Staffordshire Care Limited

Thelwall Grange Care Home

Inspection report

Weaste Lane
Thelwall
Warrington
WA4 3JJ

Tel: 01925756373

Date of inspection visit:
25 August 2021
02 September 2021

Date of publication:
02 November 2021

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Thelwall Grange is a care home providing accommodation, and personal care for up to 47 younger and older adults; some of whom lived with dementia and physical disabilities. At the time of the inspection 47 people were using the service.

People's experience of using this service and what we found
Systems and processes to safeguard people from the risk of abuse were not followed. Staff and managers had failed to raise safeguarding concerns when people had been placed at risk from harm and abuse.

Lessons were not learnt, and improvements made when things went wrong within the service. Appropriate action was not taken in response to incidents which occurred at the service and there was a failure to follow disciplinary procedures and address staff performance.

There was a failure to promote a positive culture within the service. The provider resisted information sharing and engagement with stakeholder organisations who were working to keep people safe. There was a culture of staff not reporting concerns which placed people at risk of harm and abuse. Staff told us they didn't feel confident in raising concerns directly with the provider or managers.

We were assured that Infection prevention and control measures were followed to minimise the risk of the spread of infection, including those related to COVID-19.

Medicines were managed safely. Medication administration records (MARs) were completed with up to date information about people's prescribed medicines and when they were given.

The recruitment of staff was safe. A range of pre- employment checks were carried out on applicants to assess their fitness and suitability for the role.

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 good (published 12 June 2021).
You can read the report from our last inspection, by selecting the 'all reports' link for Thelwall Grange Care Home on our website at www.cqc.org.uk.

Why we inspected
We received concerns in relation to people's safety and the leadership of the service. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

Our report is only based on the findings in those areas at this inspection. The ratings from the previous

inspection for the effective, caring and responsive key questions were not looked at during this visit. We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used to calculate the overall rating at this inspection.

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.

The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection.

We have identified breaches in relation to safeguarding people from the risk of abuse and harm and the governance of the service. Please see the safe and well-led sections of this full report.

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

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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Thelwall Grange Care Home

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 Care Act 2014.

Inspection team
The inspection visit was carried out by two inspectors and an inspection manager.

Service and service type
Thelwall Grange is a care home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
The inspection was unannounced.

Inspection activity started on 25 August 2021 and ended on 02 September 2021. We visited the service on 25 August 2021.

What we did before the inspection
We reviewed the information we received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used all of this information to plan our inspection.

During the inspection
We spoke with five people who used the service about their experiences of the care provided. We also spoke

with the registered manager and deputy manager. We reviewed a range of records. This included people's care records and a sample of medication records. We looked at safeguarding and incident and accident records and the recruitment records for one staff member employed since the last inspection.

After the inspection visit
Due to the impact of the COVID-19 pandemic we limited the time we spent on site. We reviewed records and documentation sent to us following the inspection visit and spoke over the telephone with seven staff members including care workers and ancillary staff.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- Systems and processes to safeguard people from the risk of abuse were not followed.
- We found examples where staff had failed to raise safeguarding concerns immediately when people had been placed at risk from harm and abuse. There was a significant time delay in staff telling managers about concerns. The culture of the home had not enabled the staff to feel able to report the concerns.
- The provider was obstructive by not engaging with social workers who investigated safeguarding concerns.
- A do not attempt cardiopulmonary resuscitation (DNACPR) in place for one person. This had not been put in place in accordance with the guidance. The DNACPR decision was put in place for the person during a stay in hospital. However, the decision had not been reviewed with the involvement of the person deemed as having capacity, or their GP on their return to the service from hospital.

The provider and registered manager had failed to ensure people were safeguarded from the risk of abuse. 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.

