Peak Care Limited

Grove House

Inspection report

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Date of inspection visit:
09 January 2023
10 January 2023

Date of publication:
15 June 2023

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Grove House is a residential care home providing accommodation and personal care to up to 31 people in an adapted building. The service provides support to older adults, some of whom are living with dementia. At the time of our inspection there were 18 people using the service.

People's experience of using this service and what we found
The service was not always safe. Environmental and health-related risks to people were not always well managed. People did not always receive their medicines safely. Accident and incident forms were not always completed, so lessons could not always be learnt. The provider did not always follow recruitment policies to ensure staff were recruited safely. However, people were protected from the risk of abuse and infection prevention and control measures were appropriate.

Staff did not always have the support and training needed to meet people's needs. People had not been referred to healthcare professionals when their mobility needs had changed. Risks to people's nutrition and hydration were not always well managed. People did not always receive consistent support with their hygiene needs and preferences. However, the home was well presented and people could personalise their bedrooms.

Although improvements had been made since the last inspection, systems and processes had not always been operated effectively to ensure people received a safe service where quality was able to improve consistently. The provider did not always understand or comply with regulatory requirements. However, people's care plans were written in a person-centred way, and there were systems to receive feedback from people and their relatives.

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 and update
The last rating for this service was inadequate (published 25 August 2022). There were breaches in regulation. This service has been in special measures since 25 August 2022. During this inspection, although we have found some improvements have been made, the provider remains in breach of regulations. The provider will remain in special measures as the service remains rated inadequate overall.

Why we inspected
At our last inspection, we carried out an unannounced focused inspection on 20 June 2022. Breaches of legal requirements were found. As a result, we imposed conditions on the provider's registration and served

a Warning Notice with a compliance deadline for improvement.

We undertook this focused inspection to check whether the provider had complied with the imposed conditions due to urgent risks found in relation to regulation 13, and the Warning Notice we previously served in relation to regulations 11, 12, 17 and 18, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This report only covers our findings in relation to the Key Questions Safe, Effective and Well-led which contain those requirements.

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 remained inadequate. This is based on the findings at this inspection.

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

Enforcement
We have identified breaches in relation to people's health and safety, person centred care, staffing and governance.

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

Follow up
We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Requires improvement'. However, the service remains in 'special measures'. We do this when services have been rated as 'Inadequate' in any Key Question over two consecutive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services 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 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? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Grove House

Detailed findings

Background to this inspection

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

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was conducted by 2 inspectors. An Expert by Experience also made calls to people's families as part of the inspection. 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
Grove 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. Grove House is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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

At the time of our inspection there was not a registered manager in post. A new manager had been in post for 2 months and had submitted an application to register. We are currently assessing this application.

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 professionals who work with the service. We used all this information to plan our inspection. We did not request a provider information return (PIR) before this inspection. 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.

During the inspection
We spoke with 6 people who used the service. We spoke with 8 relatives about their experience of the care provided.

We spoke with 12 staff including, kitchen staff, a member of staff employed for maintenance, care assistants, senior care assistants, the care manager, service managers, the compliance manager, the nominated individual and a director.

We reviewed 5 people's care records. We looked at 3 staff files in relation to recruitment practices. We reviewed various records relating to the management of the service including training records, quality assurance reports and accidents and incidents.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question inadequate. At this inspection the rating has changed 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.

At our last inspection, systems were not in place 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 breach of regulation 12(1) 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.

