

Holmleigh (Pirton) Limited

Pirton Grange Specialist Services

Inspection report

Worcester Road
Pirton
Worcester
Worcestershire
WR8 9EF

Tel: 01905821544

Website: www.europeancare.co.uk

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

About the service

Pirton Grange Specialist Services is registered to provide accommodation, nursing care and rehabilitation services for up to 58 people who may have support needs owing to mental health, learning disabilities or autistic spectrum disorders, Huntington's disease, dementia and neurological conditions. At the time of the inspection there were 30 people living at the home.

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

People did not always have risks to their safety managed effectively. Risks were not clearly identified for staff to follow. Important information about people's health conditions was not communicated effectively to staff for staff to ensure care was delivered safely.

Peoples' medicines were not always managed safely. People did not always get the support needed to take medicines safely. Clear action was not always taken to reduce errors or risks associated with people's medicines.

There was no registered manager in post. The clinical manager told us that improvements had been made to the systems, policies and procedures following a recent Coroner's inquest. However, we found improvement was still needed to address recommendations made after the inquiry. There were gaps in recording, no oversight of clinical risks and no effective management of agency staff, particularly agency nurses who were required to manage the shift.

There were sufficient staff to meet people's needs, however there was not always a consistent staff team who had up to date knowledge of peoples' current needs.

Relatives told us that care staff were attentive to the needs of their loved ones. They could raise concerns and felt confident that anything raised would be addressed.

People were cared for by staff who attended training relevant to their roles. The agency staff also had opportunity to access the same training as permanent staff.

People lived in an environment that was clean and well maintained.

Staff observed and followed infection control procedures in line with national guidance for reducing the spread of COVID-19.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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

Rating at last inspection

The last rating for this service was Good (published 3 December 2019).

Why we inspected

Prior to our visit, we received concerns in relation to the management of peoples' nursing needs and the management and governance of the service. This was following a Coroner's inquest which identified some shortfalls with the quality of clinical care provided. 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.

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 changed from Good to Requires Improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvements. Please see the Safe, Effective 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.

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 discharge our regulatory enforcement functions required 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 the management of people's risks and the management and governance of the service at this inspection.

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

Follow up

We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and 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 effective?

Good ●

The service was 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.

Pirton Grange Specialist Services

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 team consisted of two inspectors.

Service and service type

Pirton Grange Specialist Services 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 did not have a manager registered with the Care Quality Commission at the time of the inspection. A registered manager 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. At the time of this inspection, the provider was recruiting for a manager.

Notice of inspection

This inspection was unannounced.

Inspection activity started on 7 July 2021 and ended on 13 July 2021. We visited the office location on 7 July 2021.

What we did before the inspection

We reviewed information we had received about the service since the last inspection, this included the findings of the Coroner in their Regulation 28 report on preventing future deaths. 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 of this information to plan our inspection.

During the inspection

We spoke with one person who used the service and four relatives about their experience of the care provided. We spoke with 17 members of staff including the provider, clinical manager, nursing staff, Senior Operations Administrator, senior care workers, care workers and agency nurses.

We reviewed a range of records. This included two people's care records and multiple medication records. We looked at five agency profiles (an agency profile provides essential information about the suitability of agency staff), and three staff recruitment files for employed staff. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection

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

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 good. At this inspection this key question has now deteriorated to 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.

Assessing risk, safety monitoring and management

- Where people had risks associated with their health, risks assessments were completed however these were not always up to date or reflected the support that some people needed to keep them safe.
- Management, nursing staff and care staff's knowledge of certain people was at times, inconsistent with each other and in one example, went against health professional advice. This left people at risk of receiving unsafe care and support.
- For example, one person required oxygen to help them breathe safely. Following a score which indicated potential health concerns, a doctor gave instruction to staff to increase the frequency of oxygen to treat a chest infection. However, oxygen had not been given in line with the doctors' instruction. During our inspection visit we saw this person without their oxygen even though the written instruction from the doctor indicated the use of oxygen. Care staff we spoke with were inconsistent with what actions they took when supporting the person with their oxygen. One member of care staff said, "I haven't heard of any doctor's instruction. Yes, we take (person's) oxygen off during the day." Another member of staff said, "I never take (Person) off the oxygen. I think they are on it all the time. I do not know why they are not on oxygen today." We asked the clinical manager to seek urgent clarification on the doctors' instruction and communicate this to the staff.
- Another person was identified at risk of self-harm. Although the risk was identified in a 'resident snapshot' which was a document providing a brief overview of people living at Pirton Grange there was no specific risk assessment or care plan to inform staff how to manage the risks associated with this person. Staff we spoke with were inconsistent with their knowledge of the risks and some staff were unaware of any risks with this person. This meant that risks were not being mitigated effectively. We found systems were either not in place or robust enough to demonstrate people's risk were effectively managed. This placed people at risk of harm.
- Medicines were stored appropriately, and checks were regularly made on amounts of medicines and medicine records to identify any errors. However, we were not assured that appropriate steps were put in place to reduce the risk of errors reoccurring. For example, two care staff told us that medicines are sometimes found discarded on the floor in communal areas, one care staff member said, "Tablets can be found during cleaning. It is impossible to identify whose medicine it is as there is no missing entries on medicine records to show who has not had their tablet." We found a record of a tablet being found "stuck to the floor in lift" in a medicine incident log. The only action recorded was "medication destroyed...message in comms book for cleaning of lift." There was no indication of steps being taken to mitigate against the risk of reoccurrence.

