Greasbrough Residential & Nursing Home Limited

Greasbrough Residential and Nursing Home

Inspection report

Potter Hill
Greasbrough
Rotherham
South Yorkshire
S61 4NU

Tel: 01709554644

Date of inspection visit:
06 August 2018

Date of publication:
23 May 2019

Ratings

Overall rating for this service	Inspected but not rated

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

Summary of findings

Overall summary

The inspection took place on 6 August 2018 and was unannounced which meant the people living at Greasbrough Residential and Nursing Home and the staff working there didn't know we were visiting.

The service was previously inspected on 15 and 17 May and 6 June 2018, when we identified six breaches of regulations, the service was rated Inadequate and was placed in special measures.

We undertook an unannounced focused inspection of Greasbrough Residential and Nursing Home. The inspection was undertaken to check that the improvements the registered provider had told us about following our comprehensive inspection in May and June had been completed and legal requirements were now being met. The team inspected the service against two of the five questions we ask about services: is the service safe and is the service well led. This was because we had received concerns form the local authority and from the public regarding people's safety and the management and leadership of the service.

The areas of concerns raised by the local authority and the public did not relate to the remaining Key Questions so we did not inspect them.

At the last inspection, the service was rated inadequate. At this inspection we found the service remained inadequate. We found that the registered provider had failed to make or sustain sufficient improvements in the key questions we looked at. The service remains in special measures.

You can read the report from our last inspections, by selecting the 'all reports' link for 'Greasbrough residential and Nursing Home' on our website at www.cqc.org.uk.

Greasbrough residential and Nursing 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. It provides accommodation for up to 60 people in one adapted building. On the day of our inspection there were 48 people using the service.

At the time of our inspection there was a registered manager in post. 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.

We found continued concerns with medication management. Systems were in place to manage medicines safely. However, we found these were not followed and people did not always receive medicines as prescribed.

We identified risks were still not managed safely. Assessments identified risks to people and management

plans to reduce the risks were in place to ensure people's safety. However, these were not followed, staff did not refer to care plans and did not deliver the care and support in line with people's assessed needs. This put people at risk of harm.

Recruitment procedures were not followed so the registered provider did not ensure safe recruitment of staff.

We found the registered provider continued to not follow the dependency tool, this is a tool used to determine the hours of care required to meet people's needs. We found again there were inadequate staff on duty. Following our inspection in June 2018 the registered provider assured us the appropriate staffing levels would be in place to meet people's needs even if agency staff were required. At this inspection we found this was not the case.

Not all staff had been supported or supervised to ensure they fulfilled their roles and responsibilities.

Infection, prevention and control procedures were not always followed to ensure peoples safety.

Systems in place to monitor the service continued to be ineffective. They did identify some issues but these were not followed up to ensure they were resolved, which would help to keep people safe and maintain their wellbeing.

Further information is in the detailed findings below.

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.

Risks were not managed safely, which put people at risk of harm. Safe medication systems were not followed and people did not always receive medication as prescribed.

Infection prevention and control procedures were not always followed.

Recruitment procedures were in place but we found that these were not always followed.

Is the service well-led?

Inadequate

The service was not well led.

There was lack of governance and oversight by the registered provider.

The registered manager had implemented some new systems to monitor the service and to identify areas to develop. However, we found that these were not effective.

There were no opportunities for people who used the service, staff, or relatives to voice their opinion or be involved in the service.

Greasbrough Residential and Nursing 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 was planned to check 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 a focused inspection. This inspection took place on 6 August 2018 and was unannounced. The membership of the inspection team comprised of three adult social care inspectors.

Prior to the inspection visit we gathered information from a number of sources. We spoke with the local authority and other professionals supporting people at the home, to gain further information about the service. The feedback we received raised concerns regarding people's safety and competency of staff.

We spoke with six people who used the service and four relatives, and spent time observing staff supporting with people.

