Griffin Care Homes Limited

# Griffin House Care Home

## Inspection report

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17 September 2020
28 September 2020

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30 October 2020

## Ratings

| Overall rating for this service | Inadequate |
|---|---|

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

# Summary of findings

## Overall summary

About the service
Griffin House Care Home is a residential care home providing accommodation and personal care for up to 26 people in one adapted building over two floors with lift access. At the time of our inspection 20 people were living at the service.

People's experience of using this service and what we found
Risks to people were not always assessed, monitored and managed in a safe way. Care plans lacked information and guidance for staff on how to provide people with safe care and support. Risk assessments and associated care plans did not always reflect the risks present in people's care. The monitoring of people's care did not always take place. Parts of the environment posed a risk to people's safety.

The management of medicines was unsafe. People did not always receive their prescribed medicines at the right times and some people were administered incorrect doses of medicines. Medication administration records (MARs) were poorly maintained and the correct procedures were not followed for correcting medication errors.

The providers records for accidents and incidents did not identify what action was taken to reduce further risk to people or reflect lessons learnt. The provider failed to respond appropriately to incidents of a safeguarding nature which were brought to their attention during the inspection.

The systems in place for monitoring the quality and safety of the service were not always effective in identifying and mitigating risks to people. Audits were not robust, they failed to identify the concerns we found during this inspection. The provider lacked understanding of their role and responsibilities and regulatory requirements.

Safe recruitment processes were followed and there were enough staff on duty to safely meet people's needs. The environment was clean and hygienic, and staff followed good infection prevention and control (IPC) practices. People and their family members spoke positively about their experiences of the care provided by staff. Family members felt involved in the care of their relatives throughout the COVID-19 outbreak.

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 10 July 2019). There were no breaches of regulation found, however we made a recommendation about some medicines. During this inspection we identified good practice was not followed in relation to the safe management of medicines and we found breaches of regulations, meaning that the service had deteriorated.

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

Why we inspected
The inspection was prompted in part by notification of a specific incident. Following which a person using the service died. This incident is subject to a criminal investigation. As a result, this inspection did not examine the circumstances of the incident.

The information CQC received about the incident indicated concerns about the management of people's care and treatment. This inspection examined those risks.

Due to the COVID-19 pandemic, we undertook a focused inspection to only review the key questions of safe and well-led. Our report is only based on the findings in those areas reviewed at this inspection. The ratings from the previous comprehensive inspection for the Effective, Caring and Responsive key questions were not looked at on this occasion. Ratings from the previous comprehensive inspection for those key questions were used in calculating the overall rating at 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.

The provider took some action to mitigate the risks.

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

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 Regulation 12 (Safe care and treatment) Regulation 13 (Safeguarding service users from abuse) and Regulation 17 (Good governance) at this inspection.

Please see the action we have told the provider to take at the end of this report.

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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 act 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 safe findings below.

**Is the service well-led?**

Inadequate

The service was not well-led.

Details are in our well-led findings below.

# Griffin House Care Home

**Detailed findings**

## Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection visit was carried out by two inspectors.

Griffin House 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 who is also the registered provider. This means that they are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We telephoned the service from the car park and announced our arrival to a member of staff. The purpose of this was to obtain information about COVID-19 in advance of inspectors entering the service.

Inspection activity started on 17 September and ended on 28 September 2020. We visited the service on 17 September 2020.

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

During the inspection
We spoke with 5 people who used the service about their experiences of the care provided. We also spoke with the provider who is also the registered manager, and five members of staff including care workers and the chef. 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 10 people's care records and multiple medication records. We looked at the recruitment files for three staff employed since the last inspection.

After the inspection visit
Due to the impact of the COVID-19 pandemic we limited the time we spent on site, and were unable to speak with family members, due to visiting restrictions. Therefore, we requested records and documentation to be sent to us and reviewed these following the inspection visit. We contacted four family members by telephone about their experiences of the care provided.

We raised a safeguarding alert with the local authority relating to the care and support of four people living at the home.

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

Inadequate

# 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 improvements. At this inspection this key question has deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Systems and processes to safeguard people from the risk of abuse

- Risks to people were not always assessed, monitored and managed.
- There were inconsistencies in the monitoring and recording of fluid intake for people at risk of dehydration and for the use of air flow mattresses for people at risk of developing pressure wounds.
- There was no information or guidance for staff on the amount of fluid people at risk needed to consume over a 24-hour period. For example, one person's care plan stated they required regular fluid intake to help with a medical condition, however records showed the amount of fluid offered and consumed was significantly lower than the recommended daily amount for older people.
- There was no information or guidance for staff about the correct setting of airflow mattresses used by two people. There were also no checks in place to ensure they were in good working order or set correctly. One person's air flow mattress was switched off whilst they were on bed rest, the provider was unsure why this was and of the correct setting. The provider contacted an external healthcare professional during the inspection visit to obtain the correct settings for both people's airflow mattresses.
- Some people's care plans instructed staff to monitor their intake of food due to the health risks associated with certain foods. However, food monitoring records showed these people had eaten meals containing foods which their care plans stated they should avoid.
- We were aware of accidents and incidents which had occurred at the service. However, we were unable to assess fully whether these were safely managed and whether lessons were learnt. This was because the records sent to us by the provider did not include actions taken to reduce further risk of occurrences and any lessons learnt.
- Parts of the environment posed a risk to people's safety. Codes to keypads were written on the outside of doors to rooms which needed to be kept locked because the contents posed a risk to people's safety. This included sluice rooms and an electric meter cupboard. The codes were removed after we raised this.
- Methods used for holding fire doors posed a risk to people's safety in the event of a fire. One person's bedroom door was held open with a Zimmer frame and another person's bedroom door was held open with a peddle bin. Both people were occupying their rooms at the time. The provider failed to recognise the safety implications of this, they stated it was the person's choice to have their bedroom door kept open.

