R S Property Investments Limited

Gresley House Residential Home

Inspection report

Gresley House
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Swadlincote
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06 February 2023

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
Gresley House is a residential care home providing personal care for up to 37 people. The service provides support to older and younger adults, including people who have dementia. At the time of our inspection there were 28 people using the service. The accommodation is split over 2 floors with a purpose-built extension.

People's experience of using this service and what we found
Care records did not always contain accurate, consistent or up to date information. Risks to people were not always identified or effectively managed.

There was a lack of provider oversight of the service. Systems and processes were ineffective and failed to identify or address some issues and concerns.

Infection control measures and practices had been implemented and improvements had been made to the environment.

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

Rating at last inspection and update
The last rating for this service was inadequate (published 22 November 2022) and there were breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
We undertook this targeted inspection to check on specific concerns we had about safeguarding incidents, whistleblowing allegations and unwitnessed falls. The overall rating for the service has not changed following this targeted inspection and remains inadequate.

We use targeted inspections to follow up on Warning Notices or to check concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

Follow up
The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review.

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?

Inspected but not rated

Details are in our safe findings below.

At our last inspection we rated this key question inadequate. We have not reviewed the rating as we have not looked at all of the key question at this inspection.

Is the service well-led?

Inspected but not rated

Details are in our well-led findings below.

At our last inspection we rated this key question inadequate. We have not reviewed the rating as we have not looked at all of the key question at this inspection.

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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.

This was a targeted inspection to check on concerns we had about safeguarding incidents, whistleblowing allegations and unwitnessed falls.

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
Gresley House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. 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 who work with the service. This information helps support our inspections. We used all this information to plan our inspection.

During the inspection
We spoke with 8 staff members including the manager, supporting manager, nominated individual, housekeeping staff and care staff. 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 7 people's care records and several medication records. We looked at 3 staff files in relation to recruitment. A variety of records relating to the management of the service, including audits were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at further care records and provider policies including falls, nutrition and safeguarding.

Inspected but not rated

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 this key question was rated inadequate. We have not changed the rating as we have not looked at all of the safe key question at this inspection.

The purpose of this inspection was to check if the provider had met the requirements of the specific concerns, we had about safeguarding incidents, whistleblowing allegations and unwitnessed falls. We will assess the whole key question at the next comprehensive inspection of the service.

Assessing risk, safety monitoring and management; Staffing; Preventing and controlling infection; using medicines safely

At our last inspection the provider failed to establish systems to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12(1).

● Risks were not assessed, monitored or mitigated effectively. Where risks to people had been identified, the documentation contained inconsistent or out of date information which had not been updated following an accident or incident. For example, we reviewed 1 person's risk assessment which stated they were a low risk for choking. However, their support plans details a puree only diet and documented referrals to healthcare professionals as the result of a previous to a choking incident. This meant staff had insufficient information about the risks posed to the person whilst eating.
● The electronic care plans did not provide staff with clear guidance to adequately support people who displayed feelings of anxiety, agitation or required positive behaviour support. Staff we spoke to demonstrated a lack of understanding surrounding caring for people who required this type of support. This meant people were at risk of being cared for in an insensitive way when they experienced strong emotional reactions to situations.
● Observations during the inspection demonstrated an ineffective deployment of staff to keep people safe. The inspection team observed people left unsupervised for long periods of time and a lack of meaningful interventions when people were distressed.
● We were assured effective infection control measures were in place. We found housekeeping staff on duty during our inspection who was able to evidence a detailed checklist of tasks completed daily. All staff were observed wearing the correct personal protective equipment (PPE).
● People were supported with their medicines administration and medicines were managed safely. We reviewed the medicine administration records (MARs). The information in the medicine records showed people had received their medicines safely and in line with best practice. People who had been prescribed

'as required' medicines, had protocols in place to provide staff with guidance on how and when to safely administer these medicines.

The provider continued to not have systems established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inspected but not rated

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 the last inspection this key question was rated as inadequate. We have not changed the rating of this key question, as we have only looked at the part of the key question we have specific concerns about.

The purpose of this inspection was to check if the provider had met the requirements of specific concerns we had about safeguarding incidents, whistleblowing allegations and unwitnessed falls. We will assess all of the key question at the next comprehensive inspection of the service.

Planning and promoting person-centred, high-quality care and support; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

At our last inspection the provider had failed to effectively operate systems to ensure the quality and safety of people's care. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● People did not receive person-centred care. Staff demonstrated a lack of understanding in areas such as dementia and positive behaviour support. Support plans to provide guidance to staff were often out of date, incorrect or missing from people's care records. This meant there was no person-centred culture at the service.
● There was no effective leadership, oversight or systems in place to ensure the service was delivering quality care. At the time of the inspection there was no registered manager in post. The service was being managed by a newly appointed manager who was being supported by a manager from another home and the nominated individual. However, changes in management had led to shortfalls in the quality and safety of service provision.
● Issues identified in the Safe section of this report had not been identified by the provider. The management team in place had conducted audits and daily walkarounds, but they were ineffective in identifying concerns or issues we found during this inspection.
● Systems and processes in place for recording, reporting and analysing accidents and incidents continued to be ineffective. The provider failed to evidence robust processes to ensure investigations took place and lessons were learnt following any incident. This meant the provider had continued to miss opportunities to make improvements to the quality and safety of people.

The provider continued to not utilise systems effectively to ensure the quality and safety of people's care. This was a continued breach regulation 17 of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.