Button Space Limited

Grimsargh House Care Home

Inspection report

Preston Road
Grimsargh
Preston
Lancashire
PR2 5JE

Tel: 01772651031

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21 March 2016
22 March 2016
23 March 2016
11 April 2016

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We inspected this service on the 21 and 22 March 2016 for full days and then again on the 23 March 2016 for a short period in the afternoon to give feedback and collate information. The inspection was completed under Code B, of the Criminal Procedures and Investigations Act 1996, as concerns had been shared with the Care Quality Commission (CQC) that led us to believe breaches of legal requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 would be found. We added a day to this inspection on the 11 April 2016 as further information of concern was shared with us. We also had not received adequate assurances that immediate action required to reduce identified risks had been completed.

The home was last inspected in March 2015 when we rated the service as requires improvement overall and requires improvement for the key questions of safe and responsive. The other key questions of effective, caring and well led were rated as good. We carried out this inspection to ascertain if improvements had been made to the key questions of safe and responsive and to follow up on the information received by the CQC. The information of concern we received identified potential breaches to a number of the regulations which led us to undertake a full comprehensive inspection of Grimsargh House.

During this inspection we found the home was in breach of 11 of the regulations designed to keep people safe in residential care homes. One of these was a failure to display the last inspection ratings from March 2015.This regulation is in place to ensure people living in the home and those visiting can see how well the home is delivering safe, effective and caring services that meet the needs of people living in the home.

Other concerns were noted around the safe recruitment of staff. We were concerned that there was a lack of available information to show us staff had been recruited that were of suitable character and were suitably trained. There was also a lack of information to show us staff had been supported whilst in their role at the home. This included a lack of formal induction to the role, ongoing training and supervision to ensure they were able to complete their role competently and confidently.

We found the food at the home to be of good quality and freshly prepared. However, when people required more support to ensure they did not become malnourished, we found they did not receive the support they required. This included a lack of referral for specialist support. We found this was also the case when people became a higher risk of falls and other accidents.

We looked at the information the home used to develop people's care plans and found these were not routinely developed with the person being supported. There was a lack of valid consent acquired from people living in the home, for the care they received. Where people were beginning to develop early signs of dementia the home had not used the guidance within the Mental Capacity Act 2005 (MCA) to ensure these people were effectively supported.

The home had not assessed people's needs in the event of an emergency including how to safely evacuate

people. There was not a contingency plan in place to ensue people could continue to access a service in the event the home became uninhabitable.

Records used to administer medicines safely were poorly kept and omitted key information including how people should take their medicines. Care plans for medicines were not fully developed and no one in receipt of 'as required' medicines had a care plan, to inform staff of when these should be administered.

We found the home were not recording or acting on complaints in a responsive manner and there were no recorded complaints for the two years prior to the inspection. We were however aware of two complaints made in the last six weeks and heard one made on the second day of the inspection.

There was not a system of quality audit and the home was not monitoring how the service was being delivered. The policies and procedures at the home were not actively implemented making some audits and monitoring difficult to undertake.

The provider did not actively seek the views of people living in the home. This meant that the manager did not have a clear understanding of whether the service being delivered was what people wanted.

At the time of this inspection there was a registered manager in post who had worked at the home for over 30 years. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Following the concerns noted in this inspection we issued notice to cancel the manager's registration. The manager did not provide representations to the commission for the notice and their registration was therefore cancelled on the 7 July 2016.

Following this inspection we were given assurances by the provider that specific action would be taken to reduce the risks to people living in the home. We were not assured the action had been taken and when we revisited the home on the 11 April 2016 we found additional concerns. The provider was also issued with a notice of proposal to cancel the provider's registration. The commission received representations from the provider which were not upheld. The provider was therefore issued with a Notice of Decision to cancel their registration on the 6 October 2016.

Due to the concerns raised during this inspection we also issued an urgent Notice of Decision to the provider to ensure they could not accept any new people into the home on the 14 April 2016. The provider made appeals to the first tier tribunal against both the urgent Notice of Decision to restrict admissions and against their Notice of Decision to cancel their registration. Both of these appeals were joined and to be heard at the first tier tribunal.

The provider was inspected again in October 2016 and the report for the inspection is published. We did not find anything during that inspection to assure the commission the provider had taken appropriate steps to meet the requirements of the regulations.

In March 2017 there was an incident at Grimsargh House care home where the management and provider at the home took the steps of evacuating people to a nearby hotel. The commission found the incident which led to the evacuation was avoidable. We also found the evacuation was not managed in line with a suitable emergency evacuation plan. We found the provider had not taken, the action taken in a considered way, to

ensure the safety and well-being of the people living in the home. The commission took urgent action to cancel the provider's registration. At the time of the urgent action everyone living at Grimsargh house was moved to other suitable care homes.

The provider appealed against the urgent action taken and an appeal was heard at the first tier tribunal. The appeal was unsuccessful and as a consequence the provider's registration is now cancelled and Grimsargh House is no longer a care home at the time of writing this report.

