Runwood Homes Limited

Greenbanks

Inspection report

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02 June 2023

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Greenbanks is a residential care home providing personal care to up to 66 people. The service provides support to older people, some of whom may be living with dementia. At the time of our inspection there were 56 people using the service.

People's experience of using this service and what we found
People's records did not always contain all the information staff needed to provide safe care and their medicines were not always managed well. Staff did not always report safeguarding concerns and we did not see any evidence of learning from incidents. Staff had not always been recruited safely. People were not always supported by enough staff.

People were not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests. People were not always supported by staff with the necessary skills.

The provider's processes to monitor the safety and quality of the service were not effective.
Some staff were not always open and honest when mistakes were made.

The new leadership team had a good understanding of the issues with the service and had plans to rectify them. Staff found the interim manager approachable and supportive. People's families were kept informed and spoke positively about the care received.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 21 October 2022). The service remains rated requires improvement. This service has been rated requires improvement for the last three consecutive inspections.

Why we inspected
We received concerns in relation to the management of medicines and oversight of the service. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has remained requires improvement based on the findings of this inspection.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Greenbanks on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have identified breaches in relation to safeguarding, management of risk and medicines, staff recruitment and competency, consent and governance at this inspection.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Greenbanks

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
The inspection was completed by two 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 care service.

Service and service type
Greenbanks is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Greenbanks is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. A new manager had been recruited but they were not yet in post. There was an interim manager and handover arrangements planned.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 22 May 2023 and ended on 2 June 2023 We visited the location's service on 22 and 31 May 2023.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 3 people who used the service and 13 relatives about their experience of the care provided. We spoke with 12 members of staff including the regional director, interim manager, deputy manager, care team leaders and care staff. We reviewed 12 people's care files and 3 staff personnel files. We also reviewed records relating to managing the service.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question requires improvement. At this inspection the rating has remained requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Using medicines safely

- People's care files did not always include all information staff needed to provider safe care. For example, one person's mobility care plan described what to do if they had a seizure, but there was no risk assessment, or any other information related to this in their file. This meant there was a risk staff would not know what to do; staff we spoke with were unaware of anyone at risk of seizures.
- The provider had not ensured risks associated with poor hydration and nutrition were managed well. We reviewed a person's care record which described a choking incident but there was no risk assessment or referral to the Speech and Language Therapy (SALT) team.
- Staff did not always support people to mobilise safely. We observed staff assist a person from wheelchair to armchair without putting the brakes on the wheelchair. They stood behind the wheelchair and bent over it to steady the person. This was not good practice.
- Staff did not always complete risk assessment tools correctly and reviews were not robust. One person had a nutrition care plan which did not include updated information following a hospital appointment. We found monthly risk assessment reviews often stated, 'no change'. This meant we were not assured reviews were thorough.
- People's monitoring charts were not always completed or had unclear information. For example, a re-positioning chart for one person said 'chair' at each entry, suggesting they had not been re-positioned.
- People's medicines were not always managed safely. During our inspection we observed staff interrupted by the telephone and visitors during the medicines round. Staff did not watch people take their medicines before signing the Medicines Administration Record (MAR) and moving on to the next person. This meant there was a risk the person may not take them.
- Staff had not completed the controlled medicines book correctly. These were meant to be audited weekly, but this was not evidenced consistently. Therefore, there was a risk any errors made were not identified.

Information about risks to people was not always complete and medicines were not always managed well. This was a breach of regulation 12 (Safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff we spoke with were aware of risks to people. For example, they were able to tell us who required re-positioning and the frequency of this as well as who were at risk of falls. A member of staff said "[Person] has falls. Someone will always be with them." A relative told us, "They understand [person's] needs."
- Staff were receiving training in care planning from the local authority. All care plans and risk assessments were being reviewed; senior staff were given time to complete these as additional shifts. They would then be audited by the managers.

