The Grovecare (UK) Limited

The Grove Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
The Grove Residential Care Home is a residential care home providing personal care to 13 people aged 65 and over at the time of the inspection. The service can support up to 19 people in one adapted building across three floors.

People's experience of using this service and what we found
The provider lacked systems to safeguard people from abuse. Staff had not always been provided with training to support them in their roles.

The risks to people's personal and environmental safety were not always assessed and measures to mitigate risks were not always in place. People's medicines were not managed safely, and staff did not always follow safe practices when administering medicines.

Staff were not always following government guidance in relation to COVID-19. Staff recruitment processes were not robust.

Opportunities to learn from events had been missed and people's health needs had not always been followed up.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

People did not always receive high-quality person-centred care, the lack of oversight and effective quality monitoring systems impacted on the quality and safety of the care people received.

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 19 November 2018)

Why we inspected
The inspection was prompted in part due to concerns raised about lack of staff, neglect of service users, fire safety issues and allegations of staff being bullied. As a result, we undertook a focused inspection to review the key questions of safe, effective and well-led only.

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.

We have found evidence that the provider needs to make improvements. Please see the safe, effective and well led sections of this full report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.
If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will 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 the registration.
You can see what action we have asked the provider to take at the end of this full report.

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

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 safe care and treatment, protecting people from abuse, supporting their nutritional needs, following the mental capacity act and quality monitoring processes.

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

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? The service was always safe. Details are in our effective findings below.	**Inadequate**
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**

The Grove Residential Care Home

Detailed findings

Background to this inspection

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

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 service was inspected by three inspectors.

Service and service type
The Grove Residential 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 had a manager registered with the Care Quality Commission. This 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.

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 and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We used all of this information to plan our inspection.

During the inspection
We spoke with three people who used the service about their experience of the care provided. We spoke with nine members of staff including the providers, deputy manager, administrator, three care staff, a cook and a housekeeper.

We reviewed a range of records. This included six people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to interrogate records and seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We spoke by telephone with four relatives about their experience of the service.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse;
● The systems and processes in place to safeguard people from abuse were not robust. Although staff told us they knew who to report concerns to, we found that staff had not reported incidents of suspected abuse. The training matrix we were supplied with showed ten of the 12 staff currently showing as employed, had no record of safeguarding adults training.
● This lack of training of what constituted a safeguarding issue had led to safeguarding issues not being properly managed. For example, there were concerns around a person's behaviours towards other people at the service and these issues were not raised by staff as safeguarding concerns. There was also a safeguarding alert received by the provider regarding the person. There was no record of how this concern was dealt with.

This lack of recognition and management of safeguarding issues put people at risk of abuse was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management
● The risks to people's safety were not assessed and measures to reduce risks were not in place. Two people in the service had no assessment of any risks and others had an inadequate assessment of their risks. For example, risks relating to falls and bedrails had not been identified and care had not been planned to keep people safe. This increased the possibility of people being injured.
● Environmental risks had not been properly assessed and mitigated. People had access to two staircases. The staircase from the first to the second floor had a stairlift which further restricted access when using these stairs and posed a risk of injury should a person fall on this stairwell. Prior to our inspection one person living with dementia had been living on the upper floor and their risks had not been assessed in relation to this. After the first day of our inspection the provider put 15-minute observations in place for people and told us they would not admit anyone onto the upper floor until the area had been refurbished and environmental and personal risks had been assessed.
● Some areas of the environment were unsafe and posed a risk to people's health and safety. A cupboard housing a water tank with exposed hot pipes had been left unlocked, putting people at risk of burns. The staff flat on the second floor was also unlocked, as there were no measures in place to restrict people's access to these areas, people were at risk of entering these areas unnoticed by staff, putting them at risk of injury.
● People were exposed to the risk of legionnaires disease as there were no records to show infrequently used water outlets were being flushed regularly. This risk was exacerbated as there were several outlets on the top floor which were not in use at the time of our inspection, this increased the risk of bacteria developing in standing water. This exposed people using the service to the risk of ill health.

● People were not protected against risk should there be a fire at the service. The fire alarm system was not tested weekly due to a fault on the system. The provider told us staff were undertaking weekly fire drills. However, these drills had not been documented. The fire evacuation chairs for the first and second floor were not accessible for staff. The two chairs were locked in a bedroom on the second floor. We tested the evacuation chair situated on the second floor, due to the stair lift on this set of stairs, the chair was too wide to be used to safely support service users in an evacuation.

Using medicines safely

● People's medicines were not managed safely. During our inspection we found errors in the recording and administration of medicines. For example, one person was prescribed a medicine via a skin patch. There was no record of skin patches being administered on some of the dates they were prescribed. Errors had not been identified through the medicines audits and so no action had been taken to improve the safety of medicines administration.

