Sallong Limited

Gingercroft Residential 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 well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Gingercroft Residential Home is a residential care home providing personal care to up to 21 people. The service provides support to older people and those who may be living with dementia. At the time of our inspection there were 18 people using the service, although one of those people was in hospital at the time of our inspection.

People's experience of using this service and what we found
People were not always protected from the risk of abuse and incidents were not always identified and reported, as appropriate. However, people told us they felt safe. Staff were not always recruited safely as the appropriate checks were not always completed. There was mixed feedback about staffing levels and staff were not always deployed appropriately. Medicines management needed improving. Risks were not always fully assessed and planned for and there was not always evidence of learning following incidents. Improvements were needed to infection controls practices in the service. Quality assurance systems in place were not effective at monitoring the quality and safety of people's care. Notifications were not always submitted as required. Staff felt they worked well as a team but did not always feel supported by the provider and registered manager. The registered manager was open to feedback and eager to make improvements.

People's health needs were not always fully planned for, so staff did not always have detailed guidance. Staff told us they received training, however there were gaps in training records. Areas of the service needed refurbishing as they were in poor condition. A cellar door and open access stairs could pose a risk to people and staff, and this was not always being mitigated.

People were not supported to have maximum choice and control of their lives. Staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. Although we did see staff asking people consent before supporting them.

People were generally satisfied with the food and drinks available and had a choice.

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

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 18 February 2020).

Why we inspected
This inspection was prompted by concerns we received from the local authority about the oversight and safety of the service. A decision was made for us to inspect and examine those risks.

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
We have identified breaches in relation to people being kept safe from risk, allegations of abuse, appropriate checks not always in place for staff recruitment, getting consent from the relevant person and the oversight of the service at this inspection.

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

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.

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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Gingercroft Residential 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
The inspection was carried out by 2 inspectors.

Service and service type
Gingercroft Residential 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. Gingercroft Residential Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was 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 the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 8 people who used the service and 1 visiting relative, during the inspection. We also spoke with 5 staff including care assistants, senior carers, a head of care and the activity staff member. We also spoke with the registered manager. 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.

We reviewed a range of records. We looked at 4 people's care records and multiple medicines and daily care records. We looked at 3 staff files to check recruitment processes. A variety of records relating to the management of the service, including policies and procedures, building safety records and audits were also reviewed.

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.

Systems and processes to safeguard people from the risk of abuse

- People were not protected from the risk of abuse. Systems were not in place to identify instances of abuse.
- Staff were able to tell us about different types of abuse, how to recognise it and their responsibilities to report concerns. However, some incidents were not reported to the registered manager.
- We found incidents of potential abuse which had not been referred to the local safeguarding authority. The registered manager had not been fully aware of their responsibility to report concerns.
- This meant people may not always be protected as timely action was not always taken to review, respond to and report incidents.

People were left at risk of continuing to experience abuse. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Despite the above concerns, people told us staff were nice. One person said, "I am happy here. I feel safe, staff help us. They [staff] are nice, and friendly." Another person said, "They [staff] are kind and gentle."

Staffing and recruitment

- Staff were not always safely recruited.
- Full pre-employment checks had not always taken place, such as checks on full employment histories, identity checks and appropriate Disclosure and Barring Service (DBS) checks. This meant people could be at risk of not always being supported by appropriate staff. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

People were left at risk of being supported by inappropriate staff. This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff were not always effectively deployed to ensure people always received timely support. Staff felt it was harder if agency staff were working as they did not know people as well, but staffing was 'ok' generally.
- Staff would choose to complete paperwork in areas where they had no oversight of people. There were periods of time where communal areas were unattended, and people were left with no staff and no way of summoning assistance independently.
- It was explained to us by staff the staffing levels 'have always been the same'. The provider did not assess the staffing level based on people's support needs or the layout of the building. Some staff told us they did not always get their breaks.

● The local authority had recently fed back to the registered manager about this, and work had started to assess staffing levels.

