Gratia Residential Care Home Limited

Gratia Residential Care Limited

Inspection report

472 Groby Road
Leicester
Leicestershire
LE3 9QD

Tel: 01162311640
Website: www.gratiacare.co.uk

Date of inspection visit:
01 February 2022
02 February 2022

Date of publication:
28 February 2022

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service
Gratia Residential Care Limited is a care home providing accommodation and personal care for up to 20 people. At the time of our inspection there were 20 people using the service.

People's experience of using this service and what we found
Risks associated with people's care had not always been mitigated and signs of potential deterioration in health conditions were not always recognised. The provider failed to ensure people at risk of choking had clear consistent information in their care plans. Care records were not always up to date and reflective of people's current needs. The provider had failed to ensure people were protected from the spread of infection. Medicine was not always managed safely and administered by trained and competent staff. People were at risk of harm from other people's behaviour. Staffing levels were inconsistent, some people were not receiving additional care hours.

The provider had failed to ensure there was a robust system in place to monitor people's safety and quality of care. There was unclear leadership in the service and staff were not formally supported. People's capacity was not recorded accurately, and best interest decisions were not recorded.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

The service was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.

Right Support
The service did not give people care and support in a safe, clean, well equipped, well-furnished and well-maintained environment that met their sensory and physical needs. Staff did not support people to have the maximum possible choice, control and independence Staff did not support people to make decisions following best practice in decision-making. Staff communicated with people in ways that met their needs.

Right Care
People did not receive kind and compassionate care. Staff did not protect and respect people's privacy and dignity. They did not always understand and respond to their individual needs. The service did not always

have enough appropriately skilled staff to meet people's needs and keep them safe. People did not receive care that supported their needs and aspirations, was focused on their quality of life, and followed best practice.

Right Culture
Staff did not place people's wishes, needs and rights at the heart of everything they did. People were not supported by staff who understood best practice in relation to the wide range of strengths, impairments or sensitivities people with a learning disability and/or autistic people may have. This meant people did not always receive compassionate and empowering care that was tailored to their needs. People did not lead inclusive and empowered lives because of the ethos, values, attitudes and behaviours of the management and staff.

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

Rating at last inspection
The last rating for this service was good (published 3 September 2019).

Why we inspected
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. This included checking the provider was meeting COVID-19 vaccination requirements.

We identified significant concerns in relation to infection prevention and control. As a result, we undertook a focused inspection to review the key questions of Safe and Well-Led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from good to inadequate based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the Safe and Well-led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Gratia Residential Care Limited on our website at www.cqc.org.uk.

Enforcement and Recommendations
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 will take further action if needed.

We have identified breaches in relation to staffing, medicines, assessment of risk, infection prevention and control, governance and culture at this inspection.

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 continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service is therefore 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 of 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 findings below.

Is the service well-led?

Inadequate

The service was not Well-Led.

Details are in our findings below.

Gratia Residential Care Limited

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 Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This included checking the provider was meeting COVID-19 vaccination requirements. 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 team was made up of two inspectors.

Service and service type
Gratia Residential Care Limited 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 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 24 hours' notice of the inspection. This was to ensure we were able to manage any risks associated to COVID-19 safely.

Inspection activity started on 01 February 2022 and ended on 04 February 2022. We visited the service on 01, 02 and 03 February 2022.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used this information to plan our inspection.

During the inspection
During the inspection we spoke with three people about their experience of care provided. We spoke with four members of staff including team leaders, senior support workers and support workers.

We reviewed a range of records. This included two people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. We also looked at a variety of records relating to the management of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Preventing and controlling infection

● The provider failed to ensure staff practices promoted good infection prevention control to reduce the risk of the spread of infection to both other staff and people living in the service. Staff did not wear personal protective equipment (PPE) in line with the national guidance and were observed on several occasions either not wearing a mask, wearing the mask under their chin and below their nose. This meant the PPE was not fully effective and there was a risk infection could be more transmissible.

● Records showed staff had not received recent infection control training. Some staff had not completed this since 2016. This meant we could not be assured staff had the most up to date knowledge of infection prevention and control practices.

● The provider failed to ensure people were living in a clean and well-maintained environment. There were areas of the environment which were unclean, damaged and under maintained. For example, furnishings had rips in, equipment was rusty, porous wood was exposed and tiles in the bathroom were damaged. This compromised the effectiveness of cleaning, placing people at an increased risk of infections.