The provider failed to adequately assess and mitigate risks. This is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People told us they felt safe living at the service and family members told us they were confident that their relatives were kept safe. Their comments included; "Oh yes I feel safe here," "I'm safe and they look after me

well" "I'm really confident that [relative] is safe" and "They [relative] is much safer than when they lived at home." People commented that staff were kind and caring and treated them well.

Using medicines safely

At the last inspection we recommended that the service consider current good practice guidance for recording medicines prescribed to people and update their practice accordingly. However, at this inspection we found good practise had not been followed in line with national guidance. We also found other concerns regarding the management and recording of medicines.

- Medicines were not used safely.
- National guidance had not been followed for handwritten medication records (MARs). Some handwritten MARs lacked information about people's prescribed medicines. This included the strength of the medication and instructions for use. Despite this the MARs had been signed by the scriber and a second member confirming the accuracy of the information recorded. Some handwritten MARs had not been signed either by the scriber or a second member of staff.
- Gel was applied to a person's skin which was double the strength of the gel prescribed by their doctor. The prescription label on the box stated 5% gel, however the tube of gel inside the box was 10% gel and did not have prescription label on it. The provider confirmed staff had routinely applied the 10% gel to the persons skin.
- Some people were prescribed PRN medicines; these are medicines to be taken when required. Some of these medicines were a schedule 4 controlled drug (CD). There was a stock error that had not been investigated and a dose of medication had been given that contradicted the instructions on the PRN protocol which had also not been investigated.
- Entries recorded in the CD register showed a pain patch prescribed for one person had not been applied as prescribed. Records indicated that the patch had been applied either too early or too late. The stock balance for the pain patches recorded in the CD register did not correspond with the stock available. Staff were required to complete a body map indicating the site where they applied the patch to avoid the risk of reapplying it in the same site. However despite there being a body map in place it had not been completed.
- There were multiple examples of errors made in the CD register including incorrect dates and stock balances. Staff failed to follow the correct procedure for correcting medication recording errors.
- There were gaps in the recording of the temperature of the medication fridge. The fridge contained several items of medication which needed to be kept cool to ensure their effectiveness.

The provider failed to ensure the proper and safe management of medicines. This is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection, we raised a safeguarding alert with the local authority for four people.

Systems and processes to safeguard people from the risk of abuse

- People were not always safeguarded from the risk of abuse. Allegations of abuse in relation to medication errors were brought to the providers attention during the inspection. However, they failed to report these in line with local safeguarding procedures.
- The provider made internal enquiries into the safeguarding concerns which had the potential to jeopardise any investigations carried out by other agencies.

The provider failed to take the appropriate action to ensure people were safeguarded from the risk of abuse. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

- Systems in place to prevent and control the spread of infection were generally well managed.
- The environment was clean and hygienic.
- We were assured by the additional measures in place to help prevent the spread of COVID-19.
- There was a good stock of personal protective equipment (PPE) of an appropriate standard and staff used and disposed of it in line with current national IPC guidance.

Staffing and recruitment

- Safe recruitment processes were followed and there was the right amount of staff on duty to keep people safe.
- Applicants fitness and suitability to work at the service was assessed through a range of pre-employment checks prior to a job offer being made.
- Staffing levels and skill mix were determined based on people's needs and dependency levels.

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate.

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

- Lessons were not always learnt. The provider failed to act upon a recommendation given at the last inspection for entering handwritten information onto medication administration records (MARs).
- The provider showed a lack of understanding regarding their responsibilities for undertaking comprehensive assessments of people's needs prior to them moving into the service. This led to expected outcomes for people not being identified and planned for. For example, there was limited information recorded on how staff were to provide safe care to people with specific health conditions and the management of associated risks. The provider contacted healthcare professionals during and after the inspection to obtain the required advice and guidance.
- The systems in place for checking on the quality and safety of the service were not always effective. They failed to identify and mitigate risks associated with people's safety in relation to assessing and monitoring risk, the management of medicines and the environment.
- Medication audits carried out were not robust. Those sent to us by the provider following the inspection visit covered weekly medication stock counts only. There was no evidence of audits carried out on any other areas such as storage, disposal and recording of medication.
- Care plan audits failed to identify a lack of care planning and monitoring of people's needs.
- Incidents and accident records did not assure us that appropriate action had been taken to minimise the risk of further occurrences and that lessons were learnt across the staff team.
- The provider failed to follow the correct procedures for managing allegations of abuse. During the inspection site visit we alerted the provider of potential safeguarding concerns regarding several medication errors in respect of four people. However, the provider carried out their own internal enquiries without the direction of the safeguarding authority.

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 did not always operate in an open and transparent way by notifying the relevant agency of errors made in relation to the management of people's medicines.

We found no evidence that people had been harmed however, the provider failed to operate effective systems to ensure the safety and quality of the service placing people at risk of harm. They also failed to maintain accurate and up to date records. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● Family members told us they felt engaged and involved in their relative's care. They told us they had maintained regular contact with their relatives over the telephone and were kept up to date about their relative's care during the lockdown period.

● Staff attended regular team meetings.

● The service didn't always work effectively with others such as commissioners, safeguarding teams and health and other social care professionals.

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<br><br>The provider failed to adequately assess and mitigate risks to service users and ensure proper and safe management of medicines. |

| 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<br><br>The provider failed to take the appropriate action to ensure people were safeguarded from the risk of abuse. |

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<br><br>The provider failed to operate effective systems to ensure the safety and quality of the service placing people at risk of harm. They also failed to maintain accurate and up to date records. |

**The enforcement action we took:**

Warning notice for Regulation 17 Good governance.