● The interim manager had implemented a medicines 'gap form' for staff to complete at each shift. This was in response to allegations prior to the inspection of medicines records being completed retrospectively where errors had occurred.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● The service had eleven open safeguarding investigations at the time of the inspection. Nine of these related to allegations about the management of medicines. The provider's original investigation into these had not been robust; they completed a further report which found medicines records had been completed retrospectively. Actions taken included further training for staff.
● Staff lacked understanding of unexplained injuries as safeguarding concerns. We saw in people's records staff had documented where bruises or skin tears were found but these were not reported. We queried this with the interim manager who agreed it was clear staff filled in the paperwork but did not escalate the concerns; we were told this would be fed back to staff at the daily flash meeting.
● Staff received training in safeguarding. However, nine staff were overdue refresher training; we saw email confirmation this had been booked. A member of staff said, "I would report it if people were not looked after properly." However, they described an occasion where they had reported a concern to the previous manager, and this had been ignored. We fed this back to the provider who were investigating.
● The interim manager had identified safeguarding referrals were not made promptly. We saw this had been addressed during supervision with staff who made the referrals.

Staff did not always identify and report safeguarding concerns. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The interim manager told us investigations were completed following incidents and safeguarding concerns and learning shared with staff via a lessons learnt file. Staff we spoke with could not always describe recent incidents; they told us if anything happened, they would be informed at handover. Following the inspection, the interim manager told us they would implement an evidence sheet for staff to sign to confirm they had read and understood the lessons learned.

Staffing and recruitment
● The provider had not ensured staff were recruited safely. We reviewed three records and found none had evidence of full employment history or discussion to explain this at interview. One member of staff's Disclosure and Barring Service (DBS) check was dated three months after they started work. DBS checks provide information including details about convictions and cautions held on the Police National Computer and help employers make safer recruitment decisions.
● The provider had not ensured staff recruited from overseas had an acceptable level of English. Staff are required to meet level B1 in the Common European Framework of Reference (CEFR); we saw no evidence of this in staff files and there were concerns about the quality of some staff's English.

Staff had started work prior to receipt of DBS and full employment history was not always obtained. This was a breach of regulation 19 (Fit and proper persons employed) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The interim manager had identified issues with staff files prior to the inspection and requested the provider's HR team completed an audit. Actions were ongoing to address the findings. For example, where gaps were found in staff employment history, risk assessments were completed and awaiting sign off.
● The provider had not ensured there were always enough staff to provide safe care. Staffing levels were met

as per the planned rota, but we did not see evidence of how they were calculated to ensure people's needs were met. There was not a full-time receptionist and we saw during our visit this had an impact on care staff's time as they would have to answer the door and telephone. A relative told us, "We never recognize staff on the weekends. Sometimes nobody was at the reception on the weekends."

● People's families told us there were not always enough staff. During our visit, interactions between staff and people tended to be task related; there was little activity or social interaction. A relative told us, "There is never enough staff, there is limited staff on the weekend, not as many as on the weekdays."

● The interim manager had reviewed staffing levels and identified additional support staff required. This had not been implemented at the time of the inspection. However, we were told the provider was agreeable to what was needed. Agency staff were not used.

Preventing and controlling infection

● We were somewhat assured the provider was promoting safety through the layout and hygiene practices of the premises. There was a malodour throughout the home, and we did not see evidence of a cleaning schedule to support effective management of continence. However, during both days we saw staff cleaning throughout the building.

● We were somewhat assured the provider was admitting people safely to the service. At the time of the inspection the service were not accepting new admissions. However, there was an admissions checklist to follow when they did.

● We were somewhat assured the provider was using PPE effectively and safely. We found some PPE stations were empty or did not have gloves in all sizes. However, these were replenished during our visit, and we observed staff using appropriate PPE.

● We were assured the provider was preventing visitors from catching and spreading infections.

● We were assured the provider was supporting people living at the service to minimise the spread of infection.

● We were assured that the provider's infection prevention and control policy was up to date.

● The service supported visits from people's relatives and professionals in line with current guidance.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
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 MCA 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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.
- The provider had not ensured applications were made when people were deprived of their liberty. A person had 1-1 support from staff at all times and 30-minute monitoring was documented. This meant the person had constant supervision, but approval had not been sought for this.
- Staff lacked understanding in MCA and DoLS. Some people had gates across their bedrooms; these were at the request of relatives due to a resident who would go into other people's rooms. An expired DoLS described this being at the request of the person, but it was unclear whether this person could make their wishes known. This meant we were not assured people were supported in the least restrictive way.

