Partnerships in Care Limited

# Grafton House

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

| | |
|---|---|
| Is the service safe? | **Requires Improvement** |
| Is the service effective? | **Requires Improvement** |
| Is the service well-led? | **Requires Improvement** |

# Summary of findings

## Overall summary

About the service
Grafton House is residential care home registered to provide care to autistic people, people with a learning disabilities and mental health needs. The home is registered for to up to 3 people. At the time of the inspection 2 people were living in the home.

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.

At the time of the inspection, the location did not care or support for anyone with a learning disability or an autistic person. However, we assessed the care provision under Right Support, Right Care, Right Culture, as it is registered as a specialist service for this population group.

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

Right Support:
Staff could not always access the information required to provide safe care. Care plans and risk assessments did not always contain up to date, factual information within them.

Environmental risks had not always been identified, this meant these risks had not been mitigated putting people at risk of fire and scalding.

People were not always supported to have maximum choice and control of their lives and staff did not always 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.

Infection prevention and control measures were not consistently followed. On the first day of inspection staff failed to wear appropriate personal protective equipment as per government guidance. Cleaning schedules had gaps in the recording of tasks being completed.

People were supported by staff who had been recruited safely.

Right Care:
Unexplained injuries had not been investigated or mitigating strategies implemented to reduce any risks. Not all known risks had been assessed or mitigated.

The management of medicines required improvement. Stock checks did not tally and there were no

explanations for the gaps in these records.

People's healthcare needs were not consistently recorded. Specific care plans, risk assessments and relevant information had not always been recorded or evidenced.

Staff were not consistently trained to meet people's specific needs. Some staff were not up to date with their training and some staff had not completed the necessary training to meet people's individual needs.

People told us staff were kind. However, due to the number of agency staff deployed people did not always know the staff supporting them.

Right Culture:
Oversight of service required improvement. Systems and processes were ineffective in assessing, identifying and mitigating risks.

Staff did not always feel valued or supported at work. Staff told us, they did not receive regular supervisions or team meetings.

Information was shared with relevant professionals and significant people. Feedback was sought from people who used the service and their relatives. Feedback was in the process of being reviewed.

The provider was open to feedback and put actions in place to mitigate concerns found on inspection.

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 17 July 2019)

Why we inspected
We received concerns in relation to infection control and risk management. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

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.

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 requires improvement based on the findings of this inspection.

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

Enforcement and Recommendations
We have identified breaches in relation to risk management, medicine management and oversight at this inspection.

We have made recommendations in relation to consent.

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 five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

**Is the service effective?**

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

**Is the service well-led?**

Requires Improvement

The service was not always well led

Details are in our well led findings below.

# Grafton House

**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 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 completed by one inspector

Service and service type
Grafton House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Grafton House is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post. However, they left the service on the first day of inspection and told us they were planning on deregistering.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 1 person who used the service and 2 relatives about their experience of the care provided. We spoke with 7 members of staff including the registered manager, human resources, directors, and care workers.

We reviewed a range of records. This included 2 people's care records and multiple medication records. We looked at 3 staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

Requires Improvement

# 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 requires improvement. The rating for this key question has remained 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.

Systems and processes to safeguard people from the risk of abuse; Assessing risk, safety monitoring and management; Using medicines safely: Learning lessons when things go wrong

- People were at risk from harm and potential abuse. Unexplained injuries had not been investigated to identify a potential cause and to ensure mitigating strategies could be implemented to reduce the risk of further harm.
- People were at risk from known health conditions. One person with diabetes had no recorded information regarding what their normal blood sugar levels should be or when staff should request healthcare support. The signs and symptoms of a deterioration in the person's health had also not been recorded. This put the person at risk from risks associated with diabetes.
- Not all known risks had been assessed or mitigating strategies implemented. For example, if a person was resistive with medical support or had self-harming thoughts. This put people at risk of not receiving safe care as staff supporting the person would not know how to support them safely at these times.
- Medicine management required improvement. Gaps in people's medicine administration records (MAR) did not consistently have a reason why the medicine was not given. One person's 'as required' medicine had not been recorded as given, but there were tablets missing, there was no reason recorded for the missing tablets. This put people at risk of not receiving their medicines as prescribed.
- People were at risk of fire. An external fire risk assessment had identified high risks which required actions to mitigate these risks such as ensuring doors had effective fire and smoke strip. During the inspection we found the actions had not been completed in a timely manner.
- Trends and patterns in people's anxieties or agitation had not been reviewed or assessed due to records not being completed. This meant risk strategies to support people at these times could not be implemented.

The provider failed to ensure risks were assessed and mitigated, medicines were safely managed, and people were protected from abuse. This was a breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider was responsive to feedback and put an action plan into place to mitigate the risks identified.

Staffing and recruitment

- We found sufficient numbers of staff were deployed to maintain people's safety. However, the provider deployed high levels of agency staff who did not always have the information they required to understand people's needs. One person told us, "I don't always know who the staff are as different staff come, but they are kind."

● People were supported by staff who had been safely recruited. Safe recruitment practices were in place and the provider used references and the Disclosure and Barring service (DBS) to ensure staff did not have any criminal convictions and were suitable to provide support for the people living at the service.

Preventing and controlling infection

● We were not assured that the provider was using PPE effectively and safely. During the first day of inspection we observed staff not wearing face masks in line with guidance. However, we observed this had improved on the second and third day.

