Alpha Care Management Services No. 3 Limited

Grenville Court Care Home

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
Grenville Court Care Home is a large residential care home providing personal care to up to 64 older people many of whom are living with dementia. At the time of the inspection there were 59 people living in the home.

The care home is set over two floors each with its own lounges and dining area. People have their own rooms with en-suite facilities. The home is serviced with a large kitchen and a laundry.

People's experience of using this service and what we found
Staff were not trained in administering medicines and their competency had not been checked to ensure they could administer medicines safely. Where people received medicines as and when required, protocols and care plans were not in place.
The home was using a large number of agency staff who did not have access to accurate information on people's needs, to know how to support them. Staff had not received appropriate induction and training to provide them with the knowledge and skills to meet people's needs.
Night shifts were predominantly covered by agency staff who did not know people in the home. They were not trained to manage emergency situations, including where an evacuation may be required or emergency first aid may need to be administered.

People living at the home had specific dietary requirements which were not always met. When records were used to monitor the food and fluid people had eaten and drunk, they were not accurate or completed fully.

Where people had pressure ulcers, or were at risk of them, appropriate support was not provided. Staff did not know how best to support people and information was not shared from shift to shift to ensure people received consistent safe care.

The provider lacked effective oversight of the action the home had taken in response to serious concerns raised by the Care Quality Commission. Assurances given by some of the management team were not fulfilled.

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 11 September 2020) and there were multiple breaches of regulation. The provider was also issued a letter of intent to take urgent action due to the concerns found. The provider completed an action plan to show what they would do and by when to improve following the letter of intent which we have followed up at this inspection. At this inspection we found not enough improvement has been made and the provider remains in breach of the regulations reviewed. We have ongoing concerns in relation to the competence of staff, management of risk and of medicines. We also have ongoing concerns around the governance of the service

including the lack of effective oversight.

Why we inspected
We undertook this targeted inspection to check whether the provider was implementing the actions required to keep people safe. During a recent focused inspection to check on concerns, we had written a letter of intent to make the provider aware, we needed urgent assurances practice would improve. The provider had given us an action plan, assuring us certain action would be taken. We had received further concerns and needed to assure ourselves the action had been taken as agreed. The overall rating for the service has not changed following this targeted inspection and remains inadequate.

CQC have introduced targeted inspections to follow up on Warning Notices or to check specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

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
A Notice of Decision was served following this inspection as we found the action agreed as required during the focused inspection had not been completed. The Notice of Decision required the provider to produce weekly reports to the Care Quality Commission. These reports were to show us that, suitable staff were on the rota and that those staff had the skills, knowledge and information they needed to support people effectively and keep them safe.

We will continue to monitor information we receive about the service until we 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?

Inspected but not rated

At our last focused inspection we rated this key question inadequate. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question, we had specific concerns about

Is the service well-led?

Inspected but not rated

At our last focused inspection we rated this key question inadequate. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question, we had specific concerns about

Grenville Court Care Home

Detailed findings

Background to this inspection

The inspection
This was a targeted inspection, to check whether the provider had implemented the required actions from the action plan they sent us following a letter of intent to take urgent action. We had concerns around staff, their training and suitability to the role, we were also concerned about them having enough suitable and accurate information to know and meet people's needs.

Inspection team
The inspection was completed by three inspectors, two who attended the home to observe and talk to staff and another who led the inspection remotely, collating evidence and analysing the information to inform this report.

Service and service type
Grenville Court Care Home 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 this inspection the service had an emergency management team in place, including the provider's area manager, and two other managers, one peripatetic and one from a service rated good with the Care Quality Commission. At the time of this targeted inspection the provider was legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We had been in continual communication with the home's interim management team since the last focused inspection. We were working with professional stakeholder groups who had begun to visit the home to support improvement and we were working with the Local Authority safeguarding team to review concerns.

