Greensleeves Homes Trust

Viera Gray House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Viera Gray House is a residential care home providing personal to up to 41 people. The service provides support to people aged 65 and over. At the time of our inspection there were 30 people using the service.

Viera Gray House accommodates people across four separate wings, each of which has separate adapted facilities. One of the wings specialises in providing care to people living with dementia.

People's experience of using this service and what we found
People were not protected against the risk of harm and abuse. Staff did not have clear guidance on how to mitigate known risks as the provider failed to develop risk assessments. Incidents and accidents weren't always recorded or managed effectively. Not everyone within the service received support in a timely fashion as the provider failed to deploy sufficient numbers of staff to keep people safe. People's medicines were not managed in line with good practice. People did not receive a service that ensured lessons were learned when things went wrong.

People did not receive care and support from a service that was well-led. The provider failed to ensure adequate oversight and monitoring of the service to drive improvements. Audits undertaken failed to identify issues found at this inspection. Records were not easily accessible or in place. There was a closed culture whereby staff were not always confident in speaking out against poor practice. The provider failed to ensure guidance provided by partnership working was implemented.

The provider followed current guidance on the management of infection prevention and control.

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; the policies and systems in the service supported this practice.

The acting manager was aware of their responsibilities under the duty of candour.

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 7 October 2021).

At our last inspection we recommended that provider review their staffing, at this inspection we found the provider needed to make further improvements.

Why we inspected
We received concerns in relation to staffing levels, incident management, safeguarding and medicines

management. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

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.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Viera Gray House on our website at www.cqc.org.uk.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to risk assessments, protecting people from harm and abuse, medicines, staffing levels and the oversight and monitoring of the service at this inspection.

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.

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

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Viera Gray House

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 two inspectors.

Service and service type
Viera Gray House is a care home. People in care homes receive accommodation and nursing and personal care as a single package under one contractual agreement dependent on their registration with us. Viera Gray House 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 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 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 four people and two relatives to gather their views of the service. We also spoke with 11 staff members, including care staff, a dementia nurse specialist, the acting manager, divisional director and the provider's nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We received feedback from seven healthcare professionals who are involved with the service.

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 requires improvement. 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 always protected against the risk of abuse as the staff did not have the necessary skills and experience to keep people safe.
- During the inspection we identified an instance whereby people had been physically assaulted by other people living at the service. Instances of these types of abuse were not always reported to the relevant safeguarding team at the local funding authority.
- One healthcare professional told us, "Many of the safeguarding alerts that have come in [to our team] over the last few months were raised by external people and not the care home. [This] leads to queries as to whether staff [are able to] recognise safeguarding concerns or are they fearful to report." Another professional told us, "There have been several occasions where managers have not been made aware of serious incidents until time has elapsed, which has resulted in crisis situations. There appears to be a breakdown in communication between staff making managers aware of incidents via the appropriate channels."
- We received mixed feedback from staff in relation to reporting poor practice. Whilst staff knew how to identify, report and escalate suspected abuse, not all staff spoken with were confident to do so. This meant people were at risk of abuse.

The provider failed to operate effective systems to safeguard people from abuse. These issues are a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) – Safeguarding service users from abuse and improper treatment

- After the last inspection the provider had recruited a safeguarding lead to ensure all safeguarding systems and processes were deployed in line with good practice. At the time of this inspection we could not be assured this role had been embedded within the service. We will continue to monitor their progress at the next inspection.

Assessing risk, safety monitoring and management

- People were at risk of avoidable harm.
- During the last inspection we identified not everyone using the service had a robust risk assessment in place. We also identified the risk assessments in place failed to give staff clear, robust and succinct guidance on how to mitigate those risks.
- After the inspection, the management team confirmed they would ensure all staff would undertake training in positive response techniques in order to safely support people who were demonstrating behaviours that could cause others physical harm. This had not taken place and at the time of this inspection there were no plans for this training to be provided for staff.