Using medicines safely; Learning lessons when things go wrong

- Medicines were not always safely managed.
- Medication administration records (MARs) were not always signed. Staff supporting people with their medicines should sign MARs to confirm people had received their medicines. Records also showed people did not always receive topical medicines they were prescribed. This meant there were increased health-related risks to people who may not have received prescribed medicines.
- Protocols for topical medicines used on an as-required basis (PRN) for 1 person was not in place. PRN protocols give guidance to staff about when a medicine can be given, the reason it is prescribed and safety information. This meant staff might not know why and when this person needed to have these medicines to support their health.
- Accident and incident reports had not always been completed so lessons could be learnt, and actions could be taken to manage risks. For example, we found 4 recent occasions where people's medicines had been found in areas such as the dining room, bedrooms and corridors. In addition, the service manager told us about an incident where a person became stuck in the bath. However, accident and incident reports had not been completed in relation to these concerns. This meant we were not assured the manager had consistently investigated and managed all concerns, which increased safety risks to people.

Assessing risk, safety monitoring and management

- Risks to people's safety were not always assessed or mitigated.
- Fire risks were not always well managed. People who had recently started living at the service were not included in the occupant list in the provider's fire folder. Furthermore, one person did not have a personal emergency evacuation plan in place (PEEP). This meant in the case of a fire emergency, fire and rescue teams may not know these people were in the building or how they needed to be evacuated.
- Window restrictors were not fitted to all windows. We found 3 people's bedrooms above the ground floor did not have window restrictors fitted. This increased the risk to people who could fall out of windows. After our inspection, the provider sent us evidence window restrictors had been fitted.
- Staff had made decisions about the size of hoist slings people needed without the training or

qualifications to do so. The slings we found in 2 people's rooms did not belong to them. Incorrect sizes of hoist slings can cause discomfort to people and increase the risk of skin damage and harm from falling out of slings.

● Records showed a person had not always been supported to move regularly in line with their care plan. People are supported to reposition to relieve pressure and prevent skin tissue breakdown when they cannot manage this themselves. This increased health-related risks to this person.

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.

● However, all the relatives and people we spoke with told us they felt the care received at Grove House was safe.

Staffing and recruitment

At our last inspection the provider failed to ensure there was enough staff to keep people safe. This was a breach of regulation 18(1), (Staffing), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 18(1).

● The newest staff member's recruitment folder had no evidence of an interview record or Disclosure and Barring Service (DBS) check. DBS checks provide information, including details about convictions and cautions held on the National Police Computer. Fortunately, the staff member had a portable DBS and produced evidence of a DBS check during the inspection. However, the provider had not followed their recruitment policies and procedures to ensure safe recruitment decisions.
● During the inspection, we found enough staff to promote people's safety. Since the last inspection, the provider used a revised dependency tool to help determine staffing numbers.

Systems and processes to safeguard people from the risk of abuse

At the last inspection the provider had not protected people from abuse and improper treatment. This was a breach of regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 13.

● People were protected from the risk of abuse.
● Referrals and notifications were sent to the local authority safeguarding adults' team and CQC by the provider. This meant safeguarding concerns could be independently reviewed and investigated appropriately.
● Staff had received safeguarding training. Staff told us they felt confident in raising safeguarding concerns with managers and knew how to raise concerns externally to the local authority safeguarding adults team and CQC.

Preventing and controlling infection

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was supporting people living at the service to minimise the spread of infection.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was responding effectively to risks and signs of infection.
- 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.

Visits in care homes

- People and their relatives told us visitors were welcomed without any restrictions.

Requires Improvement

Is the service effective?

Our findings

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

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

Staff support: induction, training, skills and experience

At our last inspection the provider had not ensured staff were competent. This was a breach of regulation 18(2), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made and the provider was still in breach of regulation 18(2).

- At the time of our inspection, 8 members of staff had not received a supervision. In addition, there was no evidence any staff had received an appraisal. This meant not all staff had received opportunities to formally reflect on their practice, performance and be supported with their professional development.
- Fourteen care assistants had not received medication training but supported people to have their topical medicines. As cited in the safe section of the report, there was evidence people were not always receiving their medicines safely. This risk was further increased due to staff not having the skills and training they needed to support people in receiving their medicines safely.
- There was no evidence staff had received dementia or end of life training. Staff supported people living with dementia and had recently supported people who had died. This meant staff may not have had the skills and knowledge needed to meet people's needs in these areas.
- Not all staff had completed training deemed mandatory by the provider. This meant the provider had not effectively ensured staff had the skills and knowledge they felt was needed to support people using the service.
- The provider had not met their legal responsibility to ensure all staff had received Autism and Learning Disabilities training. Twelve staff had not completed Autism training and there was no evidence any staff had completed learning disabilities training.

