Grazebrook Homes Limited

Grazebrook Homecare

Inspection report

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Tel: 01384240502

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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

The overall rating for this service is inadequate and the service is therefore in special measures.

About the service: Grazebrook Homecare is a supported living service providing personal care to seven people with learning disabilities, and physical disabilities and adults aged 65 years and over.

People's experience of using this service:
People told us they felt safe using the service but we found care and treatment was not always provided in a safe way. The provider had failed to update care plans and risk assessments for peoples changing needs. The provider failed to ensure people's care plans and risk assessments contained accurate and up to date guidance. Risk to people was not identified therefore no plans were put in place, exposing people to harm.

No action was taken to reduce re-occurring risks. Analysis of incidents and accidents did not take place. There was a lack of good governance and oversight therefore audits and checks were ineffective.

Systems and processes were not effective in assessing, monitoring and mitigating the risks relating to environmental health, safety and welfare of people. Audits did not take place on a regular basis.

The provider had not undertaken capacity assessments, it was unclear whether people had agreed or consented to care and treatment or had contributed to the development of their care plans. The local authority had not been notified of people who may be deprived of their liberty.

People were supported to access health care services when they needed. People and their relatives told us staff were good at monitoring their health needs. Staff had completed mandatory training.

Staff treated people with kindness and respect. People said they liked the staff and relatives said they could talk to staff. People and relatives were confident if they raised a complaint, it would be dealt with appropriately.

Rating at last inspection: Rated good (report published 29/03/2016)

Why we inspected: This was a planned inspection based on the ratings at the last inspection. The inspection took place in 15 January 2019

Enforcement
Full information about The Care Quality Commission's (CQC) regulatory response to more serious concerns found in inspections and appeals is added to reports after any representation and appeals have been concluded.

Follow up

As we have rated the service as inadequate, the service will be placed 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 inspect 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 act 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.

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 effective?

Requires Improvement

The service was not always effective

Details are in our Effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive

Details are in our Responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our Well-Led findings below.

Grazebrook Homecare

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection was carried out by two inspectors.

Service and service type:
This service provides care and support to people living in shared accommodation, known as a 'supported living' setting, so that they can live in their own home as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support

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:
We gave the service 48 hours' notice of the inspection visit because it is small and the registered manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

What we did:
We sent the provider a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before our inspection, we reviewed the information included in the PIR along with information we held about the home. This included notifications received from the provider about deaths, accidents/incidents and safeguarding alerts which they are required to send us by law. We also contacted the local authority who commissioned services from this provider. No concerns were raised about the service.

During the inspection four people shared their views about the support they received, not everyone was able to do this so we also spoke with two relatives. Nine staff members were spoke to along with the registered manager who was available throughout the inspection.
Care and review records, for four people who used the service, were looked at. Management records for how people were administered medicines as well as a range of records relating to the running of the service were also looked at. These included incident and accident monitoring as well as complaints. We viewed three staff files and training records.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

Inadequate: People were not safe and were at risk of avoidable harm. Some regulations were not met.

Assessing risk, safety monitoring and management
• The provider had failed to put in place systems and processes to keep people safe from avoidable harm. We saw people were regularly falling and no risk assessments were in place. The registered manager told us they did not have any falls risk assessments. We found one person had been injured because of a fall.
• All people had a care plan and staff could tell us what support people needed. However, people's care plans lacked information on how to deliver safe care to meet new needs.
• There were no care plans in place for people who had a specific medical diagnosis'. This meant staff did not have detailed guidance to follow to ensure consistent, safe care.
• Risk assessments lacked detail and did not provide staff with enough information to safely undertake tasks with people. This meant people were exposed to risk of harm.
• Environmental risk assessments had not been carried out in people's home. During the inspection doors were seen to be propped open which created a fire risk. Staff told us this happened overnight. There were no risk assessments or evacuation plans in place for people or staff. There was nothing in place to ensure staff were safe at night.

The failure to do all that is reasonably practicable to mitigate risk to people using the service was a breach of the Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
• Systematic failings in the auditing processes meant concerns about safety, raised during inspection, were not identified. People were therefore exposed to avoidable harm.
• No analysis was in place to recognise potential risks or trends. Concerns were raised in the last inspection regarding this and it had not been addressed, people remained at risk of harm.

The failure to ensure risks relating to the safety and welfare of people using the service are assessed and managed was a breach of the Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

• Staff knew the correct procedure to protect people from risk of abuse. One staff member told us, "I would report concerns to the manager, if they did not take appropriate action I'd report to safeguarding".