We had not requested a provider information return from the provider. 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 reviewed the information we held and had received from the provider and used this to plan this inspection.

During the inspection
Two inspectors attended the home and the remote inspector spoke with and had ongoing communication with the area manager at the home during the site visit. Inspectors on site, spoke with two permanent staff and three agency workers, the area manager and peripatetic manager. We also spoke with three service users but not in detail. We looked at the records available to support people with extra care needs including repositioning charts for people with pressure ulcers and food and fluid charts for people at risk of dehydration, malnutrition and/or at risk of choking. We also looked at all records which supported staff to work the night shift and the available information on the people they were supporting.

After the inspection
We spoke with the nominated individual and sought clarification on the information seen and we continued to speak with professionals who were supporting the service.

Inspected but not rated

Is the service safe?

Our findings

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 inadequate. We have not changed the rating of this key question, as we have only looked at the part of the key question, we had specific concerns about.

The purpose of this inspection was to check if the provider had implemented the actions, they told us were required to ensure people were safe. We had concerns that staff were not competent, had not received suitable training and induction and did not have the information they needed to ensure people's needs were met.

We will assess all of the key question at the next comprehensive inspection of the service.

Systems and processes to safeguard people from the risk of abuse
- The provider had been made aware that people's needs had been neglected because key accurate information, staff needed to meet people's needs was not available.
- Where people were at risk of choking details available to staff were inconsistent, inaccurate or not available. Where people had been assessed as requiring specific food textures or thickness of drinks they were not always provided. One person who required a mince and moist diet had been given chips and crisps.
- Where people had pressure ulcers these had degraded to a level which required reporting to the safeguarding team. Information to inform staff when people had pressure ulcers was poor. Information to tell staff how to support people was inaccurate, incomplete or missing.
- The provider had not made safeguarding referrals to the Local Authority as and when they were required. We had been assured staff would all receive safeguarding training and it would be a topic included in both team meetings and supervision this had not happened.

The provider did not have procedures in place to ensure people were protected from abuse and neglect. Referrals to the safeguarding team were not made to allow the safeguarding team to support the provider in addressing concerns, to safeguard people and keep them safe. This is a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act (regulated activities) regulations 2014

Assessing risk, safety monitoring and management
- When people's needs changed risk assessments were not updated to reflect the change in need and support to be provided.
- Where people had lost significant amounts of weight and required their food and fluid to be monitored. A recognised assessment tool to reduce risks of malnutrition was not appropriately applied. Records kept were not checked to mitigate any risks identified, as we had been assured.
- Records around people's end of life choices were wither not recorded or available to staff on duty. This included key information around whether people wanted to be resuscitated or not.

● Steps had not been taken to ensure each shift worked at the home included a responsible person to take the lead in the event of an emergency. Each shift lacked an assigned and trained first aider and fire marshal. During the inspection, we were told by the area manager, one staff member was the fire marshal. We spoke with them, they did not know the fire procedures and did not know where or what PEEPs were (personal emergency evacuation plans). Without this key knowledge and information a safe evacuation could not take place.

The provider did not have systems in place to identify, manage and mitigate risks to people living in the home. This included risks in receiving the support they needed and risks associated with the environment. This is a breach of regulation 12 Safe care and treatment of the Health and Social Care Act (regulated activities) regulations 2014

Staffing and recruitment

● The home was supported by a large amount of agency staff at the time of the inspection. We inspected in the evening and five of the six staff were agency. We had shared concerns around the competence of agency staff to deliver services and support people they did not know. We had also shared concerns around who was in charge when shifts were predominantly covered by agency staff.

● On the night of inspection we were told by the area manager that one staff member was the senior in charge but they were not on shift. We were told by the day senior that another staff member was acting senior for the night, but they were not aware of this. Another staff member told us they were the senior for the night, but it was their first shift, they had not received an induction, had not read any care plans and had not worked a shadow shift with other staff members. They did not know any of the people living in the home.

