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Grafton House Residential Home

Inspection report

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Ratings

Overall rating for this service

Inadequate 

Is the service safe?

Inadequate 

Is the service effective?

Requires Improvement 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

About the service

Grafton House Residential Home is a care home providing accommodation and personal care for up to 24 older people, some of whom may live with dementia. At the time of our inspection 17 people lived at the service.

People's experience of using this service and what we found

There were not enough staff to keep the home clean and to ensure staff did not have to work excessive hours. Standards of cleanliness were poor and staff did not follow infection control guidance and procedures. Areas of the service needed redecoration, refurbishment and maintenance.

Quality assurance systems were not effective and failed to ensure compliance with regulations. Where issues had been identified, the provider did not act in a timely manner to address these.

Risks to people were not always identified and managed. Accidents and incidents were not effectively monitored to consider lessons learnt and reduce the risk to people. There were several incidents that should have been notified to Care Quality Commission (CQC) and the local safeguarding authority, but this had not been done.

Staff morale was mixed and staff turnover was high. Some staff did not feel valued by the provider. Areas of the recruitment process required improvement to ensure safe and robust recruitment of new staff.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. Medicines were managed safely, and people's nutritional and health needs were met.

The service worked with local agencies and had developed close community links. People told us they liked the staff and were happy and settled in the service.

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

Rating at last inspection and update

The last rating for this service was requires improvement (published 27 June 2019). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection sustained improvement had not been made and the provider was again in breach of this regulation and more breaches were found.

Why we inspected

We undertook this focused inspection to check the provider had followed their action plan and to confirm

they now met legal requirements. We only looked at the key questions safe, effective and well-led during this inspection. The rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.

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

Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to infection prevention and control, risk management, the environment, safeguarding, staffing, governance and failure to notify. Immediately after the inspection we wrote to the provider and requested they provided us with an action plan telling us what improvements they were making. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up

We will work alongside the provider and 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.

Special Measures

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 means 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 of 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 effective?

Requires Improvement ●

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate ●

The service was not well-led.

Details are in our well-led findings below.

Grafton House Residential 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 was completed by two inspectors on the first day and one inspector on the second day.

Service and service type

Grafton House Residential Home 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

This inspection was announced from the car park of the service on the first day of inspection. We did this to discuss the safety of people, staff and inspectors with reference to Covid-19. We told the registered manager we would be returning on the second day.

What we did before the inspection

We reviewed information available to us about this service. This included details about incidents the provider must notify us about, such as abuse. We sought feedback from the local authority and local safeguarding team. The provider submitted a provider information return in February 2020. This is

information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. This information helps support our inspections. We used all this information to plan our inspection.

During the inspection

We spoke with six people who lived at the service and observed the interactions and care delivery in communal areas of the service. We spoke with the provider (via telephone) and registered manager. We also spoke with eight members of staff, including care workers, the deputy manager, the maintenance person, the activity coordinator, a housekeeper and the cook. We spoke with three relatives during the inspection.

We looked at multiple records about people's care. We looked at other information related to the management of the service including quality assurance audits, cleaning and maintenance schedules, staff rotas, staff training records and recruitment files. Some of the documentation was reviewed at the service and some the registered manager sent to us.

After the inspection

We requested information in relation to staff rotas and quality assurance reports. We also continued to seek clarification from the registered manager to validate evidence found.

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.

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

- People were at risk of avoidable harm because the provider and registered manager had not thoroughly analysed incidents to prevent reoccurrence. One person had fallen recently and sustained serious injury, yet there had been no detailed assessment and review of the changes to the person's needs. For example, the layout of their room, bed height, flooring, mobility equipment, footwear and level of support now needed.
- Not all incidents had been recorded on appropriate forms, followed up or included in the monthly incident audits to protect people's safety.
- Not all risks to the interior of the building and grounds had been identified to support and protect people's safety. Improvements recommended by external parties such as Humberside Fire and Rescue Service and a lift engineer had not been completed. The increased risks due to these deficiencies had not been assessed and mitigated.
- Checks on equipment in the service did not assure people's safety. There were no checks on window restrictors and effective temperature checks of the hot water at outlets accessible to people were not carried out as the thermometer used was not suitable for this purpose.