The overall rating for this provider was 'Inadequate' from the time of this inspection until its cancellation In February 2018. The home was kept in special measures from the time of this inspection until the registration allowing the regulated activity to be delivered from it was cancelled in February 2018. The commission and the Local Authority worked closely with the home from the time of this inspection until all people living at Grimsargh House were moved on in March 2017.

You can see what action we told the provider to take at the back of the full version of the report.

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.

The provider did not have a contingency plan in place to ensure people were safe in the event of an emergency. There were no specific individual assessments to support people with their needs if an evacuation was needed.

There were not enough suitably trained and qualified staff to meet the needs of people living in the home.

Risks to people living in the home were not appropriately assessed to ensure the home could reduce any associated risks.

Medicines were not managed safely and had not been audited for some time. We found hand written records, incomplete records and unsigned records that had not been identified by the provider.

Is the service effective?

Inadequate

The service was not effective.

The food was generally good but when people required additional support with their hydration and nutrition it was not provided effectively.

The provider had not taken any steps to implement the requirements of the Mental Capacity Act 2005

Staff had not received any formal support for up to two years. Training records were unavailable.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring.

People had not been involved with the development of their care plans.

People we spoke with told us they were treated with respect and staff interacted with people well.

People in the home were not consulted with, before decisions were reached about their care. This Included the use of toiletries and bath towels and when to have a bath or shower.

Is the service responsive?

Inadequate

The service was not responsive.

The service did not have an activity coordinator but some activities were undertaken by staff when staff had the time

Care plans did not include all the information needed to support people in the home.

There was not an active complaints procedure.

Is the service well-led?

Inadequate

The service was not well led

There were no audits or monitoring of the service undertaken to ensure consistent standards were kept.

Risk assessments had not been completed to ensure the service was safe and to provide staff with the guidelines within which to deliver safe care.

Policies and procedures had been purchased at the beginning of the year but these had not been shared with staff or implemented in the home. Previous policies had been removed.

Grimsargh House Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on the 21, 22 and 23 March and the 11 April 2016. The first and last days of the inspection were unannounced. The inspection team included four adult social care inspectors. Three inspectors were on site on the 21 March 2016 and two were on site on the 11 April 2016. The remaining two days included one adult social care inspector.

Before our inspection, we reviewed the information we held about the home, requested information from the Local Authority and Health Watch and reviewed available information in the public domain.

During the inspection we spoke with 12 people who lived in the home and four visitors to the home. We also spoke with 13 members of staff, including the registered manager, nominated individual, senior carers, carers, administrative staff and catering staff. We spoke with one visiting professional on the day of the inspection who was a district nurse. We also spoke with a number of social workers who had cause to visit the home following the safeguarding alerts we raised during the inspection.

We reviewed all of the available 24 care plans and information on people who were on respite at the home. We reviewed the available policies and procedures and saw how these were implemented. We reviewed the information available on the staff employed by the agency owned by the nominated individual of the home and reviewed the information held on people's medicines.

We observed how staff interacted with people living in the home and how support was provided to meet people's needs. We observed how long it took staff to answer call bells and how they approached tasks that

took them away from what they were previously doing. We observed how people spent their days and how key parts of the day including meal times were undertaken.

We observed how staff and people living in the home interacted and we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We looked around the home including in people's bedrooms, all communal areas and in the gardens. We also looked at how the home was secured and made safe including the testing of the fire alarm and professional testing of equipment.

Inadequate

Is the service safe?

Our findings

On the first day of the inspection the home had 26 people living in it. People we saw around the home were generally mobile and able to vocalise their thoughts and wishes. People we spoke with told us they felt safe. One person said, "I'm very happy here, I used to fall a lot at home but I haven't since I've been here." Another said, "I can reach my buzzer if I need help and staff will come to help me."

We looked at the procedures the home had in place to ensure people were kept safe. Posters we saw in the office for safeguarding adults were out of date. The home had recently introduced new policies and within these was a comprehensive safeguarding policy. However, staff had not read the policy and it had not been implemented in the home. This included the collation of information to ensure staff had not been barred from working with vulnerable groups and the undertaking by staff of induction and training to ensure they understood both what constitutes abuse and how to report it.

Staff we spoke with had a basic understanding of safeguarding but only two had completed safeguarding training whilst working at the home and none had completed it within the last 18 months. Staff new to the home had not completed any training to ensure they could support people safely. However, we saw staff were polite and caring in how they engaged with people in the home.

All staff including the registered manager had little knowledge of the Mental Capacity Act 2005. People were restricted in the home including locked doors and bedrails but these had not been appropriately assessed to ensure they could lawfully be used.

The CQC (Care Quality Commission) inspection team identified four safeguarding concerns at the time of the inspection which when investigated were substantiated. The provider, registered manager and staff did not have a working understanding of how to ensure people were kept safe. This is a breach regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We looked at the assessments used to support people from identified risks. This included the risks of falls, malnutrition and pressure areas. We found that when these assessments were completed they were either not completed correctly or where not acted upon. For example, two falls risk assessments we looked at identified actions should be taken including potential referrals to the falls prevention team, discussion with the person's GP to consider a medication review and the introduction of certain exercise. In the two assessments we reviewed none of the actions had been implemented. One of these people had fallen up to six times in February 2016 and no action had been taken to reduce the risks associated with falling. The CQC raised a safeguarding alert for this person to ensure they were kept safe.

