Oceancross Limited

Grace Lodge Nursing Home

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

About the service
Grace Lodge Nursing Home provides accommodation and nursing and/or personal care to up to 65 people over 2 floors. At the time of our inspection, there were 31 people using the service.

People's experience of using the service and what we found
Medicines were not always managed safely. People did not always receive their prescribed medicines due to lack of stock. Staff did not always follow guidance from medical professionals when using specialised techniques to administer medicines. Medicines were not always stored safely or securely. Plans were not in place to guide staff when to administer 'as required medicines' to ensure they were only given when needed.

Risks to people's health, safety and well-being were not always managed safely. Some risks assessments had either not been completed or lacked accurate information to determine the level of risk posed. Care plans lacked detailed information for staff to follow in order to manage people's identified risks. Records relating to the safe evacuation of people during an emergency were out of date and lacked detailed information for staff to evacuate people safely.

Staff were observed following unhygienic practices whilst providing people with their breakfast. This was raised with the acting manager during the inspection. The home was visibly clean and hygienic. However, cleaning records required improvement to ensure all tasks completed were recorded. We have made a recommendation regarding this. The service was following current guidance in relation to visiting procedures and the use of masks.

Accidents and incidents had been recorded and information provided to show what immediate action had been taken to keep people safe. However, there was a lack of managerial oversight and detailed review or analysis to ensure lessons were learnt. We have made a recommendation regarding this.

Consent for care had not always been obtained in line with the principles of the Mental Capacity Act 2005. Where people had been assessed as having capacity to make specific decisions about their care, consent forms had been signed by staff and not the person themselves.

People told us, and observations confirmed, that they were supported by staff to have maximum choice and control of their lives and that staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service mostly supported this practice.

Staff did not always have access to accurate or detailed information about risks, needs and preferences regarding people's food and drink intake; this included kitchen staff. People's needs had been assessed before moving into Grace Lodge. However, care plans lacked detailed information about how to support people and important information from initial assessments had not always been transferred to people's care plans.

Governance systems in place had failed to identify issues and drive necessary improvements to the safety and quality of the service people received. Audits and checks had not identified the issues we found during the inspection and where issues had been identified, action had not always been taken to address them.

Notifications of incidents had not always been reported to CQC as required by law.

We could not be certain the service promoted a person-centred culture; this was because records relating to people's care and support lacked detailed information and guidance for staff to follow. Staff told us morale amongst the staff team had been low and that they had not always felt supported, especially when raising concerns to the previous manager.

The provider and acting manager were responsive to the feedback we provided both during and after our inspection. They provided some evidence of what action they intended to take to improve people's care plans and had taken action to address some of the medicines issues we identified.

People told us they felt safe and interactions between staff and people living in the home were observed to be kind and compassionate. There were enough staff to support people and provide care in a timely manner.

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

Rating at last inspection
The last rating for this service was good (published 25 September 2021).

Why we inspected
The inspection was prompted in part by notification of an incident following which a person using the service died. This incident is subject to further investigation by CQC as to whether any regulatory action should be taken. As a result, this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk of people's prescribed medicines. As a result, we undertook a focused inspection to review the key questions of Safe and Well-led only.

During the inspection process, we identified additional concerns that sat outside the key questions Safe and Well-led. We were therefore required to also review the key question of Effective.

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

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 changed from good to inadequate based on the findings of this inspection.

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

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.

Enforcement and recommendations
We have identified breaches in relation to risk management, medicines management, consent, notifications of incidents and governance.

We have made recommendations in relation to infection prevention and control practices and the review and analysis of accidents, incidents and safeguarding concerns.

Please see the action we have told the provider to take at the end of this report.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

This service was not safe.

Details are in our safe findings below.

Is the service effective?

Inadequate

This service was not effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

This service was not well-led.

Details are in our well-led findings below.

Grace Lodge Nursing Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the 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
This inspection was carried by 2 inspectors and a medicines inspector on day 1 and an inspector and medicines inspector on day 2.

