Grove Park Healthcare Group Limited

Grove Park

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Insufficient evidence to rate
Are services safe?	Insufficient evidence to rate
Are services effective?	Insufficient evidence to rate
Are services caring?	Insufficient evidence to rate
Are services responsive to people's needs?	Insufficient evidence to rate
Are services well-led?	Insufficient evidence to rate

Summary of findings

Overall summary

Grove Park is a hospital that provides acute inpatients mental health services for adults of working age in two wards (nine beds on each) and one nursing unit which provides care for 31 older people with complex needs.

We inspected the acute inpatient mental health wards at Grove Park on 29 June 2022. This was an unannounced, focused inspection following information of concern we received about the safe running of the service. These concerns were about poor staffing levels and staff competence, the management of patient's risk and the way physical health monitoring of patients was being carried out The service had suspended admissions following concerns raised by the local NHS trust commissioning the acute inpatient mental health beds and therefore there were only four patients on the wards at the time of the inspection.

As this was a focussed inspection, we did not inspect any of the key questions in full so did not award ratings.

- The service did not consistently provide safe care. The service had in the week prior to inspection, following concerns being raised by a number of sources, reviewed all risk assessments for the current patients. These had improved but prior to this, risks were not being managed effectively.
- At the time of the inspection there were no emergency medicines on the wards. Managers told us that these had been ordered but we found that no one had followed up on these and they had not been received. This meant that the service would not be able to respond appropriately in the event of an emergency placing patients at significant risk. We raised our concerns with the service; managers confirmed that emergency medicines had been received 15 days after the inspection.
- There were not enough staff trained in immediate life support (ILS) to respond in a timely manner to emergency medical situations. This training had been booked but staff had not yet completed it. This meant there were not always staff on site with ILS training to respond to medical emergencies or who could administer the emergency medicines. Staff had not all received mandatory training to ensure they were competent and confident to carry out their roles and keep patients and staff safely.
- Staff did not develop detailed care plans in a timely manner for patients on admission. Managers did not ensure that staff received training, supervision and appraisal in line with their policy and best practice. Patients did not receive all physical health assessments in line with best practice on admission.
- Staff did not carry out venous thromboembolism (VTE) assessment in line with National Institute for Health and Care Excellence (NICE) guidelines.
- The service was not well led. The provider did not have a robust governance system to assess, monitor and make improvements to the service. Leaders did not have clear oversight of the safety and quality of the services.

However:

- Prescribed medicines for the four current patients were managed safely.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Acute wards for adults of working age and psychiatric intensive care units	Insufficient evidence to rate	

Summary of findings

Contents

Summary of this inspection

Background to Grove Park

Grove Park is owned by Grove Park Healthcare Group Limited. Grove Park is a hospital that has two acute mental health wards for adults of working age, and one nursing unit for older adults with complex needs. The unit had 31 beds. At this inspection we inspected the acute wards only. The acute wards have nine beds each. At the time of inspection there were only four patients on these wards.

Grove Park is registered to provide the following regulated activities:

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Accommodation for persons who require nursing or personal care

The service did have a registered manager at the time of inspection. who was on a period of leave. A registered manager, along with the registered provider, is legally responsible and accountable for compliance with the requirements of the Health and Social Care Act 2008 and associated regulations.

Grove Park was registered with the CQC in February 2022 and therefore had not previously been inspected. We did not rate this service at this inspection because we did not look at all of the key questions in full.

How we carried out this inspection

Before the inspection we reviewed information that we held about the service. During the inspection, the inspection team:

• spoke with a management consultant who had been recruited to drive improvements in the service, the managing director by phone, one ward manager, one assistant psychologist, two nurses, one health care assistant and the Mental Health Act administrator.

• spoke with two external professionals from a partner service;

• looked at four care and treatment records of people using the service, including their medicines records

• looked at a range of policies, procedures and other documents relating to the running of the service.

The team that inspected the service comprised of two CQC inspectors and a specialist advisor with a background in mental health nursing.