● At this inspection we found the provider continued to fail to develop robust risk assessments. For example, there had been an incident whereby one person engaged in behaviours that demonstrated they were dissatisfied and/or anxious and resulted in physical harm to another person living at Viera Gray House. Despite this incident, there was no risk assessment in place for staff to follow to safely de-escalate these behaviours and protect others in close proximity.
● We also identified following this incident there had been a review of the person's risk assessment, however the provider had failed to accurately reflect this person's behaviour and the support they required in a risk assessment.
● Staff had an inadequate understanding of what constituted an incident which would require reporting to management or the completion of Antecedent Behaviour Consequence (ABC) charts. An ABC chart is a record of specific behaviours that are recorded and analysed to identify trends and patterns enabling qualified healthcare professionals and care staff to implement strategies to minimise those behaviours.
● A healthcare professional told us, "I do not feel that staff have a good understanding of dementia and the effects that the disease can have on resident's behaviour."
● We reviewed one ABC chart and found that there was one recorded incident, however staff confirmed there had been prior incidents which had not been recorded. One staff member told us, "Some staff aren't that wonderful about filling out the paperwork." This meant any healthcare professional analysing the data, would not have a true reflection of the person's behaviour and therefore strategies implemented would not effectively meet the person's needs.
● During the inspection we spoke with staff who confirmed they had not received physical intervention training, however felt this would provide them with the necessary skills to keep people safe.
● One staff member told us, "I do feel concerned as to whether residents are always in the right placement [at Viera Gray house] and whether this home is equipped to help those residents." A healthcare professional said, "Since the manager left, we still aren't getting risk assessments in timely way. We suspect this may be because they aren't on file but have been reassured by managers that all residents have care plans and risk assessment in place."
● We shared our concerns with the management team who advised us that there had been training in how to identify stimuli that could cause people to engage in behaviours that demonstrated they were dissatisfied and/or anxious and how to proactively respond to these behaviours. However, recognised physical intervention techniques training had not taken place.
● On the second day of the inspection, the management team informed us that physical intervention training had been scheduled for the week commencing 17 October 2022. We will review their progress at the next inspection.
● The management team's ongoing failure to respond swiftly to our concerns did not reassure us that people living at the service were safe from avoidable harm.

Using medicines safely
● People did not always receive their medicines as intended by the prescribing GP.
● Prior to the inspection we were made aware of an incident whereby one person receiving respite at the service, had not received their medicines for 14 days, which was in direct contrast to the recommendation of the prescribing GP.
● A healthcare professional told us, "Historically [the service] have struggled with medicines administration; and there have been many safeguarding and service concerns from the home in relation to this. It appears to be a big issue that will take some time to unpick and change the culture."
● Another healthcare professional said, "Some staff show exceptional insight into understanding the need and reason for medications prescribed, particularly when choosing whether to give a PRN dose. However, there is notable disparity between staff and their threshold before giving PRN medication."
Since the last inspection the provider has implemented the use of registered nurses from an agency to

administer medicines, to minimise the risk of errors.
● During the inspection we looked at the medicines administration records (MAR) and identified there were no PRN 'as and when required' protocols in place. A PRN protocol gives staff person specific guidance on when and under what circumstances medicines need to be administered.

The provider failed to ensure an embedded culture where effective systems were in place to keep people safe from harm. All of these issues are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staffing and recruitment
● People did not receive support from adequate numbers of staff to keep them safe.
● Prior to the inspection we received information in relation to a shortage of staff on the Wren unit. During the inspection we identified there were three staff allocated to Wren unit in the morning, which meant there were insufficient numbers of staff to support people to get up at the time they preferred. This had resulted in some people not receiving support with personal care until 10.30am. This meant they received their breakfast at approximately 11am and their lunch at 12.30hrs.
● People, their relatives, staff and healthcare professionals confirmed there were inadequate levels of staffing in some units. Comments included, "I don't know how they do their staffing ratio. But there seems to be a trend that incidents are not witnessed by staff which makes me query if there are enough staff on each unit", "There are not enough staff here. If you need staff, it's not easy to get one if they are busy doing their routine work. Sometimes you have to wait a long time for help, maybe more so on the weekend" and, "We [staff members] are breaking our backs up on Wren [unit], I've thought of resigning."
● At the end of the first day of the inspection we shared our concerns with the management team who told us they were looking to address this. After the first day of the inspection the nominated individual sent us an action plan which stated they would use domiciliary staff members to support with breakfast enabling all care staff on Wren unit to provide personal care. We reiterated our concerns regarding the possible changes to staffing levels on Wren unit and the nominated individual confirmed they would increase staffing levels to four staff in the unit in the mornings.
● We will continue to monitor their progress with these stated aims at the next inspection.

The provider failed to ensure sufficient numbers of staff were deployed to keep people safe. These issues are a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014 - Staffing

● Pre employment checks undertaken by the provider ensured only suitable staff were employed. We reviewed staff recruitment files and found these confirmed prior to an offer of employment, two satisfactory references, an application form, photographic identification and a Disclosure and Barring Service check. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Learning lessons when things go wrong
● People did not receive a service that learned lessons when things went wrong.
● The provider failed to ensure there was an embedded culture where lessons were learned, and action was taken to mitigate repeat incidents.
● During this inspection we identified issues found at the previous two inspections had not been adequately addressed and in some cases, repeat mistakes continued to be made. For example, the lack of risk assessments in place for people who engaged in behaviours that could cause harm and distress to others. We shared our concerns with the nominated individual who was unable to provide us with a satisfactory response.