The provider had not ensured staff had the skills, training and support to meet people's needs effectively. This was a continued breach of regulation 18(2), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Referrals were not made to health professionals for changes to people's mobility needs. Equipment had been used to support people to mobilise without referrals to professionals such as occupational therapists. This included a newly renovated bath where the manager told us a person had become stuck. The manager

also felt the bath was not appropriate to meet the needs of all the people who lived at Grove House. This meant there was an increased risk of injury or harm to people where staff used equipment to move people which they had not been assessed for by a relevant health or qualified professional.

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

● People's care plans were not always consistent in relation to swallowing difficulties. One person's care plan contained information that conflicted with information kitchen staff had about their dietary needs. This increased choking-related risks to this person, who required their food to be of a softer texture. Further, it meant up-to-date advice from speech and language therapists had not always been fully incorporated into people's care plans.

● A person was having their fluid intake monitored but there was not always clear guidance on how much they needed to drink. There was also no evidence the person's fluid intake had been reviewed to ensure they had been drinking enough. This increased health-related risks to people who could experience poor hydration.

The provider had not done all that was reasonably practicable to mitigate risks to people. This was a breach of regulation 12(1)(2)(b), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Our observations of people's mealtime experiences were positive. People were offered choices and had appropriate support to eat where needed. There was plenty of food and drink available to people throughout the day.

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

● People's choices were not always considered. A person told us, "It could be weeks before I have a bath. I'm tired of asking." We checked the person's records and did not find evidence the person had received regular support with a bath or shower. This meant there was an increased risk people's needs and preferences concerning personal hygiene were not always consistently supported.

The provider had not always ensured people received support to meet their personal hygiene needs and preferences. This was a breach of regulation 9, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Since the last inspection nationally recognised tools were used more effectively and updated to reflect people's changing needs. For example, the Malnutrition Universal Screening Tool (MUST) was used to identify and take action where people were at increased risk of poor nutrition.

● People's needs were assessed appropriately before they came to live at Grove House. Following the previous inspection, the provider was required to seek permission from CQC before people can move into Grove House. Care plans had been created for people around these assessed needs.

● We saw evidence the provider had worked with GPs and District nurses in people's records. At the time of our inspection, the manager was awaiting medicines reviews from the GP for referrals they had made.

Ensuring consent to care and treatment in line with law and guidance

At our last inspection, there was a risk people's rights under the MCA may not be upheld. This was a breach of regulation 11, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 11.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

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

● The service was working within the principles of the MCA. We found people's capacity to make particular decisions had been appropriately assessed. Where people needed to be deprived of their liberty, the provider had submitted applications for authorisation to do so.

Adapting service, design, decoration to meet people's needs
● The home was well maintained and in a good state of repair.
● People had decorated their bedrooms with pictures, their own furniture and items of sentimental value.

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 inadequate. At this inspection the rating for this key question has remained 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.

At the last inspection, the provider had failed to implement and operate effective systems to ensure the quality and safety of the service. 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 and the provider was still in breach of regulation 17.