Using medicines safely; Assessing risk, safety monitoring and management
● Medicines were not always safely managed, and risks to people were not always assessed and planned for.
● One person was at risk of choking. Their care plan was not always being followed and staff were not aware it was still a risk. This put the person at ongoing risk of harm.
● One person was at risk of falls and there was not always further review and consideration of how their risk of falls could be reduced. Another person had displayed distressed behaviour, but this was not reflected in their care plans to guide staff how to support this person during these times.
● Staff were not always aware of people's risks so would not always know how to keep people safe.
● One person had been prescribed an antibiotic. Staff told us they had received this but there were gaps over 2 days in the recording and staff had failed to identify this. This meant we could not be sure the person received their medicines as prescribed.
● There was mixed quality guidance in place for 'when required' medicines. Some guidance needed more detailed protocols to help guide staff when the medicine was needed. However, some appropriate protocols were in place.

Risks to people were not always assessed and planned for and medicines were not always managed safely. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Despite the concerns noted above, people told us they felt safe. One person said, "I feel much safer than at home as I felt frightened at home." Another person told us, "I feel safe because the staff are here to help."
● Stock levels of tablet medicines matched records showing people were receiving them as prescribed.
● Checks, such as on gas, electrical and fire detection systems were made to ensure they remained safe for people to live there.

Learning lessons when things go wrong
● Lessons were not always learned when things had gone wrong, although some improvements had started.

● Reviews were not always undertaken following incidents, such as falls, to ensure the most appropriate measures were in place to learn from the incident.
● The provider had started to review incidents to look for themes. However, as there were not always clear systems in place to identify incidents, we could not be sure this analysis would cover all incidents which had occurred.

Preventing and controlling infection
● We were not assured the provider was promoting safety through the layout and hygiene practices of the premises. A recent infection control audit from health professionals identified a large number of actions showing hygiene practices in the home were not always suitable. The registered manager had started rectifying some of these actions.
● We were not always assured that the provider was making sure infection outbreaks can be effectively prevented or managed. One person was COVID positive during our inspection. One staff member we spoke with was unaware of this.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection. One person was able to remain in their room while they were COVID positive and there was

signage to prompt staff to use PPE when entering the room.
● We were somewhat assured that the provider was preventing visitors from catching and spreading infections. A recent COVID-19 outbreak had not been reported to external agencies. We were also not informed until partway through our visit that there was a COVID positive person in the home.
● We were somewhat assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
There were no restrictions on visiting.

Requires Improvement

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 good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- The provider had failed to ensure appropriate decision-specific mental capacity assessments were carried out. This meant people were not being protected by the MCA.
- DoLS applications had been made. A DoLS application would only be needed for those who do not have the capacity to decide about the restrictions imposed on them. However, as the provider had not carried out capacity assessments, we could not be sure these DoLS applications were appropriate.
- One person's relative had signed consent and was recorded as making decisions on behalf of the person. However, the person's ability to make their own decisions had not been checked and the relative's legal authority to make these decisions had not been verified. This meant the person was not being protected.

Peoples' rights were not always protected. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Despite the concerns above, we observed staff asking consent prior to supporting people.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier

lives, access healthcare services and support
● People's needs were not always fully assessed so we could not be sure people would receive support from other agencies in a timely manner.
● One person had a document in place which stated they were not for resuscitation. The reasons for this being in place were not clear and it was not clear the person had been involved in the decision. This had not been identified or questioned by the anyone from the service.
● People with health conditions which could cause them to need medical attention if they displayed symptoms, did not always have clear plans in place. Staff were not always aware of people's health conditions.
● Another person had their skin assessed and they were considered at risk of skin damage. The provider used a risk score to determine what risk level they were. There was no clear plan about how to support the person to reduce the risk of skin damage. This score had also been added up incorrectly.
● Another person was being supported by visiting professionals. However, there was no clear plan in place about how staff should support the person in between the visits from professionals.

Risks to people were not always assessed and planned for. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● Staff were not always trained sufficiently to support people effectively.
● Staff told us they completed training and told us they completed a number of online training courses. Staff were generally able to answer our knowledge-check questions, however their training was not fully effective as we found instances of potential abuse which had not been reported.
● Records showed there were gaps in training for staff. It was not clear what level of induction new staff undertook.
● There was no evidence staff new to caring had undertaken the Care Certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.
● Despite this, people felt permanent staff knew what they were doing. One person said, "I feel confident staff know what they are doing and have been trained."