The home kept records of accidents and incidents. The home used a basic reporting template without any detail of control measures or after accident monitoring to ensure people were kept safe. The records were torn from a loose leaf book and put into a filing cabinet ready for review by the manager. However, some records were misplaced and when the manager reviewed the information no further action was taken. There was no consolidation of accidents or incidents either by person or accident/incident type which could help

the manager reduce the risks of reoccurrence.

The above matters constituted a breach of Regulation12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because information about risk was not used to inform assessment and risks were not managed or mitigated to ensure people received safe care and treatment.

We looked at available information on how the home would manage incidents. The home did not have a contingency plan in place at the time of the inspection. This would normally include risk management plans for major incidents including fire and loss of power. We were assured this would be done following the inspection. We requested this again in early April and it had still not been received at the time of writing this report.

The fire records we looked at were poorly completed and the fire alarm had a fault that had not been fixed since January 2016. We saw fire doors held open by cardboard and many doors that did not fit in their frames. The CQC requested the fire department completed an urgent assessment to ensure the property was protected against the risks of fire. This assessment led to a number of actions the provider needed to complete, to protect the home and the people who lived there in the event of a fire.

We looked at the information the home held to support individuals in the event of an emergency. We saw a number of fire risk assessment (awareness) templates with people's names on but many had not been completed. The assessments did not inform staff how to support people in the event of the need for evacuation.

When providers do not have procedures in place to safely manage incidents and ensure the continuation of service in the event of the home becoming inhabitable this is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw the home had utility professional testing certificates but there were not any certificates to show the hoists had been serviced on the day of the inspection. We were supplied these after the inspection and noted one of the hoists failed the test.

We saw each person's file had a dependency assessment tool. The tools we looked at were not always completed in accordance with the care plans and assessments within the files. For example, one dependency tool scored one person 0 for mobility showing they were independent or had minimal needs; this person was also scored 0 for vision and for dressing. Information in their file showed the person had very poor distance vision and no near vision. The person had fallen three times in February 2016 and used a walking frame and was also agitated and confused. We found inaccuracies of this type on the three dependency tools we looked at in detail. Dependency tools are used to inform the staffing numbers required to meet the needs of people in the home but Grimsargh House did not use the tools for this purpose.

It was acknowledged that most people at the home had a low level of need. However, approximately 20% required additional support with their day to day living that was not provided and most did not receive the social and emotional support they would have liked. Staff and people in the home told us they did not have the time to talk with people as often as they would like to and some shifts were particular busy and people had to wait. The CQC had to raise safeguarding alerts for people with additional needs to ensure plans were put in place to meet those needs. This included support with people's diet, support with their mobility and mental health.

The staffing rota was not completed and given to staff in a timely way. Staff told us they were often

presented with a rota for the following week on the Friday before. Staff told us they worked for up to 10 days at a time without a break as there were not enough staff to cover the rota. When staff didn't come into work because of sickness or leave, shifts were either not covered, covered by staff who had already worked over their weekly hours or the registered manager had to come back into work. The provider had agreed to use agency staff to cover the rota but it was over three weeks after the start of the inspection that this was implemented.

When there are not enough staff to meet the needs of people living in the home this is a breach of regulation 18 of the Health and Social Care Act HSCA 2008 (Regulated Activities) Regulations 2014.

There was no evidence in the home that the provider or any agency working on behalf of the provider had followed basic recruitment procedures. This included a lack of application forms, interview notes and requests for and receipt of suitable references. There was also a lack of available information required under Schedule 3 of the Health and social Care Act to ensure people were suitable for employment. This included a lack of evidence that the necessary checks had been undertaken with the Disclosure and Barring Service to show people were safe to work with vulnerable groups of people. At the time of writing this report we had received evidence to show all but three staff had some basic checks completed in the last four years.

A lack of effective and safe recruitment procedures is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed medicines being administered on two occasions. We saw that staff spoke to people politely. We observed medicines were signed for on one round before they were administered and medicines were put in front of people without the staff member observing the medicines were taken. On one medicines round the inspector advised the staff member of a simpler system to help them when administering medicines and reduce the risks of mistakes.

We looked at the Medicines Administration Record (MAR) and saw that many of them were handwritten. We sometimes found that MARs were handwritten when medicines were received mid cycle or were to be taken for a short period of time. We found on this occasion that many longer term medicines were recorded by hand on the MARs. We noted MARs were not signed by staff to say who had written the record nor were they counter signed to show a staff member had double checked the entry to reduce the risk of mistakes.

When looking closely at the MARs we saw many initials used to say medicines had been administered was just one letter and there was not a master record of every staff member's way of signing the MAR. We also saw that some medicines had been refused for up to three weeks and the home had not taken any action to ensure these people remained safe. We spoke with the manager about our concerns and advised they should speak to the appropriate GP and pharmacist, as a matter of urgency, to ensure people were safe when refusing their medicines. We also asked for them to arrange for as many MARs to be printed as possible to reduce the risk of errors.

