Grazebrook Homes Limited

Grazebrook Homecare

Inspection report

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Tel: 01384240502

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14 February 2019

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The overall rating for this service is inadequate and the service is therefore in special measures.

About the service: Grazebrook Homecare is a supported living service providing personal care to seven people with learning disabilities, and physical disabilities and adults aged 65 years and over.

People's experience of using this service:
People told us they felt safe using the service but we found care and treatment was not always provided in a safe way. The provider had continued to fail to update care plans and risk assessments for peoples changing needs.
The provider continues to fail to ensure people's care plans and risk assessments contained accurate and up to date guidance. Risk to people was not identified therefore no plans were put in place, exposing people to harm.

No action had been taken to reduce re-occurring risks. Analysis of incidents and accidents was not kept. There was a lack of good governance and oversight therefore, audits had not been completed since the last inspection.

Systems and processes were not effective in assessing, monitoring and mitigating the risks relating to environmental health, safety and welfare of people. Environmental Audits had not taken place since the last inspection.

The provider had not undertaken capacity assessments since the last inspection, it was unclear whether people had agreed or consented to care and treatment or had contributed to the development of their care plans. The local authority had not been notified of people who were deprived of their liberty. The provider did this on the day of inspection

Rating at last inspection: Rated inadequate (report published 22/02/19)

Why we inspected: In the previous inspection we found a breach of regulations. The provider informed us what they would do to meet the requirements. The information shared with CQC about the management of risks indicated potential concerns about the safe care and treatment of people and a lack of governance and oversite. This was a focused inspection that examined those risks.
The inspection took place on 14 February 2019

Enforcement
Full information about The Care Quality Commission's (CQC) regulatory response to more serious concerns found in inspections and appeals is added to reports after any representation and appeals have been concluded.

Follow up
As we have rated the service as inadequate, the service will be placed 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 inspect again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not, enough improvement is made within this timeframe, so that there is still a rating of inadequate for any key question or overall, we will act 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.

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.

Grazebrook Homecare

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection was carried out by two inspectors.

Service and service type:
This service provides care and support to people living in shared accommodation, known as a 'supported living' setting, so that they can live in their own home as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support

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 unannounced.

What we did:
We reviewed the records held on the service. We reviewed action plans provided to us following the previous inspection.

During the inspection two people shared their views about the support they received, not everyone was available as the inspection was unannounced. We looked around two people's homes, with their permission. We also spoke with the registered manager, who is also the nominated individual, the deputy manager, the office and quality manager and two members of staff.

We looked at care records and risk assessments for four people who used the service. Management records for how people were administered medicines as well as a range of records relating to the running of the service were also looked at. These included incident and accident monitoring as well as complaints.

Inadequate

Is the service safe?

Our findings

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

Inadequate: People were not safe and were at risk of avoidable harm. Some regulations were not met.

Assessing risk, safety monitoring and management
• The provider continued to fail to put in place systems and processes to keep people safe from avoidable harm. We saw people had fallen and no risk assessments were in place. The registered manager told us they were planning to do this but had not yet completed any falls risk assessments or put any measures in place to manage the risk of falls for people. We saw injury to a person because of a fall.
• Risk assessments continued to lack detail and did not provide staff with enough information to safely undertake tasks with people. This meant people were exposed to risk of harm.
• All people had a care plans and staff could tell us what support people needed. However, people's care plans continued to lack information for how to deliver safe care to meet changing needs.
• There continued to be no care plans in place for people who had a specific medical diagnosis'. This meant staff did not have detailed guidance to follow to ensure consistent, safe care.

• A staff member told us, "anybody working here who was new, could not safely support people using this paperwork".
• Environmental risk assessments had not been carried out in people's home. During the inspection we saw no consideration given to lack of window restrictors, location of tumble dryers and hot radiators. There was nothing in place to ensure sleep in staff were safe.

The failure to do all that is reasonably practicable to mitigate risk to people using the service was a continued breach of the Regulation 12 HSCA RA Regulations 2014.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
• Continued systematic failings in the auditing processes meant concerns about safety, raised during inspection, were not identified. People were therefore exposed to avoidable harm.
• There continued to be no analysis in place to recognise upcoming risks or trends.
• We saw a documentation of an altercation between two service users that had not been reported to the local authority. We asked the provider to do this and we raised a safeguarding concern.