Adapting service, design, decoration to meet people's needs
● There was a door in use at the top of cellar steps, which if left open and unattended could pose a risk to both people and staff. People could be at risk of falling down the stairs and staff could be at risk of becoming trapped in the cellar. The registered manager told us to manage the risk, a staff member would stand at the top of the stairs if staff needed to access the cellar. However, we observed this not being done.
● The stairs to upper floors were open to access for people. We did not observe anyone attempt to use these stairs unaccompanied; however, the provider did not have adequate risk assessments in place should people attempt to use the stairs without staff present. The risk assessment stated people would have an individual risk assessment, however we did not see these were in place.
● The building was tired in places and needed redecoration, however it was free from malodours. The environment was in need of repair such as chipped paint along skirting board, frames and doors.

Supporting people to eat and drink enough to maintain a balanced diet
● People were generally satisfied with the food choices. Four people told us they thought the food was 'okay'. Another person said, "We have lovely choices and fresh food which is nice." Another person told us they could ask for something else if they didn't like the menu choices.

● We observed people being offered drinks periodically during the day.
● One person was not always supported appropriately with their food when it had been identified there was a choking risk. We have referred to this in the safe key question.

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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Quality assurance systems were not in place or were not embedded. The provider had minimal evidence of oversight of the quality and safety of the service.
- The provider had recently completed a review of 6 months' worth of incidents to look at trends. However, as there was not a clear system in place to identify when an incident had occurred, we could not be sure this review would cover everything.
- The provider had meetings with the registered manager to discuss the home. However, these were not effective at maintaining oversight and assessing quality.
- The provider was not monitoring people's bowel movements effectively, where this required monitoring due to risk. Staff would record everyone's movements on one document, making it difficult to track the length of time between their bowels opening. This was not person-centred. There was also no evidence of oversight of this document. Therefore, the lack of system in place could put people's health at risk.
- A medicines audit had taken place in August 2023 which had identified some gaps in recording which stated an incident form had been completed. We asked the registered manager for the details of this and it could not be located.
- A safeguarding folder was in place. However, the quality of the information was often unclear or a poor level of detail. Staff had completed a body map had been completed by staff showing unexplained injuries. However, this had not been shared or identified and therefore appropriate action had not been taken.
- The provider did not have a staffing dependency tool in place to help them assess the staffing levels to ensure there were enough staff. The registered manager had started to complete a tool the local authority had provided them with.
- The providers recruitment policy did not cover all aspects of the recruitment process and did not cover how they intended to ensure staff remained suitable to work with people who used the service.
- The provider was unable to continuously learn as systems were not in place to reliably capture and analyse information about the quality and safety of care, so opportunities were missed.

Quality assurance systems in place were not effective. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● We could not be sure the provider would not always be able to act on their duty of candour as incidents were not always known or investigated further.
● Notifications were not being submitted, which is required. The provider had not submitted these and the registered manager was not fully aware of their responsibility to submit notifications, either.
● The last inspection rating was being displayed, as required.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People had been involved in doing a survey about their thoughts of the service and this had received positive responses. One person we spoke with said they would speak to the registered manager if they needed to raise concerns, but they had not needed to.
● Staff told us they felt supported by their colleagues but did not always have confidence in the provider or registered manager. One staff member said, "I don't think the home is managed well. There's no direction or leadership."
● Staff did not always feel the registered manager was visible but did comment if they did see the registered manager with people, they had a nice approach. Staff were also observed to have a nice approach with people.

Working in partnership with others
● The registered manager was open to feedback and open to working to resolve the issues we and the local authority identified during our visits.

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 11 HSCA RA Regulations 2014 Need for consent People were not having their right's protected as the principles of the Mental Capacity Act 2005 were not being follow and consent had not always been sought from the relevant people.

The enforcement action we took:

Notice of Proposal to impose conditions on the 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 Risks to people were not always assessed and planned for.

The enforcement action we took:

Notice of Proposal to impose conditions on the 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 People were not always protected from potential abuse as systems were not in place to effective identify, investigate and report possible concerns.

The enforcement action we took:

Notice of Proposal to impose conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance systems in place were not effective at identifying and addressing concerns.

The enforcement action we took:

Notice of Proposal to impose conditions on the 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 Appropriate checks were not always made on staff to ensure they were suitable to work with people who used the service.

The enforcement action we took:

Notice of Proposal to impose conditions on the provider's registration.