The provider had failed to ensure risks were appropriately assessed and mitigated. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

- People were at risk of infection. There were ineffective systems in place to ensure good standards of cleanliness were maintained and to prevent and control infection.
- The provider did not act on professionals' guidance to improve standards in infection control and people remained at risk. The community infection control team had completed an audit on the 27 July 2020 and identified significant shortfalls, they had made 34 recommendations in their report.
- At this inspection, standards of hygiene across the service remained poor. For example, we found bedding, flooring, furniture, and equipment was dirty. There was a strong malodour in one bedroom.
- There were no arrangements for the safe segregation and disposal of potentially contaminated PPE and offensive waste.
- Cleaning schedules did not include all cleaning duties and were poorly completed. There were insufficient hours allocated for cleaning in the home.
- COVID-19 guidance was not always fully assessed and followed, despite assurances provided to the CQC that these were in place, for example, the cleaning of frequently touched surfaces.

Infection prevention and control systems were ineffective placing people at risk of infection and ill health. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- The domestic hours provided were insufficient to protect people, staff and visitors from the risk of the spread of infection.
- The hours had been increased at the start of the pandemic from four to five hours a day, but this was still insufficient provision to improve and sustain the standards of hygiene required. The domestic worker said, "I don't have time to complete all the cleaning."
- When domestic staff were on leave, the shifts were not covered and care staff were expected to complete cleaning tasks on top of their caring duties. Rotas showed 20 domestic shifts were not covered in the last four months.
- Sufficient numbers of care staff were not employed to care for people safely.
- There was a high turnover of staff. Some staff worked excessively long shifts and hours each week to cover staff sickness and leave, which could impact on their wellbeing and the quality of care they provided.

The lack of sufficient staff meant people were not safe. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff recruitment processes were in place; more detail regarding previous employment history was needed to ensure safe recruitment practices.
- The registered manager confirmed during the inspection they were recruiting more care workers.

Systems and processes to safeguard people from the risk of abuse

- People were not always safeguarded from the risk of abuse.
- We identified three incidents which should have been reported to the local authority safeguarding team but had not.

Systems were not in place to prevent and protect people from abuse and improper treatment. 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.

Using medicines safely

- Medicines arrangements were safe and managed appropriately.
- People received their medicines as prescribed.
- Protocols to guide staff when 'as and when required' medicines should be administered were in place. One person told us staff regularly asked if they wanted any pain relief.

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

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

- The environment had not been properly maintained.
- Items of furniture were worn, broken and needing repair or replacement. This included a commode, door, shelving, tables, chairs, and chests of drawers.
- Paintwork was marked on most windows and radiator covers. Varnish had worn off shelving, handrails and the stairs revealing bare wood.
- There was a hole in one person's bedroom wall. The flooring in the pantry, laundry storeroom, dining room and lounge was damaged and worn.
- People's comfort and dignity were compromised by the poor standard of bedding and linen in use. Stained pillows were found in cupboards and on beds. Threadbare and stained sheets and pillow-cases were seen on beds.
- The registered manager told us new linen had been obtained and should have been in use, however it was found in a bag in the laundry.

Failure to ensure the premises and grounds were properly maintained is a breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The linoleum flooring had been replaced recently in four bedrooms with replacement scheduled for four more bedrooms. New commodes and beds had also been provided. On the second day of the inspection the registered manager purchased new bedding.

Staff support: induction, training, skills and experience

- Although staff had completed a course in infection prevention and control in recent months, their practice and understanding required improvement given the number of shortfalls found in relation to the standards of hygiene in the service. The registered manager had ordered a new training package in this area to support this.
- New staff completed an induction programme which included shadowing more experienced staff and mandatory training. Two newly recruited staff told us the induction training had been very thorough and they felt supported by the staff team. All staff had access to ongoing training to develop their skills.
- There was a supervision and appraisal system in place. Staff told us the registered manager was approachable and they could discuss issues as they arose.

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

- People's needs were assessed and their preferences were considered when arranging their care.
- Assessments were used to develop care plans which supported staff to provide care in line with people's needs and personal routines.

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 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. 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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- Where people lacked capacity, decisions were made in their best interests. For example, decisions had been made whether to test people for COVID-19.
- Staff sought people's consent and included people in making decisions.
- Staff recognised restrictions on people's liberty and applications to deprive people of their liberty had been made. Systems were in place to monitor any conditions put in place and when a new DoLS application was needed.