Service and service type
Grace Lodge Nursing Home 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. Grace Lodge is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was not a registered manager 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 this information to plan our inspection.

The provider had completed a provider information return (PIR). However, due to technical reasons, this information was not used to help plan the inspection. The PIR 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.

During the inspection
We spoke with 2 people who used the service and 6 family members about their experiences of the care provided. We spoke with 10 members of staff; including nurses, care staff, kitchen staff and domestics. In addition, we spoke with the acting manager and provider.

We reviewed 6 people's care records and medicine administration records for 8 people. We looked at 4 staff files in relation to recruitment and a range of other records related to the overall management of the service.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

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 good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

- Medicines were not always managed safely.
- Where people were prescribed time specific medicines, such as paracetamol, staff were not always recording the times they had been administered. This meant we could not always be certain the required time gap was being observed. This placed people at risk of overdose.
- People's prescribed medicines were not always available due to lack of stock.
- Staff did not always follow health/medical professional guidance when administering medicines via a specialised technique, for example through a percutaneous endoscopic gastrostomy (PEG). This placed people at risk of harm.
- Medicines were not always stored safely. No action had been taken when fridge temperatures were recorded to be out of safe range. This placed some medicines at risk of becoming ineffective or harmful.
- Where people were prescribed 'when required' medicines, plans were not always in place to guide staff as to when these medicines should be used.

The failure to ensure medicines were managed safely, placed people at risk of avoidable harm. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following the inspection, the provider told us they had taken action to address some of the issues we identified. This included changing medicines supplier to ensure people always had the required stock in place. However, we are not assured at this time that medicines will be consistently and effectively managed as the provider had not identified all of these concerns themselves. We will check that these changes have been embedded successfully and sustained to reduce risk at our next inspection of the service.

Assessing risk, safety monitoring and management

- Risks to people's health, safety and well-being were not always managed safely.
- Some risk assessments had either not been completed or contained inaccurate information to determine the level of risk posed. For example, 1 person's assessment in relation to nutritional risks had not taken into consideration recent weight loss. This meant their overall risk score was inaccurate.
- Care plans lacked detailed information for staff to follow in order to manage people's identified risks and keep them safe from avoidable harm. For example, where people had diabetes, there was no information or guidance around how to identify changes in health and what action staff should take. Also, where 1 person had a catheter in place, there was no guidance in place for staff to ensure their catheter was safely managed to reduce the risk of infection.
- Staff did not always follow correct guidance when people's blood sugar levels dropped below their normal

range. This placed them at risk of becoming unwell.
● There was a lack of accurate and detailed information available to help staff and emergency services safely evacuate people in an emergency. The 'fire risk assessment cover sheet' had not been reviewed since September 2022 and the 'resident fire check' did not accurately reflect current people living in the home. In addition, there was no information about people's mobility support needs or level of understanding.

A lack of detailed and accurate information regarding people's identified risks, placed people at risk of avoidable harm. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The acting manager and provider had acknowledged that improvements were needed to people's care plans and had taken action to address issues following our initial feedback. However, we are not assured at this time that medicines will be consistently and effectively managed as the provider had not identified all of these concerns themselves. We will check that these changes have been embedded successfully and sustained to reduce risk at our next inspection of the service.

Preventing and controlling infection
● We could not always be certain that safe infection prevention and control practices were being followed.
● On day 1 of our inspection, staff were observed carrying trays with multiple plates of uncovered food into people's rooms, placing the tray on the bed then moving to the next room. This practice was unhygienic and placed people at risk of possible infection.
● A nurse was observed carrying out unsanitary practice whilst providing care to a person with a PEG.
● The home was observed to be visibly clean. However, cleaning records did not fully reflect all cleaning tasks being completed and when. This meant we could not be certain all measures were in place to ensure the home remained clean and hygienic.

