

Midland Care Homes Ltd

Grassmere Residential Care Home

Inspection report

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Ratings

Overall rating for this service

Inadequate 

Is the service safe?

Inadequate 

Is the service effective?

Requires Improvement 

Is the service caring?

Requires Improvement 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

About the service

Grassmere Residential Care Home is a care home registered to provide personal care for up to 26 people living in a converted building over two floors. Many people were living with varying stages of dementia; there were also people living with a range of complex health care needs that included those diagnosed with a mental illness, diabetes and neurological conditions. At the time of our inspection, there were 25 people living at the home.

People's experience of using this service and what we found

Since the previous inspection in June 2017, there had been changes in ownership and management of the home. During this inspection we found that the registered provider was in breach of regulations in relation to safe care, person centred care, maintenance of premises and governance. We saw that there were some aspects of the building that were not well maintained and in need of refurbishment to make it a more pleasant place for people to live.

People, relatives and staff gave us feedback about the changes that had been introduced by the provider that had not enhanced people's experiences of care. The provider acknowledged that many improvements were needed to improve the quality of the environment and the care offered.

Work was needed to make sure risk assessments were up to date and reflected people's current needs. Staff did not always know how to keep people safe because there was a lack of detailed guidance available to them. Staff did recognise signs of abuse and understood how to report concerns.

Care plans needed updating to reflect individual choices and preferences; they also needed to be reviewed as people's needs changed to ensure they received responsive care. People told us they wanted more activities to keep them active and that were in line with their interests.

Improvements were needed to make sure all information was given to people in a format they could understand so they could become more involved in their care. Staff that had worked at the home for a long time knew how people preferred to communicate because they were familiar with their needs.

Staff treated people with care and respect.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests. However the policies and systems in the service did not support this practice.

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 16 August 2017). Since this rating was awarded the

registered provider of the service has changed. We have used the previous rating to inform our planning and decisions about the rating at this inspection.

Why we inspected

This was a planned inspection based on the previous rating.

Enforcement

We have identified breaches in relation to safe care, person centred care, maintenance of the premises and quality assurance processes at this inspection.

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.

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.

Follow up

We will request an action plan for 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate ●

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement ●

The service was not always effective.

Details are in our effective findings below

Is the service caring?

Requires Improvement ●

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement ●

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate ●

The service was not well-led.

Details are in our Well-Led findings below.

Grassmere Residential Care 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 Care Act 2014.

Inspection team

The inspection team consisted of one inspector and one inspection manager on 16 July 2019. On 17 July 2019 the inspection team consisted of two inspectors.

Service and service type

Grassmere Residential Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. At the time of the inspection the registered manager was away from work and has subsequently resigned.

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, to support the planning of this inspection. This included details about incidents the provider must notify us about, such as abuse.

We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection

During the inspection we spoke with eight people who used the service and three relatives about their experience of the care provided. We spoke with six staff members including senior care workers, care workers, the cook and domestic staff. We also spoke to the nominated individual; the nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included four people's care records and multiple medication records. We also looked at two staff files in relation to recruitment and a variety of records relating to the management of the service, including policies and procedures.

We also gave the provider the opportunity to discuss any improvements or developments with us throughout the inspection.

After the inspection

We continued to seek clarification from the provider to validate evidence found. We looked at training data and other records relating to people's care. We spoke with the local authority and health professionals who regularly visit the service.

Is the service safe?

Our findings

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

This was the first inspection for this service since the change in ownership.

This key question has been rated inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People were supported by staff who understood the signs of abuse and appropriate action to take should they have concerns. Staff we spoke with were able to describe the action they would take to report any concerns. Staff told us and records confirmed that training had taken place to aid staffs' knowledge of up to date safeguarding procedures.

Assessing risk, safety monitoring and management

- We found that risks to people's care had not always been clearly identified and managed well. In one case there were no detailed risk assessments of the persons behaviour and no risk management strategies or de-escalation techniques to support the person. A lack of robust risk management processes had put people and staff at risk of harm. Staff told us they were not always confident in supporting people when they demonstrated behaviours that put them or others at risk.
- Some people's nutritional needs had been assessed as high risk which meant people were at risk of choking and/or weight loss. One person was seen by Nutrition Services and they recommended a fortified diet, this meant a diet where additional nutrients and calories were added to their diet. The risk assessment had not been updated and this meant staff were not aware of the recommendation and the person had not received the recommended fortification of their meals. They had not reached their target weight and remained at risk of malnutrition.
- We saw the environment was not well maintained and placed people at risk of harm. We saw that there were exposed electrical wires, floors were uneven in places and presented a trip hazard and the external door to the garden was broken and could not be locked to prevent unauthorised access or egress.

