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 caring? | **Requires Improvement** |
| Is the service responsive? | **Requires Improvement** |
| Is the service well-led? | **Inadequate** |

# Summary of findings

## Overall summary

This unannounced inspection took place on 6 and 11 September 2018. This was the provider's first inspection since registration.

Gingercroft residential home is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home is registered for up to 21 people. At the time of the inspection 19 people were using the service.

There was a registered manager in post who supported us throughout the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the inspection on 6 September 2018 we found concerns about the safety of the service and the governance systems in place to ensure continuous improvement. We wrote to the provider asking them to immediate action to improve. We returned to the service on 11 September 2018 and found that some action had been taken, however further improvements were required. We found three breaches of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The overall rating for this service is Inadequate which means it will be in special measures.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

There had been a failure in the leadership and governance of the service. There were no systems to monitor or improve the quality of care and no strategic vision or provider oversight.

The service was not safe as the provider had not taken prompt action to comply with the fire regulations. Risks associated with fire safety had not been minimised. The systems the provider had in place to ensure the quality of the service was maintained were ineffective.

Risks associated to supporting people with behaviour that challenged had not been assessed. People were not being supported safely when showing signs of anxiety and aggression. People's medicines were not always stored and administered safely and substances hazardous to health were not managed safely.

The principles of the Mental Capacity Act 2005 had not been followed to ensure that people's capacity to consent to their care had been assessed. Staff felt supported however they had not received all the training they required to care and support people safely.

The provider had not provided the information people needed in accessible formats, to include easy read versions of documents such as menus and the complaints procedure. The environment supported people to be independent with their mobility, however consideration to supporting people living with dementia had not been made.

People were not always having their personal identified care needs responded to. There was no information available about people's protected characteristics to ensure all of people's needs were identified and met.

There were sufficient numbers of staff however they were not always deployed effectively throughout the service. When employing new staff, safe recruitment procedures were followed.

The provider had not taken prompt action to keep people safe and this did not demonstrate a caring approach to people. People did not have information available to them in a format they could understand dependent on their individual communication needs.

People had access to health care professionals when they were unwell or their needs changed and they had a choice of food and were supported to eat and drink sufficient amounts.

People's right to privacy was respected and they were supported to remain in contact with families and friends. People's end of life wishes were met.

The registered manager was open and transparent and respected by staff and people who used the service. Staff liaised with other agencies to support people with their individual needs. Accidents and incidents were analysed by the registered manager to minimise the risk of them occurring again.

## 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 consistently safe.

People were not protected from the risks associated with a fire as fire regulations were not being met.

Risks to people were not always minimised through effective risk assessments.

People's medicines were not stored or administered safely.

Staff were not always deployed effectively throughout the building to keep people safe.

New staff were employed through safe recruitment procedures.

People were being safeguarded from the risk of abuse and accidents and incidents were analysed by the registered manager.

### Is the service effective?

**Requires Improvement**

The service was not consistently effective.

The principles of the MCA were not always followed.

Staff had not received all the training they required to fulfil their roles effectively.

People's protected characteristics had not been identified within their assessment of needs.

The environment did not meet the needs of people living with dementia.

People had access to health care professionals when they were unwell or their needs changed.

People had a choice of food and they were supported to eat and drink sufficient amounts.

### Is the service caring?

**Requires Improvement**

The service was not consistently caring.

The provider had not taken prompt action to keep people safe and this did not demonstrate a caring approach to people.

The provider had not ensured that people had information available to them in a format they could understand dependent on their individual communication needs.

People's right to privacy was respected.

## Is the service responsive?

**Requires Improvement**

The service was not consistently responsive.

Not all people were receiving care that was responsive to their individual needs.

The provider had a complaints procedure, however it was not available in a format for all people to be able to understand and use.

People would be supported at the end of their life in a way in which they chose.

## Is the service well-led?

**Inadequate**

The service was not well led.

The provider had not taken action to improve the quality of service for people and they were in breach of fire regulations.