Consent had not been obtained in line with legislation and guidance. This was a breach of regulation 11 (Need for consent) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The interim manager told us they spoke to relatives following the inspection and removed the gates. They were aware a review was required to ensure all residents had the relevant documentation related to MCA, best interests decisions and DoLS.
- Staff received training in MCA and DoLS via eLearning. The interim manager had requested face to face training from the local authority to improve staff understanding.

Staff support: induction, training, skills and experience
- The provider had not ensured staff were competent for their roles. Staff did not receive competency

assessments for moving and handling and we observed poor practice during our inspection. We reviewed staff medicines competency assessments and found some identified areas where staff would benefit from further training, but we saw no evidence this was arranged. This meant we were not assured the competency assessment process was robust.

● Staff told us the level of spoken English among some staff made communication difficult. A member of staff said, "You explain something and are forever checking and asking if they have done something and they just look at you. Some people just don't understand what you are saying. We need people who understand English better." Another staff member said, "Sometimes there's a barrier there. Some of these residents don't understand. We need more people who speak good English."

● Staff mandatory training compliance for some staff was very low. The interim manager had sent reminder letters to staff with a deadline of 7 days to complete. Some bank staff were no longer offered shifts as they were non-compliant with training.

Staff did not always have the required skills for their role. This was a breach of regulation 18 (Staffing) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The interim manager had considered having champions in moving and handling to complete spot checks. Training would be required for this; in the meantime, they planned to arrange for staff from another service to do them.

● The interim manager confirmed staff understanding following team meetings by asking individuals to confirm what had been said. They also observed staff on the care floor. Staff had been told not to speak in their own language on the care floor, but if they needed to clarify they had understood they were to speak with someone who could translate in another room; the rotas were managed to ensure there was always staff available to translate.

● The regional manager had sourced English lessons to support those staff and told us they felt staff were aware they were difficult to understand and made efforts to aid communication by, for example, bending down to the residents and speaking more slowly.

● Staff were booked for additional training; courses had been arranged in pressure ulcer prevention, behaviour which may challenge and infection prevention control.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● People had not always received a robust assessment of their needs prior to admission to the home. Some people had mental health needs which meant they were not suitable for the home; efforts were being made for these people to move on. At the time of the inspection, the service had voluntarily stopped new admissions and a new process had been implemented for when this re-started. This was very detailed to confirm the needs of people could be met.

● A person who appeared to be cared for in bed had a monitoring chart with entries which said 'up'. Staff said sometimes the person liked to get up. We queried this as there was no hoist or sling in the room; they then told us the person did not get up. The reason for this was unclear; no capacity assessment had been completed. We fed this back to the interim manager to look into. They told us they thought everyone had the equipment needed but planned to implement a register to confirm this.

● People's protected characteristics such as nationality and religion were recorded in care plans.

Adapting service, design, decoration to meet people's needs

● The service was not well maintained. The décor in people's rooms was basic. We saw some scratches to walls and dirty lounge chairs. There was an unpleasant odour throughout the home and some rooms were cluttered.

● The interim manager had identified issues with the environment prior to our inspection and actions to

improve it were ongoing. A lot of clutter had been removed. The facilities team had visited and there were plans to remove/replace mismatched furniture, flooring, ceiling etc and improve the décor of the home and garden.

● Staff did not always ensure doors were locked as required. Ongoing maintenance work around the home meant files were in different places. For example, a linen cupboard was unlocked, and people's daily observation records were stored there.

Supporting people to eat and drink enough to maintain a balanced diet

● People's dining room experience was task oriented. There was no interaction from staff other than offering a choice of meals and encouragement to eat. However, staff ensured people understood the choices available by holding out the two meals available to aid understanding. We observed staff offering verbal encouragement for people to eat independently.

● The interim manager had identified weight loss reporting was not being completed correctly. People were not a concern if the amount of weight lost was maintained the following month. The interim manager fed back they should consider fortifying diets and refer to the GP if weight loss continued. The regional hospitality team were providing support for the kitchen to improve the dining room experience.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● People were supported to access appropriate healthcare support when needed. A relative told us, "[Person] has access to a chiropodist."