We spoke with six care workers, one nurse, one domestic, the administrator, the maintenance person, the registered manager and the registered provider. The directors were also present at the feedback meeting. We looked at documentation relating to people who used the service, staff and the management of the service. We looked at twelve people's care and support records, including the plans of their care. We saw the systems used to manage people's medication, including the storage and records kept. We also looked at the quality assurance systems to check if they were robust and identified areas for improvement.

Inadequate

Is the service safe?

Our findings

At our last inspection in June 2018, this key question was rated as inadequate. This was because risks to people and medication were not managed safely and staffing did not meet the needs of people. At our inspection of 6 August 2018, we found appropriate action had not been taken and other concerns were identified. At this inspection we found the service continued to be inadequate.

Risks associated with people's care and treatment were not managed in a way that supported people to remain safe. Risk assessments were in place but did not include vital up to date information or take in to account measures put in place to minimise them. For example, one person's care records had not been updated following a recent fracture. This meant that the care plan was not accurate. The fracture they had sustained required the person to rest for it to repair. The care plan still stated they were fully mobile and steady on their feet. We observed this person in the lounge with a new care worker. The person stood up and tried moving their feet up and down and the care worker moved with them. This could have put the person at risk.

The person who had sustained the fracture had a mattress on their bedroom floor at the side of their bed. Staff told us this was in case they tried to get up unaided, it would mean they fell on the mattress and not on the floor. This was not included in the care plan, which was contradictory, stating that the person required all areas to be free from trip hazards and obstacles. During our inspection we saw this person sat on the edge of the bed drinking tea without support and the mattress was in place on the floor. This could have placed the person at risk of falling.

Another person's care plan indicated they required snacks and high calorie drinks in between meals. Food and fluid charts from 30 July 2018 to 5 August 2018 did not record any snacks apart from a banana on one occasion and only juice in between meals on occasions. In another person's health care record dated 10 July 2018, we saw advice from the dietician which stated that the first line treatment plan should commence, including weekly weights and offer finger foods due to wandering. However, the care plan dated 4 July 2018 and the evaluation sheet had not been updated with this advice and did not reflect the person's current needs. We asked to see food and fluid charts and they could not be located. According to the malnutrition universal screening tool (MUST) weight record, the person had not been weighed since 4 July 2018 despite the dietician requesting weekly weights. These examples showed that people were at risk of malnutrition.

We found medication procedures were still not followed to ensure medications were administered safely. We found many errors with the recording of medication on receipt, administration and when medication was either disposed of or returned to the pharmacy.

We found the carried forward amounts were not always recorded on the medication administration record (MAR). This meant it was not clear how many medicines were in stock to be able to effectively audit. We found when entries were hand written the staff member recording the medicine did not always sign and there was not a second signature to confirm it had been checked and was recorded correctly. We also found

there were still some gaps on the MAR's, where staff had not signed to confirm the medicine had been administered.

We found peoples creams and ointments which were to be applied to the skin, were still not recorded properly and it was not evident people were having these applied as prescribed. For example, we looked at a selection of 'Topical' medication administration records (TMAR's). Topical is a medication that is applied to a particular place on or in the body. Most often topical administration means application to body surfaces. We could not evidence that people had received their topical medicines as prescribed. One person's TMAR indicated that cream should be applied after each change of their continence pads. However, the TMAR recorded that this had occurred only once on the 29, 30 July and 4, 5 August and nothing recorded for the 31 July. Another person was prescribed two creams 'as directed.' We spoke with two staff about one cream and asked them where they would apply it. One said, "On the legs I think as they are dry." The other care worker said, "I think it is the sacrum." We also asked a senior care worker and they said, "I wouldn't apply it anywhere without asking the nurse first." This showed that the staff did not know the current needs of the people in their care.

The TMAR for another person indicated that on 21 July 2018, they had a grade two pressure area on the sacrum and back of their right knee and dressings had been applied. The next recording on the TMAR was 28 July when creams were applied, but there was no update on the pressure areas. Prior to the pressure areas being identified the record showed that the cream had been applied to sacrum on 3,4,6,13,14,17 July and no other information had been recorded about any skin deterioration.