We saw that not all MARs had a picture of the resident whose record it was or details of any allergies. Many records did not include instructions on how to take the medicines including, with or after food and what if anything to avoid when taking the medicines including citric drinks

New procedures for medicines had recently been introduced to the home, but these had not been implemented. The associated policies for managing medicines were following current best practice but staff had not read them. Medicines management did not include an audit of records or stock and we found a number of stock reconciliations were incorrect. We discussed this with the manager who could not account

for the differences.

On the last day of the inspection in April 2016 we saw that many records were still handwritten, there were gaps on the MARs that could not be accounted for and staff who had recently been appointed responsibility for medicines had not received any formal training. The CQC raised a safeguarding referral with the Local Safeguarding Authority to ensure plans were put in place to reduce the risks to people of not receiving their medicines safely.

The home did not have a medicines fridge and medicines were kept in a tub in the catering fridge. The temperature of the fridge was checked and it was below the recommended temperature. We again discussed this with the manager and shortly after the inspection were shown a receipt for the purchase of a medicines fridge.

We looked at medicine's care plans and found them to be poorly completed. There were no specific plans for high risk medicines including medicines for angina and two staff we spoke with on the first day of the inspection did not know which residents had been diagnosed with angina or what a glyceryl trinitrate GTN spray was or how to use it. A GTN spray is used when people suffering from angina have chest pains. The spray should be used immediately and gives temporary relief to the pain. If pain persists then an ambulance should be called. The manager assured us the information on how to use the GTN spray would be put in the front of the MAR book and information would be shared at handover or via a team meeting. We saw on the last day of our inspection that the information had been added to the MARs book but the information had not been formally shared with all staff by way of a structured handover of the information, discussed in a staff meeting or shared via a memo with all staff.

When medicines are not managed safely there is a risk people will not get the medicines they need, when and how they need them. This puts people at risk and is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how the home managed controlled drugs and found they were stored appropriately and the three stock conciliations we completed were accurate but as with normal medicines this system was not regularly audited by the manager.

We looked at the physical environment and its general cleanliness. We saw that generally the main communal areas were clean and tidy. However, we saw a number of the bedroom floors needed cleaning. We asked people when the floors in their rooms were last cleaned and were told a few days ago. We looked at the homes cleaning schedule in the evening and night staff files and saw it hadn't been completed for the two weeks prior to the inspection. The domestic cleaning duties folder contained a weekly cleaning rota that had not been completed for the three weeks prior to the inspection. We asked the manager if they checked the schedules and if the work had been completed and were told they sometimes do. The manager could give no explanation as to why there were large gaps in the schedules prior to the inspection.

We looked at the available equipment to manage clinical waste. We saw one bin with a clinical waste bag in it was a swing bin and was full to the top. Swing bins are not ideal waste reciprocals for clinical waste as the waste touches the lid of the bin every time it is used. We raised this with the manager and shortly after the inspection saw a receipt for the purchase of a pedal clinical waste bin. We also saw there were smaller pedal bins in people's rooms with clinical waste signs on the top without clinical waste bags, which is not in line with best practice guidelines.

The home had one sluice room which was not fit for purpose. There was no Personal Protective Equipment

(PPE) in the sluice room, no dedicated clinical waste bin and only a very dirty sink. The hand wash sink was holding storage. The room was very dark and very dirty. The floor area was mainly covered with storage or items to be disposed of and the room had no measures in place to reduce the risk of infection or cross contamination. We requested the infection control team to complete an audit of the property to support the manager in this area. This audit led to actions the home needed to complete to ensure infection control risks were reduced.

There was a lack of soap in the soap dispensers and hand gel was missing from a number of the reciprocals including the one to the front door. This was still empty on the last day of the inspection, 20 days after this was bought to the attention of the manager.

When the home does not have active procedure to reduce the risk of infection and cross contamination this is a breach of Regulation 12 of the Health and Social Care Act HSCA 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

People we spoke with who lived in the home gave a mixed response when we asked them if they felt their needs were met. One person told us, "I get what I need, I have a poorly foot and staff tell me I have to keep it up, which I do and it's getting better." Another person told us, "I am not asked what I need; I think staff think I'm a nuisance."

We observed staff interacting with people and, in a general sense, staff were doing their best. What was clear was that if people presented with needs, staff were unclear how best to support them. For example, one person said they were in pain and staff did not ascertain if they either needed or could have some pain relief. Another person had started to have difficulty with finding the toilet but staff had not implemented an effective plan of how to support them. Staff were pleasant but did not appear to have the skills to meet more than people's basic needs.

On each day of the inspection there were no available records to show what training staff had received. We requested the training matrix on five occasions to three different people. We were assured it would be sent. However, all we received was a schedule of training which was to be delivered in the coming year. None of the staff we spoke with told us they had received any training in the last 12 months. One told us they had received some fire training in the last three months, but it was evident this had not been effective, as they struggled to silence the alarm once activated. When one of the inspectors attended the home on the 15 April 2015, some training records were made available. It was clear that no training had been provided in the last 12 months and those staff that had started work in the last 18 months had not received any training or formal induction.