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

- Medicines audits had not identified people who may not have received their topical creams as prescribed. This meant systems were not always effective at ensuring people always received their prescribed medicines to manage health-related risks.
- The provider's systems had not identified people had not been supported to reposition when they needed to be or supported to have baths or showers regularly. In addition, they had not identified eating and drinking needs were not always accurately documented or monitored. This meant there was not effective management oversight of people's care needs which increased the risk of people not having their health, safety and preference needs met.
- The providers oversight of environmental risks was not always effective. Although there were systems in place to check 'window restraints' in the service, this had not been effective at identifying there were window restrictors missing from some windows. This increased safety risks to people.
- As cited in the safe section of the report, the provider had not followed their recruitment policies and procedures. This meant the provider's preemployment monitoring processes had not highlighted missing information before the staff member started working. This increased the risk of recruitment decisions not ensuring staff were appropriate for their roles.

Continuous learning and improving care; Working in partnership with others

- There were no established systems to recognise when people needed to be referred to external health professionals for their changing mobility needs. Staff had made decisions about mobility aids when they did not have the skills or qualifications to do so. This increased safety risks to people.
- Accident and incident policies were not fully embedded. Records were not always completed when accidents and incidents occurred. This meant opportunities to learn and improve people's care were not always taken.
- The provider had not operated their training and supervision policy effectively. Furthermore, the provider had not met legislative requirements for staff to receive learning disabilities and autism training. This meant

the provider had not followed their own policies to ensure staff were trained and supported to meet people's needs.

The provider had failed to implement and operate effective systems to ensure the quality and safety of the service. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We have found similar concerns and continued breaches during this inspection. The provider contacted CQC prior to the inspection due to being unable to renew their insurance policy. They told us their renewal or obtaining a new policy was dependent on the service receiving an improved overall rating. They asked that we carried out the inspection before their renewal was due. However, systems and processes were still not fully effective at improving the safety and quality of the service people received and lessons had not always been learnt from the previous inspection.
● The provider did not always meet regulatory requirements. Following our previous inspection, we imposed conditions on the provider's registration to make us aware of all incidents and accidents. We imposed this condition to support the provider to manage safety risks to people. Despite making the provider aware of their legal responsibilities numerous times before the inspection, they had not always complied with the conditions to make us aware of all incidents and accidents. This meant the provider did not always work well in partnership with CQC to promote people's safety. We will continue to monitor this.

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
● Improvements had been made to the management structure at the service. The service now had a manager. The previous registered manager had also returned to support the service's development in the care manager role. Although this resulted in people's care plans being updated and more consistent reviews, people's care plans were still not always accurate and up to date and did not always result in people's health needs and preferences being met.
● Staff told us they were confident in approaching managers with any concerns they had.
● Surveys were carried out to help inform the progression of the service. Where there had been concerns, we saw evidence the manager had started to address these. For example, some people had not known who the manager was, so the manager had spent time talking to people to explain they were the new manager.

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's policies and procedures supported an open and honest approach when things went wrong, and relatives told us they were kept informed of any concerns, changes and updates about people. For example, a relative told us staff had made them aware of an error where a person received a prescribed medicine at the wrong time. However, they were not informing CQC of all required information in line with conditions imposed.

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 had not always ensured people received support to meet their personal hygiene needs and preferences. This was a breach of regulation 9, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 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 enforcement action we took:

We issued a Notice of Proposal to vary the conditions of the provider's registration with CQC to no longer be authorised to carry on regulated activities at Grove House. This proposal has been adopted, and a Notice of Decision was issued. This means the provider can no longer provide accommodation for persons who require personal care at Grove House.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to implement and operate effective systems to ensure the quality and safety of the service. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We issued a Notice of Proposal to vary the conditions of the provider's registration with CQC to no longer be authorised to carry on regulated activities at Grove House. This proposal has been adopted, and a Notice of Decision was issued. This means the provider can no longer provide accommodation for persons who require personal care at Grove House.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured staff had the skills, training and support to meet people's needs effectively. This was a continued breach of regulation 18(2), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

We issued a Notice of Proposal to vary the conditions of the provider's registration with CQC to no longer be authorised to carry on regulated activities at Grove House. This proposal has been adopted, and a Notice of Decision was issued. This means the provider can no longer provide accommodation for persons who require personal care at Grove House.