R S Property Investments Limited

Gresley House Residential Home

Inspection report

Gresley House
Market Street, Church Gresley
Swadlincote
Derbyshire
DE11 9PN

Tel: 01283212094
Website: www.gresleyhouse.co.uk

Date of inspection visit:
22 November 2022
30 November 2022

Date of publication:
07 February 2023

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Gresley House is a residential care home providing personal care for up to 37 people. The service provides support to older and younger adults, including people who have dementia. At the time of our inspection there were 30 people using the service. The accommodation is split over two floors in a purpose-built building.

People's experience of using this service and what we found
The provider lacked oversight of the service and did not ensure sufficient and effective management. This resulted in a lack of effective audits which meant issues and concerns were not being picked up or addressed.

People were not protected from risks associated with their individual needs and wider environment. The provider did not effectively implement measures to reduce risks. People's medicines were not always managed in a safe way.

People did not always receive care in a personalised way. People were not supported to continue taking part in hobbies that interested them and activities were not developed to support people with specific needs. People's care plans contained incomplete and inconsistent information.

People were not 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 care plans and systems in the service did not support this practice.

The service relied heavily on agency staff, some of whom we could not be certain had been checked for suitability prior to supporting people. People told us they sometimes had to wait for support. Staff said they were very rushed and felt they could not spend quality time with people.

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 2 November 2022) and there were breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
The inspection was prompted in part due to concerns received about risk management. As a result, we undertook a focused inspection to review the key questions of safe, responsive 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 requires improvement to inadequate based on the findings of this inspection.
You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Gresley House Residential Home on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to managerial oversight, personalised care, safeguarding and risk management 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.

Special Measures
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 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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Gresley 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 Health and Social Care Act 2008.

Inspection team
This inspection was carried out by 2 inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Gresley 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. Gresley House Residential Home 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 not a registered manager in post.

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. 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 3 people about their experience of the service. We carried out observations of interactions between staff and people. We spoke with staff both on site and over the phone. In total we spoke with 15 members of staff including managers, domestic staff and care staff. We reviewed medicine management and 4 people's records relating to their medicines. We checked recruitment files. We looked at documentation in relation to incidents, accidents and safeguarding. We requested and reviewed offsite information and documentation relating to the running of the home including audits, policies and training data. We requested and reviewed 9 people's care plans offsite.

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 requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; preventing and controlling infection

At our last inspection the provider had failed to sufficiently protect people from risks associated with unsafe premises, equipment and infection prevention and control measures. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- Risks were not assessed, monitored, mitigated or managed effectively.
- Where risk to people had been identified, the provider did not ensure staff had adequate information or measures in place to adequately prevent and protect people from these risks. For example, where it had been identified a person was at risk of leaving the home unaccompanied, information had not been clearly recorded about this risks and guidance for staff was limited. This placed the person at continued risk of leaving the home unaccompanied.
- Staff did not have clear guidance on how to support people who expressed feelings of anxiety or agitation. Care plans contained limited information around this support. For example, one person's care plan stated, "this behaviour can be managed by trained staff using planned interventions" but did not go on to expand on what these interventions were. This put people at risk of not being supported in the most effective way.
- Fire safety was not managed well. Fire drills had not occurred regularly. A staff member told us, "I don't know even know where the fire point is, I've not had any training regarding fire safety. I didn't really have an induction; I was not shown around the home."
- People's personal emergency evacuation plans (PEEPs) did not consistently record enough information to enable staff to be able to support them in a safe way. For example, PEEPs did not have people's room numbers on them or have a step-by-step plan of evacuating for each individual, including any adapted ways of communication or what equipment should be used.
- The home, environment and equipment were found to be dirty. Ineffective cleaning posed an increased risk of infection transmission.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider supported people to have visitors in a safe way and carried out testing for infections in line with guidance.