● Some people living in the service lacked mental capacity to consent and make decisions around COVID-19 testing and receiving the COVID-19 vaccinations. Staff were unable to provide us with evidence that mental capacity assessments and best interest decisions had been carried out relating to this. This meant the impact of both COVID-19 testing and vaccinations on people was unclear.

From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency. We checked to make sure the service was meeting this requirement. We found the service did not have effective measures in place to make sure this requirement was being met.

● There was a lack of systems and process to ensure the provider was assured that all staff had received both of their COVID-19 vaccinations. Team leaders told us staff have evidence of their vaccinations on their file. However, we reviewed three staff files and only one contained proof of staff COVID-19 vaccines.

We identified a breach of Regulation 12(3), but the Government has announced its intention to change the legal requirement for vaccination in care homes.

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

● Risks associated with people's care and support had not always been recorded consistently and staff were unable to tell us how to support people safely. Some people were prescribed thickener for their drinks to prevent them from choking. Staff gave us inconsistent information on what level of fluids people were prescribed and how to achieve this. This meant people were at increased risk of choking.

● One person was prescribed a modified diet due to a risk of choking; this was reviewed last in 2013. We

observed the person being assisted with their meal. They continually had coughing episodes throughout their meal. We discussed this with staff members who told us this was normal for that person. However, consistent coughing episodes during meals and drinks, could be a sign of a deterioration in their swallowing and aspiration, which placed the person at an increased risk of choking.
● Records showed staff were not consistently trained to ensure they had the knowledge and skills needed to support people safely with swallowing problems and eating and drinking or identify a decline in health conditions.

Using medicines safely
● Medicines were not managed safely. Records showed some staff had not received training in the administration of medicines. However, Medicine Administration Records (MAR) showed these staff members had administered medicines to people on more than one occasion.
● The provider failed to ensure staff administering medicines were skilled and competent. The provider had a policy in place which stated all staff should receive an annual competency to ensure they were safe to administer medicine to people. However, during the inspection we requested to see these but the person in charge was unable to provide them and told us competencies do not take place. Some staff had not received medicine training since 2014.
● We observed secondary dispensing taking place in the service. This meant two members of staff were administering medicines to people. One staff member read the MAR chart and the other dispensed the medicine and administered it to people. This meant there was a higher risk of people receiving the wrong medicine.
● Minimal least restrictive care and support methods were recorded where some people displayed symptoms of distress. One person's care plan stated the senior in charge would decide if 'as needed' medicine should be administered. There was no clear and consistent guidance recorded in care notes to suggest at what level of distress this medicine should be administered. This meant there was a risk of chemical restraint.

Systems and processes to safeguard people from the risk of abuse
● The provider failed to ensure people were protected from avoidable physical and emotional harm.
● One person's eating and drinking risk assessment stated they required a small spoon to eat their meals to reduce their risk of choking. We observed a staff member supporting them with their meal with a tablespoon, not in line with the risk assessment. This increased the person's risk of choking. Furthermore, we addressed this with the member of staff who removed the persons meal and told us it was a big bowl and the person did not need to finish it.
● Care plans did not always support least restrictive practice. One person displayed signs and symptoms of distress which could cause harm to others. Guidance for staff stated the person should be taken to their room for time out. Additionally, staff told us chocolate was locked away as one person would eat a lot of it and they would vomit. However, there was no information recorded in the persons care notes about how this decision was taken and how it was managed safely, in line with the persons preferences. This meant people were at risk of experiencing restriction and seclusion.

Due to poor infection control, risks not being managed safely and consistently and unsafe practices relating to the management of medicines. This was a breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 – Safe Care and Treatment.

Staffing and recruitment
● Staffing levels did not always meet the needs of people living in the service. Team leaders led the service but also worked on the floor to support people, which led to periods of the day which felt chaotic.

● One person's care record stated they required one to one care hours for nine and a half hours a day, every day. However, this was not observed during the inspection and records did not identify these additional hours being provided. On one occasion, the person became distressed attempting to harm another person using the service but was not supported by the one to one care hours. This placed the person and other people at risk of avoidable harm.
● We requested to see information about how safe staffing was calculated at the service. However, we were not provided with this. A team leader told us there should be six staff members on the morning shift. Furthermore, the rota showed inconsistencies and there were multiple occasions where there were less than six members of staff on duty during a morning shift.
● The provider had failed to ensure staff received training appropriate to their role, which placed people at risk of not receiving the right care. For example, not all staff had completed training relating to Diabetes, catheter care and Autism, even though people were living with these conditions.