● We spoke with the permanent member of staff on shift and four of the agency carers, none had received an induction from the provider. We saw one person who thought they were about to fall requesting help from staff. Staff did not know their name and we heard staff call them by two different names. We heard staff ask each other where people's rooms were and they did not know.

The provider had not assured themselves the staff on duty were competent in their role. They had not assured themselves staff had the information and training required to meet people's needs and keep them safe. This is a breach of regulation 12 of the Health and Social Care Act (regulated Activities) regulations 2014

Using medicines safely

● We had continued to receive concerns around the safety and suitability of medicines administration. We were not assured medicines were administered as required and were administered by staff that were competent to do so.

● On the night of the inspection we were told by the senior on duty that they were only to administer the next morning's medication. We were aware of people who required medicines at bedtime and one person who required medicine at a particular time to manage Parkinsons disease. We asked if they had received a competency test to ensure they were competent in administering the medicines and were told no.

● When we looked at the medicine administration records (MARs) for people we found that teatime and evening/nighttime medicines had all been given together by the day senior before they left. People had not received their medicines as prescribed.

● We looked at the MARS and saw some people had received paracetamol medicine too close together and earlier than the required four hours between doses. MARs had gaps in them without any record as to why and some had handwritten changes to prescriptions which has not been double signed or included an explanation as to why the prescription had changed and who had authorised it.

● We looked at four medicine care plans and found they were not consistent with the medicines people

were being administered. Where people were to receive medicines as they required them there was not a protocol to assist staff in when this was. This was particularly important when people lived with dementia as they could not always vocalise their needs or whether they were in pain or discomfort.

Medicines were not safely administered, recorded or managed. This is a breach of regulation 12 (Safe Care and treatment) of the Health and Social Care Act (regulated activities) regulations 2014.

Inspected but not rated

Is the service well-led?

Our findings

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 Inadequate. We have not changed the rating of this key question, as we have only looked at the part of the key question, we have specific concerns about.

The purpose of this inspection was to check if the provider had implemented the actions, they had assured us they would following a letter of intent to take urgent enforcement action. We had concerns staff did not have access to accurate information to keep people safe and provide them with the support they needed. We were also concerned staff had not received appropriate training, induction and supervision to the role they were undertaking.

We will assess all of the key question at the next comprehensive inspection of the service.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Working in partnership with others
● The provider had been informed about our concerns following the last focused inspection in August 2020. We were provided with action plans detailing how the provider had and would make the requirements necessary to keep people safe. This inspection showed those action plans had not been implemented.
● The provider again took immediate action to remove some of the management team on site and placed an operations director in place to continue to move the action plans forward. However, we continued to be concerned about oversight at the home and the provider's systems to ensure actions were both being implemented but also that they were effective at addressing concerns.
● We had been told by the area manager that extra care monitoring records were available for all those that needed them, this included food and fluid charts and repositioning charts. We had been told these were reviewed daily and action was taken to address any concerns. When we inspected this was not the case and records showed people were not in receipt of enough fluid or nutrition. The records for those that required repositioning to protect their skin integrity or reduce risks to already developed pressure ulcers had not been repositioned as required. This showed us either records were not appropriately kept when support was provided or people were not in receipt of the support they needed. This also showed us records were not reviewed or checked and action was not taken to address concerns.
● We were told accurate information had been given to staff to provide them with the knowledge they needed to meet people's support needs. We were told action had been taken to ensure staff had the skills to provide that support. When we inspected, we found this was not the case. Information on people's dietary needs was missing or contradictory, handover records did not give staff information on people's end of life choices and information was not available to assure us staff had been appropriately trained and had their competency tested to safely administer medicines.

The provider had not assured themselves that action plans were implemented to meet identified concerns. The provider had not assured themselves records were accurate and ineffective oversight remained at the

home at the time of the inspection. The was not an effective system of quality audit or assurance. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act (regulated activities) regulations 2014.