Using medicines safely
• During the last inspection, it was identified 'as and when required' medicine protocols lacked sufficient information to administer the medicine safely and consistently. We found this was still a concern on this inspection, we also found 'as and when required' medicine protocols did not state a safe time between doses. People could be given their medicines in an unsafe way

• One person had epilepsy rescue medication, staff gave us incorrect information as to when the medicine would be given. The care plan and protocol was not easily accessible to staff and had not been reviewed in over 10 years. However, staff advised us the person had not had a seizure for over 10 years.
• Audits of medicines had been completed but not on a regular basis, at the time of inspection, some people's medicines had not been audited since June 2018. Lack of auditing means errors in medicine records would not always be identified, people were at risk of not receiving medicines as prescribed.
• We found systems were in place to ensure medicines were stored correctly. Staff completed stock checks on 'as and when' required medicines. However, one person's rescue medicine was in a sealed box and had not been opened. Staff were unable to tell us if the medicine was fit for use or if the correct amount was inside the box.
• Staff had been assessed as competent to give medicine, however there was no system in place to refresh this competency to ensure staff were still following the correct practice.

The failure to ensure medicines were managed safely was a breach of the Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• People told us they received their medicines in a way they wanted with the support they required. Staff also told us they had received training in how to give medication safely and training records showed this.
•. We saw body maps in place to advise staff of where to administer creams for people. Staff completed a medicines administration record (MAR) to confirm people had received their medicines.

Preventing and controlling infection
• Staff had received training in infection control. Staff told us personal protective equipment was available to them.

Staffing and recruitment
• People and relatives told us they thought there were enough staff.
• One person told us, "If we really need help we can call for it, we use our telecare system or we can call [registered manager]." Telecare devices allow you to call for help if you have a problem at home.
• A member of staff told us, "There are enough staff. We all help each other and make sure shifts are covered."
• Improvements were required to ensure recruitment processes were robust

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

RI:□The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority.

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

Ensuring consent to care and treatment in line with law and guidance
• The provider could not show they had acted in accordance with the requirements of the Mental Capacity Act 2005. There was no evidence of capacity assessments for people that may lack capacity or best interest's decisions being completed in relation to people's medicine management or personal care routines.

The failure to ensure care and treatment is being provided with the consent of the relevant people was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• Care plans and risk assessments did not show how people made choices, therefore staff did not have guidance about how people made their decisions, as a result people may have not be given choice.
• There was no evidence of how choice was made by people who were non-verbal or had limited communication. We saw people were doing group activities but there was no evidence to suggest these activities were what people wanted.
• People who could communicate easily told us they made decisions about their day to day lives, one person told us, "I like to go out and see my friends, I can do this whenever I want."

Staff support: induction, training, skills and experience
• Care plans had some information about health and social needs and sexuality but lacked sufficient detail.
• People appeared comfortable in the company of the staff. A relative told us, "I see the staff on a regular basis and [relative] knows them well and trusts them."
• We saw people were supported by staff who knew them well, staff told us they had an induction and ongoing training.

• One person told us, "We have the same staff and all new people have an induction."

Supporting people to eat and drink enough to maintain a balanced diet
• Staff told some people needed a special diet for diabetes, there was no care plan to show what diet was needed.
• People told us they go food shopping and choose what they want to eat and drink. A relative told us, "There has never been an issue about [relative] not getting the foods they want."

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
• People were supported to access healthcare services including their GP and the dentist. We saw some people were supported to access an annual health check.
• We saw one person was unable to be weighed but a health tool had been completed in relation to their weight. The registered manager told us they would support the person to be weighed at a specialist centre.
• Care plans and risk assessments lacked sufficient detail of people's needs and did not detail how to deliver consistent care.

Adapting service, design, decoration to meet people's needs
• People told us they chose what they wanted in their homes and bedrooms, one person told us, "I am going to have a fish tank in my room"
• Staff told us, "A physiotherapist recommended [person] change their bedroom floor, we helped them do this."

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

RI:□People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Supporting people to express their views and be involved in making decisions about their care
• There was no evidence in care plans and risk assessments to suggest people who could not verbally communicate had been supported to express their views.
• There was no evidence in care records to suggest people who could not verbally communicate had been involved in decisions about their care.
• One person regularly completed an activity and told us, using sign language, they did not enjoy it. Staff were not aware of this. Staff also told us that one person did not enjoy going to bingo however we saw that this person was still going.
• Staff told us they involved people in writing their daily notes, a person told us, "I know what goes into my daily records, I help the staff write them."
• Where people could verbally communicate, we saw staff supporting them to make choice.

Respecting and promoting people's privacy, dignity and independence
• People who could talk to us said they were encouraged to be independent. We saw that some people had time unsupported by staff
• One person told us, "The staff always knock on my door before entering my bedroom."