You can find information about how we carry out our inspections on our website:

https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Summary of this inspection

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The provider must ensure all staff working with patients have undertaken the required training to ensure they are competent to deliver safe and good quality care to patients. In addition, they must receive regular supervision and appropriate levels of support from managers. (Regulation 18)
- The provider must ensure there are appropriate emergency medicines available at all times and that staff are trained and competent to use them when needed. (Regulation 12)
- The provider must have effective governance processes in place to ensure it assesses, monitors and improves the safety and quality of the services as needed. Leaders must ensure they have clear and robust oversight of the service. (Regulation 17)

Action the service SHOULD take to improve:

- The provider should ensure all patients have a venous thromboembolism (VTE) assessment in line with National Institute for Health and Care Excellence (NICE) guidelines.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Insufficient evidence to rate	Insufficient evidence to rate	Not inspected	Not inspected	Insufficient evidence to rate	Insufficient evidence to rate
Overall	Insufficient evidence to rate	Insufficient evidence to rate	Insufficient evidence to rate	Insufficient evidence to rate	Insufficient evidence to rate	Insufficient evidence to rate

Acute wards for adults of working age and psychiatric intensive care units

Insufficient evidence to rate

Safe	Insufficient evidence to rate
Effective	Insufficient evidence to rate
Well-led	Insufficient evidence to rate

Are Acute wards for adults of working age and psychiatric intensive care units safe?

Insufficient evidence to rate

Safe staffing

The service did not have enough suitable skilled nursing and medical staff to keep people safe from avoidable harm.

There were a number of vacancies within the service. Managers told us they were actively recruiting to try and fill these vacancies.

The service had high levels of agency nurses and health care assistants. We reviewed data that showed some weeks there were up to 61% agency staff used. Some night shifts were covered entirely by agency nurses. This meant that there were not always nurses on shift that knew the patients and their risks well. At the time of inspection managers weren't clear whether agency staff had completed Prevention management of violence and aggression (PMVA) training but once this was raised they provided information that all agency staff had been PMVA trained. This meant that managers had not assured themselves there was always staff that were PMVA trained on shifts.

Staff shared key information to keep patients safe when handing over their care to others. We found that recently the provider had updated their handover forms to make them more detailed so staff coming onto a shift could have a clear overview of any changes to patient needs or any concerns.

Medical staff

The service had enough medical cover and a doctor available on call for out of hours. This was being reviewed as the current arrangement consisted of a number of junior doctors and a consultant psychiatrist and this had not always worked effectively with regards to communication and knowledge of the patients.

Mandatory training

Staff had not all completed their mandatory training. Leaders reported that approximately 50% of mandatory training had been completed. This meant there was a potential risk to patients and staff safety because staff were not adequately trained to fulfil their role.

The provider had booked a schedule of training for staff so they could complete their mandatory training in the near future.

Assessment and management of patient risk

Staff did not consistently manage risks to patients and themselves well.

Acute wards for adults of working age and psychiatric intensive care units

Insufficient evidence to rate

We reviewed risk assessments for all four patients on the wards. These were not consistently detailed which posed a risk to patients whose risks were not being adequately identified or managed. We found that all the current patients had recently had an updated risk assessment which was more detailed and thorough, this had been completed following concerns being raised prior to inspection about the lack of risk assessments and risk management within the service.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store prescribed medicines. However, the service did not have emergency medicines on site.

We reviewed medicines records and staff completed records accurately using an electronic system. We did not see any medicines that had been missed for the patients currently on the wards.

Staff stored and managed all medicines and prescribing documents safely. Medicines were stored at appropriate temperatures to ensure they were safe to use.

The wards did not have any emergency medicines. Managers told us that these had been ordered but we found that no one had followed up on these and they had not been received. This meant that the service would not be able to respond appropriately in the event of an emergency placing patients at significant risk. We raised our concerns with the service; managers confirmed that emergency medicines had been received 15 days after the inspection.

Reporting incidents and learning from when things go wrong

Managers did not consistently investigate incidents or share lessons learned with the whole team and the wider service.

We reviewed the providers incidents. These were not stored in a consistent orderly way and lacked detail. This inconsistency meant there was a risk of incidents being missed and not being monitored effectively.

We did not see evidence that incidents were being reviewed for themes and trends by management and senior leaders.

Staff gave mixed feedback about incidents and whether they received debriefs or whether lessons learned from incidents had been shared with the team.

Are Acute wards for adults of working age and psychiatric intensive care units effective?

Insufficient evidence to rate

Assessment of needs and planning of care

Staff did not consistently assess the physical and mental health of all patients.

Staff completed a mental health assessment of each patient. We saw that there had been delays in completing care plans after admission. The provider had recently reviewed and updated all current patients care plans following concerns being raised.

