Brighterkind (Granby Care) Limited

The Granby

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This focused inspection took place on 26 April 2018 and was unannounced.

We carried out this inspection because between February 2018 and April 2018 we had been notified of a number of health and safety concerns which included, equipment failure (wheelchair) and falls in the service resulting in serious injuries. The inspection looked at two of the five questions we ask about services: is the service safe? And is the service well led? This is because we needed to know if people were safe in the service; and that the identified risks associated with the notifications we had received had been dealt with appropriately.

This report only covers our findings in relation to these topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Granby on our website at www.cqc.org.uk.

No concerns or significant improvements were identified in the remaining Key Questions during our inspection activity so we did not inspect them. The ratings from the last comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection.

At our last comprehensive inspection in March 2017 the service was rated as good.

The Granby is a 'care home' providing nursing and residential care to a maximum of 82 older people and people with a physical disability. At the time of our inspection there were 60 people who used the service.

People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

There was a registered manager in post. A registered manager is a person who has registered with CQC 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.

People were not always protected from avoidable harm or risk. Where accidents and incidents had occurred, assessment, monitoring and mitigation of risk towards people who used the service with regard to accidents/incidents and falls was not always robust.

People remained at risk from a lack of management oversight to ensure health and safety checks were robustly implemented. On-going quality assurance checks and oversight by the management team had failed to ensure that gaps identified in the provider's health and safety checks completed in April 2018, had been implemented.

The provider did not always maintain people's data following the Data Protection Act 1998 in that archived records of care and treatment were not stored securely or confidentially.

The provider is in breach of two regulations of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulations 12 and 17. You can see what action we told the provider to take at the back of this report.

There were sufficient staff on duty to meet people's needs. People told us they felt safe and recruitment of staff was carried out robustly.

Infection prevention and control measures were effective. The service was clean with no malodours.

Medicines were managed safely by staff who completed training in medicine management and safeguarding awareness. They were able to speak confidently about these areas of practice.

This is the first time the service has been rated as Requires Improvement.

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 consistently safe.

The monitoring, review and mitigation of risk for people who used the service was not robust.

People were protected from the risk of abuse. Medicines were managed safely and infection prevention and control practices were effective.

The review of staffing levels and skill mix was robust and recruitment of staff was completed safely.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The management within the service did not effectively support the quality assurance systems within the service. Known risks were not acted upon and archived records of care were not stored securely.

The registered manager supported the staff team and ensured that people who used the service were able to make suggestions and raise concerns.

The Granby

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.

We undertook an unannounced focused inspection of The Granby on 26 April 2018. The inspection team consisted of two inspectors.

The inspection was prompted in part by notification of an incident following which a person using the service sustained a serious injury. Because this incident is subject to a criminal investigation, we did not investigate the circumstances of the incident during the inspection. However, the information shared with CQC about the incident indicated potential concerns about the management of risk of falls, falls from height, falls from a wheelchair and unsafe equipment. This inspection examined those risks.

The team looked at two of the five questions we ask about services: is the service safe? And is the service well led? This is because we needed to know if people were safe in the service; and that the identified risks associated with the notifications we had received had been dealt with appropriately. No concerns or significant improvements were identified in the remaining Key Questions during our inspection activity so we did not inspect them. The ratings from the last comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection.

Between February and March 2018 the provider had notified us of four injuries sustained by people at the service in relation to falls. These along with the latest incident above were the reason we decided to carry out a focused inspection looking at risk and how this was monitored and managed within the service. Two of these incidents are being looked at by the safeguarding team at North Yorkshire County Council.

Prior to our inspection we looked at the information we held about the service, which included notifications sent to us since the last inspection. Notifications are when providers send us information about certain changes, events or incidents that occur within the service. We also contacted North Yorkshire County Council (NYCC) safeguarding and commissioning teams, and we spoke with the police who conducted an

initial investigation into the cause of the incident. We asked the registered manager to provide us with copies of the care records for the four people who sustained injuries and these were collected from the service a week before to our inspection. The information we gathered was used to plan our inspection.

At this inspection we spoke with the registered manager and four members of staff including two maintenance people. We spoke with people as we walked around the service, but did not carry out any in-depth discussions.

We looked at the care records of five people who used the service including care plans and risk assessments. We checked the service contracts for equipment and services, plus the health and safety records and risk assessments completed by the maintenance team. We looked at accident and incident reports and quality assurance documentation including audits. We measured all of the restricted window openings within the service to ensure they were safe for people.

We reviewed three recruitment files for staff members and obtained copies of the staff training plan and four weeks of work rotas. We looked at five medicine records and checked records relating to infection prevention and control and safeguarding. We asked the provider for additional information at the end of our inspection and this was sent to us by 2 May 2018.