Ensuring people are well treated and supported; equality and diversity
• One person said, "Staff are brilliant, they are dedicated, understanding and kind", another person said, "It feels like a family atmosphere."
• Relatives told us they liked the staff and staff were friendly. One relative said, "[relative] doesn't like change, they need consistent staff, [relative] knows and trusts the staff."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

RI:□People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
• Staff reviewed care plans but there was no evidence of how this process involved or was communicated to people or their relatives. We saw care plans did not reflect people's current needs.
• A person had recently been diagnosed with a new health condition, this had not been reflected anywhere in the person's care plan. The affect the diagnosis had on the person's life had not been recorded and staff did not have guidance to follow.
• People had good links with family and friends and staff supported people to maintain this. One person told us, "My niece and nephew visit, sometimes I visit my family in their home, staff will drop me off and pick me up."
• Staff told us one person used Makaton, Makaton is a form of sign language. Staff said, "We had Makaton training from Ridge Hill, it was centred around [person] as they use their own version of the signs."
• Care plans stated religious preference.
• People had care plans for expressing sexuality, although they lacked detail.

Improving care quality in response to complaints or concerns
• There had been no formal complaints since our last inspection
• People and relatives knew how to complain, one person told us, "If I am not happy, I'll speak to staff or [registered manager]." A relative told us, "I could speak to the staff or [registered manager], or I could go to safeguarding or the CQC."

End of life care and support
• We saw some information was recorded about end of life care but limited information was provided and it did not outline future wishes. No-one was receiving end of life care at the time of the inspection.

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

Inadequate: There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

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

• Numerous concerns were identified with records. These included incomplete, inaccurate risk assessments and care plans, lack of incident and accident analysis and lack of details in relation to critical information on medicine records. Where risks were identified, there was inconsistencies in the records.

• We found people's diagnosis and care needs were not identified in care records. Not keeping records that are fit for purpose put people at risk of harm from inappropriate care or treatment

• There were systematic failures in the provider's audit process. Quality assurance continued to be ineffective and did not pick up on the issues identified at this inspection. These included concerns with recruitment checks, care plan audits, risk management and medicines. We found one person's medicine record had not been reviewed in 10 years. This posed possible risk to people's health, safety and well-being.

• Recruitment checks weren't always robust. We found one staff members references did not match their employment history. We found [DBS] checks had been completed but not re-checked, we found a staff member had been employed for 10 years and not had any checks on their criminal record since starting. The registered manager showed us they had now added a disclaimer to the supervision form, staff will sign to say they had not had any convictions.

The lack of robust quality assurance meant people were at risk of receiving poor quality care and should a decline in standards occur, the providers systems would potentially not pick up issues effectively. This was a breach of the Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility; Continuous learning and improving care

• Incidents did not prompt learning to improve care. We saw a person had a serious injury after a fall. The person had fallen before and no action had been taken to mitigate further risks.

• The systems and processes in place were not adequate and failed to identify risk. The registered manager told us there was a falls analysis in place but on checking, this was a document which showed all incidents for people and did not analysis patterns or trends.

• There were no action plans following the last inspections and no actions from the audits that had been completed so improvements had not been identified.

• Outcomes of health appointments were not linked to risk assessments or care plans, one staff member said, "I used google to find out about [person's] new diagnosis, we didn't have any training." We saw there was no care plan or risk assessment for this person's health need.

• Staff and people told us the registered manager was approachable.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• There were no records to show people, relatives or other appropriate persons had been involved in decisions about care and treatment.
• On the day of inspection, the provider told us eight people may be deprived of their liberty. Governance systems and processes had not identified people may have been deprived of their liberty so the local authority was not made aware. People can only be deprived of their liberty to receive care and treatment when it is in their best interest and legally authorised under the Mental Capacity Act 2005.
• Care plans stated religious preference.
• People had care plans for expressing sexuality, although they lacked detail.

Working in partnership with others
• The service communicated frequently with the GP and other professionals when required.

It is a legal requirement that the overall rating from our last inspection is displayed within the service and on the provider's website. We saw the rating was displayed in the office but not on their website. The provider amended this within 24 hours.

The registered manager had failed to notify us of a serious injury. Not notifying The Care Quality Commission of a serious injury is a breach of Care Quality Commission (Registration) Regulations 2009: Regulation 18

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
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents A serious incident was not notified to CQC

The enforcement action we took:

We served a fixed penalty notice

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People had not consented to care and treatment.

The enforcement action we took:

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not always receiving care that was safe and there was risk of harm

The enforcement action we took:

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

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance 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.