The home had not provided staff with the appropriate training to complete their role. We looked at how else the staff had been supported to ensure they were effective in meeting people's needs. We were told the care planning paper work had changed in January 2016, we asked staff what training had been provided to support them in completing the new paper work. We were told that someone had gone through the paper work with some of the seniors but no training had been provided to other staff. The training that had been provided had not been formal and was not tested to ensure staff were using the paperwork correctly. The home did not have any team meetings and staff did not have one to one supervision with a more senior member of staff. There was no form of competency testing to ensure staff were knowledgeable in certain aspects of their role including medication or moving and handling and no one had received an appraisal in the last two years since the new provider had taken over the home.

When staff are not supported as necessary to enable them to carry out the duties they are employed to do it is a breach of Regulation 18 of the Health and Social Care Act HSCA 2008 (Regulated Activities) Regulations 2014.

We looked in all the available 24 care files to ascertain the consent gained by the provider to deliver the support people needed. There was no consent, of any kind, in any of the files. We saw spaces for consent on some assessments but none had been signed on the day of the inspection. There was no signed consent for

the home to administer people's medicines, for the use of bedrails, to take photographs or share information.

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. The application procedures for this in care homes and hospitals are 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 were being met.

We found the home had not begun to introduce the principles of the MCA. No one living in the home had their capacity assessed to determine if they were able to make particular decisions about their care and treatment themselves. As a consequence, there was no information available on any best interest decisions made, to support people that may lack capacity to give consent to their own care and treatment.

The front door to the home was locked and people could not exit the home without the staff entering a key code. There were no assessments in any of the files we looked at to ascertain who was and who wasn't safe to leave the home unattended. The service had not applied for authorisation under DoLS to restrict any person from leaving the home. We saw and were told of occasions where people wanted to leave the home. On the day of the inspection one person had wanted to leave and was taken up the drive with the manager. The person did not want to go back into the home and staff had to physically encourage them to return causing an injury to the manager's arm. We were told the person had fluctuating capacity but there were no assessments or best interest decisions to support this person with decisions around leaving the home.

When people's consent is not sought prior to support being provided or people's capacity is not assessed to determine if they can give consent prior to support being provided it is a breach of Regulation 11 of the Health and Social Care Act HSCA 2008 (Regulated Activities) Regulations 2014.

One or more of the inspectors ate food prepared by the home on more than one occasion. We found the food to be plentiful and home cooked. People we spoke with mostly liked the food prepared but two people we spoke with, liked particular foods; they would have liked to be on the menu. We saw some preferences were recorded about what people liked to eat but there was not any evidence these had been incorporated into the weekly menu. We discussed the menu with the person who completed the weekly shopping and were told it was developed on the shopping provided. On each day we were at the home there was only one choice of meal.

Most people at the home were able to eat unaided and were able to vocalise if they did not like the food presented to them. However, some people were not eating as much as they needed to ensure they did not lose weight. We saw three people had lost quite significant amounts of weight in the three months prior to the inspection. The home kept weight monitoring charts and recorded people's weight mostly monthly. We saw weight losses had been recorded in this file and the information had not been transferred into people's plans of care. No action had been taken to increase the monitoring of people's diets and no referrals had been made for specialist support.

We found notes in people's records about food allergies and foods to avoid that upon discussion with the chef they were unaware of. This left a risk of people eating food that may cause them harm. We also found when one person was on a pureed diet all the food was pureed together; this left a risk of them not eating the food they needed because it didn't taste like it was meant to.

One person had lost up to 18 pounds in three months. They did not have a plan of care around their nutrition and hydration and the MUST (Malnutrition Universal Screening Tool) used to assess the risk of malnutrition had not been completed since August 2015. Weight loss was not identified in the daily notes or in any relevant care plans. We spoke with the chef and the staff about this person and they were not aware they were losing weight, the chef had not been asked to prepare more calorific food for this person and staff had not been requested to monitor what they ate. The CQC raised a safeguarding alert for this person to ensure they were kept safe.

We looked at five MUST records for people and found they were either not fully completed or were completed inaccurately. For example, all the information was not completed in order for the assessment to determine risk likelihood or the information was inaccurate. One person had a recording of obese on their MUST record when clearly they were not. This would have impacted on the overall score for the assessment and determined them to be a lower risk of malnutrition than they were.

We looked at some of the food and fluid charts, the home had been completing, for people who they had assessed as requiring additional support. We found records were poorly completed with gaps in records where days had not been completed. We could not identify a clear rationale as to why some people had their nutrition and hydration monitored and some did not. For example, one person was being monitored and they had steadily gained weight for the previous six months.

When people's nutrition and hydration needs are not met and the risk of potential malnutrition is not captured this is a breach of Regulation 14 of the Health and Social Care Act HSCA 2008 (Regulated Activities) Regulations 2014.

We spoke with a visiting district nurse who spoke highly of staff at the home. We were told when they visit the staff come with them and take an interest in what they are doing. We were told when they request actions are taken to support people with health conditions, they are taken and people steadily improve.

We saw evidence of visiting opticians and chiropodists and saw people were supported to attend appointments as required. The GP was called when people requested this and people told us staff made sure they took any prescribed medicines to ensure they got better.

