

Mr B & Mrs W Stedman

# Garrett House Residential Home

## Inspection report

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## Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

**Requires Improvement** ●

Is the service well-led?

**Requires Improvement** ●

# Summary of findings

## Overall summary

### About the service

Garrett House Residential Home is a residential care home providing personal care to 31 older people at the time of the inspection, some people were living with dementia. The service can support up to 45 people in one adapted building.

### People's experience of using this service and what we found

The governance systems in place were not robust enough to effectively and independently identify shortfalls and address them promptly. Once other professionals identified some shortfalls, prior to our inspection visit, the service had started to make improvements in the areas identified. However, these were not fully implemented, and we identified further concerns.

We were not assured risks were being adequately assessed and mitigated. The records relating to the care and support provided to people were not adequately maintained. This included daily records, and the records of how much people had to drink were not always being completed. Care plans and risk assessments varied in quality, in some areas they were good in others they were contradictory and did not identify and provide guidance for staff on how risks in people's daily living were being reduced. When people had moved into the service, their needs had not been sufficiently documented to advise staff on the support they required and preferred. This was in the process of being improved.

There were insufficient staff to ensure people were being provided with person centred care which met their emotional as well as their 'task based' physical needs. There was a risk at night that people would not be provided with their care needs in a timely way. Both day and night care staff had domestic responsibilities, which took them away from their caring duties.

Staff training had not been kept up to date to ensure staff were provided with the current information to meet people's needs safely and effectively. This was in the process of being improved.

We were not assured all incidents were being reported appropriately to other professionals. The local authority had identified a risk relating to an area in the environment, this had not been addressed prior to the risk being pointed out by other professionals.

We were assured the service was clean and hygienic and staff were wearing appropriate personal protective equipment. There were arrangements in place for people to have visitors safely.

People received their medicines when they needed them. There were safe systems in place for the management of medicines.

For more details, please see the full report which is on the CQC website at [www.cqc.org.uk](http://www.cqc.org.uk)

## Rating at last inspection

The last rating for this service was good (published 3 April 2019).

We also undertook a targeted inspection (published 9 March 2021) where we looked at the infection control measures in place. The overall rating for the service had not changed following the targeted inspection and remained good. Targeted inspections do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

## Why we inspected

The inspection was prompted in part due to concerns received about staffing, the provision of safe care, infection prevention and control and care planning. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

We also checked the provider had made improvements following our last targeted inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the safe and well-led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Garrett House Residential Home on our website at [www.cqc.org.uk](http://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 monitor the service and discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safety, staffing and governance at this inspection. Please see the action we have told the provider to take at the end of this report.

## Follow up

We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. 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 return to visit as per our re-inspection programme. If we receive

any concerning information we may inspect sooner.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### **Is the service safe?**

The service was not always safe.

Details are in our safe findings below.

**Requires Improvement** ●

### **Is the service well-led?**

The service was not always well-led.

Details are in our well-Led findings below.

**Requires Improvement** ●

# Garrett House Residential Home

## **Detailed findings**

### Background to this inspection

#### The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided 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

The inspection was undertaken by one inspector.

#### Service and service type

Garrett House Residential Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had two managers registered with the Care Quality Commission, one of the registered managers were also one of the providers. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

#### Notice of inspection

This inspection was unannounced.

#### What we did before the inspection

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 reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used all of this information to plan our inspection.

During the inspection

Inspection activity started on 20 May 2021 when we visited the service. We spoke with one of the registered managers and three members of the senior care team. We also spoke with four people who used the service. We observed part of the medicine round, and interactions between staff and people using the service. We reviewed the recruitment records of three staff members and medicines administration records.

Following our inspection visit we asked the service to send us records and we collected further records from the service, which we reviewed remotely. These records included the staff rota, staff training records, the care records of nine people who used the service and sections from another two people's care records. A variety of records relating to the management of the service, including audits were reviewed.

We received telephone and electronic feedback from the relatives of 12 people and from 10 staff members.

On 16 June 2021 we fed back our findings of the inspection to both registered managers and the assistant manager.

