Griffin Care Homes Limited

Griffin House Care Home

Inspection report

Shaw Lane
Prescot
Merseyside
L35 5BZ

Tel: 01514263012

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24 February 2021
26 February 2021
01 March 2021
02 March 2021

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Griffin House Care Home provides accommodation for up to 26 people who need help with their personal care. At the time of the inspection 20 people lived in the home. Some of the people living in the home, lived with dementia.

People's experience of using this service
We conducted a focused inspection of this service looking at the domains of safe and well-led. This was to follow up concerns identified at the last inspection with regards to people's care, and also because CQC had received information of concern in respect of the management of the service.

At this inspection, we found that the provider had failed to take adequate action to improve the standards of care and safety. Concerns with the management of risk, medicines, record keeping, leadership and governance were identified again at this inspection. New concerns relating to staff recruitment were also identified.

Staff did not always have sufficient guidance on how to provide safe and appropriate care. Medication management was unsafe and placed people at risk of avoidable harm.

Infection control standards and government guidance for staff to follow was not always clear or being followed to protect people from the risk of infection such as COVID-19.

There were enough staff on duty to support people however, staff members were not always recruited safely. The provider had not always ensured sufficient information on the skills, experience or character of persons employed was obtained before they were given an offer of employment or started working in the home. After the inspection, and in response to our concerns the provider put a tool in place to ensure robust recruitment checks were undertaken in future.

Record keeping in relation to people's care and the management of the service were not always properly maintained. It was a difficult and time -consuming process, trying to access information about the service from the provider. Some of the records when provided, were not consistent with the rotas which raised questions with regards to their authenticity.

The systems in place to monitor quality and safety remained ineffective. The provider, who is also the registered manager of the service, did not have a sufficient understanding of best practice or the regulations. This meant the service could not be considered to be safe or well-led.

Accident and incidents and safeguarding events were recorded. Care staff were friendly, and treated people kindly. People's relatives confirmed this and felt their loved ones were well looked after.

Rating at last inspection and update
The last rating for this service was inadequate (published 30 October 2020).

At this inspection enough improvement had not been made and the provider was still in breach of regulations. We identified continued breaches in relation to Regulation 12 (safe care and treatment) and Regulation 17 (good governance) and a new breach of Regulation 19 (Fit and Proper Persons) with regards to the service.

Why we inspected
We undertook this focused inspection to follow up on the concerns we identified at the last inspection and to check whether the Warning Notice we previously served in relation to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been met. Prior to this inspection we had also received information of concern in relation to medicines and the management of the service.

We undertook a focused inspection on the Key Questions of 'Safe' and 'Well -led'. These were the areas we had concerns about at the last inspection. 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. This report only covers therefore our findings in relation to these Key Questions.

Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection. The overall rating for the service has not changed following this focused inspection and remains inadequate.

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

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.

Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
The overall rating for this service is 'Inadequate' and the service remains in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of

inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe

Details are in our Safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our Safe findings below.

Griffin House Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this focused 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 under the domains of safe and well-led, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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 undertaken by three inspectors.

Service and service type
Griffin House Care Home is a care home. People in care homes receive accommodation and personal care. 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.

At Griffin House Care Home the registered manager was also the provider of the service.

Notice of inspection
We telephoned the service from the car park on the day of the inspection and announced our arrival to the provider. The purpose of this was to obtain information about COVID-19 in advance of inspectors entering the service.

Inspection activity started on 24 February 2021 and ended on 02 March 2021. We visited the service on 24 February 2020.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We liaised with both the Local Authority and the NHS infection Control Team to gain information on 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. We used all this information to plan our inspection.

During the inspection
We spoke with the manager, the senior care assistant, two care assistants, the chef and a domestic member of staff. We reviewed a range of records. This included two people's care records, a sample of medication records, four staff recruitment files and records relating to the management of the service.

After the inspection visit
Due to the impact of the COVID-19 pandemic we limited the time we spent on site, and were unable to speak with family members, due to visiting restrictions. Therefore, we requested records and documentation to be sent to us and reviewed these following the inspection visit. We contacted three relatives by telephone about their experiences of the care provided.

We continued to seek clarification from the provider to validate evidence found.

Inadequate

Is the service safe?

Our findings

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

At the last inspection, this key question was rated as inadequate. At this inspection, this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

At the last inspection, the provider failed to ensure the proper and safe management of medicines. This was a breach of Regulation 12 (Safe care and treatment) 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.

Using medicines safely

- Medicines that needed to be taken before, with or after food were not always administered with due regard to this. This increased the risk of medication side effects or the medication not being fully effective.
- Thickening medication prescribed to thicken people's fluids to prevent them from choking were not managed safely. This increased the risk of a choking incident occurring. There were also no records to show that people's fluids had been thickened as required. After the inspection, the provider put in place a document for staff to record when thickener was added to people's drinks.
- Staff did not always have enough information to ensure that as and when required (PRN) medicines such as painkillers and inhalers were administered appropriately or, at the right dose. This meant there was a risk people would not receive the right medication when they needed it.
- Eyedrops were not managed safely. One person was prescribed five different eye drops and cream. There was no information on how to administer them safely. The same person was also given eyedrops which were out of date.
- Medicines competency assessment designed to assess a staff member's ability to administer medication safely, had been carried out by the provider. The provider had not been trained to assess staff competencies. Their own ability to administer medications safely had also not been assessed.