We found some people were prescribed medicines to be given on an 'as and when' required basis, known as PRN medicines. We found some people still did not have PRN guidelines in place to instruct staff when to administer the medicines. Some people were living with dementia and were unable to tell staff when they required their medicines. Therefore, without any guidelines or protocols in place to guide staff, people may have required these medicines but not been given them. These medicines included pain relief so people may have been left in pain. We saw one person in pain and no protocol was in place to guide staff on how the person presented when they required their pain relief. We also found when it was given staff did not record exact time given, reason or if it was effective so it was impossible to evaluate if the pain relief was effective. Therefore, staff were not managing the person's pain.

Monitoring of medication storage rooms was completed. However, the room was still operating above recommended levels and we found it was over 28 degrees centigrade during our inspection.

The staff had not had any additional training since our last inspection in safe administration of medicines and had not received any competency assessments or supervision to cover areas needed to develop. At this inspection we continued to find poor management of medicines that meant people did not always receive prescribed medicines.

People were not always protected by the prevention and control of infections. The home generally appeared clean although not very well maintained. We found some furniture was damaged and not able to be properly cleaned, carpets were stained, equipment was damaged and not able to be cleaned, for example, bed rail protectors and rusty shower chairs, which were identified at our last inspection.

We were also informed by the local authority that a recent outbreak of diarrhoea and vomiting was not properly managed. It took three weeks to eradicate and effected several people who used the service. Staff did not follow basic infection control measures there was lack of personal protective clothing and people were not barrier nursed when they were affected. This put people at risk.

This is a continued breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment. Risks associated with people's care were not always managed effectively. Medicines were not managed safely and infection control procedures were not followed.

At our inspection of June 2018, we were assured by the registered provider that the staffing levels would be maintained following the dependency tool to ensure people were safe. On the day of our visit we were told this was still in place and showed a staff rota. Our observations did not reflect this, we found communal areas not observed by staff and at times no staff around or insufficient staff available to meet people's needs. When we examined the dependency tool the hours assessed as required were not provided. We discussed this with the registered manager who told us they would ensure the additional staffing hours were covered by agency staff. This should have been in place following our last inspection as the registered provider gave us assurances in writing that this would be maintained. The registered provider had failed to ensure sufficient staff were deployed to meet people's needs.

We also found staff were not assessed or supervised to determine that they had the competencies to fulfil their roles and responsibilities.

This was a continued breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing. The service did not make sure there were sufficient numbers of suitable qualified staff to support people.

We looked at recruitment procedures as this had been raised as a concern by the local authority. We looked at five staff files and found that three of the five staff had not been employed safely. The recruitment procedure had not been followed, they had not obtained references from previous employers but had character references only. One staff member had some concerns raised but these were not explored or investigated to ensure they were safe to work. These concerns were discussed in full with the registered manager and registered provider who agreed to look into the issues and deal with them with the individual staff.

This was a breach of Regulation 19 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Fit and proper persons employed. The registered provider did not follow safe recruitment procedures.

During our tour of the building we found that oxygen cylinders were not being appropriately stored. We found one cylinder was propping open a bedroom door. Four additional bottles of oxygen were seen to be stored in the same bedroom, this posed an increased fire hazard and was not in line with safe storage of gases. We brought this to the attention of the registered manager who removed the oxygen. Where medical oxygen is prescribed there must be records kept of its prescription and administration; including the flow-rate and length of use. The will ensure that people are protected by receiving the treatment as prescribed by their doctor. This information was not stored in peoples care plans. Where medical gases are used and stored there must be appropriate risk assessment and risk management procedures documented and in place, we found that risk assessment were insufficient in highlighting all the risks.

People were not always safeguarded from the risk of abuse as people's needs were not always met and they were put at risk. We submitted three safeguarding referrals to the local authority following our inspection.

Inadequate

Is the service well-led?

Our findings

At our last inspection of 15 and 17 May and 6 June 2018, this key question was rated as inadequate. This was because systems in place to monitor the service were not effective. At our inspection of 6 August 2018, we found although new audits had been implemented and actions identified they were not addressed or followed up by staff so were still not effective. At this inspection we found the service continued to be inadequate.