The provider's systems and processes to ensure safe care required improvement and was a breach of Regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (regulated activities) Regulation 2014.

Staffing and recruitment

- People told us they did not have to wait long for care and support and we observed that on the day of inspection there were enough staff on duty to meet people's needs. We spoke to staff and a healthcare professional and most of them said there were enough staff.
- Checks such as references and DBS checks were carried out on staff before they started working in the home to make sure they were suitable. The Disclosure and Barring Service (DBS) helps employers to ensure staff are safe to work in a service.

Using medicines safely

- People received their medicines safely and as prescribed. A person we spoke with told us, "I have painkillers and tablets for dementia, paracetamol if I need them. They [staff] get my tablets for me on time". We saw that daily records were maintained by staff showing when people had received their medicines as prescribed.
- Staff had received training in how to administer medication.

Preventing and controlling infection

- We found there were ineffective infection control measures. We saw there were no paper towels or hand sanitiser available for people to use. This meant that people and staff could not be assured that their hands were sanitised and this increased the risk of cross infection. The monitoring checks carried out a month prior to inspection had not identified this.
- We saw staff wearing aprons and gloves however these items were not always disposed of correctly. We saw plastic gloves in an unlidded waste bin in the resident's lounge. We also noted other contaminated items in an unlined bin in the upstairs bathroom.
- We saw a number of areas around the premises that needed improving. The carpet in the residents' lounge was stained and there was an odour, the plastic table cloths in the dining room had holes in them making them difficult to keep clean. In the kitchen, the extractor fan was broken and the floor had been repaired with tape and was dirty. We were concerned about the security of the premises. This meant that people were not living in a clean, homely and safe environment.

The provider's systems and processes to ensure effective infection control measures required improvement and was a breach of Regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (regulated activities) Regulation 2014.

Learning lessons when things go wrong

- Accident and incidents were recorded by staff. The information was not analysed by the management team to identify any patterns or trends. This meant there was no evidence of how the provider had learnt from previous events and put that learning into improving the delivery of service.

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.

This was the first inspection for this service since the change in ownership.

This key question was rated as requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs were assessed prior to admission to make sure their needs could be met by the service. We saw information about a known risk in one person's pre-assessment that had not been considered in their care plan and showed that the assessment process wasn't effective and exposed people at risk of their needs not being met.

Staff support: induction, training, skills and experience

- Records showed that most staff had received training to enable them to meet people's needs. However, this training had not always resulted in staff being competent. For example, training to support people when they demonstrated behaviours that put them or others at risk. The staff told us they were not confident in this area and did not feel the training equipped them to manage behaviours that were considered challenging. This meant people were at risk of not receiving the support they needed to keep them safe
- Staff told us and records showed us that staff had received an induction to the service. Where required, staff had started to complete the Care Certificate. This is a nationally recognised set of standards designed to give new staff the basic knowledge required to deliver safe and effective care.

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

- People were mostly happy with the food that was provided. Meals were pre-plated in the kitchen and then shown to people to help them choose. We saw hot and cold drinks were offered in the morning and afternoon but there were no side tables in the lounge for people to put them on. We saw one person had been given a meal with a plate guard on the wrong way, this was not noticed by staff and did not support the person to eat independently in a dignified way.
- Staff knew which people were on a soft diet, however staff did not know that one person needed a fortified diet because they were at risk of malnutrition.
- People were weighed regularly, and appropriate referrals had been made to professionals for their input to support people but the professional's guidance had not been consistently followed.
- People were able to access the satellite kitchen to make themselves a snack or a drink if they were able to do so. Staff told us that some cultural diets were catered for, people told us that Caribbean food was not offered and they relied on family to provide it, staff spoken with confirmed this.

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

- People had access to healthcare services when required to promote their health and well-being. One health care professional told us that the service deals with concerns 'quickly'.
- Staff monitored people's health care needs and would inform relatives and healthcare professionals if there were any changes in people's health needs.
- Systems were in place such as handover meetings, to update staff coming on duty with people's health and support needs. However these were not always effective as staff did not know that one person required a fortified diet.

