GSR Care Ltd

The Grange Nursing Home

Inspection report

9 Elm Avenue
Attenborough
Nottingham
NG9 6BH

Tel: 01159253758

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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
The Grange Nursing Home is a residential care home providing accommodation and personal and nursing care, in one adapted building care. Twenty-three people were staying at the home at the time of the inspection; two of these people were receiving respite care. People residing at this home were aged 65 and over and some were living with dementia. The service can support up to 29 people.

People's experience of using this service and what we found
The governance and quality assurance systems at the home were ineffective and had failed to identify and act on the concerns raised during this inspection.
The relationship between the nurses and the registered managed was ineffective. Neither had taken responsibility to ensure that care plans and risk assessments were completed for new admissions and reviewed when people's needs had changed. Robust competency assessments of the performance of the nurses was not carried out. This was contributed to by the lack of a clinical specialist at the home since September 2020. This placed people at increased risk of harm.

Healthcare professionals have raised concerns about the failure of staff to act on recommendations they had made to improve people's care. This had placed people at increased risk of harm.

The provider had recently recruited a compliance manager and they were supporting the registered manager with installing new auditing processes to address the shortfalls at this home. As these processes were new, we were unable to assess the effectiveness and sustainability to improving the care people received.

People were not always safe living at the Grange Nursing Home. The heating broke down and measures put in place to in response to this were not safe. Some areas of the home were cold, and the unsafe use of portable heaters placed people at risk of burns and increased the risk of fire.

People experienced care that placed their health and safety at risk. A person was placed at risk as processes to keep them safe had not been followed. A review of an incident involving this person had been carried out, but records were not updated to reflect changes made. This placed the person at continued risk of harm. People's care records and risk assessments did not always reflect their current needs.

Pressure wound management was ineffective in reducing the risk of harm. Records used to assess and act on this risk were not appropriately completed or reviewed. Medicine management was inconsistent. Where people required 'as needed' medicines, protocols were not always in place to ensure safe and consistent administration. There was limited reviewing of incidents. Opportunities for learning from mistakes was not utilised to reduce ongoing risks.
The home was, overall, clean and tidy; however, we identified some areas which could pose a risk of the spread of infection. At the time of the inspection there were no positive Covid-19 cases at the home. Staff

were in place to respond to people's needs; call bells were responded to quickly by staff.

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)
This service was registered with us on 24 October 2019 and this is the first inspection.
The last rating for the service under the previous provider was Good, published on 29 August 2018.

Why we inspected
We received concerns in relation to people's care, safety, staffing, the home environment and the management of the home. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.
We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them.
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 see what action we have asked the provider to take at the end of this full report.

Enforcement
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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment which included the assessment of risks to people's health and safety, care planning, medicines, safeguarding and infection control. We also identified a breach of the legal regulated to governance and duty of candour.

After the inspection visit, we sent the provider a letter of intent advising them of possible urgent enforcement action and requiring an action plan for immediate improvement of the concerns identified. We were not provided with a sufficient response to mitigate risk.

The provider advised us of their intention to close the home following inspection and cancellation of their registration is underway.

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 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.	**Inspected but not rated**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inspected but not rated**

The Grange Nursing 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.

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
This inspection was carried out by two inspectors and a specialist advisor (nurse).

Service and service type
The Grange Nursing Home 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.

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.

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. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We asked them if they held information about this service. We used all of this information to plan our inspection

During the inspection
We spoke with three people who used the service and asked about their experience of the care provided. We spoke with 11 members of staff including, the registered manager, compliance manager, nurse, senior care worker, two care workers, laundry assistant, domestic staff, chef and kitchen assistant. We spoke with two visiting Tissues Viability Nurses who were reviewing the pressure care provided for two people.

We reviewed a range of records. This included parts of or all care records of 15 people; we also looked at multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were also reviewed.

After the inspection
The registered manager and compliance manager provided additional records as required. These were sent to us within the required timeframe. We reviewed these documents such as training data and quality assurance records away from the home and used these to support our findings of the inspection.

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.

This is the first inspection for this newly registered service. This service has been inspected but not rated.