● A healthcare professional told us, "Following a serious incident in 2020, [the service] have shown some improvements in their communication to our service when risks have been escalating. However, this is not always consistent and there have still recently been serious incidents which have not been escalated in the appropriate channels which have resulted in a safeguarding alert being raised."
● After the first day of the inspection the nominated individual sent us an action plan to address our concerns, however the action plan was not robust and dates to ensure all actions completed was for December 2022. We informed the management team this was an unsatisfactory response and they updated their action plan. We will continue to monitor their progress in these stated aims at the next inspection.

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

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.
● People received support from staff that understood the need to ensure people's consent to care and treatment was sought prior to being delivered.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were 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 was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● The service ensured that current government guidance and best practice was adhered to, to ensure people visiting the home did so safely.

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

- People received care and support from a service that was inadequately managed.
- There was an embedded culture whereby there were systematic and widespread failings in the overall management and oversight of the service.
- The provider failed to ensure systems and processes in place identified the issues found at this inspection. For example, lack of risk assessments, insufficient staffing levels, poor medicines management, poor safeguarding management, lessons learnt and behavioural management support for staff.
- We also identified the provider failed to take adequate action to address our previous concerns for examples, staffing levels and physical intervention training.
- After the first day of the inspection the nominated individual submitted an action plan, however, this failed to adequately address our concerns. The nominated individual then updated the action plan after the second day of the inspection. This action plan stated the deadline for works to be completed was the 12 December 2022 which was insufficient.
- During the inspection we spoke with the management team and shared the concerns we had identified. The management team were not aware of the gravity of our concerns. The nominated individual told us, "It's safe to say we're here as we know there were issues otherwise, we wouldn't be here. I think there's a few things you've seen in a different light to us and it's been helpful to get that feedback."
- In August 2022, the service was subject to a cyber-attack that impacted their electronic recording systems. Since the cyber-attack the service have attempted to obtain access to the documents, however with limited success. Despite this, the provider has failed to duplicate certain documents that they are required to have to ensure staff have the information they require to support people safely. For example; risk assessments, PRN 'as and when required' medicines protocols and records of incidents and accidents.

Working in partnership with others; continuous learning and improving care

- People did not always benefit from a service that worked in partnership with health services to drive improvements.
- One healthcare professional said, I can't say they [the service] have followed up on any recommendations [I have made]." Another healthcare professional said, "Viera Gray are always welcoming of partnership working with our team and we have developed good working relationships with staff. However, we provide a disproportionately high level of resource to Viera Gray than any other care home in the borough."
- Records showed the service liaised with the GP, mental health team and dementia specialists. However, guidance provided wasn't always implemented into the delivery of care. For example, staff failed to

complete accurate ABC charts.

The provider failed to deliver a service that was well-led. These issues are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● Since the last inspection the registered manager had de-registered with CQC. At the time of the inspection there was an 'acting manager' in place to oversee the day to day running of the service.
● The nominated individual told us they were keen to ensure the service improved and were taking action to address all areas identified in the inspection.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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 culture within the service was impacted by the poor oversight and leadership, and records showed and a staff member told us, there was a closed culture at Viera Gray House.
● We received mixed feedback from relatives and staff about the management of the service. One relative told us, "Recently there feels like there's a lack of authority from the top, but there are some nice staff doing their best. I don't feel we're getting the responses we did in the past." A staff member said, "I like [acting manager's name], she is very approachable and listens to what we say. From what I've seen I can't fault her."

● The acting manager was keen to ensure they worked within the principles of the duty of candour.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People and their relatives' views were sought through quality assurance questionnaires.
● The questionnaires covered all aspects of the service. For example, the environment, support provided, staff knowledge, medicines and communication.
● We reviewed the 2021 questionnaire and found responses were favourable in relation to the level of support provided, cleanliness of the service, atmosphere and requests being dealt with promptly.

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	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to deliver a safe service. Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) 2014. Regulation 13(1)(2)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to deploy sufficient numbers of staff to keep people safe. Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014. Regulation 18(1)

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to deliver a safe service. Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014. Regulation 12(1)(2)

The enforcement action we took:

We imposed urgent 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 The provider failed to deliver a service that was well-led. Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. Regulation 17(1)(2)

The enforcement action we took:

We imposed urgent conditions on the provider's registration.