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

- We looked at how people's individual needs were met by the design and decoration of the home. We found improvements could be made in the home for people living with dementia. For example, more thought was needed to help people find their way around the home safely and to know where they were. There were very few dementia friendly signs or use of colour to help people find certain rooms or orientate themselves.
- People, relatives and staff told us a number of areas needed improvement to make the home homelier and more welcoming. One member of staff said, "There isn't a nice place in the home" and a relative told us, "It's not set up for elderly residents." Our observations confirmed that the home was in need of refurbishment, and where work had been commenced it had been left incomplete.
- Carpets and flooring needed replacing and the décor needed updating. There were very few pictures, photographs, games and books to stimulate conversation or encourage activities.
- The home had some large communal areas, these were loud and there was no quiet space for people to relax. The garden was not well-maintained and the ramp to access the lawn was too narrow for wheelchair users.

The provider's systems and processes to ensure the premises were suitable for the purpose for which they are being used required improvement and was a breach of Regulation 15 Premises and equipment of the Health and Social Care Act 2008 (regulated activities) Regulation 2014.

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 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.

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.

- The provider did not have a robust system in place to record mental capacity assessments and best interests' decisions. However, staff understood the importance of checking people gave consent before they provided care and support. People told us and we saw staff asking for consent before they provided support.
- The provider had submitted DoLS applications where they believed people could not consent to receive care and treatment at the home.

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

This was the first inspection for this service since the change in ownership.

This key question was rated requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- People and their relatives were generally happy with the care they received and how staff treated people. One person told us, "Staff know you well and can have a laugh and a joke. Staff talk to you, communicate with you, pretty good girls". One relative said, "Some of the members of staff are fantastic".
- We observed positive interactions between people and staff and we saw staff using people's names. Some people were muddled with their words, but staff were able to interpret their needs based on familiarity. Staff spoke with kindness and compassion about the people they supported.
- Whilst individual staff members were caring, we found that the lack of management oversight in relation to risk assessments, care planning and accessible information meant that some people may not have been cared for effectively.

Supporting people to express their views and be involved in making decisions about their care

- Care plans did not include information about people's likes and dislikes. Most people and relatives told us they had not been involved in their care planning so that they could be involved in saying how they wanted their care to be provided.
- People who could tell us said they were able to make some choices such as the clothes they wore, the time they wanted to get up and go to bed and what they ate and drank from the daily menu options available.
- We did not see any information in an accessible format that would support people living with dementia or cognitive impairment to be involved in decision making about their care.

Respecting and promoting people's privacy, dignity and independence

- People, who were able, told us they were encouraged to do as much for themselves as they were able.
- People told us their privacy and dignity were mostly respected. One person said, "They [staff] always knock door before entering".
- Confidential information was stored securely and only accessible to authorised staff.

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

This was the first inspection for this service since the change in ownership.

This key question was rated as requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People and relatives told us that they had not been involved in the planning of their care and support or in the review of their care plan. The care plans we looked at were not person centred, they did not reflect individuals' choices and preferences or demonstrate how the service supported people as individuals in line with their needs and preferences.
- The care plans we looked at had not been updated when the person's needs had changed. This meant staff could not always give the most effective support. For example, we saw from records that one person had fallen many times in their bedroom, the care plan and risk assessments were not updated to reflect this. This meant that the risk to this person had not been reduced and staff had no clear guidance on how they could provide better support to this person.
- Activities available in the home were not planned or tailored to meet individual needs but decided for people without consideration to their life history, taste and interests.

This was acknowledged by the provider and we were told that plans were in place to review all the care documentation.

The provider's systems and processes to ensure person centred care required improvement and was a breach of Regulation 9 Person centred care of the Health and Social Care Act 2008 (regulated activities) Regulation 2014.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- There were no consistent systems in place to ensure people that lacked the mental capacity to understand decisions being made about their care and support received information they needed in an accessible format. This meant that some people may not have been supported to make decisions and choices about their care.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- The provider employed an activities co-ordinator however the people who were able told us the activities offered did not meet their needs.

- We saw staff trying to engage people in some activities during the inspection but there was no evidence that people had been consulted about what activities they would like or reflected their interests. We did not see activities or hobbies that were person-centred. One person told us that they used to like gardening but there was nothing to interest them other than watching sport on TV.
- We spoke to three relatives and they told us more activities were needed to stimulate people.
- We saw that the service had received a written complaint from a relative about the reduced number of activities. The provider told us activities are offered twice per day on most days however, there is no indication that people are asked what they would like to do.

Improving care quality in response to complaints or concerns

- We received mixed feedback about response to complaints. People told us they knew how to complain but not everyone was satisfied their concern had been resolved. One relative told us the complaint got lost and was not investigated. Another relative told us that they were happy with the response they received.
- We did not see any information around the home that would support people with a cognitive impairment to make a complaint.