● Best practice guidance to reduce the risk of administration of medicines was not followed. Identification pages with photographs were not always available in people's medicine administration records (MAR) to support staff to administer medicines to the right people. One person with no identification sheet, preferred to be called by a name different to their forename. Both names were used in different places in their MAR. This lack of clear recording put the person at risk of not receiving their prescribed medicines. This risk was exacerbated by the deployment of new and agency staff.

● Staff were not following safe practices when administering medicines. Some medicines required two staff to oversee the administration to ensure they were used correctly. Staff did not follow this process therefore there was no oversight to reduce the risk of medicine errors and to ensure medicines were not misused.

● The storage of medicines was poor and increased the risk of misuse. Boxes of skin patches did not reconcile with the numbers dispensed. For example, one box had been dispensed with two skin patches in, but we found five patches in the box. Several bottles of medicine had not been dated when opened and the prescription label on one bottle was incomplete so may make it unsafe to administer.

Preventing and controlling infection

● We were not fully assured that the provider was promoting safety through the layout and hygiene practices of the premises. There were no records of high touch areas being cleaned throughout the day and cleaning schedules had gaps in the records. However, the home appeared clean.

● We were not assured that the provider was preventing visitors from catching and spreading infections.

● We were not assured that the provider was meeting shielding and social distancing rules.

● We were not assured that the provider was admitting people safely to the service.

● We were not assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were not 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.

● Infection control practices were not robustly followed.

We were not asked for evidence of negative COVID-19 tests or of our vaccination status when we attended the service on 17 November 2021. One member of staff was not wearing a mask when we arrived at the service on 17 November 2021. This was not in line with government guidance and as a result put people at risk of infection.

Learning lessons when things go wrong

● Opportunities to learn from accidents and incidents had been missed.
● One person's records showed they had a lump on their head. There was no information on how the injury had occurred or how the person had been supported following the injury. Records also showed the person had fallen three times in a month. Their mobility care plan written in November 2021 stated there had been an analysis undertaken regarding the person's falls. However, there was no further information on the measures taken to reduce the risk of falls for the person. This failure to learn from incidents and accidents placed people at risk of injury.

People were not always protected from risks that impacted on their safety, this was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● The recruitment practices were not robust.
● Three staff files were reviewed during our inspection and issues were found with all three. There was a lack of interview notes, application form or references in place.

This lack of complete recruitment processes put people at risk of being cared for by staff unsuitable for their roles and was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Prior to our inspection we received information the service was short staffed. On the days of our visits staff told us staffing had been difficult as several staff had left and there had been times when agency staff had not arrived for shifts. One member of staff told us staff were pulling together to ensure shifts were covered. On the first day of our inspection there were only three members of staff on duty, a cook, a care worker and the deputy manager. We were told the housekeeper had rung in sick. The deputy manager told us there should be two care staff on duty herself, a housekeeper and a cook on duty. The deputy manager told us they were continuing to recruit staff and work to ensure safe staffing levels. We saw evidence staffing levels planned were in line with the provider's established staffing levels

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 the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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

- People's needs had not been consistently assessed and recorded. We saw that people had not been assessed to see if they needed any support to help them prevent developing pressure sores. People had also not been assessed to ensure they were not at risk of malnutrition. Additionally, where risk assessments had been completed, they had not been regularly reviewed to ensure the care provided continued to meet people's needs. This lack of use of recognised assessment tools meant people's needs may have changed but their care would not reflect these changes.

Staff support: induction, training, skills and experience

- Staff had not always received training to support them in their roles. The training matrix showed several gaps in areas such as safeguarding adults, health and safety, supporting people living with dementia, food safety and mental capacity training.
- One member of staff who worked nights as a single waking night staff was showing as not undertaken any of the above training. Their record also showed they were only in the process of completing their moving and handling, fire safety, Infection prevention and medicines training. This lack of training support put people at risk of being supported by staff who did not have the necessary skills for their role.

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

- People's health needs were not always followed up to ensure effective treatment of chronic conditions. One person's record showed a letter from their GP requesting they make an appointment for a check on their condition. There was no evidence that this had been done.
- Referrals were not always made to healthcare professionals when needed. One person had been treated by district nurses for a chronic condition, as their condition had improved the district nurses had discharged the person. However, care records identified some deterioration in the person's condition and staff had treated the person themselves. There was no information to show they had contacted the district nurses to ask advice on their actions. We raised these concerns with the deputy manager who told us they would ensure the person received the support of a healthcare professional.