This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- During our visit, we saw how a lack of management and clinical oversight may not promote positive outcomes for people. For example, at 12.30pm, one person who had a catheter, we saw the day bag was full. We checked at 4.30pm, only then was support being provided. The person's door remained open while staff emptied the catheter, which we did not feel promoted privacy and dignity.
- Environmental and health and safety checks were completed and where improvements were needed, actions were taken. During our visit we identified some fire safety checks had not always been completed. We told the senior operations manager about this and the importance of these being completed at the specified times.
- Each person had a personal emergency evacuation plan (PEEP) which reflected the support they would need to evacuate the premises safely, in the event of an emergency.

Using medicines safely

- There were systems to ensure that medicines were administered in line with peoples' prescribed medicines. Where people had PRN medicines there were clear protocols and guidelines for nurses and care staff to follow. PRN medicines are medicines that are prescribed to be given as required at times when a person needs them, for example pain, anxiety or epilepsy seizure management.
- All care staff that were administering medicines had regular training around the safe use of medicines. Systems and processes to safeguard people from the risk of abuse
- Relatives told us they believed their loved ones were being looked after safely. One relative said "I have no doubt that (Person) is safe. The staff are attentive and caring."
- There were clear systems and processes in place to protect people, where needed referrals were made to the local authority safeguarding and CQC notified of accidents or incidents. However, risk management was not always effective, and people were left at risk by not having clear instruction to staff on how to keep people safe. For example, managing potential risks with people at risk of self-harm, or ensuring that treatment is in line with medical advice.
- Staff received training in safeguarding, staff we spoke with understood the principles of safeguarding. Staff knew where the policies relating to safeguarding or whistleblowing were kept and knew who to contact if they needed to raise concerns.

Learning lessons when things go wrong

- There had recently been an investigation at the home related to a person's care provided by nursing and agency staff. Recommendations had been made by the Coroner in a regulation 28 report on preventing future deaths. We found that while some improvements had been made in the monitoring and recording of people's clinical observations, action was still needed to address all issues identified during the Coroners' inquest. Improvement was needed in managing people's individual risks and clinical needs. Also, there was a lack of management oversight of the ongoing practice and skills of individual agency nurses.
- Policies, procedures and how certain tasks were needed to be undertaken, had been implemented, but they had not always driven required improvements. For example, there was no effective oversight or supervision of the practice of agency staff and areas of concern remained in the management of people's clinical needs. We discussed our concerns with the provider and management so these could be improved and more time for certain staff to embed that learning into everyday practices.

Staffing and recruitment

- The provider's recruitment process included checks to ensure staff who worked for the service were of a suitable character. Staff files showed recruitment checks were robust, which included checks on staff

through the Disclosure and Barring Service (DBS).

- Agency staff recruitment checks were not so thorough because we saw a lack of suitable checks being followed up. For example, agency profiles did not always record what type of security check was completed or the date this was applied for. The senior operations administrator sought clarification and provided assurance that suitable checks had been completed for the agency staff.
- The provider did not always have a consistent staff team which communicated well together. The provider relied on agency nurses and from our discussions, those nursing staff were not always updated of people's recent changes in health and wellbeing. The provider told us that they were currently recruiting new staff, but recognised the challenges posed by COVID-19, and their remote location in attracting new staff.
- There were enough staff to ensure people received care and support when needed. However, our observations throughout the day showed a lack of shift management. Staff told us they would go to nursing staff for direction, however during our visit, agency nurses were on duty but did not always have up to date knowledge of people's needs and knowledge of changes within the home that may have taken place whilst they were away from the service.

Preventing and controlling infection

- The home was clean and increased checks because of the current pandemic ensured the home environment reduced the risk of cross infection.
- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were 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 somewhat assured that the provider was using PPE effectively and safely. On a number of occasions during our visit, we saw a senior staff member not correctly wearing a face mask in communal areas of the home.
- 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 assured that the provider's infection prevention and control policy was up to date.
- We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

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 the last inspection this key question was rated as good. At this inspection this key question has now remained the same.

This meant people's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law, Continuous learning and improving care

- People had assessments prior to moving into the home so their personal needs and wishes were identified. There were regular reviews, one relative told us "We are due to review the care plans and risk assessments, it happens every year and gives us some confidence that care plans are up to date."
- People's oral health had been considered and there were plans in place to ensure their needs were met.