● People's care plans contained information about who was involved in supporting their healthcare needs. We saw visits from other professionals such as the GP were recorded in their files.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Working in partnership with others

At our last inspection the provider's quality assurance systems and processes were not always effectively used to assess, monitor and improve the quality and safety of the service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- The provider's processes to monitor the quality and safety of the service were not effective. Audits were not always completed. We did not see evidence of medicines audits prior to April 2023. The April 2023 audit was completed with some issues identified but no action plan. A weekly audit completed in May 2023 did not identify the issues we found during the inspection.
- The interim manager had completed a falls audit. This identified trends such as where and when most falls were occurring, but no evidence of action taken to address this.
- The provider had not ensured staff were aware of incidents and lessons learned. We reviewed an incident report and found the actions were not always relevant and appeared to have been copied and pasted from other incidents. We did not see any evidence of analysis of incidents to identify themes. A relative told us, "We don't think they do any investigation because [person] had another fall after a few days."
- The provider had not ensured people's care plans and risk assessments were completed correctly. The audits we reviewed lacked detail, therefore we were not assured there was oversight to ensure people's needs were met. There were no audits of monitoring charts, meaning the issues we found had not been identified.
- The provider did not have oversight of MCA and DoLS. There was a tracker of applications made but no evidence these had been followed up or reviewed and notifications were not always submitted to CQC when DoLS were approved.

The provider's quality assurance systems and processes were not always effectively used to assess, monitor and improve the quality and safety of the service. This was a continued breach of regulation 17 (Good governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service did not have a registered manager at the time of our inspection. However, a manager had been recruited who would apply to be registered with CQC. There were plans for the new manager to have a handover from the interim manager in the following month.
● The interim manager was aware people's records needed to be reviewed. Staff were receiving training in care planning and all people's records were being updated. The aim was for these to be completed within the month.
● The regional manager told us the provider had a process called 'helping hands' whereby managers from other services visit to do a thorough audit of all aspects such as medicines and infection prevention and control. This would be requested when they had made planned improvements as an additional check.
● The provider had a process to check compliance. This involved a monthly visit from the regional manager who would review some residents and staff files. This process had not been followed recently. They were aware of the issues and, once addressed, these compliance visits would resume for ongoing monitoring of the service. The regional manager told us, "We [regional manager and interim manager] have been so open with families, the local authority and CQC. We know where we are, admitting failings and have robust plans to fix them."
● The interim manager was working well with other professionals to improve the service.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The service had not always been open and honest when things went wrong. There was a lack of transparency from some staff and a tendency to complete records retrospectively and not report errors.
● People were not always supported with person-centred activities. There were group activities in the mornings and 1-1 in the afternoon. During the inspection we observed staff playing a game with people; however, they left part way through, and people struggled to continue without support. A relative said, "We told them more entertainment is needed on the weekends." Another relative told us, "I wish sometimes they gave more time to [person] and just listened to them."
● The interim manager had requested a detailed program from the activities co-ordinator and there were plans to use an external company for support with more activities. They also planned to relaunch 'tools down', to give staff time to spend with residents.
● The interim manager felt supported by the provider, who had been responsive to what was required to improve the home and told us staff were receptive to change. They said, "I've not had any push back from staff, they are eager and want to do well and get it right, they are not uncaring."
● Staff felt supported by the interim manager. A member of staff said, "[Manager] supports us more. I feel more happy to ask for help. It's different now. New manager is very good, there to listen."
● People's relatives gave positive feedback about the culture of the service. A relative told us, "The care staff are quite kind and helpful." Another relative told us, "The care staff are friendly and approachable. We are happy with the service."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Staff attended team meetings. A member of staff told us, "I felt better yesterday after the meeting where we were told to move on and support each other." Daily flash meetings were also held with staff to re-iterate key messages.
● People's relatives felt informed by the service. They had attended a meeting with the interim manager and told us they received updates by telephone. One said, "We had a meeting last week. As far as I know, a lot of things are happening with the new management." Another relative told us, "They phone me all the time if there are any changes or if [person] is having any treatment."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Consent had not been obtained in line with legislation and guidance

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Information about risks to people was not always complete and medicines were not always managed well.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Staff did not always identify and report safeguarding concerns.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's quality assurance systems and processes were not always effectively used to assess, monitor and improve the quality and safety of the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 19 HSCA RA Regulations 2014 Fit and

personal care	proper persons employed Staff had started work prior to receipt of DBS and full employment history was not always obtained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not always have the required skills for their role.