Systems and processes to safeguard people from the risk of abuse

- People were not always protected from the risk of abuse or neglect.
- A person, who was at risk of harm if they accessed the community alone, was found to have left the home unnoticed by staff. Procedures to ensure the person's movements were monitored had not been followed. Following the incident, the person's care records, and risk assessments had not been updated with details of how to ensure their safety. This placed the person at ongoing risk of harm.
- Several people had sustained skin damage whilst at the home, due to poor pressure care. This had not been reported to the local authorities safeguarding adults team as required.

People were not protected from abuse and improper treatment. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- People were at risk of harm as the environment was not managed safely.
- After our inspection we were informed the heating broke down for over a week and measures put in place in response to this were not safe. Some areas of the home remained cold putting people at risk of hypothermia. The unsafe use of portable heaters placed people at risk of burns. Furthermore, portable heaters were positioned against or under flammable objects which increased the risk of fire.
- Risks to people's health and safety had not always been assessed and mitigated. Two people, both with complex health conditions, did not have any care plans or risk assessments in place to inform staff how to provide safe care and to reduce the risks to their safety.
- People were not protected from the risk of pressure ulcers as risk assessment and care planning was ineffective and unsafe. Where people had pressure sores, there was limited information about how to care for them and records did not evidence that people had been repositioned at the required intervals to reduce further pressure damage. Health professionals had expressed concerns to us about ineffective wound management.
- Recording of care provided was inconsistent. A person who required their nutrition to be provided by a tube into their stomach had five gaps on their nutritional monitoring charts. This meant we could not be assured they had received the required nutritional support on these occasions. Another person's records did not state that their catheter had been cared for as required. Poorly completed records placed people at risk of receiving inconsistent and unsafe care.
- Other risks to people's safety had not been identified or addressed. For example, we saw staff using a wheelchair which had brakes that were not working, and the clinical waste room was unlocked and unattended at times throughout the inspection. Furthermore, plans to ensure safe evacuation in the event of an emergency were not kept up to date, which posed a risk to people in the event of a fire.

Using medicines safely

● People's medicines were not managed safely.

● 12 people required medicines on an 'as needed' basis, for example, to reduce symptoms of pain or anxiety. There were no protocols in place to inform staff when they should administer these medicines. This posed a risk people may not receive their medicines appropriately or when needed.

● Some people received pain relief via a transdermal patch (transdermal patch attaches to the skin and contains medication). The application site, and removal of patches was not always recorded. This placed people at risk of skin damage from over application on the same site, or drug overdose.

● During inspection, external health professionals raised further concerns about medicines practices. These were referred to the local authority safeguarding adults team for further investigation.

Learning lessons when things go wrong

● Opportunities to learn from adverse events had been missed.

● There was no effective process to review and learn from incidents. Although incidents logs were completed when an incident had occurred there was no evidence of the any analysis of the incident, what went wrong and how they could reduce the risk of recurrence. For example, when a person left the home unsupervised no learning had been shared with staff. This was a missed opportunity to learn lessons and reduce the risk of people experiencing further harm or injury.

Preventing and controlling infection

● People were at risk of infection.

● Measures to prevent the spread of infection including COVID-19 were inconsistent and we were not fully assured that people were protected from this risk. The provider's Infection Prevention Control policy for new admissions stated certain paperwork must be completed for all new arrivals. Records showed this had not been completed for the most recent arrival. This meant the person could pose an infection control risk to others in the home.

●Opportunities for social distancing were also missed, increasing the risk of the spread of infection.

●We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. We found chipped tables, worn bed side tables and, a dirty microwave. Cleaning schedules did not include the cleaning of wheelchairs and hoists.

The provider's failure to provide safe care and treatment was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

●There were enough staff in place to respond to people's needs. People's call bells were responded to quickly. Upon arrival we noted most people were out of bed and were eating breakfast. When people required support with moving from one part of the home to another, staff were available to support them. People were not left alone in communal areas.

● Safe recruitment processes were followed. The required information such as application forms, references and criminal record checks were in place. We did note that one person had not provided evidence that they were had the right to work in the UK. The registered manager told us they were aware of this and would ensure they received the required paperwork.