Using medicines safely

At our last inspection the provider had failed ensure medicines were administered as prescribed and records reflected people's needs. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● Medicines were not safely managed.
● People who were supported with medicines which were administered 'as and when required', did not have clear documentation around when staff should support them with these. For example, for people who were prescribed medicine to support with anxieties, there was no clear guidance for staff on when to administer, nor was any documentation being completed as to why they had administered the medicine or what the outcome was. This meant people were at risk of not having their medicines as prescribed, and a risk that the medicine was not being used to effectively manage anxiety.
● We found medicines stock level discrepancies and stock counts were not being clearly recorded or effectively audited. This meant the provider could not be certain people had received medicines, or the right amount of medicine.
● For example, we found a one person's topical medicine had not been opened or administered but had been signed on the MAR as having been administered on the morning of the inspection.
● Some people received medicines via a patch on their body, for example pain relief patches. Documentation for recording the location of medicine patches was not being used effectively. This meant people were at risk of overabsorption of their medicines due to the site of application not being rotated.

Systems had not been established to ensure effective medicines management. This placed people at risk of harm. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Staffing levels were not sufficient to meet people's needs in a safe and effective way.
● At the last inspection it was found the provider was reliant on agency staff to cover a significant number of shifts to maintain staffing levels. At this inspection the provider continued to rely on agency staff, and there were no permanent staff on night shifts only agency.
● People's needs were not always met promptly. A person told us, "Sometimes I have to wait for staff when I press the buzzer, so then I will shout."
● Staff told us they were rushed, and our observations confirmed this. A staff member said, "We are always short staffed, at a push we can meet people's needs, but if we had more [staff] on I would like to spend more time with them, you feel like they are on a conveyer belt and I don't like that."
● The provider used a staffing dependency tool to establish staffing hours and the home was staffed in line with this. However, the tool lacked detail regarding people's specific needs to ensure the tool reflected the requirements of the home This therefore impacted the validity of the tool and in turn the established staffing level requirements.
● The provider carried out relevant pre-employment checks to ensure permanent staff suitability for the role. However, agency staff profiles and evidence of induction were not available on the day of inspection for 2 of the agency staff who had worked the night before. This meant the provider could not be sure of the suitability of agency staff.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

● People were not always protected from the risk of neglect and abuse. There was no effective system in place to ensure lessons were learnt when incidents occurred.

● Staff were trained in safeguarding and knew how to appropriately raise safeguarding concerns. However, staff told us they were not comfortable to go the management with concerns.

● Most incidents, accidents and safeguarding concerns were being documented and shared with relevant agencies. However, there was no evidence of outcomes or learning from internal investigations. There was no system in place to communicate to staff lessons learnt.

● There was no evidence of any effective actions being taken or any analysis of incidents or concerns to identify any areas for improvement or to prevent incidents reoccurring.

The provider failed to ensure effective systems were in place to protect people from the risk of neglect and abuse. The provider failed to effectively carry out investigations. This was a breach of regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● We found people's assessed capacity was inconsistently recorded in care records, this meant it was not clear for staff on when they shouldn't or should act in someone's best interest.

● If needed, appropriate legal authorisations were in place to deprive a person of their liberty.

● Staff were trained in MCA and understood how to work within the principles of the MCA; however, due to the inconsistent documentation they were not always able to do so.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People did not always receive care in a personalised way that met their individual needs and choices. Whilst care plans did document some of people's preferences, there was little evidence of the provider actively seeking to meet these. This meant people did not have their wider social and cultural needs met.
● Care plans prompted staff to involve people in 1 to 1 activities, activities specific for people living with dementia, and activities that would remind them of their younger lives and hobbies. Whilst there was an activities coordinator, they were only part time and did not conduct activities that met people's documented needs.
● Staff stated they had very little time to interact with people.
● People's religious needs were documented but there was no guidance for staff on how to meet them. For example, one person's care plan only stated the person, "requires support and provisions to meet their religious and spiritual needs," but no information on what these might be.
● Staff did not feel care plans contained enough information to enable them to support people in an individualised way. A staff member said, "The care docs don't have enough information, we just speak to people and staff who have been here longer [to get information]." This meant there was a risk not all staff were getting the required information to meet people's needs, particularly when the home was only staffed by agency at night.
● Care plans were not always updated to reflect people's current needs. A staff member said, "I feel like nothing gets updated when people's needs change, unless something seriously bad happens or if family member raises an issue." This meant staff were not provided with information to ensure they could meet people's changing needs.
● We reviewed 9 people's care plans and found inconsistent and incomplete information. Some care plans included relevant information about people's wider needs such as religion and sexuality however others did not. We found a care plan that used the wrong person's name, demonstrating it had not been developed in a personalised way.

The provider failed to ensure people's care was planned and delivered in a personalised way. This placed people at risk of not having their needs met. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the

Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● People's individual communication needs were not being met.