Supporting people to eat and drink enough to maintain a balanced diet; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- People's nutritional needs and preferences were met. People's weight was monitored, and action taken when concerns were raised such as referral to dietitians.
- People enjoyed the food. One person said, "The cook is very good and the meals are all lovely. I haven't had a bad one yet." Another person told us their mango smoothie was delicious.
- People were provided with a variety of meals and refreshments throughout the day. At lunch time on the first day, we found some shortfalls with presentation and improvements were made on the second day with the provision of new crockery and tablecloths.
- People's healthcare needs were met in a timely way. Staff supported people to access healthcare services and followed professional advice. Feedback we received from visiting professionals was positive, they were satisfied with the care of their patients and felt staff communicated well with their team.
- Information was recorded and ready to be shared with other agencies if people needed to access other services such as hospitals.
- Relatives told us they were happy with the care and kept informed of any changes. A relative said, "Yes, the staff are very good at keeping us informed of any changes and if they need to contact the GP. We have no worries about that."

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 requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders did not ensure the delivery of high-quality care.

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

- At the last inspection, the provider had not notified CQC of all events which had occurred within the service as legally required to do. We issued a fixed penalty notice and the provider paid in full.
- At this inspection, the provider had again failed to notify the CQC of all notifiable incidents that happened in the service. This included allegations of abuse and serious injury.

This was a breach of Regulation 18(2) of the Care Quality Commission (Registration) Regulations 2009. We will take action outside of the inspection process in relation to this matter.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

The service has been rated requires improvement at the previous four comprehensive inspections. At our last inspection, we found shortfalls in the management of risk. Not enough improvement had been made at this inspection and the provider was now in breach of regulation 17.

- Enduring shortfalls in the recording, monitoring and analysing accidents and incidents continued to put people at risk of receiving poor care.
- Not all incidents had been recorded appropriately or included in audits. Analysis was ineffective which made it difficult for the management team to learn from incidents and reduce the risk of reoccurrence.
- Audits in place did not drive forward improvements. Governance systems had failed to identify the concerns we found during the inspection. These included areas such as environmental repairs and renewal, cleanliness, infection control practices, risk management, reporting safeguarding concerns and staff deployment.
- The provider had failed to address shortfalls highlighted to them by external parties in a timely way and had not followed their action plan to address these. For example, the community infection control team had visited the service on 27 July 2020 and made 34 recommendations. At our visit, we found many shortfalls in compliance with the provider's action plan.
- There were shortfalls in records and this included cleaning and maintenance records.
- The management approach from the registered manager and provider was not consistent and this had led to delays in the development and implementation of new recording and management systems.

The provider had failed to implement effective systems to assess, monitor and improve the quality and safety of the service and ensure compliance with the regulations. This was a breach of Regulation 17 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- Staff morale was mixed. Some said they felt the registered manager and senior staff were supportive but did not feel valued by the provider. They did not consider their concerns were fully listened to or acted on, including their concerns around staffing, the facilities and resources.
- There were meetings for people and staff to express their views about the service.
- People were happy and settled at the service, they liked the staff and were satisfied with their care. One person said, "I'm very happy here. My room is lovely and the staff are a great bunch. They really friendly and always popping in to see me for a chat."
- Relatives told us they were satisfied with their family members care; the management and staff were all approachable and they knew how to complain if they needed to.
- The service worked with external health and social care professionals. The registered manager explained how they had completed reviews and consultations with professionals using the tablet computer.
- Since our inspection additional support has been offered to the service from the local authority provider development team to help drive the improvements needed and this has been well received by the provider and registered manager.

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 12 HSCA RA Regulations 2014 Safe care and treatment Failure to effectively assess and mitigate risk and ensure appropriate standards of hygiene and robust infection prevention and control procedures were in place put people at increased risk of harm. Regulation 12(2) (a)(b)(d)(h)
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 Failure to safeguard people from the risk of abuse through non reporting of incidents. Regulation 13(1)(2)(3).
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Failure to maintain the premises and grounds which did not ensure people's safety, comfort and wellbeing. Regulation 15(1)(e)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Failure to ensure adequate numbers of suitably skilled and competent staff had been deployed to ensure the safety and wellbeing of people and staff.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>Failure to have effective governance systems in place in order to identify shortfalls and corrective action to drive improvement in the quality and safety of the services provided and ensure compliance with regulations.</p> <p>Regulation 17(1)(2)(a)(b)(c)(f)</p>

The enforcement action we took:

We issued a warning notice.