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.

This is the first inspection for this newly registered service. This service has been inspected but not rated.

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

● There was not a positive, person-centred culture at The Grange Nursing Home. Staff told us they had people's wellbeing at heart; however, their practice did not always reflect this. As a result, some people had experienced or were at risk of experiencing significant harm to their health and safety.

● The provider had not ensured that people received the minimum expected level of good care. Area of care, such as safeguarding and pressure care, were poorly executed and resulted in people experiencing poor outcomes.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● The provider had not ensured that staff were clear about their roles and understood how to provide safe, consistent and appropriate care for people.

● There was a strained relationship between the nursing staff and the registered manager. Neither took ownership for ensuring people's care records and risk assessments were completed; meaning for some people, these records were not in place. This had a negative impact upon the safety of the care provided to these people.

●Records of care and support were not accurate or up to date. Records showed nurses replaced pressure wound dressings; however, no other care treatment and assessment of wounds was completed. The registered manager had not ensured an appropriate review of this process had been completed; meaning people were placed at risk of increased harm.

● There was insufficient clinical leadership at the home. The clinical lead left the service in September 2020, this meant the registered manager who did not have a clinical background was unable to provide consistent oversight or identify the shortfalls in nursing performance.

Continuous learning and improving care

● There was limited focus on learning and improving care. There were significant failings in several areas that had not been identified by the provider's auditing processes.

● When incidents had occurred or changes to people's care needs had been identified, there was no process in place for review and update of records. This placed people at significant risk of receiving unsafe, inconsistent and inappropriate care.

●The provider had recently employed a compliance manager to work with the registered manager. This was to review the quality assurance processes that were in place and to assess their effectiveness in identifying risks to people's health and safety as well as the home environment. We were shown some new audits that the compliance manager had put in place; however, these had not yet been used and therefore we were

unable to assess their ability to drive sustained improvements.

Working in partnership with others

●Prior to the inspection several partner agencies raised concerns with us about the care provided at the home. Concerns included staff not always acting on recommendations and advice provided by professionals who had visited the home. This included the assessment management of pressure sores to reduce these risks.

● Further concerns with partnership working came to light during the inspection. External health professionals told us they observed a representative of the provider shouting at the registered manager during a call with health professionals and they advised the registered manager not to share information about people's care.

● During our inspection, we wrote to the provider outlining our most serious concerns and requesting that action was taken to mitigate risk. In response, the provider advised us they had taken the decision to close the home. They did not respond to the immediate concerns specified in our letter which left people at risk of harm.

● The quality of care deteriorated further , this resulted in the local authority and CCG taking action to ensure the safe and effective running the home.

The provider's failure to ensure good governance and leadership was a breach of regulation 17 (Good Governance) 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

● The provider had not shared information in an open and transparent manner when things had gone wrong.

● During the course of the inspection, we were informed by the local authority and CCG that the heating had broken at the home. Upon further investigation, it emerged that the heating had broken 6 days earlier, the provider had not reported this to any external agencies. This meant people were left in an unsafe environment for a prolonged period.

The providers failure to share information in an open and transparent manner was a breach of regulation 20 (Duty of candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

●There were some examples within people's care records where they had their care needs discussed with them. We also saw examples where people's relatives had been consulted and were involved with decisions about their family member's care needs.

●A survey had been completed to obtain people's views and although the results had not been fully analysed, responses were positive. We noted relatives had commented positively on the care provided for their family members.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider's failure to provide safe care and treatment was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

After the inspection visit, we sent the provider a letter of intent advising them of possible urgent enforcement action and requiring an action plan for immediate improvement of the concerns identified. We were not provided with a sufficient response to mitigate risk.

The provider advised us of their intention to close the home following inspection and cancellation of their registration is underway.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider's failure to protect people from abuse and improper treatment was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The enforcement action we took:

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Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's failure to ensure good governance

Treatment of disease, disorder or injury	and leadership was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The enforcement action we took:

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Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour
Treatment of disease, disorder or injury	The provider's failure to provide safe care and treatment was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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