The systems the provider had in place to ensure the quality of the service was maintained were ineffective.

The registered manager was open and transparent and respected by staff and people who used the service.

The registered manager and staff liaised with other agencies to support people with their individual needs.

# Gingercroft Residential Home

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This was the provider's first inspection since registration. The inspection took place on 6 and 11 September 2018 and was unannounced. The overall rating for this service is inadequate.

The inspection was undertaken by two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with eight people who used the service and one relative and observed people's care. We spoke with the registered manager, a senior carer and three care staff. Following the inspection we spoke the fire service.

We looked at three people's care records and medication records. We also looked at staff rotas and audits, three staff recruitment files and maintenance records for the home.

Inadequate

# Is the service safe?

## Our findings

We looked to see if the environment was safe for people who used the service, visitors and staff. We found that several internal and external fire doors had been identified by the fire service as unsatisfactory and a risk to people. These had been identified and brought to the provider's attention 12 months ago. The provider had an external company complete a risk assessment however the risk assessment did not identify how to mitigate the risk to people in relation to the fire doors being none compliant with the fire regulations. We discussed this with the registered manager who told us that the provider had been gaining quotes for the fire doors to be replaced. The provider was not meeting the fire regulations and this put people at serious risk of harm. When we returned to inspect on 11 September 2018 we found that the provider had partially mitigated the risks to people by increasing the staffing levels at night. However, fire doors were yet to be replaced and people were still at risk as the fire regulations were not being fully met.

We checked how people's medicines were being managed and found that they were not always being stored and administered safely. Staff had hand transcribed one person's medication administration record (MAR) and had omitted to add in the dosage of the medicines to be given. We found that there were some items of medication in use which may have been out of date. The date of opening had not been written on the items and they had an expiry date of 28 days after being opened. The fridge in which medication was stored was open and not kept locked and there were items in there such as bottles of drink which could contaminate any medicines being stored in there. This put people at risk of not having their medicines administered in a safe way.

We looked at two people's care records and found that they were at times being held by care staff for personal care intervention. This had been agreed through the Mental Capacity Act procedures for one person but not the other. However, there were no comprehensive risk assessments in place for the management of challenging behaviour and staff had not been trained to safely hold people. This put people at risk of harm due to inappropriate and unsafe restraint.

These issues constitute a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that in bathrooms there were several commode pots soaking in a disinfectant. These bathrooms were able to be accessed by people who were living with dementia and who would not recognise the dangers of the liquid. This put people at risk of harm as substances hazardous to health were not being managed safely. When we returned to inspect on 11 September 2018 we saw that the disinfection had been removed from the bathrooms and this had reduced the risk of harm.

We checked to see if people were protected from infection and found that the service was clean in all living areas, bathrooms and bedrooms. We saw staff used clothes and aprons at the required times and there were mostly hand washing facilities throughout the home. However, we the laundry sink was dirty and full of lime scale and behind the washing machine was ingrained dirt. People's soiled laundry was being washed together in one washer as there was only one washing machine to use and there were no sluice facilities for

commode pots to be cleaned to a sterile standard.

People and staff told us that there were sufficient numbers of staff to meet people's needs in a timely manner during the day. A relative told us: "I do feel there is enough staff to care for everyone, I haven't seen anything to tell me otherwise". However, one person told us: "I don't feel it's safe at night as there are only two carers and there is a lot to do and they are quite impatient and rushed sometimes. A resident fell out of bed only last night and they had to call the ambulance for them and deal with that and to fill forms in and it's just two carers". At our inspection on 11 September 2018 we found that the provider had increased the staffing levels at night to support a safe evacuation due to the ongoing risk to people in the event of a fire. However, we saw there were times during the inspection people were left with no staff supervision of interaction. We saw one person who was known to exhibit behaviour that may offend or put others at risk alone with another person. They were exhibiting inappropriate behaviour and we had to find a member of staff to support the person. All the staff were in one end of the service completing records. We discussed this with the registered manager who recognised that a member of staff should be deployed throughout the home.

