Gratia Residential Care Home Limited

Gratia Residential Care Limited

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

About the service
Gratia Residential Care Limited is a residential care home providing personal care to 17 people at the time of the inspection. The service can support up to 20 people.

People's experience of using this service and what we found
Right Support: People experienced and were at immediate risk of harm through misdirected behaviour from others living at the service and fire safety risks. There was not enough staff to ensure people were supported at all times of the day and night. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this poor practice. Medicines were poorly managed. Staff training and competency was not up to date, and they had not received training in Positive Behaviour Support, to help guide approaches to people using the least restrictive measures.

Right Care: Care was not always person centred. People were not always treated with dignity and respect. People were infantilized and staff used degrading descriptions of people.

Right Culture: The culture of the service was poor. Leadership was inconsistent, making staff feel unsupported. Punitive measures were used by staff when supporting a person who experienced strong emotional reactions. This segregated the person, instead of including them.

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 inadequate (published 25 February 2022) and there were breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
We carried out an unannounced focused inspection of this service on 1, 2 and 3 February 2022. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment and good governance.

We undertook this unannounced focused inspection to check they had followed their action plan and to

confirm they now met legal requirements in the key questions of safe and well-led.

We inspected and found there was also concerns with people's eating and drinking, so we widened the scope of the inspection to the key questions of safe, effective and well-led.

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 not changed and remains inadequate. This is based on the findings 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.

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

Enforcement
We have identified breaches in relation to safe staffing levels, failure to reduce risks to people, the management of quality and safety, the building and environment and failure to always treat people with dignity and respect, at this inspection.

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 request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures
The overall rating for this service is 'Inadequate' and the service remains 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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Gratia Residential Care Limited

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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was completed by 2 inspectors.

Service and service type
Gratia Residential Care Limited 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. Gratia Residential Care Limited 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 two registered managers in post.

Notice of inspection
This inspection was unannounced.

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
Not everyone who lived at the home was able to share their views with us. As a result of this, we spent time observing interactions between people and the staff supporting them.

We spoke with 14 members of staff including both registered managers, 3 senior care assistants and 9 care assistants.

We looked at a range of documents including 9 people's care plans and risk assessments, 3 staff recruitment records, training records, DOLS records and mental capacity assessments. We also reviewed audits and governance, medicines records and observed medicine administration. We conducted checks of the building, grounds and equipment.

Inadequate

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 inadequate. The rating for this key question has remained inadequate. This meant people were not safe and were at risk of avoidable harm.

At our last inspection the provider failed to ensure people were receiving safe care and treatment relating to infection prevention and control, medicine management and safeguarding people from avoidable harm. This was a breach of regulation 12(1) 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 12(1).

Assessing risk, safety monitoring and management; Systems and processes to safeguard people from the risk of abuse

- People experienced and were at immediate risk of avoidable harm through safety incidents. One person had a history of displaying inappropriate behaviour towards others. This was identified as a serious risk to people during our last inspection, however there was no improvement at this inspection. The provider had failed the safely manage the risk.
- People were not always kept safe from the risk of abuse. Safeguarding systems failed to ensure all allegations of abuse were reported to the appropriate authorities. Whilst staff had received training in safeguarding, both staff and leaders failed to recognise potential and actual safeguarding matters.
- Personal Emergency Evacuation Plans (PEEPS) did not contain sufficient information for staff to enable them to safely support people to evacuate the building in an emergency. For example, three people had epilepsy. Staff had no suitable and up to date guidance to follow in relation to this specific need. This placed people at risk of being unable to be evacuated in line with their individual needs.
- People were at risk of injury through a lack of water checks. Water temperature checks had not been completed regularly which placed people at risk of being scalded.

Using medicines safely

- Medicines were not managed safely. Staff had added handwritten prescriptions to people's medicine administration record (MAR) without a second staff member checking the accuracy of this. This placed people at risk of receiving their medicines incorrectly.
- Medicines which had been prescribed for people 'as required' were not managed safely as they were not on people's MAR charts. This meant there was no record of when people had received their 'as required' medicines, placing them at risk of accidental overdose from another member of staff.
- Controlled drugs were not managed in a safe manner. One person had been prescribed a Schedule 3 controlled drug. This means there are tighter rules around what has to be done to manage this medicine safely. Two staff must sign the person's MAR chart once the medicine has been administered, however staff failed to do this. This is not in line with law and guidance and placed people at risk of harm from these

poorly managed medicines.
● Guidance for staff on where to apply creams was not in place for 2 people. This was not in line with national guidelines for managing medicines in care homes. This meant people were at risk of having the cream applied to the incorrect area of the body, rendering it ineffective to the area which required the cream.