Acute wards for adults of working age and psychiatric intensive care units

Insufficient evidence to rate

Staff were not carrying out assessments for venous thromboembolism (VTE) in line with National Institute for Health and Care Excellence (NICE) guidelines. This meant that patients had an increased risk of developing a VTE that would go undetected. However, patients had other physical health assessed after admission and regularly reviewed during their time on the ward using recognised tools.

Skilled staff to deliver care

Managers did not ensure they had staff with the range of skills needed to provide high quality care. Staff had not been receiving supervision or team meetings.

Managers did not ensure staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff.

Managers did not ensure staff were supported through regular supervision of their work. This meant that staff performance and training needs were not being monitored.

Managers did not ensure staff attended regular team meetings. Staff told us the service had not been arranging team meetings to share key information and learning about updates to clinical practice and learning from incidents to help ensure they did not reoccur.

Are Acute wards for adults of working age and psychiatric intensive care units well-led?

Insufficient evidence to rate

Governance

Our findings from the other key questions demonstrated that governance processes did not operate effectively at team level and that performance and risk were not managed well.

Senior leaders acknowledged that they needed to introduce an effective governance system to the service, and that the provider had not ensured this governance system was in place before the service had opened.

Leaders did not operate robust systems to assess. Monitor and improve the safety and quality of the services. Governance meetings had not been in place at the service. These should be in place to ensure managers and senior managers have clear oversight of the service such as audits and quality assurance processes. We were told, on inspection, that meetings were being implemented and would be in place moving forward. Morning huddles were also going to begin following inspection so staff from all disciplines could have a daily discussion of any developments or incidents that had happened since the previous day.

We identified that audits had not been regularly carried out to identify areas for improvement in the service. One recent care plan audit and one recent medicines audit had been carried out but there had not been effective oversight of the service to monitor it effectively and drive improvement.

Acute wards for adults of working age and psychiatric intensive care units

Insufficient evidence to rate

Following on from the concerns that were raised by a number of sources the recent concerns being raised the management consultant and senior leaders had created an improvement plan to address the concerns and improve the service moving forward. Some improvements had been made already such as the risk assessments and care plans being updated and staff training had begun and had been scheduled to complete.

Leadership

Leaders did not always have the skills, knowledge and experience to perform their roles. They did not have a good understanding of the services they managed.

During the inspection there were no senior staff on site with appropriate knowledge of the service. This meant key information that should have been easily accessible on a day to day basis could not be easily located. The registered manager was on a period of leave; the ward manager for the acute wards was on annual leave; and the management consultant was only in his second week at the service. This meant there was a lack of effective leadership in place with no one being accountable for the day to day safety and quality of the service and no one with clear oversight of the risks, issues and performance.

Culture

Staff did not consistently feel respected or supported. They could not always raise any concerns without fear.

Staff had mixed feelings and experiences of the service. Some felt able to raise concerns with leaders while others felt they could not. Staff did not have regular supervision or team meetings to enable or encourage them to feel safe to speak of any concerns they had. This also meant that there was not a regular space for staff and managers to share information on risk or for learning to be shared.

Management of risk, issues and performance

Teams did not have access to the information they needed to provide safe and effective care.

The service did not have a risk register. A risk register is used by managers and senior leaders to collate the key risks in a service for example, staffing. This meant that leaders had not clearly identified the key risks for the service, such as the difficulties with staffing and did not have structured plans in place to effectively manage these risks. Following the inspection the management consultant told us that they were creating a risk register to have effective oversight of risks and to be able to put risk management plans in place to mitigate risks as much as possible.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury Assessment or medical treatment for persons detained under the Mental Health Act 1983 Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider did not ensure all staff working with patients had undertaken the required training to ensure they are competent to deliver safe and good quality care to patients. Staff did not receive regular supervision and appropriate levels of support from managers.

Regulated activity	Regulation
Treatment of disease, disorder or injury Assessment or medical treatment for persons detained under the Mental Health Act 1983 Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have effective governance processes in place to ensure it assesses, monitors and improves the safety and quality of the services as needed. Leaders did not ensure they had clear and robust oversight of the service.

Regulated activity	Regulation
Treatment of disease, disorder or injury Assessment or medical treatment for persons detained under the Mental Health Act 1983 Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not ensure there were appropriate emergency medicines available at all times and that staff were trained and competent to use them when needed.