Staff support: induction, training, skills and experience

- Staff told us about training in areas like catheter care, epilepsy care and positive behaviour support, all of which they felt were relevant to their roles.
- The provider had made changes to aspects of the support that agency staff received whilst working in the home. This was after the concerns raised by the Coroner in their findings. This included providing opportunities for agency staff to access the same training that permanent staff received. However, we found some agency staff had completed between 15 and 19 training courses on the same day. We shared our thoughts about the effectiveness of this practice which applied to a high number of agency staff. Whilst we welcomed these changes, concerns remained about the lack of day to day supervision and support of agency staff.
- Staff told us that when they commenced working for the provider, they had a full induction that included training and shadowing shifts so that they were given time to get to know the people that lived there.

Supporting people to eat and drink enough to maintain a balanced diet

- People were assessed to ensure that food and fluids were prepared in the most appropriate way to meet their needs. These needs were documented for the staff and kitchen staff to use and key information was accessible in the food preparation areas of the home.
- Relatives told us their loved ones appeared to enjoy the food and they did not share any concerns over people's diets or nutrition.
- We did not see any vegetarian options on the day of inspection, however staff told us that other options were prepared if people did not want what was on the menu. The menu we saw showed that some people had made different choices of food.
- Where identified in people's care records food and fluid amounts were monitored and where concerns were identified support from other health professionals had been sought.

Staff working with other agencies to provide consistent, effective, timely care, Working in partnership with others, Supporting people to live healthier lives, access healthcare services and support

- Other health professionals provided support to people and care staff to ensure that needs were met effectively. We found examples where people had input from physiotherapy to assist with mobility, another person had support from an epilepsy service. Relatives told us that where needed support from other agencies was sought in a timely way.
- The management team welcomed the inspection and our feedback, especially around some areas that still needed updating.

Adapting service, design, decoration to meet people's needs

- Relatives were positive about the environment. One relative said, "(Person) has the freedom to move about. I think the layout of the building is fine and meets the needs of people that live there."

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 Act 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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- The provider reviewed people's capacity to make decisions and where people had restrictions, these were regularly reviewed to ensure they remained relevant, without unnecessarily restricting a person's freedom.

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 good. At this inspection this key question has now deteriorated to requires improvement.

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

- At the time of our visit, there was no registered manager in post. The registered manager had left April 2021. The provider was currently recruiting for a registered manager.
- The clinical lead manager told us they had improved their systems, policies and processes following a Coroner's inquiry related to communication, recording and monitoring of a person's vital signs during a clinical emergency.
- However, at this visit we found the key themes identified during that inquiry, had failed to be fully implemented and managed which meant the risk of people receiving the right levels of treatment and support was compromised. This was contributed to by a lack of effective management oversight. There was no registered manager and there had been further changes to senior management since the Coroners' inquest and subsequent findings.
- There was no effective oversight or systems to ensure people received their medicines safely. Medicines audits and checks had not picked this up.
- Care plan audits and reviews had not always identified the issues we found regarding people's current health and welfare. Staff were not always aware; some staff had been identified as key workers for people they had very limited knowledge of. One staff member told us they could not understand this.
- There was no process to check the effectiveness of the handover between shifts. We found staff or nursing staff were not always aware of the full picture of a person's condition that may have changed over time. This meant important information may not be passed on.
- Relatives and some staff told us the culture at the home was not always one that welcomed open and honest feedback. Immediately following our inspection, we received a concern from a staff member. We followed these issues up with the provider who responded to us with their findings.

The provider's governance was not effective, including quality assurance and auditing systems. This placed people at risk of harm. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We saw some positive examples of auditing that did seek and act to drive improvement. A range of clinical, environmental and health and safety checks were completed to ensure people received good care.
- The provider completed regular and timely audits. Where audits and checks were delegated to others, these were followed up and reviewed. Regular checks completed by the management team and internal quality processes, ensured actions were taken. However, some of these quality processes had failed to

identify the issues we found during our inspection.

- The provider used the services of an external consultant to complete a 'mock CQC inspection'. Identified improvements were followed up to create a service improvement plan. We saw actions were taken to address those issues.

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 legal responsibility to offer an apology when things went wrong. For example, complaints had been followed up, responded to and closed.
- Statutory notifications had been sent to us for notifiable incidents. These were reviewed to ensure actions were taken to reduce similar incidents from happening again.

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

- Communication was sought from people and their relatives' feedback and staff. Recent surveys had been sent to seek current feedback and we were told; actions would be taken.
- Plans to support families with visiting in line with government guidelines were in place.
- Staff training continued to be reviewed and refreshed. Further training was planned over to ensure staff had current knowledge of good practices and remained confident to support people.

Working in partnership with others, Continuous learning and improving care

- The management team on site during our inspection visit, welcomed the inspection and our feedback, especially around the areas that had improved.
- Whilst we identified that improvement is needed in the overall governance of the service. Learning had taken place; we were shown improvements made to the systems of monitoring and when to take action regarding people's needs. These had been made following the outcome of the Coroner's findings.

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
Treatment of disease, disorder or injury	Systems were either not in place or robust enough to demonstrate risk was safely identified or effectively managed. This placed people at risk of harm.

The enforcement action we took:

To serve a warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider's governance was not effective, including quality assurance and auditing systems. This placed people at risk of harm.

The enforcement action we took:

To serve a warning notice