Preventing and controlling infection
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. Areas of the home were unclean, and equipment was unclean. Cleaning practices at the service were not effective in removing dirt and debris.
● We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed. High touch point areas were not always recorded as cleaned, meaning people could not be sure areas within the home had been decontaminated to prevent the spread of infection.
● We were not assured that the provider was using PPE effectively and safely. The inspection found multiple occasions where staff and management wore facemasks incorrectly.
● We were not assured that the provider was supporting people living at the service to minimise the spread of infection. During the medicine round, staff did not change gloves between people, and did not decontaminate their hands between people as there was no hand sanitiser available on the medicines trolley.
● Whilst in date, we were not assured that the provider's infection prevention and control policy was being implemented and embedded into staff practice.

Systems failed to establish, assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Visiting in care homes
● The provider followed current government guidance in respect of visiting in care homes.

Staffing and recruitment

At our last inspection the provider failed to ensure a sufficient number of skilled and trained staff were deployed in the service. This was a breach of regulation 18(1) 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 18(1).

● There were not enough staff to meet people's needs. Night-time staffing numbers were not enough to ensure people could safely be evacuated in a timely manner should an emergency occur.
● Staff performance was not monitored adequately. This meant poor performance was not always identified, and staff continued to support people using inappropriate techniques.
● Staff were not safely recruited. We reviewed 3 staff files and found none of them to meet legal requirements because they did not contain proof of staff members identity. Two files also did not contain sufficient references to ensure they were of suitable character and experience to complete their role.

The failure to provide enough suitably trained staff to meet people's needs placed people at risk of harm. This was a continued breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

Learning lessons when things go wrong

● Accidents and incidents were not reviewed regularly, meaning patterns and trends were not identified. For example, the Registered Manager had failed to review incident forms and therefore had not identified the use of punitive measures recorded by staff in respect of a person. The lack of analysis meant lessons could not be learned when things had gone wrong and there was a risk of a reoccurrence, which placed people at risk.

●The Registered Manager also failed to investigate new incidents in a timely manner. A serious safety allegation had been made to staff, who completed an incident form, and made the Registered Manager aware, however when the inspection commenced 3 days after the allegation, no investigation had commenced. The Registered Manager was unable to provide robust justification for the failure to commence an investigation immediately, which left people exposed to the risk of harm.

Inadequate

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 inspection on 19 July 2019 we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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

● The facilities and premises did not meet people's needs and promote their independence. The garden and grounds were poorly maintained. We observed large cracks in paths making them very uneven, and noted the paths were too narrow to permit a wheelchair to go along. Multiple people living at the service were unable to mobilise without a wheelchair and many others had poor mobility. This meant the majority of the garden was inaccessible to them.

●Rubbish and debris were found around the grounds. Fences surrounding the garden were extremely dilapidated, impacting on people's safety and security.

●Bedrooms varied in personalisation. All were painted a neutral colour, however some evidence of personalisation was apparent in several people's bedrooms.

The service was not always clean, well maintained or secure. This was a breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

● Staff did not have sufficient training to support them in their role. For example, at our last inspection we identified staff did not have Positive Behaviour Support (PBS) training. This training is important to help staff understand how to support people who were experiencing strong emotional reactions to a situation or their environment, resulting in them hitting out, kicking or shouting. At this inspection, staff had still not received this training.

● Staff did not always receive competency checks. Where competency checks identified the need for further retraining, this was not provided, meaning staff continued to work outside of best practice principles.

● Staff training records were not kept up to date. Staff who no longer worked at the service were listed, however evidence of competency checks for active staff was missing. This meant it was not easy for the registered manager to easily identify staff training needs and ensure staff were encouraged to increase their skill sets with additional training.

Failing to ensure staff were adequately trained and competent was a further breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● People were placed at risk due to staff not following specialist dietician instructions. For example, one person was at risk of choking due to regurgitating their meal. Their specialist eating and drinking plan stated

they must remain upright for 30 minutes after each meal with staff supervision. Staff failed to stay with the person once they had finished eating, placing them at risk of choking.
● Staff failed to respect people's preferences in relation to the food they wanted. One person had changed their mind about eating the hot lunch provided. Staff offered a sandwich as an alternative, and sought the person's views on filling, bread type, and cut. When the sandwich was brought to the person, the bread type and cut had been disregarded and alternatives provided without consultation of the person.
● Lunch time observations during the inspection found people waiting up to 1.5 hours for their meal. This impacted on people's wellbeing. One person became very distressed due to the long wait, which affected 3 other people. Another person had fallen asleep whilst waiting.
● The dining environment was noisy, with competing noise from a TV and radio. People were allocated set seats to sit in and there was no deviation from this. Blanket measures were in place by staff as they placed a blue plastic apron on every person without consulting them first. One person became very distressed by this, and only then was provided with the choice of wearing the apron or not.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Assessments were not completed for people to ascertain who was at increased risk of pressure sores. One person was at risk of pressure sores due to having limited mobility. The failure to complete the nationally recognised assessment placed the person at increased risk of pressure sores, as risk factors had not been identified in order for staff to provide effective pressure area care.
● Care plans varied in consistency. Whilst some were detailed, and contained personalised information specific to people, others contained inaccurate information.

