had been shouted at for not knocking. Another care worker asked the team leader if they could go for a break and was told to ask the senior which took so long they did not get a break. All care staff on the first and second days of our inspection did not get the breaks they were entitled to or were not able to get a drink until very late. On the third day following the provision of additional staff by the provider we saw care staff taking a break and the atmosphere was calmer.

The management team did not attend the shift handovers but received handover from the senior. They also used a shift leader 24 hour communication report. This showed which staff were on duty, admissions, deaths, falls, health and safety checks and visits planned and was brief. It also showed if staff had completed daily monitoring checks 'all checked no issues'. This meant that there was a lot of passing of information and reliance on handover sheets, verbal information and acceptance by management that all checks had been completed. For example, 'turns', night checks and food and fluid charts had been completed but not effectively analysed to ensure people were having their needs met. Staff did not feel they had the information they needed to provide care for individuals. We saw examples of where care plans did not contain adequate information and where the handover sheet did not include important information.

Staff said they did not feel valued or part of a team. They said they were not thanked and we did not see this during our inspection. 'Walkie talkies' were used frequently to tell staff going about their tasks to hurry up and answer a call bell. We were with staff when this happened and saw they were in the middle of another task. Care staff said the management rarely offered to assist or answer a call bell themselves even if it was nearer the office. People, staff and relatives told us the management team rarely came out of the office and sometimes took their lunch whilst staff were struggling to meet people's needs in the lounge/dining room. During our inspection the registered manager and team leader came to assist in the dining room. Following the meal period staff and a relative came to tell us they had not seen that happen before.

There were quality assurance processes in place and audits were being undertaken, for example looking at people's weights, falls risk and care plan reviews. However, these were not effective and had not identified the concerns we found or looked at the service provision to ensure people were safe and their needs met. People's care records were not an accurate record. This meant staff did not have the correct information to meet people's needs safely and/or in line with their wishes and preferences. People's care records did not always record the decisions taken in relation to their care and treatment. The registered manager said they sent falls details to head office monthly. There were 23 falls in September 2017. Each falls report described the circumstances and what action had been taken. Actions taken appeared appropriate such as updating risk assessments and prevention plans and informing health professionals. However, the wording and circumstances of some of the falls, as all people living at the home were at high risk of falls, indicated prevention measures were not always being followed or being effective. For example, in September individual falls reports stated; person found on floor, staff heard shouting twice, visitors reported a fall twice, another person reported a fall to staff, staff heard shouting three times and staff heard a thud.

The registered manager provided us with copies of medication audits that they carried out each month.

These did not identify any of the issues that we found and did not look at the storage arrangements of medicines but concentrated on gaps in recording on the MAR charts. The medicines policy that the registered manager gave us stated that it was due to be reviewed on March 2017 and July 2017. This had not been undertaken.

The Head of Quality and Compliance completed monthly provider checks at the home. A report of findings was sent to the registered manager. We looked at reports from May to August 2017. These highlighted areas that we also raised during this inspection in October 2017. For example, that daily notes should include interactions. Staff said, and we saw there was no time for interactions to record. Issues also included, tables should made attractive with condiments and menus should be in place. This had not happened. Weights were recorded as needing to be audited regularly; these were recorded but no action to check people were receiving adequate diet in practice. As we found also, those people who could not be weighed and having arm measurements had inconsistent and ineffective recording and measuring. This was also the case for people needing high calorie diets, people had been identified as being at risk but in practice their care plan was not being followed. It was noticed that people were referred to as room numbers. There was discussion about staffing levels but not in relation to people's high level of need in detail. A comment was made about people receiving breakfast late and 'some near misses with customers being found outside the rear kitchen' outside. One person was particularly described as a frequent faller, we saw this person unsupervised in the lounge on more than one occasion despite the report saying their care plan needed updated as a matter of urgency.

Additional comments noted in the monthly provider quality monitoring reports included, ensuring all staff signed to say they had read care plans, a person's 4kg weight loss had been reported to the GP and another person's 3kg over two months weight loss had not been well managed. Food and fluid charts were not related to the weight loss in practice. A comment said nutrition was not monitored well, someone had not had breakfast until 11am, a person with diabetes had been missed for breakfast and records were ineffective or incomplete. One comment said a person was not having their medication with food as prescribed and not having three meals a day as food was not being re-offered if asleep. Room checks were noted to be poor. There were also various comments relating to medication errors, mainly relating to 'as required' medication, drug rounds taking a long time and senior staff not completing medication audits.

Comments had been raised by staff about lack of staffing and the response had been, 'this is not a budget management issue to get more staff but to review and consider the deployment of staff'. Some actions had been taken to look at deployment of staff such as some staff commencing a shift earlier. Staff were given opportunities to discuss any issues within supervision sessions and regular meetings but they did not feel listened to because there were no actions taken. People and relatives were also given opportunities to give feedback through an annual satisfaction survey. The last survey results from 2016 were displayed outside the office. They showed the findings and what the service were going to improve upon. However, although the poster said there was 100% satisfaction the comments and improvements to work on highlighted areas such as, Lack of staff is difficult at meal times, need for more activities for people who are in bed a lot of the time, more mature staff who don't have to be told about things that need doing, not always having to ask for a bath and having bed changed and access at the entrance door being at times very slow. We did not see that any of these issues had been addressed in practice.

Therefore, although some of the issues we had found during this inspection in October 2017 were also identified through the provider's quality assurance systems, the provider had failed to ensure the issues were addressed in a timely manner to keep people safe. Therefore, people remained at risk of harm.

There were also monthly manager's meetings and a monthly operational board meeting. These minutes

from September 2017 discussed staff describing the service as 'unsafe' and questioned the need for so many checks for people saying, 'what are we checking for'. However, people's practical high dependencies had not been recognised. There was a high staff sickness noted but no discussion about why staff were going off sick in high numbers. Staff were described as, 'not appearing to be doing what is asked of them' and catheter care was used as an example. A decision was made by the service at this time not to accept further admissions.

There was a lack of effective governance arrangements to ensure people received effective, safe and good quality care. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.