The failure to ensure risks relating to the safety and welfare of people using the service are assessed and managed was a continued breach of the Regulation 12 HSCA RA Regulations 2014.

Using medicines safely
• It was identified 'as and when required' medicine protocols lacked sufficient information to enable staff to administer medicines safely and consistently. We also found 'as and when required' medicine protocols did not state a safe time between doses. People could be given their medicines in an unsafe way. A safeguarding concern was raised with the local authority, in relation to 'as and when required medicines' following the

inspection.
• Audits of medicines had not been completed since the last inspection. Lack of auditing means errors in medicine records would not always be identified, people were at risk of not receiving medicines as prescribed.
• We found systems were in place to ensure medicines were stored correctly however, we found a medicine cabinet, in a shared home, was left open. We also found a new cycle of medicines were being stored on top of a kitchen cupboard. This medicine was accessible to people living in the house who it was not prescribed to and may lack capacity to recognise the risk of consuming it.
• Epilepsy care plans and protocols had been reviewed since the last inspection.
• We saw some staff medicine competencies had been refreshed since the last inspection. This was to ensure staff were still following the correct practice.

Staffing and recruitment
• We saw one person required support from two staff for personal care, staff told us," when [person] needs support with personal care, we call the office or the manager and someone supports us. On evenings or weekends, we have to call a member of staff who is not on shift"
• A member of staff told us, "There are enough staff. We all help each other and make sure shifts are covered."
• Improvements had been made, since the last inspection, to recruitment processes and staff files had been audited.

Preventing and controlling infection
• Staff had received training in infection control. Staff told us personal protective equipment was available to them.

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

Inadequate: There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
• Numerous concerns continued to be identified with records. These included incomplete, inaccurate risk assessments and care plans, lack of incident and accident analysis and lack of details in relation to critical information on medicine records. Where risks were identified, there was inconsistencies in the records. The Registered Manger continued to fail in ensuring accurate up to date documents were in place to maintain peoples safety and wellbeing.
• We found people's diagnosis and care needs continued to not be identified in care records. Not keeping records that are fit for purpose put people at risk of harm from inappropriate care or treatment
• There continued to be systematic failures in the providers audit process. Quality assurance continued to be ineffective and did not pick up on the issues identified at this inspection. These included concerns with, care plan audits, risk management and medicines. This posed possible risk to people's health, safety and well-being.

The lack of robust quality assurance meant people were at risk of receiving poor quality care and should a decline in standards occur, the providers systems would potentially not pick up issues effectively. This was a breach of the Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• It is a legal requirement that the overall rating from our last inspection is displayed within the service and on the provider's website. We saw the rating was displayed in the office but not on their website. The provider amended this within 24 hours.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility; Continuous learning and improving care
• Incidents continued not to prompt learning to improve care. We saw documentation of two altercations between service users which had not been identified and notified to the local authority.

• The action plan provided, following the last inspections, did not outline appropriate times frames for the provider to take action to mitigate serious risks to people.
• Outcomes of health appointments did not link to risk assessments or care plans. We saw this at the last inspection and no improvements had been made. Therefore staff did not have up to date information about people's health needs

A failure to have effective systems and processes in place to monitor and mitigate risks to people was a

breach of the Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had failed to notify the local authority and subsequently CQC of two safeguarding concerns. Not notifying The Care Quality Commission of a serious injury is a breach of Care Quality Commission (Registration) Regulations 2009: Regulation 18

• Staff demonstrated commitment to the people they were supporting. Staff and people told us the registered manager was approachable.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• There continued to be no records to show people with limited communication, relatives or other appropriate persons had been involved in decisions about care and treatment.
• On the day of inspection, the provider had failed to notify the local authority of all the people who may have been deprived of their liberty, despite being raised at the last inspection. People can only be deprived of their liberty to receive care and treatment when it is in their best interest and legally authorised under the Mental Capacity Act 2005.
• Care plans stated religious preference.
• People had care plans for expressing sexuality, although they lacked detail.

Working in partnership with others
• The service communicated frequently with the GP and other professionals when required.

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
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA RA Regulations 2014 Safe Care and treatment People were not always receiving care that was safe and there was risk of harm.

The enforcement action we took:

We served a notice of decision to impose conditions on the provider's registration.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA RA Regulations 2014 Good Governance There were insufficient governance systems in place to monitor and improve the quality of the service.

The enforcement action we took:

We served a notice of decision to impose conditions on the provider's registration.