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 service did not always complete accurate mental capacity assessments. One person had mental capacity assessments in place for 5 areas of care. These capacity assessments recorded the person did not have the mental capacity to make decisions on those topics. A DOLS application had been submitted for this person, however, it had been rejected as the DOLS assessment process found the person had the mental capacity to make the decisions. The mental capacity assessments for the person had not been adjusted and meant the person was at risk of losing choice and control over their life, should staff members follow the capacity assessments.
● Other mental capacity assessments in place for people were in date and contained accurate information.
● DOLS applications had been submitted and renewed when the time limit was approaching. At the time of the inspection, none of the people living at the service had conditions on their DOLS form which fell under the provider's responsibility.

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

● People's health information was not always accurately recorded. For example, 1 person was waiting to see health professionals regarding their weight loss. The inspection found inaccuracies in the information recorded about their weights, which impacted on the validity of information that could be shared with the health professionals.

● The service was inconsistent when dealing with people's health, care and support needs. During the inspection, 1 person was complaining of severe pain. Staff acted immediately and offered to telephone the GP. However, another person's pressure cushion was in extremely poor condition, and staff had failed to report this issue, and obtain a replacement cushion.

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 our last inspection we rated this key question inadequate. The rating for this key question has remained 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.

At our last inspection the provider failed to ensure there was a robust quality assurance system in place to monitor safety and quality of people's care. The provider failed to ensure effective oversight to identify shortfalls. This was a breach of regulation 17(1) 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(1).

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Systems and processes failed to ensure people were always treated with dignity and respect. Staff were observed to speak about people in a derogatory way. For example, a staff member called a person a 'good boy' on 2 occasions which infantilized them and was not respectful or dignified. A team leader referred to people who needed support to eat their meals as 'feeders'. This demonstrated a poor culture ingrained within the service, as leaders also failed to empower people.
- Incident forms recorded punitive measures were used for 1 person when they experienced strong emotional reactions to situations. One form stated the person had been, 'sent to their room.' The registered manager had failed to identify inappropriate approaches by staff. This meant the person was segregated, instead of included.
- Leadership at the service was inconsistent. One staff member told us leaders changed ways of doing things constantly. They said, "This is said to be done to benefit people, although it affects people as it changes routine." The staff member also told us these changes were implemented in a, 'we will do it my way' approach from leaders and management.
- The culture of the service did not empower staff members. Staff told us they did not feel supported by the registered manager and other leaders. One staff member said they received support from colleagues but,"… not so much from management."

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

- The registered manager failed to ensure sufficient oversight and governance of the service. Audits had not been completed or were ineffective at identifying issues. This meant the service could not assess, monitor, and improve the quality and safety of care delivered.
- Accidents and incidents were not reviewed regularly, meaning patterns and trends were not identified.

When new incidents occurred, the registered manager failed to investigate them in a timely manner or make the appropriate safeguarding alerts.

● Staff told us workloads were uneven, and not all staff members contributed equally to the smooth running of the service. One staff member said, "I feel we all should set a good example to all staff and residents whether we are a carer, senior, team leader or management. Often the atmosphere is not nice at Gratia due to some of these staff not setting a good example."

● Leadership within the service was weak. Leaders were out of touch with issues occurring in the service. For example, the medicines round was observed to be running 1 hour late on an inspection day. When the registered manager was asked why this was, they were unaware this had occurred, and therefore unable to provide a robust explanation for this.

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

● Staff raised concerns with the inspector about a lack of confidentiality. This was particularly regarding the leaders of the service. Staff advised that personal information discussed in confidence with managers was often leaked to other members of the staff team.

● Staff feedback identified a theme in relation to communication issues from leaders. Staff felt communication between themselves and the management team was poor. This impacted on their ability to complete their role. One staff member said, "Communication between management - there is lack of it, never enough."

Continuous learning and improving 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

● Governance systems failed to evidence reflective practice taking place within the service. This meant leaders failed to identify issues and implement plans to remedy these issues.

● Action plans completed by the provider to drive improvements were ineffective. Serious concerns found at the previous inspection had failed to be rectified at the time of this inspection.

● The registered manager failed to keep up to date with changes or new publications of guidelines. For example, they were unaware of the Quality of Life tool available on our website, to support services for people with a learning disability and/or autistic people. They told the inspector they had not read other industry-supporting guidance.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a continued breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.