People were being safeguarded from abuse as incidents of potential and actual abuse were being reported to the local authority by the registered manager. However, staff we spoke with had varying understanding of the safeguarding procedures. One staff member told us: "If there was a serious incident of abuse I would expect the registered manager to deal with it". This staff member was unable to tell us what they would do if the registered manager was unavailable. We saw the registered manager was addressing this in staff meetings and they had devised a flow chart so all staff would know what to do if they suspected someone had been abused.

We looked at the way in which staff were employed and found that the provider carried out pre-employment checks prior to offering them a job. Pre-employment checks would include the completion of disclosure and barring service (DBS) checks. DBS checks are made against the police national computer to see if there are any convictions, cautions, warnings or reprimands listed for the applicant. This meant that people would be cared for by staff who were fit and of good character.

Accidents and incidents were analysed by the registered manager and we saw that action was taken to minimise the risk of the incident occurring again. For example, we saw one person had been falling more frequently and they had a sensor mat put in place to alert staff to when they were mobilising independently.

Requires Improvement

# Is the service effective?

## Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Staff we spoke with had limited understanding of the MCA although we observed that generally they sought people's consent before providing care. We saw in some people's care records that it was noted that their relative was lasting power of attorney for either health and welfare, finance or both. However, the registered manager had not seen official evidence of this. They told us they would ask the relatives for a copy of the orders as proof.

The Deprivation of Liberty Safeguards is part of the MCA 2005. The legislation sets out requirements to make sure that people in care homes are looked after in a way that does not inappropriately restrict their freedom. We saw that one person had a Deprivation of Liberty Safeguards (DoLS) authorisation in place and referrals had previously been made for one other people. However, a mental capacity assessment had not been completed before the DoLS referrals had been made. This meant that the person's capacity to consent to the restriction that was being referred had not been assessed and consideration to the fact that they may be able to consent to the decision had not been made.

Prior to agreeing to people being supported at the service the registered manager completed an assessment of their needs. However, the assessments did not contain all the information they would need to care for the person comprehensively. People's assessments did not contain any information about people's protected characteristics under the Equalities Act. This meant that people's diverse needs had not been identified and plans put in place to ensure they would be met at the time of admission. However, we saw that the registered manager had developed a form which some people had and some had not completed following their admission which noted any specific needs to be considered. The registered manager told us that there was no one with any diverse needs that they were meeting currently living at the service.

Staff we spoke with told us they felt supported to fulfil their roles and were offered training to be effective. However, we found that staff were not trained to hold people safely and they were being asked to this on occasions. The registered manager was supervising staff and managing their performance and when it had been identified that staff required extra support, this had been arranged for them.

We found that although the environment met the physical needs of people who used the service with handrails, raised toilet seats and assisted bathing facilities, it lacked decoration and design to meet people's needs in relation to their dementia. NICE (National Institute for Clinical Excellence) guidelines state; For people being supported within a care home or specialist extra care housing, the care provider has the ability to control and change the environment to a much greater extent. They should be aware of the value of creating homely settings that enable people to participate in day to day living activities; of having simple layouts that are easy to follow; of the impact that contrasting colours, good signage and effective lighting can have; and of the benefits that a secure garden can offer. We found that the decoration did not support

people to orientate to time and place. There was no clear signage and we were told that one person kept entering other people's bedrooms. This meant that people living with dementia were not supported to maintain their independence whist orientating throughout the building.

Staff told us and we saw that there was a handover of people's needs daily so they were aware of any changes to people's needs. Staff at the service liaised with other agencies to ensure that people's health care needs were met. For example, one person's needs in relation to their mobility had changed due to a recent injury and they had been referred to and seen an occupational therapist. We saw this person's care plan had been regularly updated to inform staff how to support this person safely when helping them to move. One person who used the service told us: "I only see the doctor if I need to and it's never been a problem, I have had an eye test quite recently and I see podiatrist every 6-8 weeks".