After the inspection

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

# 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 good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

### Assessing risk, safety monitoring and management

- There was not always enough detail in people's care records to guide staff how to recognise risks and take appropriate action to mitigate them. For example, one person required anticoagulant medicines, there was no guidance in the person's care records which showed the specific risks associated with these medicines, such as if they had a fall.
- We were not assured risks were sufficiently assessed and staff provided with guidance to reduce these risks. One person required a gluten free diet; they were being provided with a drink which included gluten. There was no information in their records which showed how this may affect the person. Another person was at risk of choking, their care records did not sufficiently identify how these risks were being reduced.
- People who had moved into the service did not always have risk assessments completed to guide staff on specific risks and how to reduce them. One person's hospital discharge notes stated they were at extreme risk of falls, there was no risk assessment in place until almost two months after they had moved into the service. This was also the case for two people who required a diabetic diet.
- Prior to our inspection we received concerns about a balcony on the first floor which was unsafe and could cause people harm. On the day of our inspection visit, this was being addressed, and we were advised at our feedback a risk assessment had been carried out in this area. This had not been independently assessed and addressed by the service.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We received records which demonstrated equipment, such as electrical equipment and moving and handling equipment was regularly checked to ensure they were safe to use and fit for purpose.
- Despite the shortfalls we identified, people and their relatives told us they felt the service was safe.

### Staffing and recruitment

- Staff told us there were not enough of them to meet people's needs. Feedback from staff and records reviewed showed the service provided was task orientated rather than person centred. We received mixed views from people's relatives about the staffing numbers. One person's relative told us their family member had raised with them that staff did not always provide assistance when requested.
- There were two staff working during the night from 10:30pm, despite concerns being raised by the local authority prior to our inspection. Some people required the support of two staff, where these people were

being supported, there were no other staff available to support other people promptly or manage any incidents or accidents.

- Shifts where domestic and care staff were absent were not always covered. There was no laundry staff, and reduced domestic staff working weekends. This meant the care staff had to cover these duties as well as their caring role. Both day and care staff were required to undertake domestic and catering tasks which took them away from their care duties.
- The activities shifts were not always covered. We were concerned about the lack of activities, and how the gap was bridged due to people not receiving their usual number of visits from relatives, to reduce boredom. We received feedback regarding people being bored and not being stimulated, this included people who remained in their bedrooms. There was little indication in records to show how people were being provided with support and interactions to reduce isolation.
- There was not always a staff member available in the communal areas to support people, and there had been incidents between people when staff were not present.
- Staff training had not been kept up to date. We were not assured staff had received the training they needed to meet people's needs safely and to recognise and act on any issues. This included training in diabetes and pressure care.

The systems in place to ensure there were enough skilled staff deployed to provide people with person centred care were not robust. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- During feedback the registered manager told us they had employed additional night and day care staff and activity staff. They told us they would review the staffing numbers against the needs of the people living in the service.
- The assistant manager told us they were in the process of updating the staff training.

Systems and processes to safeguard people from the risk of abuse

- We could not be assured all incidents had been documented and reported appropriately. Prior to our inspection we received feedback relating to an incident of a fall, which was not reported to safeguarding. One registered manager told us the incident form was not available and it may have been shredded by accident. It remains unclear if there was a safeguarding incident or not, or if it was witnessed or unwitnessed.
- The assistant manager told us all incidents and accidents were being reviewed and they were calling the local authority safeguarding team to discuss incidents and check if any safeguarding referral was required. We saw evidence to show this was happening, following guidance provided by the local authority.
- Staff told us they had received training in safeguarding and understood how to report any concerns. Some said they would report incidents of abuse but were worried they would not be supported by the provider and registered manager to do so.

Using medicines safely

- We received concerns prior to our inspection relating to the management of medicines.
- We reviewed the processes for the safe management of medicines and found people received their medicines when they needed them and there were systems in place for the safe storage, obtaining and disposal of medicines.
- Staff who were responsible for giving people their medicines had been trained to do this safely. We observed part of the lunch medicines round and saw this was done safely.

Preventing and controlling infection

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was meeting shielding and social distancing rules.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was accessing testing for people using the service and staff.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.
- We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

#### Learning lessons when things go wrong

- As a result of feedback provided to the service from the local authority, the management team had actioned improvements to prevent future issues arising. This including monitoring of incident forms to ensure actions were taken to limit reoccurrences.
- Improvements had been made following our last targeted inspection where we reviewed the infection prevention and control processes in the service.
- The management team had introduced 'resident of the day' where people's care records and needs would be reviewed and keep any risk assessments and guidance for staff to reduce them up to date.