Inadequate

Is the service safe?

Our findings

The maintenance records we looked at showed that there was a series of health and safety checks which were completed by the maintenance team on a weekly and monthly basis. However, these did not cover the whole of the building and some had been completed inconsistently, which meant people were left at risk of harm.

For example, maintenance records showed window restrictor checks had not been completed from January 2018 to March 2018. The maintenance team told us the omissions were due to the recent refurbishment of the windows. The maintenance team told us they presumed the contractor would leave the windows in the same state as found; with restrictors fitted. The provider had failed to complete checks to ensure this was the case, which meant people were at risk of avoidable harm.

Because of the failure to complete checks to maintain the health and safety of people who used the service an incident occurred in April 2018, where a person came to harm. The incident prompted the maintenance team to check all the windows in the service. Records showed they found that six rooms did not have window restrictors in place.

During our inspection we found there were on-going safety risks due to window contractors leaving rooms unattended, unlocked and with windows missing or window restrictors not in place. At 11:15 we walked into a room that was being refurbished and we found the door lock had been disabled. There was no one in the room and the workmen had removed the sashes from the window leaving an opening in the wall that presented a risk from falls to people who used the service. We discussed our concerns with the maintenance team who immediately spoke with the workmen about safety. However, when we returned to the room later on in the day at 15:40 we found the workmen had gone home, leaving the door un-lockable and the window without restrictors fitted. Because of our feedback the maintenance team fitted the door lock and window restrictors.

We asked the registered manager for a copy of the risk assessments completed for the on-going refurbishment work of the windows. We were given the contractor's risk assessment, but we found this related to the safety of their workforce and not that of people who used the service. The provider had carried out their own risk assessment in August 2017, but the controls they said were in place to reduce risk to people were not being followed. These included monthly checks of windows and restrictors, local area of works being secured where restrictors were deactivated and work area inspection on completion of works. This left people at risk of harm.

Following our feedback to the registered manager and area manager at the end of the inspection we were sent an up to date risk assessment from the provider. We were told the contractor had been spoken with by the provider and the contractor had taken appropriate action with their workforce. The maintenance team had implemented daily checks on the work completed at the end of each day.

We noted that the bannister heights of the staircase were 900mm and posed a potential risk of falls to

people who used the building. We discussed with the registered manager about current legislation and building regulations and they agreed to look at this further. Following the inspection we received a risk assessment completed by the provider on the risk of falls in relation to the height of the bannister. This included guidance for staff on how to mitigate the identified risks.

As part of our walk around of the building with the maintenance team we visited the third floor of the service, which was being used as a storage area. In one unused room there were two windows without restrictors. Although doors on this floor had notices which stated they must be kept locked, we found they were open. We noted that items such as aerosols and personal care records were stored in the rooms that were open. The access to the aerosols presented a risk to people's health and safety. The unlocked doors meant confidential documentation was not stored securely and was accessible to people without restriction.

A notice stating 'Fire door keep locked shut' had been ignored by staff and was open. This meant people had direct access to the roof void. The maintenance team acted immediately to lock this area. We advised the registered manager to contact the fire officer to confirm that the fire doors could be locked, without it affecting the safe evacuation of the building.

Prior to an incident in April 2018 where a person suffered harm from a fall from a wheelchair we found that the provider had failed to ensure staff followed their risk assessment process for use of wheelchairs. Staff were expected to carry out visual checks of wheelchairs before use, but we found they failed to report any defects seen to the maintenance team. Care files also lacked risk assessments and care plans for the safe use of wheelchairs. This meant people were left at risk of avoidable harm.

Equipment used to assist people in the service was not always fit for purpose. Records from January 2017 up to March 2018 showed that wheelchair checks and maintenance/repair were not part of the health and safety routines carried out by the maintenance team. There was also no contract agreement in place for maintenance from an outside contractor. Following an incident in April 2018 all wheelchairs in the service had been checked and 10 with identified faults had been removed from service and locked away until they could be disposed of or mended. A new protocol for red tagging and removing of wheelchairs until repaired had been put in place.

There was evidence the registered manager was recording accidents and incidents within the service and reporting on these to the provider. However, control measures to reduce risks were not put in place until after an event occurred. The ineffective oversight, assessment and monitoring of risk meant people's health, safety and wellbeing was not always protected or promoted.

Because of the concerns we found, the provider is in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People told us they felt safe in the service. Staff received training on making a safeguarding alert to the local authority for further investigation where appropriate to do so. Staff told us they would have no problem discussing any concerns with the managers and were confident any issues they raised would be dealt with immediately.

