Key Healthcare (St Helens) Limited

Grace Court Care Centre

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

Grace Court Care Centre is a residential care home providing personal and nursing care to 28 people at the time of the inspection. The service can support up to 30 people within one building. All bedrooms and facilities are located on the ground floor of the service.

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

Systems in place to monitor the quality of the service were not effective and failed to identify or address the concerns identified during this inspection. Improvements were needed to make the service safe and well-led.

The deployment of staff meant that sufficient staff were not always available to ensure that people's needs and wishes could be met at all times. Staff had not always undertaken updated training for their role in a timely manner.

Recruitment practices and records needed improvement to help ensure that only suitable people were employed at the service.
We have made a recommendation about the safe implementation of infection, prevention and control practices.

Safe systems were in place for the management of people's medicines.

People's care needs and identified risks were recorded and reviewed on a regular basis.

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

Rating at last inspection and update

The last rating for this service was requires improvement (published 28 December 2019). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected

We received concerns in relation to aspects of the service provided at Grace Court Care Centre. 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. The overall rating for the service has not changed.

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 coronavirus and other infection outbreaks effectively.

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 Grace Court Care Centre on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service 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 staff recruitment, training 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 meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 well-led?

Requires Improvement

The service was not always safe.

Details are in our well-led findings below.

Grace Court Care Centre

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 carried out by three inspectors. The inspection site visit was carried out on 29 October 2020 by two inspectors.

Service and service type
Grace Court 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
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 judgments in this report.

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

During the inspection-
We spoke with five people who used the service. We spoke with seven members of staff including the registered manager, nurses and care staff.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

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

After the inspection
We continued to seek clarification from the registered manager to validate evidence found during the visit to the service and information sent to during the inspection process.

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. 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.

Staffing and recruitment
At the last inspection systems were either not in place or robust enough to ensure sufficient staff were on duty at all times to meet people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that further improvements were needed and the provider remained in breach of this regulation.

- Sufficient numbers of experienced staff were not always available to meet people's needs. We identified times where improvements were needed to the deployment of experienced staff around the service. The lack of staff available in some areas put people at risk from not receiving the person centred care and support they needed in a timely manner.
- Recruitment records for three staff members did not contain all of the information required to demonstrate that thorough recruitment procedures had been followed.
- Training records showed that not all staff had received planned refresher training for their role as scheduled.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to ensure that sufficient experienced and trained staff were deployed at all times to meet people's needs. This placed people at ongoing risk of harm. This was a continued breach of Regulation 18 (Staffing) and also a breach of Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were not 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 not 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 not assured that the provider's infection prevention and control policy was up to date.

We have also signposted the provider to resources to develop their approach.

We recommend that the provider ensure that updated guidance in relation to preventing and controlling infection is implemented at all times.

Using medicines safely
At the last inspection systems were either not in place or robust enough to demonstrate people's medicines was effectively managed. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that improvements had been made and the provider was no longer in breach of this regulation.

● Policies, procedures and good practice guidance were in place for the safe management of people's medicines.
● Prescribed medicines and food supplements for people were stored appropriately. This was an improvement following the previous inspection.
● Homely remedies were in use for people when required. This was an improvement following the previous inspection.
● Medication administration records (MAR) were in use to record people's medicines. These records were completed appropriately. This was an improvement following the previous inspection.

Systems and processes to safeguard people from the risk of abuse
● Effective safeguarding procedures were in place. Staff had access to information about how to protect people from harm.
● Safeguarding concerns relating to people were reported to external agencies when required.

Assessing risk, safety monitoring and management
● People's care planning documents detailed potential risks for people. This was an improvement following the last inspection.
● Identified risks for people were monitored. For example, people identified as being at risk from weight loss had their weight monitored on a regular basis. This was an improvement following the last inspection.
● Regular checks and monitoring around the environment and equipment took place to maintain a safe environment for people to live.

Learning lessons when things go wrong
● Procedures were in place to support staff in responding and recording accidents and incidents that occurred. However, information recorded relating to incidents required improvement to ensure that they contained more detailed information.
● Lessons were learnt and improvements made following accidents and incidents. For example, following reported incidents, observations were increased for one person and changes were made to a person's care plan.
● Information relating to accidents and incidents was reported to the provider on a weekly basis. This enabled the provider to monitor, and make improvements when things went wrong.

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the service management was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. However, it is proportionate and fair to note the significant impact of the COVID-19 pandemic.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

At the last inspection systems were either not in place or robust enough to demonstrate that governance within the service was effective. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that further improvements were needed and the provider remained in breach of this regulation.

- Systems in place to monitor and ensure quality and safety were not always effective and put people at risk of not receiving the care and support they needed.
- Monitoring systems had failed to identify and consider improvements which could be made to encourage freedom of movement, personal choice and promote decision making. For example, people living on one unit had no access to the other communal facilities within Grace Court. This limited the opportunities for people to choose, for example, where to eat their meals or spend their time during the day. It also limited the opportunity for people to form friendships with other people they lived with.
- There was a lack of up to date information accessible to people around the building. Activity boards were not completed. This meant people did not have information to make choices about leisure activities they may like to participate in. During the Covid-19 pandemic, the opportunity for people to see their loved ones is limited. Having the opportunity to engage in meaningful activities within the home is important for people's emotional wellbeing.
- The monitoring of some staff practices needed to improve to ensure people received safe and person centred care. The appropriate monitoring of the use of PPE, and implementation of infection, prevention and control procedures was not always sufficient. We also observed interactions with some people by staff to be task focused with limited positive social interaction.

Systems were either not in place or robust enough to demonstrate that governance within the service was effective. This placed people at risk of not receiving their planned care. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed our concerns with the registered manager who demonstrated a commitment to explore these areas and make improvements.

● Since our last inspection other improvements had been made. A system was in place for the oversight and monitoring of people's care planning documents. Due to electronic network connections, the electronic care planning and recording systems were only partially in use and therefore not fully effective. Whist this network problem was being addressed, paper records were in use.

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 registered manager and the provider had an understanding of their responsibilities in responding to people who use the service under the duty of candour following incidents and when things had gone wrong.

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

● Although the registered manager had been informing the Care Quality Commission of incidents and events which occurred at the service, we identified that two incidents had hadn't been reported appropriately. We discussed this with the registered manager who was aware of their duty to inform the Care Quality Commission of these incidents. Following the inspection we received the required notifications.

Continuous learning and improving care; Working in partnership with others

● The registered manager was participating in a borough wide development programme with the local Clinical Commissioning Group. This programme was designed to further develop services providing nursing support to people.

● Learning took place from accidents and incidents to minimise the risk of re-occurrence.

● The registered was in the process of making arrangement to improve the décor and furnishings in the communal lounge areas to create a more 'homely' environment for people living with dementia. In this planning, the registered manager was referring to guidance from an outside agency.

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 Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Systems were either not in place or robust enough to demonstrate people's rights under the Mental Capacity Act were fully considered and planned for.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were either not in place or robust enough to demonstrate that governance within the service was effective. This placed people at risk of not receiving their planned care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Systems were not robust enough to ensure that safe staff recruitment procedures were implemented. This placed people at ongoing risk of harm. This was a breach of Regulation 18 (Staffing) and Regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Systems were either not in place or robust enough to ensure that sufficient staff were on

duty at all time to meet people's needs.