Concerns were noted for those people who could not vocalise how they were feeling and could not necessarily share any concerns they had for their own health and wellbeing. Following this inspection the service had agreed to become part of the Quality Improvement Programme and as part of this people's needs at the home would be reassessed by appropriate professionals to ensure their needs were being met and appropriate referrals to specialist teams were made. This included the falls prevention team and incontinence teams where recommendations have already been made.

Most people living at the service were mobile and had a low level of support needs. However, there were some people who, once assessed appropriately, may be living with dementia. The current environment at Grimsargh House required some work to make it a suitable environment for people living with dementia. The flooring at the home was uneven and some floor coverings were highly patterned; this can cause confusion and may increase the risk of falls. The walls were mainly plain white in colour and signage in the

home was poor. This may lead to people living with dementia becoming insecure within their environment as they become less familiar with the layout and location of particular rooms including their own bedroom and the facilities.

We recommend the provider completes the King's Fund dementia environment audit to ascertain how they can best meet the needs of people living with dementia in the home.

Requires Improvement

Is the service caring?

Our findings

People we spoke with who lived in the home told us they knew the staff and got on well with them. They told us there had been some changes in the staffing but things had calmed down a bit. One person told us, "The staff are lovely." Another said, "I know most of the staff and they all treat me ok."

One person told us they would like to go out to church every now and then. When we asked why they didn't they told us they had never been asked if they wanted to. We saw a visiting church undertake a sermon on one afternoon we were at the home. This showed us the home had considered people's faith but had not had specific conversations with people as to how they would like to practise their faith.

We did not see any negative interactions between people living in the home, the staff or manager and found the atmosphere calm. Staff joked with people and we often heard singing over the course of the inspection.

When we looked at care plans we did not see any evidence of people being involved in how their care was planned or delivered.
People we spoke with told us they were asked if they wanted to go to bed but one person told us they were told when it was time to get up. We asked people about how often they had a bath or shower and each told us a specific day. We saw a bath rota in the office which confirmed this was how baths were managed. One person told us, "I have a bath every Monday and I'm happy with that." They were not sure what would happen if they didn't want one on the Monday but thought they would probably have to wait until the next week. We looked at the records for personal care and saw people did routinely have a bath or shower on the same day each week. This also appeared to be the case for cutting people's nails. We saw one person's nails were long and dirty but could not find any record to say they had refused to have them cut.

Three people we spoke with told us they wanted to stay in their rooms and they were given the choice to do this. However, one person told us they wanted to come out of their room. When we asked the manager about this we were told as soon as they were brought into the lounge they wanted to go back into their room. There had not been any exploration or discussion with the person as to why this was the case.

When we looked in bathrooms we saw toiletries. We also saw one bathroom had a pile of towels on wall shelves. We asked the staff what these were used for and were told they are for when people have baths. The toiletries were used when people didn't have their own. There was no records in people's files that this had been discussed with them and if they were happy with this.

We were told the bathroom light had gone out in one person's ensuite. The light was broken for approximately six weeks. Instead of the home repairing the light the person was given a commode to use in their room until the light was fixed. The person and their family were not happy with this and despite raising concerns it was not rectified.

When staff do not involve people with their own care or enable and support them to understand the choices available to them so they can make informed decisions it is a breach of Regulation 9 of the Health and

Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw staff knocked on people's doors before entering their rooms and ensured the doors were closed when supporting people with their personal care. We saw rooms were decorated with people's personal possessions and people told us they liked their rooms.

The home provided hairdressing and chiropody facilities for everyone in the home. Everyone we saw was well presented with the exception of one person's nails.

The home had an open visitors policy and all the visitors we spoke with told us they felt welcome at the home and could talk to the staff about any concerns they had.

Inadequate

Is the service responsive?

Our findings

We spoke with people living in the home about the available activities. We were told most afternoons they sit quietly and watch the television but they can always have a sing song. One person told us, "I like to do crosswords and read the paper and there is always a new one available." Another told us, "I would like to get out more, but am told staff need to come with me and they aren't always available." The home did not have a dedicated activity co-ordinator.

We asked the manager and staff about how people could get out into the community and were told it depends on staff availability. One staff member told us of one resident that they thought should go out more but didn't. We looked at this person's file to ascertain the details of any assessment around visiting the community and one was not available. We were told one had not been completed and were assured one would be done.

We looked at people's care plans that were relatively new to the home. We found initial assessments completed by the home were not always accurate and did not reflect the needs of the person coming into the home. For example, one person who had recently moved into the home was of a low weight but was scored obese on their initial nutrition assessment. This person was also scored very highly on their waterlow (pressure ulcer prevention tool). This may have been reflective of their needs, but scores were used which were not available within the guidance for completing the form. When initial records are not completed accurately there is a risk needs are not going to be assessed accurately and a risk needs may not be met.

We looked at how the home assessed and reviewed people's needs and then how they developed care plans to support the identified needs. We saw the care plans had all been rewritten in January 2016. We looked in detail in six people's care files and pathway tracked aspects of their care and support needs. We found information was generally lacking to ensure people's needs were met. For example, one person's weight had fluctuated in the three months prior to the inspection, first gaining four pounds a month for two months, then losing seven pounds. This person's care plan had not changed and no additional action had been taken to ascertain the reason behind their fluctuating weight. Their food and fluid intake was being monitored but when we reviewed the records there was no increase or decrease in food consumed in relation to their change in weight. There was nothing within their care plan to inform staff of how best to support this person.