People told us they were happy with the food choices. One person told us: " If you don't like the food options for the day they will always do something else for you. I usually have toast for breakfast and sometimes I will have a cooked breakfast, about twice a week, they are always happy to do it for me". We found that people were supported to eat and drink sufficient amounts to remain healthy. If concerns in relation to the people's food and fluid were noted, records were kept monitoring this. No one was on a special diet although some people preferred their food prepared to a softer consistency and this was facilitated for them. Some people were given alternative plates, bowl and cutlery to allow them to eat independently. We saw that staff encouraged people to eat their meals and people were offered salt and pepper for seasoning.

Requires Improvement

# Is the service caring?

## Our findings

People told us that they were treated kindly and our observations of staff interactions supported this. One person told us: "I love it here, I am very happy, lovely carers, all very polite and friendly". However, the provider had not considered the risk to people's safety in a timely manner in relation to the fire safety and this was putting people at serious risk of harm. This did not demonstrate a caring and compassionate approach to people's care.

In August 2016, all providers of NHS care and publicly funded adult social care must follow the Accessible Information Standard (AIS). Services must identify record, flag, share and meet people's information and communication needs. The standard aims to make sure that people who have a disability or sensory loss are given information in a way they can understand to enable them to communicate effectively. The provider had not provided the information people needed in accessible formats, to include easy read versions of documents such as menus and the complaints procedure and the use of pictures and photographs and technology so that people had access to the information they needed in a way that helped them understand their care and make choices about how they lived their life. This meant that people did not always have the information they needed to make decisions about their care and support.

People and their relative's were involved in the planning of their care. One relative told us: "We got together before my relative moved in and agreed what they needed. They keep me involved with what is going on". We saw the registered manager reviewed people's care plans regulary to ensure they were still relevant to people's needs.

Everyone who used the service had a room of their own. Some people chose to spend the majority of time in their rooms and this was respected. People's rooms had been personalised with items from their own home.

People's friends and relatives were free to visit. One person told us: "I have a phone in my room which I pay for, a landline. It's very useful, I can keep in touch with friends and family and they can call me too". People were offered the support of an advocate when they had no other representative.

Requires Improvement

# Is the service responsive?

## Our findings

Not all people who used the service were receiving care that met their individual needs. People who had the capacity to make choices about their care, did so and were offered the freedom to do as they chose. However, we found that people living with dementia were not afforded the same quality of care. The registered manager told us that the needs of several people had changed and they were requiring more support. However, the staffing levels had not increased for several years and the environment had not been updated to meet their needs. We saw that people who were living with dementia were left alone, unsupervised with little or no social interaction.

Staff we spoke with described how two people's behaviour had been controlled with medication when there had been a deterioration in their needs due to dementia. There were no care plans in place to support these people in relation to their dementia and associated behaviours although there had been health professional input. Although staff we spoke with knew people well, for example, one staff member told us that one person liked to sit and watch sport. Staff did not offer the person the opportunity to watch the sport of their choice and they were left to wander through the building most of the day. We later saw this person behaving in an unsociable manner towards another person and had to call staff for support. If this person had been actively engaged in an activity of their liking this may have been prevented. When we inspected on 11 September 2018 we saw that these two-people identified were still left unsupervised and unengaged in any activity.

These issues constitute a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that people had been out in the local community during the summer and there were some activities on offer. One person told us: "We have a church service on a Wednesday morning, I used to go to the church before I came in here, I haven't wanted to go to it since, they have asked me. People from the church come to visit me too which is lovely". Some people told us that there was a lack of activities available. Two people told us that singers and keep fit had been stopped and that they had enjoyed these activities. The registered manager told us that they tried hard to offer people activities and that it was difficult finding things that people would participate in. Entertainment and evening activities had been arranged at people's request and people then refused to attend or stated they had not enjoyed it.