● We were not fully assured that the provider was promoting safety through the layout and hygiene practices of the premises. We found gaps in recording of cleaning. However, the home appeared clean and tidy.

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was supporting people living at the service to minimise the spread of infection.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was responding effectively to risks and signs of infection.

● 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.

Visiting in care homes

● The provider followed government COVID-19 guidance on care home visiting. Visitors were given appropriate PPE.

Requires Improvement

# Is the service effective?

## Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff support: induction, training, skills and experience; Staff working with other agencies to provide consistent, effective, timely care

- People were at risk of not receiving care and support in line with their assessed needs.
- Care plans and risk assessments did not always contain updated, factual information within them. We found one person's care plan stated they required 1:1 support when with other people. Staff told us this information was incorrect. Another person's care plan stated they had a positive behaviour support (PBS) plan to guide staff on supporting the person appropriately. We found no evidence of a PBS plan being in place and staff told us they had not read any PBS plans for the person.
- Staff could not always access people's care plans and risk assessments. During the inspection we found we could not consistently access these documents. Agency staff told us they were unable to read people's care plans or risk assessments. This put people at risk of receiving unsafe care as staff did not have the necessary information to support them appropriately.
- Not all staff had up to date training to understand people's individual needs. The training matrix evidenced gaps in training for safeguarding, mental capacity, fire, infection prevention and control, behaviour that communicates distress, moving and handling, epilepsy and diabetes. This put people at risk of not receiving safe care from staff who had not got the required skills and knowledge.
- Staff told us they had not received regular supervision or meetings to share information, discuss concerns and to gain support within their roles.

The provider failed to ensure staff had the necessary skills and knowledge to provide safe care. This was a breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider implemented a new training plan after feedback to ensure staff completed the relevant training courses.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.
People can only be deprived of their liberty to receive care and treatment when this is in their best interests

and legally authorised under the MCA.
In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA , whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● The provider had not always assessed people's capacity for specific decisions. For example, there were no Mental capacity assessments or best interest decisions completed regarding sharing personal information with significant people. This put people's right to privacy at risk.
● When people had been assessed as lacking the capacity to make specific decisions, there were no best interest decisions recorded. This meant people were at risk of not receiving the least restrictive option.

We recommend the provider reviews staff training and understanding in the principles of the Mental Capacity Act.

● The provider had made appropriate referrals regarding DoLS.

Supporting people to eat and drink enough to maintain a balanced diet; Supporting people to live healthier lives, access healthcare services and support
● Records were not consistently completed to evidence people's meal choices. When people had health conditions that required support with healthy eating, this was not consistently evidenced. However, people told us they chose their meals.
● Referrals to healthcare professionals were made as required. For example, we saw referrals made to speech and language therapists (SALT). People were supported to access the doctor, optician and dentist as required.
● People had hospital passports which were used by health and social care professionals to support them in the way they needed.
● People's oral health and any support they required was recorded. Records evidenced staff supported people appropriately with oral health needs.

Adapting service, design, decoration to meet people's needs
● The environment was homely and well presented.
● People's bedrooms were personalised and decorated to individual preferences.

Requires Improvement

# 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 this key question has been rated 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The provider's audits had not identified the missing or incorrect information found on inspection. For example, we identified some missing and incorrect information in people's care records.
- Systems and processes were not in place to identify when information had not been recorded. For example, we found gaps in the recording of cleaning tasks, food temperatures checks, anxiety records, medicine equipment checks and food records.
- Systems and processes were not effective in identifying when actions had not been completed to reduce risks. For example, the provider had not identified the fire risks.
- Systems and processes failed to identify when a person was at risk of harm or abuse. There were no audits completed on records of injuries and we found unexplained injuries that had not been investigated.
- Audits completed on medicine records had not identified the concerns we found with medicine management. We found stock checks did not tally up and gaps on medicine records did not have any actions identified.
- Systems and processes failed to identify when staff were unable to access information required to provide safe care. The provider had not identified that agency workers were unable to log onto the electronic care planning system and had failed to identify and rectify the issues permanent staff had in accessing information due to regular connection issues.
- Not all staff felt supported within their roles by the provider. Staff told us of issues they had raised that had not been addressed. Staff did not always feel valued or respected within the service.

The provider failed to ensure adequate systems and processes were in place to assess, monitor and improve the quality of the service. This was a breach of regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider was engaged and open to the inspection process and remained open and transparent throughout. Concerns found on inspection were responded to promptly and an action plan put in place.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care; Working in partnership with others

- Systems were in place to take account of people's opinions of the care they received by an annual survey. However, the results of survey were not specific to the individual services. People told us they knew how to

complain if needed.
● Relatives were kept up to date with their loved one's progress and any incidents that may have occurred. However, at times due to staffing there was a breakdown of communication for a period of time.
● People and relatives were involved in the care planning process and stated they were involved in regular reviews of care.

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 provider understood their responsibility under the duty of candour. The duty of candour requires providers to be open and honest with people when things go wrong with their care, giving people support and truthful information.

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 17 HSCA RA Regulations 2014 Good governance<br><br>The provider failed to ensure adequate systems and processes were in place to assess, monitor and improve the quality of the service. |

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<br><br>The provider failed to ensure risks were assessed and mitigated and people were protected from abuse.<br>The provider failed to ensure medicines were safely managed. |

**The enforcement action we took:**

Warning Notice