The management of medication remained unsafe. This was a continued breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At the last inspection people's support was not always assessed or delivered in a way that mitigated risks to their health and well-being. This was a breach of Regulation 12 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.

● The majority of people's risks were assessed but information on how to mitigate people's risks or meet their needs was not always sufficient. Records did not always show risk management advice was properly followed.
● At the last inspection, the provider was advised staff had no information or guidance on how to ensure people's pressure mattresses were on the correct setting to mitigate their risk of a pressure sore developing. At this inspection, we found the same. We checked one person's pressure mattress and found no information for staff to follow and no checks had been made on the pressure mattress to ensure it was in good working order.
● At the last inspection the provider was advised that improvements to some bedroom doors were needed to ensure they closed properly and provided sufficient protection in the event of a fire. At this inspection, we found no adequate improvements had been made. The provider's fire evacuation policy was also unclear and did not provide staff with clear guidance on how to evacuate people safely.
● Accidents and incidents were recorded and monitored. We saw that appropriate action in relation to these had been taken.

The provider had still not ensured risks in relation to people's care were properly managed to prevent avoidable harm. This was a continued breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● Infection prevention control procedures (IPC) including those relating to COVID-19 were not clear or, being followed in accordance with government guidelines. For example, the provider's admission visitor policies were unclear and the provider had not committed to testing visitors to the home prior to entry in accordance with government guidelines.
● The manager (provider) had not ensured that they and their staff team were wearing facial masks properly, to protect people and other staff from the risk of contracting COVID-19.
● Staff signing to confirm that areas of the home had been cleaned to mitigate the risk of COVID-19 did not always match the names of staff on duty. This raised concerns about the authenticity of these records.

Infection control did not adhere to government guidelines to protect people from the risk of, or, spread of infection. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Checks on the safety and suitability of staff to work with vulnerable people were not properly completed prior to employment.
● Some of the staff members employed did not have a fully completed job application form on file, proof of identity, previous employer references, a contract of employment or a disclosure and barring check undertaken prior to being offered a position of employment. After the inspection and in response to our concerns, the provider's put in place a tool to ensure that robust recruitment checks were undertaken in future.
● On the day we visited, there were enough staff on duty to meet people's needs.

The provider's recruitment procedures were not robust and did not ensure only fit and proper persons were employed. This was a breach of Regulation 19 (Fit and proper persons) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

At the last inspection, the provider had failed to take the appropriate action to ensure people were safeguarded from the risk of abuse. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, enough improvement had been made and the provider was no longer in breach of this regulation.

- The provider had introduced a system for ensuring any safeguarding concerns in relation to people's care were recorded and acted upon.
- Staff spoken with, knew the process to follow to report potential incidents of abuse.
- Relatives of people living in the home, told us they felt people were safe.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

At the last inspection this key question was rated inadequate. At this inspection, this key question has remained the same. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At the last inspection, the provider failed to operate effective systems to ensure the quality and safety of the service which placed people at risk of harm. They also failed to maintain accurate and up to date records. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider remained in breach of Regulation 17.

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

- At the last inspection, the provider did not always operate in an open and transparent way, at this inspection we found the same. It was a difficult and time-consuming process to access information about the service, which should have been readily available. The authenticity of some of the records was also of concern.
- The provider (who was also the registered manager of the service) demonstrated that they lacked an understanding of the health and social care regulations and knowledge of best practice guidance.
- The provider's governance arrangements were not robust. The provider's 'walkaround' audits for nutrition, environment, record keeping provided to CQC were all blank and it was clear they were not embedded or an integral part of the provider's governance arrangements.
- Medication audits were not robust as they did not identify the concerns we found during this inspection. Care plan audits were meaningless. They did not identify what information in relation to people's care needed improving, for staff to have clear information on their care.
- Fire safety did not comply fully with fire safety standards. The provider had been advised of this at the last inspection but failed to take appropriate action.
- Infection control did not comply with government guidelines on infection control and COVID-19. The provider's quality assurance checks had not identified this. The provider also refused to follow government guidelines and participate in lateral flow testing for visitors to the home as they did not believe these tests were accurate.

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

● Records in relation to people's care did not always contain adequate information and were not always completed properly. This meant it was difficult to tell if people received the care they needed and if this care promoted good outcomes for people.
● The provider had not improved the service or people's care in response to the concerns identified at the last inspection.
● It was difficult to tell what learning was gained from the provider's quality assurance checks and shared with the staff team in order to improve the service, as these checks were ineffective and not fully completed.

The governance arrangements in place were not robust and record keeping was not always adequately maintained. This was a breach of Regulation 17 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; Working in partnership with others
●Relatives told us that staff at the home kept them up to date on their loved one's well-being and engaged with them well.
●At our last inspection, the provider had not always engaged in a positive way with stakeholders such as the Local Authority. At this inspection, we saw that the Local Authority had initiated regular meetings and updates from the provider with regards to the service. The provider had engaged with this process.
●People received support from a range of other health and social care professionals such as the district nurse teams, local GP and mental health services, as required.