There was no one using the service who was receiving end of life care. The registered manager told us that they worked with the 'Marie Curie' nurses who would spend time with people when their life was drawing to a close. Some people had their end of life wishes recorded and the registered manager told us that some people did not want to discuss their thoughts on the subject. They told us that they would add this into the pre- admission assessment so they could be sure that people's wishes were captured prior to admission into the service.

The provider had a complaints procedure which was visible in the reception area. However, it was not in an accessible format for people with sensory needs to be able to understand it. The registered manager told us

that there had been one formal complaint and we saw that it had been investigated and concluded according to the provider's policy.

Inadequate

# Is the service well-led?

## Our findings

At our inspection on the 6 September 2018 we found the provider had not taken prompt action to keep people safe and mitigate the risk when alerted to the fact that several fire doors were unsatisfactory and were putting people at immediate risk of harm. These doors had been identified over 12 months ago by the fire service and two external subsequent risk assessments still noted the doors as not being satisfactory and a high risk.

Following the inspection on 6 September 2018 we asked the provider to take immediate action to mitigate the risk to people and we reported our findings to the Fire service who visited the service on 11 September 2018. At our inspection on the 11 September 2018 we found that the risk associated with fire safety had only been partially mitigated. The provider had not visited the service to discuss the concerns and people were still at risk of harm as the fire regulations still were not being met.

This was the registered manager's first managers position. They had received no formal support and supervision to ensure they were meeting the required standards. The provider did not carry out any quality monitoring of the service through visits and check and there was no action plan for continuous improvement. This meant that provider could not be sure that the service they provided met regulations and was of a good standard for people who used the service.

The information the provider had submitted in their 'provider information return' (PIR) was not accurate. The PIR was submitted in May 2018 and stated that the fire doors should be replaced within 12 months. However the fire service had agreed 6-12 months from July 2018. This meant that this information did not reflect the actual timescales that the fire regulations should be met within.

The provider's PIR stated that people who exhibit behaviour that challenges would be supported with the effective use of risk assessments and with the use of distraction techniques. We found that this was not the case and there were no comprehensive care plans to support people at times they became anxious of aggressive. Two people were being held for personal care yet staff had no training in how to do this safely. We found there was a reliance on medication to control people's behaviour and they lacked stimulation and support.

There was no clear vision and strategy for the service. The registered manager told us that the needs of some people using the service had changed and they required more support in relation to their dementia. The registered manager told us that this was not the service user group the provider planned to care for. However, the PIR stated that the service could meet the needs of people with dementia. Yet we found that people's needs in relation to their dementia were not being met.

We saw that the local authority had carried out a quality audit in July 2018 and that they had identified several concerns around the management of people's medicines. Although some improvements had been put in place, we found that the same issue in relation to hand transcribing onto a MAR and other areas of medication practise had not been acted upon. This was still evident on our inspection on 11 September

2018.

There were insufficient systems in place to monitor and improve the quality of the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager knew their responsibilities in relation to their registration with us and they liaised with other agencies to provide coordinated care. They had taken action to reduce the risks to people due to the concerns found at this inspection. However, the resources they required were not available and this was hindering the process. They had notified us of significant events as they are required to do. The registered manager demonstrated openness and transparency throughout the inspection identifying areas that they recognised required improvement.

Staff told us that the registered manager was supportive and approachable and we saw that they supported staff to improve their practises if issues had been identified. We saw staff meeting minutes which the registered manager had discussed safeguarding, whistleblowing procedures and medication practises. Unfortunately, on the day of the inspection both these areas continued to be of concern.

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 9 HSCA RA Regulations 2014 Person-centred care<br><br>People were not always receiving care that met their personal needs. |

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<br><br>People were not always receiving care that was safe and protected them from harm. |

**The enforcement action we took:**

We served a warning notice.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>There were insufficient governance systems in place to monitor and improve the quality of the service. |

**The enforcement action we took:**

We served a notice of decision to impose conditions on the provider's registration.