Due to the deployment of staff and lack of staff training for specialised conditions, this placed people at risk of receiving inappropriate care and support, which would not promote positive outcomes. This was a breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 18 – Staffing.

● The provider continued to carry out pre-employment checks on new staff members. This included obtaining a reference of character and conducting a DBS check. A DBS checks: Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

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 our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. 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.

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

● The provider failed to ensure there was a robust quality assurance process in place to monitor safety and the quality of people's care. Audits which had been completed did not identify concerns relating to the management of medicines, staff training and other shortfalls found during our inspection.

● People's records were not always stored in a secure way in line with GDPR (General Data Protection Regulations). People's care records were left unattended on the dining room table for most of the inspection and MAR charts were kept on a table next to the medicine trolley which was stored in the lounge. This meant unauthorised people could access people's personal information.

● Staff training data was not fully accessible. We did not receive full training information for 15 out of 26 staff working at the service. Therefore, we were not assured all staff had received mandatory and appropriate training to their role

●Accidents and incidents were recorded and audited monthly. However, there was no information on how people were being positively supported to reduce the risk of these incidents reoccurring. This meant there was a risk incidents were likely to re-occur and people were at risk of physical and emotional harm.

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

● The provider failed to demonstrate formal support was in place for staff. Staff did not receive supervision sessions in line with the provider policy. The policy states staff should receive at least six supervision sessions per year. However, in the last 12 months records showed staff had only received one supervision. Furthermore, there were no staff meetings recorded since January 2020. This meant there was a lack of evidence to show the communication between staff and leaders in the service.

● There was limited evidence to suggest people were involved in the running of the service and decisions relating to their care. Reviews had been carried out in the care plans. However, there was no information recorded about the persons preferences, wishes and comments. Additionally, some information in care plans did not reflect current support being provided to people. This meant there was a risk of people receiving care not in line with their needs and preferences.

● Mental capacity assessments were not always consistent and contained conflicting information. One person's mental capacity assessment stated they had capacity to consent to care. However, the outcome of the assessment was that they lack capacity. Nor, were there best interest decisions recorded to enable staff to act in their best interests and the least restrictive way. Therefore, we were unable to determine people's levels of mental capacity and what decisions they could make for themselves.

Due to poor governance, lack of oversight with medicines management, staff training and formal support for staff this placed people at risk of receiving poor quality of care. This was a breach of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17 – Good Governance.

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

● Staff did not always demonstrate positive interaction with the language they used when talking to people. For example, we observed staff telling people "sit down", "drink your drink" and "don't do that." This language is negative and does not promote choice and active participation.

● We observed limited meaningful activities taking place for people. One person's care plan stated they like music and to shake a maraca. However, when the person showed signs of distress, staff handed the person a maraca, commented, 'Here you go' and walked away from them, showing minimal engagement. This meant interactions were not meaningful.

● Staff practices did not support people having maximum choice and control. Nor, did it achieve good outcomes for people. One person in the service liked to remove an item of their clothes. During the inspection there were several occasions where staff put the item of clothing back on the person, which led to the person showing signs of distress.

● We asked the person in charge about their knowledge of the duty of candour and they were unable to tell us what this meant. This meant there was a risk that if an incident took place in the service which met the duty of candour criteria, the process may not be followed in line with the legislation as they oversaw the home.

Working in partnership with others

● There was evidence that people had input from other medical professionals. For example, speech and language therapists, community nursing and community psychiatric teams.

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 Regulation 12(1) and (2)(a)(c)(d)(g)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Safe care and treatment. The provider failed to ensure people were receiving safe care and treatment relating to infection prevention and control, medicine management and safeguarding people from avoidable harm. Regulation 12(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There was a lack of systems and process to ensure the provider was assured that all staff had received both of their COVID-19 vaccinations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Staffing. The provider failed to ensure a sufficient number of skilled and trained staff were deployed in the service. The provider failed to ensure people's one to one additional care hours were provided.

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 17 HSCA RA Regulations 2014 Good governance Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Good Governance - 2 (a) (b) (c) (d)(ii). The provider failed to ensure there was a robust quality assurance system in place to monitor safety and quality of peoples care. The provider failed to ensure effective oversight to identify shortfalls.

The enforcement action we took:

We served a warning notice.