# 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 as good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- Records relating to the care provided to people and their needs and preferences were not sufficiently detailed to evidence people always received the care they required. Care plans and risk assessments were contradictory in parts and did not identify the specific support people required with their diverse needs, including needs associated with behaviours others may find challenging and anxiety.
- Prior to our inspection, we received concerns that six people did not have a care plan, or risk assessments in place. During our inspection, these were being completed on the electronic care planning system. Following our visit, the registered manager told us there were paper care plans in place and sent us them for three people. The care plans did not include guidance for staff about how people's needs were to be met.
- There were no risk assessments in any of the three people's care plans, this was despite risks being evident from the limited information provided. One person's records showed in the care plan and referral form that they did not eat meat. The daily care notes showed the person had been given meat. The person told a staff member they did not eat meat five days after they had moved in, which was then reported to the chef.
- Daily records sometimes identified when people had been provided with 'tasks' such as personal care, however, there was very little about how and where the person spent their day and their wellbeing. There was no evidence of how people had been provided with a person centred service from the records provided.
- Records relating to how much people had to drink each day were poor, with some days having no entry at all and other days showing people had as little as 100mls to drink. This was a risk as there was no way of ascertaining from records that people were provided with enough to prevent dehydration.

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

- Prior to our inspection, we received information that some records had gone missing from the service, other professionals identified the provider was not registered with the Information Commissioners Office, which organisations who process and store personal data are required to do by law. This was done following our inspection visit. We were concerned the provider had not independently identified this was required.
- Feedback received from staff was they did not feel confident and empowered in raising concerns of poor practice, referred to as whistleblowing. We received feedback that staff were asked if they had reported concerns to other professionals, which one staff described as a, "Witch hunt."
- Some staff told us they did not feel supported by the registered managers. They gave us examples of how

one of the registered managers had shouted at them in front of colleagues, which they found humiliating. We also received information that they felt intimidated and had to gauge what mood the registered manager was in before approaching them.

- Monitoring systems were not robust enough to identify shortfalls and address them in a timely way. There were some audits provided to us, not all included a date of completion and who had completed them. Some did not have an action plan, despite shortfalls being identified. Those that did have an action plan, did not include timescales for completion or indication when actions had been taken.

Continuous learning and improving care

- Staff training was not kept up to date to ensure staff received the most current information they needed to provide people with safe and effective care. For example, not all staff had received training in dementia and supporting people with behaviours others may find challenging.

The governance systems were either not in place or robust enough to monitor the service provided and address shortfalls in a timely way. All of the above is a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Since our last comprehensive inspection there had been new bathrooms installed which were large and accessible for people's use.
- The assistant manager told us staff training was in the process of being improved and two courses a week were being provided until they had got up to date. The management team had also introduced a daily manager walk round, to check any issues which required addressing.
- Despite concerns raised by staff about the support they received, they were committed to providing people with a caring service and spoke about people in a caring way. Some staff referred to the good teamwork with colleagues and how hard they had worked during the pandemic.

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

- We received mainly positive feedback from people using the service and relatives about the care provided and received.
- We received mixed feedback about if the service kept relatives up to date about their family member's wellbeing or any incidents. Some told they were not always kept updated and requests for information were not always responded to. Relatives did tell us they were kept up to date relating to the pandemic.
- We saw the satisfaction questionnaires completed by people, relatives, professionals and staff in November 2019. We saw actions were taken as a result of comments made, including providing a breakdown to people's next of kin relating to petty cash. The assistant manager told us they planned to send out new questionnaires.
- Since our last infection control inspection, the service had improved the space available for people to have visits with their families, to ensure they could enjoy their visits in privacy away from other people using the service.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The management team told us they understood their duty of candour procedure and we were provided with information to show people's relatives were kept updated regarding the pandemic and how this had affected the service and people living there.

Working in partnership with others

- The registered manager told us the local GP surgery had been helpful relating to providing vaccinations for coronavirus people using the service and staff, where required.
- Prior to our inspection the local authority safeguarding team had asked for records to be sent to them as part of an investigation. These had not been provided promptly, however, they were now being provided.
- The service had accepted support from the local authority, including the provision of workshops relating to the recording of the care people had received.

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 12 HSCA RA Regulations 2014 Safe care and treatment  Systems were either not in place or robust enough to demonstrate safety was effectively managed.  Regulation 12 (1) (2) (a) (b) (d)
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance  The governance systems were either not in place or robust enough to monitor the service provided and address shortfalls in a timely way.  Regulation 17 (1) (2) (a) (b) (c) (f)
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing  The systems in place to ensure there were enough skilled staff deployed to provide people with person centred care were not robust. This placed people at risk of harm.  Regulation 18 (1) (2) (a)