● People's communication needs were documented in their care plans, including how people preferred to be communicated to. The management stated they would be able to provide information in alternate sources if required but were not supporting anyone with such requirements. We identified this was not the case. For example, we found in people's care plans information indicating they would benefit from large print.

● One person's care plan documented they required an interpreter and staff were to use picture cards to communicate; it also stated they had poor eyesight. However, there was no evidence they had been supported with this to enable them to communicate their needs. A staff member said, "We can't meet [person's] needs, I feel terrible for them. [The provider] printed some cards off but they need to be seen by an optician. They have been with us quite a few months and they haven't got glasses. They are now quite depressed and low in mood."

Improving care quality in response to complaints or concerns

● Complaints and concerns were not being learnt from to improve care quality.

● Only 1 recorded complaint had been received since last inspection. This had been investigated in line with the provider's complaints policy and responded to. However, there was no evidence of any consideration of learning from this complaint to improve care quality.

● It was not clear what the provider's process was when informal concerns were received and there was no evidence these were documented, responded to or learnt from.

End of life care and support

● At the time of the inspection no one was receiving end of life care, however management said they did sometimes provide this support if required.

● End of life care had been considered in people's care plans, and it had been documented where people declined to discuss this.

● Staff did not receive training on how to support people at the end of their lives. Therefore, it is not evident staff would be able to effectively support people if the need arose.

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 requires improvement. 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

At our last inspection the provider had failed to effectively operate systems to ensure the quality and safety of people's care. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● There was no effective leadership, oversight or systems in place to ensure the quality of care delivered. At the time of the inspection there was no registered manager in post. The service was being managed by a newly appointed manager, who had no previous management experience and was unable to adequately discuss with us the running of the service. The service was also being supported by a manager from another home and the nominated individual.
● Issues we had identified in the safe and responsive sections of this report had not been identified by the provider. Numerous audits had been carried out, but they were not effective in identifying concerns. Where concerns had been identified, they had not been actioned adequately or promptly.
● For example, we found a soiled and stained cushion in a bedroom in which a cushion audit had been carried out a few days prior which identified no concerns. Medicine audits and checks were being carried out weekly but had not picked up on the issues we discovered as mentioned in the safe section of this report.
● Documentation not kept in a complete and contemporaneous way. We found issues in people's care plans as identified in the responsive section of this report. We also found governance and handover records to have missing information; for example, there were incomplete incident forms and they were not being noted on handover documents.
● There was a lack of identified outcomes and learning from previous incidents and complaints meaning the provider missed opportunities to improve the experience and the safety of people living in the home.
● The provider failed to safely manage and mitigate risks associated with the environment and those specific to people's conditions, as identified in the safe section of this report. This placed people at increased risk of harm, injury or neglect.

Systems in place had not been utilised effectively to ensure the quality and safety of people's care. This was a continued breach regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

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

● There was not a person-centred culture and staff were not actively engaged or involved by the service.

● The provider lacked clear leadership, which resulted in low staff morale. Staff did not have confidence in the management or the provider and did not feel comfortable approaching them. A staff member said, "If the management are not going to listen to and support the staff, what do they expect us to do? We can't stay."

● Staff told us they had requested numerous meetings with management to discuss concerns, but this had not been arranged. They had only had one meeting recently and a staff member described this as "a big telling off".

● People did not always receive person-centred care as described in the responsive section of this report.

● The provider sent out quarterly questionnaires to relatives. However, there had been very little response to allow for any analysis or actions as a result.

● A quarterly newsletter was sent out to relatives, this included information about what was going on in the home and a COVID-19 update.

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; Working in partnership with others

●The provider did understand the duty of candour and there was evidence to demonstrate the provider had contacted relatives when incidents occurred.

● The provider had notified the commission of certain events. However, accident and incident forms were not detailed enough to establish if any further events were notifiable. In addition, when we got feedback from staff, they informed us of multiple incidents that may have been notifiable which we had not seen documented or had been notified about.

● The local authority also advised they were not kept informed of managerial changes within the home.

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 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure people's care was planned and delivered in a personalised way. This placed people at risk of not having their needs met. Regulation 9

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to ensure effective systems were in place to protect people from the risk of neglect and abuse. The provider failed to effectively carry out investigations. Regulation 13