There were contingency arrangements in place so that staff knew what to do and who to contact in the event of an emergency. The fire risk assessment for the service was up to date, but required review after our concerns about the locked/unlocked fire doors on the third floor. Fire safety training for staff was completed and fire drills/evacuation scenarios took place on a regular basis. The last recorded dates for these were in

March and April 2018. Personal emergency evacuation plans (PEEPs) for people who used the service were in place and up to date. A PEEP records what equipment and assistance a person would require when leaving the premises in the event of an emergency.

The provider had a business continuity plan in place for emergency situations and major incidents such as flooding, fire or outbreak of an infectious disease. The plan identified the arrangements made to access other health or social care services or support in a time of crisis, which would ensure people were kept safe, warm and have their care, treatment and support needs met.

Records showed us that service contract agreements were in place for moving and handling equipment such as hoists and slings, fire safety, electric, gas and water systems. The associated equipment was regularly checked, serviced at appropriate intervals and repaired when required.

Robust recruitment practices were followed to make sure new staff were suitable to work in a care service. These included application forms, interviews, references and checks made with the disclosure and barring service (DBS). DBS checks return information from the police national database about any convictions, cautions, warnings or reprimands. DBS checks help employers make safer decisions and prevent unsuitable people from working with vulnerable client groups. Monthly checks of nursing registrations were carried out to ensure the nurses remained on the Nursing and Midwifery Council (NMC) register and were deemed fit to practice.

The registered manager sent a monthly return to the provider, which included staffing levels and people's dependency needs on it. We checked four weeks of the staff roster; this indicated there were sufficient staff on duty over the 24 hour period to meet people's needs. Agency staff were used to cover gaps in the shifts and the registered manager obtained agency profiles and tried to use the same agency staff for continuity of care. All staff including the agency workers had an induction to the service, which was signed off by the manager or senior nurses. We observed people were settled and relaxed in the service. Any calls for attention throughout the day were dealt with straight away and people received a good standard of care. We observed staff and people chatting to each other and there were good interactions between everyone we saw.

An infection prevention and control audit had been completed and had an action plan in place. We looked at the communal areas and in some people's bedrooms (with their permission). Premises were clean and there were no malodours. One person told us, "My room is clean and they change the bed linen regularly."

The arrangements for managing people's medicines were safe and staff received refresher training updates to ensure their knowledge remained effective. People's medicines were kept under review and medicines were administered to people in a safe way. People were helped and supervised if they needed to be. One person said, "I get them (medicines) on time and that is fine with me."

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post who was supported in their role by a deputy manager and nurses.

During this inspection we found that systems and processes were not established and operated effectively to ensure the service was assessed or monitored for safety in relation to the fundamental standards. The provider and registered manager had failed to do all that was reasonably practicable to ensure safety and quality, and use information to improve the service and mitigate risks.This failure led to two breaches of the Regulations in relation to safe care and treatment and assessment/monitoring of risk.

Provider visits had been carried out monthly and monthly audits had been completed by the registered manager. However, the provider's own governance and quality assurance processes had failed to identify and rectify the breaches of Regulation and risks to people who used the service (which we found during this inspection). This meant the provider had failed to implement timely and responsive actions to mitigate the risks of harm to people who used the service. This resulted in two people being seriously injured.

For example, the monitoring, assessment and auditing of risk within the service did not cover the whole building and the work practices within it. Following two incidents in April 2018 the provider carried out a comprehensive health and safety audit of their practices and documentation. A number of issues were found and an action plan was put in place. However, when we inspected a week later, we found some areas of risk remained such as access to rooms with unrestricted windows and access to unlocked storage rooms on the third floor of the service.

We found that confidential archived records were not kept secure, as we saw files stored on shelves in open store rooms on the third floor.

The provider is in a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although we found concerns around governance and oversight of the service, we also received a lot of positive feedback from staff and people who used the service. They were complementary about the registered manager and their interactions with them.

We saw that the registered manager ensured staff training, supervisions and support were in place and up to date. The registered manager also completed a daily walk around the building speaking to people, relatives and staff during this time.

Feedback from people who used the service, relatives, health care professionals and staff was usually obtained through the use of satisfaction questionnaires, meetings and staff supervision sessions. Records were made available to us for us to see that these took place on a regular basis.

We asked for a variety of records and documents during our inspection. These were readily provided for us

by the registered manager. Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The registered manager had informed CQC of significant events in a timely way.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure risks to people's health and safety and the mitigation of those risks were sufficient to keep people safe from harm, including those around equipment and the environment. Regulation 12 (1)(2)(a-b)(d-e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance A lack of governance and oversight within the service meant effective systems and processes to assess and monitor the compliance of the service were not in place. The registered provider failed to assess, monitor and mitigate risk to the health, safety and welfare of people who used the service. Records relating to the care and treatment of people were not kept secure at all times. Regulation 17(1)(2)(a-c)