We recommend the provider seeks guidance from a reputable source around infection prevention and control practices and updates their process accordingly.

● Visits to the home were conducted in line with current visiting guidance.

Learning lessons when things go wrong; Systems and processes to safeguard people from the risk of abuse
● Accidents, incidents and safeguarding concerns were not always reported to CQC and other stakeholders as required. We have referred to this further in the well-led section of this report.
● Accidents and incidents lacked managerial oversight to show what action had been taken following incidents occurring.
● We could not be certain that lessons were being learnt when things went wrong. This was because there was a lack of review and analysis of incidents to help identify patterns and trends and prevent them occurring in the future.

We recommend the provider seeks guidance from a reputable source around the review and analysis of accidents, incidents and safeguarding concerns and updates their process accordingly.

● Staff had received safeguarding training and knew what actions they needed to take if they had any concerns.
● People told us they felt safe. One person said, "I've never had any problems. The staff are nice. They look after me. Yes, I feel safe."

Staffing and recruitment

● We observed there to be enough staff on duty to support people safely. Requests for help and support were responded to in a timely manner.

● People told us staff provided support when they needed it. One person said, "I don't wait for very long. They [staff] help me when I need it."

● Safe recruitment processes were in place. A range of pre-employment checks were completed on new applicants to ensure they were suitable to work at Grace Lodge.

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 last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

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.

- Consent for care was not always obtained in line with the principles of the MCA 2005.
- Assessments completed for 2 people stated they had capacity to make decisions about their care. However, their consent forms had been signed by a representative of the home. This meant we could not be certain they had been supported to make their own decisions.
- One person who had been assessed as not having capacity, had a family member with legal authorisation to make decisions about their care. However, their consent form had been signed by a representative of the home and not the family member.

A failure to obtain consent in line with the MCA 2005, is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People and family members told us, staff always asked for consent before carrying out care and support tasks.
- Applications to deprive people of their liberty had been completed appropriately and in line with the MCA.

Supporting people to eat and drink enough to maintain a balanced diet; Assessing people's needs and choices; delivering care in line with standards, guidance and the law
- Staff did not always have access to accurate or detailed information about risks, needs and preferences

regarding people's food and drink intake. For example, there was no information or guidance available for staff to support 1 person with risks associated with choking.
● Kitchen staff had not been provided with accurate and up-to-date information about people's dietary requirements. For example, 4 people with diabetes had been assessed as requiring a low sugar diet. However, kitchen staff were only aware of 1 person who required this. In addition, kitchen staff were not aware of 1 person who needed their food to be fortified due to a risk of weight loss.
● People's needs had been assessed prior to moving into Grace Lodge. However, staff did not always have access to detailed information about how to support them. For example, 1 person had a diagnosis of Parkinson's Disease. There was no information about how this condition affected their health or how staff should support them.
● Important information from initial assessments completed by health and social care professionals was not always transferred to people's care plans. For example, 1 person required a modified diet due to choking risks. Information in their hospital discharge notes about why they required this and how to support them had not been included in their nutrition care plan.

A lack of accurate and detailed information regarding risks associated with food and drink intake and people's identified needs, placed people at risk of avoidable harm. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Food preference sheets had been completed that detailed people's likes, dislikes and preferences in relation to food and drink. However, this information had not been shared with kitchen staff. We raised this with the acting manager who took action to address this.
● We observed people being supported with their meals in a kind and compassionate way by staff.
● Kitchen staff told us if people requested it, they provided alternative meals to suit people's individual preferences.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● Care plans contained evidence that people had received support from healthcare services. However, some records suggested staff had not always requested this support in a timely manner or whether support had been considered as being required.
● Where healthcare advice had been provided, care plans had not always been updated to reflect any changes in support needed. For example, 1 person had been reviewed by the SALT team due to choking risks. The update in this person's care plan stated, 'refer to dietician's letter' and had not included detail about the advice that had been given.