We looked at how people's changing needs were assessed and how this impacted on the support provided to them. We found that people's needs were predominantly low in the home but when people did present with higher level needs they were not appropriately assessed. For example, one person had very poor eyesight and poor mobility. They used a frame for mobilising and were assessed as a medium risk of falls. However, their dependency scores for both eyesight and mobility were 0 dictating they were independent or very minimal needs. This person had fallen three times in the last month and no action had been taken and their care plan or risk assessment had not been updated to reflect this.

We saw the home did use extra care monitoring records such as food and fluid charts and body maps.

However, these were not reviewed or used to inform care plans. We saw when they were completed the records were poor and it was difficult to ascertain if they served any real purpose in supporting the home to ensure people's needs were met. For example, when one person had a body map completed identifying areas of concern in October 2015 a plan was put in place to manage this and then each monthly review stated no change. There is no evidence of any further action being taken and no record any previous action had improved the person's condition.

We saw a number of care plans included blanket statements such as, 'won't wear their glasses' and 'doesn't like to wear their hearing aid'. These were not reviewed or the reasons behind them explored. We saw records which stated people had poor hearing or poor sight and professional testing had not been undertaken for some time. This meant that people's communication and eyesight could be worsening and steps had not been taken to support people with this.

In all of the files we looked at we did not see any evidence they had been discussed with the person themselves. We saw limited information that family members had been involved in three of the 24 files we looked at. This meant people were not given the opportunity to influence their own care.

When needs are not appropriately assessed and reviewed and plans are not put in place to meet those needs it is a breach of Regulation 9 of the health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

The manager did not have a record of any complaints received by the home. When we asked to see the complaints policy we were told one was not available as there had not been any received in the two years preceding the inspection. We were later told a new complaints policy was available but it had not as yet been implemented in the home. We asked why no complaints had been logged or recorded. We were told people, "really just have niggles which we deal with at the time". During the course of the inspection we were told of one complaint that had been made to the manager and we overheard another given to the administrator that were not recorded.

When homes do not have an available and implemented complaints policy and procedures detailing how complaints (including niggles) should be managed there is a risk homes may miss opportunities to improve. There may also be a theme to niggles received which, when recorded, could be managed appropriately.

The home did not have a procedure for handling complaints; including receiving, recording, investigating and responding to complaints this is a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Inadequate

Is the service well-led?

Our findings

The home had a current registered manager who had been in post for a number of years. The registered manager had worked at Grimsargh House in one capacity or another for over 30 years.

There had been some long standing staff at the home but some of them had recently left or been dismissed. We could not ascertain how or why this had been done as there were no records available. The CQC had received a number of complaints from previous employees about the circumstances under which they had been dismissed. Staff felt there had been a lack of co-operation from the provider to help them understand the rationale for their dismissal.

There was no available evidence on site that any staff had formal written contracts of employment. This was confirmed for us by both staff and the management. Supervision had not taken place for up to two years and there was no written record of any staff meetings. On one day of the inspection we were provided with both an old and new employee handbook. Both included details of recruitment, staff supervision and appraisal, grievance and disciplinary. Appraisals had not taken place and there was no evidence any formal disciplinary, grievance or capability procedures had been followed for both current and historic staff.

When appropriate procedures are not followed to respond to potential concerns about a person's fitness after they are appointed to a role it is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed our concerns with the manager and director. We were told the staff were employed through an agency. The agency was owned by the provider at the time of the inspection. We asked for the phone number of the agency on at least two occasions and it was not provided. When we raised concerns with the provider and manager about the lack of employment checks for staff it was the manager and administrator at the home who undertook the work to ensure they were completed not an external agency. We also saw the manager and administrator sending off application forms for the recruitment of new staff. The manager confirmed to us that is was them that interviewed new staff, albeit there were no records to support any staff had been interviewed on site. When we asked the manager about how the agency worked we were told it just all goes through the provider. When the provider does not maintain and keep secure records that are required in relation to people employed in carrying on the regulated activity it is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We have ongoing concerns with how staff are recruited, managed and supported at the home and will be investigating this further.

On the day of the inspection we spoke with one visiting professional who told us they felt the staff at the home responded appropriately to their advice and took care to follow their instructions to support people. However, since the inspection we have heard from other professionals including external commissioning support groups with whom the home and provider had not worked so well. We found that there was a lack of understanding of the roles of the different professional organisations. The provider and manager did not

have an up to date understanding, of the methodology and regulations, required for registration under the Health and Social Care Act (Registered Activities) Regulations 2014.

The home did not have an active set of policies and procedures. New policies had been purchased and brought to the home in January 2016. The policies took account of the new methodology for inspection and regulations. However, the manager had not read them and staff had not looked at them. No training had been provided to either the manager or staff team to support the new polices being implemented. The old policies and procedures were not available and as such there was not any formal structure for the provider to measure the home's performance. Of particular concern were the three dogs in the home. There were people living in the home with pulmonary conditions which could be affected by pets. The provider had not risk assessed this before the dogs were allowed in the home.