Learning lessons when things go wrong: Assessing risk, safety monitoring and management

- There was a failure on behalf of the provider to acknowledge, learn and make improvements when things went wrong within the service. When engaging with partner organisations the provider had been defensive and obstructive.
- Learning had not taken place following disciplinary investigations and procedures and staff performance had not always been addressed and dealt with appropriately.
- Risks to people were assessed and risk management plans put in place to minimise the risk of harm. However, risk management plans for people at risk of falls were not always followed.
- Sensor mats in place for two people assessed as being at high risk of falls were not safely managed. The mat for one person was unplugged whilst they were in bed and the mat for another person also in bed failed to activate when tested. A member of staff made several attempts to activate the mat before it worked.

The provider and registered manager had failed to assess, monitor and improve the quality and safety of the service being provided to service users. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- The service was struggling to maintain staffing levels. The registered manager told us this was due to an

increase in staff sickness and because several staff had chosen to leave following recent investigations.
● We received mixed feedback from staff about staffing levels, with some staff telling us there were occasions when they were short staffed due to staff calling in sick at short notice. However other staff told us almost every shift they worked was understaffed due to staff sickness and staff not being replaced. Some staff commented that staff shortages caused them stress because they were unable to give people all the care they needed.
● Safe recruitment procedures were followed for the one staff member recruited since the last inspection.

Preventing and controlling infection
● We were assured that good practice was followed to prevent and control the spread of infection, including those related to COVID-19.
● Cleaning schedules were in place and followed. Cleaning of high touch areas had improved since the last inspection.
● Staff had access to current IPC guidance, and they were provided with a good supply of PPE which they used and disposed of appropriately.

Using medicines safely
● Medicines were used safely.
● Medication administration records (MARs) were completed with information about people's prescribed medicines including how they were to be used and when they were given.
● Protocols were in place and records maintained for the use of medicines prescribed to be given 'as and when required' known as PRN.

Inadequate

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 the last inspection this key question was rated as good. At this inspection this key question has deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The provider operated a closed culture within the service and resisted information sharing and engagement with stakeholder organisations. There was a lack of partnership working with stakeholder organisations who were working to keep people safe.
- There was a culture of staff not reporting concerns which placed people at risk of harm and abuse.
- There was a lack of openness and transparency when sharing information about events that had gone wrong at the home. For example, safeguarding concerns were not dealt with in an open and objective way and appropriate action had not been taken when staff performance needed to be addressed.
- We received mixed feedback from staff about the management of the service. Some staff told us they had confidence in managers whilst other staff told us they did not. Staff comments included; "Managers are approachable and supportive" and "Don't feel supported by management. They have their favourites and if you not one of them they don't listen."
- Since the last inspection CQC have received several concerns and complaints about the service. Contacts told us they don't feel able to raise their concerns directly with the provider or managers as they feel their complaints won't be listened to and dealt with.

Working in partnership with others

- At this inspection we highlighted to the registered manager that the provider had not worked collaboratively or engaged effectively with key organisations.
- We found evidence of a lack of transparent and collaborative partnership working with external stakeholders and other services. The provider had been a barrier of the thorough investigation of safeguarding concerns.
- The registered manager and deputy manager were open and engaged with the inspection process and provided all the information that was requested.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- We were concerned that the provider, managers and staff were unclear about their role and responsibilities for responding to and managing quality performance and risks
- Staff failed to act upon safeguarding concerns in a timely way and the provider and managers failed to take the necessary action to mitigate risk and improve the quality and safety of the service.

● Staff told us there was no management oversight at the service during weekends. This was reflected on checking recent staff rotas covering a five-week period commencing 28 June 2021.

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: Continuous learning and improving care

● An open and honest culture was not always promoted at the service.

● Staff were not always open and honest when things went wrong. They failed to acknowledge and act upon incidents and safeguarding concerns in an open and transparent way.

● Investigations into incidents and concerns raised with managers did not always take place were this was required.

The provider failed to operate effective systems to ensure the safety and quality of the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider and registered manager had failed to ensure people were safeguarded from the risk of abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to operate effective systems to ensure the safety and quality of the service.