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

- People's nutritional needs were not always managed safely. We saw one person whose care record showed they required thickener in their drinks, being given a drink without thickener. The person coughed when being supported to drink. We raised this with the deputy manager who told us the instructions around

the use of thickeners for the person was "as needed." Staff were not supported with information on when the thickener would be needed. We asked the deputy manager to clarify the instructions with the prescriber to ensure the person was supported safely.
● Staff supporting people at the mealtime we observed did not support them in a person-centred way. One staff member supporting a person did not engage with them while they were eating. The member of staff offered food before the person was ready and they gave the person a spoonful of food before telling them what it was.
● People's weights were not consistently recorded. One person's weight chart had weights recorded and then crossed out. This meant staff were not monitoring the person's weight to ensure their weight was stable.

The lack of assessment and management of people's health needs were a further breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Adapting service, design, decoration to meet people's needs
● We found some elements of the environment unsafe. We have reported on this in our safe section of the report.
● The service was homely and had a designated area for relatives to visit safely.

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.

● Systems were not in place to identify people's needs in relation to the MCA or to protect their human rights. For example, one person who lacked mental capacity did not have an up to date deprivation of liberty safeguarding (DoLS) authorisation in place. Their DoLS had expired in January 2020. There had been no application to renew the person's DoLS, despite the service user continued lack of capacity and the need for decisions being made in their best interests. Other people's care plans showed a lack of assessment of their mental capacity despite information showing assessments should have been undertaken.

The lack of effective systems in place meant people were not supported in line with the MCA was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

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

- There was a lack of oversight of the quality and safety of the service provided for people. At the time of the inspection, the registered manager had been absent from the service for a period of two months. The provider's oversight of the management of the service prior to his absence had been ineffective. They had not identified that the systems in the home were failing to identify areas of poor care. This had led to shortfalls in the level of care people had experienced.
- There was a lack of effective systems in place to assess, monitor and mitigate risks to people. This had resulted in the shortfalls highlighted in the other sections of this report related to falls, management of people's weights, safe administering of medicine, staff training and people's care plans. This had impacted on both the safety and quality of care people received and had resulted in a lack of learning from incidents and events.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The provider's ineffective systems had not ensured that people received high-quality person-centred care. Throughout our visits we saw people were unkempt. Two gentleman had beard growths they would not normally have. One person told us this, and the admission picture on the other person's care plan showed a well-dressed and clean-shaven person, there was no information in their care plan to show they had refused personal care.
- Systems did not ensure people received personal care when they required it. Care records showed staff assisted one person with their personal care, but daily bath and shower records recorded on several occasions showed the person was in bed. There was no indication of what support was provided by staff on those days in their daily notes or care plan.
- The provider had failed to provide effective training and oversight to ensure staff were working to a high standard of care. During our inspection we saw some behaviours by staff that lacked empathy and did not support people's dignity. One member of staff told a person they were supporting, they had their slippers on the wrong feet. However, they did not rectify this. We also heard two members of staff talking about how a person was wearing someone else's trousers which were far too big for them, again no attempt was made to rectify this.

The lack of oversight of the quality monitoring systems impacted on quality of care people received and

was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

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

● Although we had received statutory notifications from the service as they were required by law to report to us. The registered manager had not submitted a small number of historical notifications. This had been highlighted to the provider and the deputy manager addressed this. We were assured processes were in place to manage this moving forward.

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

● People and their relatives were not always consulted or involved with the running of the service. Relatives told us they had not been told the registered manager was off. There was a lack of knowledge among relatives about who was running the service. One relative said, "(I) don't know who's in charge now, but I'd speak to the carers if there was a problem and they would put me on to someone who could help."

● Staff told us there had been a lack of engagement with them by the registered manager. However, since the registered manager's absence, the provider had identified the service had not been safely managed and had taken steps to resolve the situation. They had employed a new deputy manager who previously worked at the home, to provide day to day support to staff. In addition, they identified that they needed to increase their oversight and provide support. They have an action plan in place to address this.

Working in partnership with others;

● Staff at the service had not always worked in partnership with health professionals. As reported in our effective section of the report, staff did not always follow instructions from visiting health professionals. One health professional told us the staff at the service used to be very responsive, but in recent months they felt their guidance was not always actioned.

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 11 HSCA RA Regulations 2014 Need for consent People were not supported in line with the Mental Capacity Act.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Lack of adequate systems and practices to protect people from the risk of abuse.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The risks to people's safety were not assessed and actions to mitigate risk were not in place.

The enforcement action we took:

We issued the provider with a warning notice. Improvements in the care provided for people must be achieved by 28 January 2022.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The quality monitoring systems and processes in place at the service were not robust, and the lack of oversight by the provider impacted on the quality of care people received.

The enforcement action we took:

We issued the provider with a warning notice. Improvements in the care provided for people must be achieved by 28 January 2022.