The management structure at the home was confusing. We were told different perspectives by the provider, registered manager and appointed consultant, as to the role of the consultancy company. These varied from managing the finances and doing the shopping to acting as a conduit between the home and the provider. The staff were also confused as to the roles of the different people in the home. Over the course of the inspection we noted the roles of staff changed from day to day. One day one person was the administrator and another they were a care assistant, likewise for another person from cook to senior carer. There was no available evidence in the home to support these people had received the required induction and training to undertake the roles which they were performing. This was of particular concern for one staff member who was administering medication without appropriate training.

Care and support could not be provided in a safe and effective way to the people living in the home as there was not an appropriate, consistent and measured way to guide the management of the service. This left a risk of inappropriate and unsafe care being delivered and is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home did not have a set of quality audits or a system of quality assurance. After the inspection we requested the provider inform us of how from their perspective they ensured the service was assessed and monitored to improve the quality and safety of the services provided. This was to include the quality of the experience of service users in receiving those services. Also how they assessed monitored and mitigated the risks relating to the health, safety and welfare of service users and others who may be at risk. The response did not clarify how the provider was doing this. The letter did say how going forward they would address some of the concerns identified within the feedback from this inspection but a clearly defined quality monitoring system was not identified.

Over the course of the inspection we requested to view a number of documents including risk assessments, monitoring information and information the home had to show how people who lived in the home and, where appropriate, their families were involved in and consulted with, on how the home was run. We were told by the manager a large amount of information was not available. Since the inspection the provider has indicated that records that should have been held secure had been removed by people and hidden almost in an act of sabotage. It is the registered manager's and provider's responsibility to ensure records are held securely. Where information of a sensitive and confidential nature is mislaid, the police should be informed and action taken to protect the individuals involved. To date the police have not been informed of these concerns. The police have however been made aware of the concerns of the Care Quality Commission.

Risk assessments were not available for the property and for specific identified risks. This included for one person who had restricted mobility whose room was on a corridor with uneven flagged flooring which included a manhole cover. The corridor also held the laundry and sluice room and was seen to be used to

store the hoover and people's washed laundry. This also included one person who had a wardrobe placed in such a way they were required to twist and bend increasing the risk of falling. We requested the wardrobe be moved after identifying this risk and discussing the risk with the room occupier.

Risks to the building had not been identified as there was a lack of environmental audits. This included fire doors that were wedged open or that didn't fit in the frame, a lack of window restrictors and poor and uneven floor coverings.

The home had not developed or embedded a system of quality assurance and did not hold resident and relative meetings to gather their feedback. There was not a suggestion box or any other formal route for feedback on the service to be gathered. Questionnaires and feedback requests had not been provided for people who lived in the home since this provider took ownership over two years previously. We were assured this process had begun but again no clear quality assurance system was in place at the home or identified going forward.

When there is not a clearly defined and operating system to assess and monitor service provision it is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider and home were not displaying the ratings from their last inspection in March 2015. This is a breach of Regulation 20a of the Health and Social Care Act (Regulated Activities) Regulations 2014.

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	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not sent to the commission all required notifications of other incidents, including serious injury notifications and notifications of allegations of abuse.

The enforcement action we took:

Notice of Decision to cancel manager's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not involved with developing their care plans. Assessments were not completed correctly and when needs were identified they were not met.

The enforcement action we took:

Urgent Notice of Decision to restrict any new admissions to the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Consents were not acquired from people before support was provided. People's capacity was not assessed to determine if they could give consent.

The enforcement action we took:

Urgent cancellation of provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments were either not completed or not completed accurately. Where risks were identified appropriate action was not taken to mitigate risks. Emergency planning had not taken

place and medicines were not managed safely. Staff were not recruited or managed to deliver a safe service.

The enforcement action we took:

Urgent cancellation of provider's registration

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 Safeguarding procedures were not followed and staff had not been trained in appropriate safeguarding procedures. Restrictive practice was implemented but not legally assessed.

The enforcement action we took:

Urgent cancellation of provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Where people were at risk of malnutrition the home did not take the required steps to support them.

The enforcement action we took:

Urgent cancellation of provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider did not have an active complaints policy and procedures. Complaints were not recorded, investigated or managed to improve the service.

The enforcement action we took:

Notice of Decision to cancel manager's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service did not have a system of quality audit to monitor how the service was delivered. People using the service were not asked for their feedback on how the service was provided. Accurate records were not kept securely.

The enforcement action we took:

Urgent cancellation of provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed There was no available evidence staff had been safely recruited. Staff did not have a formal contract of employment. There was no available evidence to inform the decision that staff had become unsuitable to carry on their role and there were no records of either capability or disciplinary before staff were dismissed.

The enforcement action we took:

Urgent Notice of Decision to restrict admissions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The provider was not displaying the ratings from the last inspection in March 2016

The enforcement action we took:

Notice of Decision to cancel manager's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The were not enough suitably trained staff to meet the needs of the people living in the home. Staff did not receive training and supervision to enable them to competently fulfil their role.

The enforcement action we took:

Urgent cancellation of provider's registration.