The registered provider could not evidence that they continuously improved or learned lessons to develop the service. We looked at a range of audits and found that documentation had slightly improved, however, they remained ineffective. The weight loss audit identified people who were losing weight and a comments column gave an indication of actions taken. For example, the dietician had advised that stage one advise should be followed. We spoke with the registered manager who confirmed that this meant food and fluid charts should be maintained, weigh the person weekly and ensure fortified food are offered. We looked at this person's care plan and found that their care plan had not been updated to reflect these changes. The person was not being weighed on a weekly basis and no food and fluid charts were completed. There was no evidence to suggest the person was receiving a fortified diet.

We looked at the falls audit and found the form had improved to include an analysis of falls over the previous three months, the location of the fall and any action taken to minimise the risk of falling. We saw that healthcare professionals had been involved when needed, however, it was not evident that their advice had been followed. For example, one person had been seen by the falls team who advised that maximum supervision should be offered when mobilising, a falls sensor should be provided in their bedroom and to encourage purposeful activity to avoid boredom. We found no evidence of this.

Another person's care plan audit stated that the risk assessment had been reviewed monthly and was person centred. The risk assessment had been updated in May 2018 however, it did not incorporate all measures which should be in place, as indicated by the falls team. For example, a sensor mat. The care plan evaluation for July had been completed too early and stated that no falls had occurred during this month. However, we found that the person had four falls in July as indicated on the falls audit and accident forms.

These examples showed that although initial action had been taken but there was no ongoing monitoring to ensure care plans had been updated and to check that people received appropriate care and support.

A care plan audit had taken place and identified some areas of improvement. These areas were collated in a report and passed to the relevant key workers. However, care plans were not checked to ensure the updates had taken place.

An audit had been introduced to monitor daily charts. However, this had not identified that some people did not have food and fluid charts when these had been identified as being required. The audit had last been completed in June 2018, when an action plan was put in place to address concerns raised. However, these actions were not complete.

The registered provider had an infection control audit, which was completed by the housekeeper with no management oversight. The last infection control audit was completed on the 8 June 2018 and identified that three bedroom carpets required cleaning. No other concerns were identified. There had not been an infection control audit since as the housekeeper had been on holiday. The concerns we raised about the environment, as part of our inspection, had not been identified through effective audits of the service.

The registered provider did not have a clear vision or promote a positive culture that achieved good outcomes for people. Since our last inspection there had been no management meetings to guide the leaders within the home in driving the service forward. The registered manager had expressed that they wanted to step down from this post, however, no action had been taken by the registered provider to facilitate this. This had an impact on the leadership of the home.

People who used the service, their representatives and staff were not engaged or involved in the service. No formal engagement with relatives, residents and staff had taken place. The registered manager told us they had spoken with visitors to the home about the last inspection. Relatives who visit less frequently and people living at the home had not been spoken with. There had been no staff meeting to raise concerns formally and to guide staff in what standards the registered provider expected.

This was a continued breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance. The registered provider did not have effective quality monitoring systems in place.

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
Treatment of disease, disorder or injury	The registered provider failed to ensure risks were managed safely in regard to risks to people and medication management. infection prevention and control measures were not followed so people were not protected.

The enforcement action we took:

We have kept the service in special measures and proceeding with the notice of proposal.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The registered provider had failed to ensure effective quality monitoring and governance were in place.

The enforcement action we took:

We have kept the service in special measures and proceeding with the notice of proposal.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed
Treatment of disease, disorder or injury	The registered provider had failed to ensure staff were recruited following safe procedures.

The enforcement action we took:

We have kept the service in special measures and proceeding with the notice of proposal.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing
Treatment of disease, disorder or injury	The registered provider had failed to ensure there were sufficient numbers of staff on duty to meet peoples needs.

The enforcement action we took:

We have kept the service in special measures and proceeding with the notice of proposal.