Staff support: induction, training, skills and experience
● Records indicated that staff had received training relevant to their role.
● Most staff told us they felt they had received the training they needed to support people. However, some staff told us they had not received training in relation to adding thickening powder to people's drinks or how to apply topical creams.
● Staff had received formal supervisions. However, some staff told us these had not been completed in recent months.
● Family members felt staff were knowledgeable and told us their relatives were well looked after.

Adapting service, design, decoration to meet people's needs
● The service had been adapted to meet people's needs.
● People's rooms had been decorated to their choice.

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 good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Continuous learning and improving care

- Governance systems in place had failed to drive necessary improvements to the safety and quality of the service people received.
- Audits and checks that had been completed had not identified the issues we found at this inspection in relation to risk management, medicines management, care plans, accidents and incidents, and consent.
- We could not be certain that scores awarded following some audits were an accurate reflection of the quality and safety of the service. For example, an infection prevention and control (IPC) audit completed by the service in May 2022 gave a score of 100%. However, in June 2022, an external health professional completed an inspection and gave a score of 52%.
- Where audits had identified issues, we could not be certain action had been taken to address them. For example, internal health and safety maintenance audits completed in August, September and November 2022 had identified that 3 window fly screens were broken. These remained broken at the time of our inspection.
- Family members told us they did not always feel their complaints had been listened to, investigated and acted upon. This meant there were missed opportunities to improve the care people received.

Lack of effective systems in place to identify issues and drive necessary improvements to the safety and quality of the service is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider had implemented clinical reviews since November 2022. The aims of these reviews were to identify any changes to people's health and whether appropriate action had been taken to ensure they received the right support. Further work was required to ensure these were fully embedded and completed effectively.
- The provider acknowledged their lack of oversight of the service and told us they had already taken action to address this. We will check that these changes have been embedded successfully and sustained to reduce risk at our next inspection of the service.

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

- Notifiable incidents had not always been reported to CQC as required by law.
- We found 4 incidents that had occurred between April 2022 and November 2022 that had not been shared with CQC.

Failure to report notifiable incidents to CQC is a breach of Regulation 18 Care Quality Commission (Registration) Regulations 2009.

● The previous registered manager had resigned from their post a week prior to our inspection. The provider had promoted a nurse to acting manager.
● On day 1 of our inspection, the acting manager had acknowledged that improvements were needed to the overall quality and safety of the service.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Records relating to people's care and support needs lacked detailed information and guidance for staff to follow. This meant we could not always be assured people were receiving person-centred care.
● The provider and acting manager were aware that improvements were needed to people's care plans. They provided evidence of how they intended to address these issues.
● Some staff told us they had not always felt supported by the previous manager, particularly when raising concerns about how they had been treated by some senior staff. One staff member said, "I reported issues to the previous manager, but they didn't do anything about it."
● The acting manager told us they had implemented regular meetings with staff to enable them to discuss any concerns. They were aware of the low morale and were working to address these issues.

Working in partnership with others
● We could not always be certain that referrals to health and social care professionals had been completed in a timely manner by staff or managers.
● We saw evidence from some records that where health professionals had been involved in people's care, the service followed advice and guidance. However, care records did not always reflect, in detail, the advice/guidance given.
● The provider and acting manager were responsive to our feedback throughout the inspection and took some action to address issues found.

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
● The provider was aware of their legal responsibility to be open and honest when things went wrong.

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 Incidents had not always been reported to CQC as required by law.

The enforcement action we took:

NoP to cancel provider registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Consent for care and treatment had not always been obtained in line with the principles of the MCA 2005.

The enforcement action we took:

NoP to cancel provider registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always managed safely. Records relating to risks to people's health, safety and well-being were either not completed, not accurate or lacked detailed information for staff to follow.

The enforcement action we took:

NoP to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems had failed to identify issues and drive necessary improvements to the quality and safety of the service provided.

The enforcement action we took:

NoP to cancel provider registration.