End of life care and support

- End of life care was not provided at the time of our inspection but had not been planned for while the person could take part in deciding how they would want to be cared for.
- Care records did not consistently record people's wishes in relation to end of life.

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.

This was the first inspection for this service since the change in ownership.

This key question has been rated inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. At the time of the inspection the registered manager was away from work, staff did not feel that they had adequate leadership and direction to provide the service in a way that met legal requirements.

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

- Most staff we spoke to did not feel listened to or valued. Staff told us appraisals, staff meetings and training were often done in their own time, without any reimbursement.
- The culture of the home was not person centred. A staff member told us that new bedding had been bought for everyone without consideration of people's individual preference.
- Whilst we saw people being offered a choice of meals, these were already plated up and people were asked to choose a meal and not specifically what they would like on their plate.
- The provider acknowledged that care plans were not person centred and said that they will update them.

Continuous learning and improving care

- There were a range of audits and checks in place, but these were not effective. This meant that areas of concern identified at this inspection had not been identified by the provider. For example, management oversight of care records did not identify that risk assessments and care plans had not been updated to reflect changing needs. This meant that some people were not supported safely.
- The provider did not have a system in place for recording mental capacity assessments and best interests' decisions to evidence where people had been involved in decisions about their care.
- Audits had failed to identify that areas of the home were unsafe and not designed to meet the needs of people with dementia.
- Audits had failed to identify that the training provided wasn't consistently effective in providing staff with the right skills to meet people's needs.
- Other audits such as infection control checks were not accurate and the provider cannot rely on the validity of the information provided. Audits stated basic requisites were available, yet staff told us paper towels and hand gel to support people to keep their hands clean were not readily available and our observations confirmed this.
- The Provider Information Return was not reflective of the service being provided. The care records and risk assessments were not up to date, people were not supported to access the community regularly and there were no links with the local or wider community.

The failure to ensure the service was effectively monitored was a breach of Regulation 17 of the Health and

Social Care Act 2008 (regulated activities) Regulation 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- We saw that people had attended service user meetings with the provider and there had been improvements made to the service at the request of the service users. For example the service had employed a cook as people were unhappy with pre-prepared food.
- Relatives told us that they have been sent questionnaires to complete about the service, and we saw records of these. One relative was worried about laundry being misplaced, the provider spoke to the staff about this.
- The provider meets monthly with a different service user to complete a survey on the quality of the service. However, it was not clear how people who lacked capacity were supported to engage with this.
- We saw no imagery around the home in terms of the diversity of people the service supports, for example in relation to race, culture and sexuality.
- There is very little community engagement. People told us they rarely go out. We asked a staff member about any links with the local community and they were unaware of any.

Managers and staff are clear about their roles, and understand quality performance, risks and regulatory requirements

The provider had notified us of incidents and events as they are legally required to do so.

- Staff were not supported to understand their roles through regular supervision meetings and the absence of the registered manager meant staff were left without adequate leadership and direction.
- There was a staffing structure in place, but we saw that there was a lack of oversight to ensure staff were clear on their role and fulfilling them. For example, staff were not completing cleaning to the standard to maintain adequate hygiene standards.

Working in partnership with others

- A staff member told us that the home had good working relationships with a number of other health and social care organisations that supported people. For example, the advanced practitioner at the local GP surgery, district nurses and the community mental health team visited people regularly.
- Staff and relatives told us people are supported to attend hospital appointments.
- The service had missed opportunities to develop community links and promote a community presence, for example, we asked a number of the public to help us locate where the home was within the street but no one had heard of or knew of the service.

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 9 HSCA RA Regulations 2014 Person-centred care People who used the service were at risk of poor care as care plans were not person-centred and did not reflect individual preferences.

The enforcement action we took:

We have asked the provider to send us a report that says what action they are going to take.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who used the service did not always receive safe care and treatment as risk assessments were inadequate. People who used the service were not protected from the risks of infection as there were inadequate infection control measures in place

The enforcement action we took:

We have asked the provider to send us a report that says what action they are going to take.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment People who used the service and others were not protected against the risks associated with unsafe or unsuitable premises.

The enforcement action we took:

We have asked the provider to send us a report that says what action they are going to take.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People who used the service were at risk of poor care as there was ineffective management

oversight in relation to person-centred care, mental capacity and best interests decisions and quality assurance audits.

The enforcement action we took:

We have asked the provider to send us a report that says what action they are going to take