Avon Care Limited

Grosvenor Hall

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Grosvenor Hall is a residential care home providing personal care to people with dementia. The service can support up to 23 people in one adapted building. At the time of this inspection, 12 people lived at the service

People's experience of using this service and what we found
Risks which affected people's health, safety and wellbeing were not always documented. This meant that staff did not always have adequate information to manage and mitigate risks to people. Accidents and incidents had not been thoroughly recorded and action had not been taken to reduce risks. People had not been provided with sufficient fluids and their weights were not monitored to highlight any concerns.

Safeguarding concerns had not been reported by staff and management. Staff were not clear of their roles and responsibilities in relation to safeguarding.

The service did not have sufficient infection prevention and control measures in place. Government guidance in relation to COVID 19 had not been followed.

Medicines had not been managed safely. Staff had not received appropriate training and competency assessments. Guidance from other professionals had not been followed.

Agency staff were not familiar with people and their needs. Agency profiles were not in place and they had not been provided with an induction into the service.

For people who had care plans and risk assessments in place, these only contained basic information. They had not been updated when changes in people's needs occurred. Some people did not have any care plans and risk assessment in place.

There was a lack of quality assurance processes in place to monitor the quality and safety of the service. There was a clear lack of provider oversight and they had not ensured effective and competent management was in place. Records that contained personal information had not been stored appropriately.

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

Rating at last inspection
The last rating for this service was requires improvement (report published 19 October 2019.)

Why we inspected
We received concerns in relation to management of the service and the quality of care and support that was

being provided. There had been a number of safeguarding concerns raised by other professionals. As a result, we carried out a focused inspection to review the key questions of safe 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.

The overall rating for the service has changed from requires improvement to 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 Grosvenor Hall on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to the safety of people and the risk of harm. We also identified breaches in relation to the management and monitoring of the service, person-centred care and nutrition at this inspection.

Because of the serious concerns relating to people's welfare and safety we have taken enforcement action to prevent the provider from operating a regulated service at this location.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Grosvenor Hall

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.

Inspection team
The inspection was carried out by one inspector.

Service and service type
Grosvenor Hall 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.

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 as well as recent safeguarding concerns that had been raised. We sought feedback from the local authority and other professionals who worked with the service. We used all of this information to plan our inspection. 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.

During the inspection
We spoke with two people who used the service, the care manager who was providing management cover, a team leader, two care staff and two agency staff workers. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could

not talk with us.

We reviewed a range of records. This included nine people's care records in part and five medication records. We looked at four staff files in relation to supervision and training. We also looked at records relating to the management of the service, including staff rotas.

After the inspection
We continued to speak to the local authority and other professionals who were regularly visiting the service. As a result of what we found on the inspection visit, we raised further safeguarding concerns with the local authority for investigation. We continued to communicate with the provider to ensure the safety of people.

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 requires improvement. 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

- People were not protected from the risk of harm.
- Systems and processes were not followed to ensure any safeguarding concerns were appropriately recorded and responded to. For example, staff had not reported concerns to the local authority as required, which meant concerns had not been investigated.
- Staff did not have a full awareness of their roles and responsibilities in relation to safeguarding people. Training in this area had not been provided.

Failure to establish and operate systems and processes effectively to prevent abuse of service users and failure to investigate and report any allegations 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

- Risks to people had not been appropriately managed. Risk assessments were not in place where required and action had not been taken to reduce risks.
- Where risk assessments were in place these had not been routinely reviewed or updated when accidents had occurred to further reduce risks. For example, one person suffered three falls in a short period of time, but a falls risk assessment had not been completed.
- Due to the high use of agency workers, staff were not always aware of the risks to people and how these should be managed. Records did not provide clear, accurate, up to date information which put people at increased risked.

The provider failed to assess the risks to the health and safety of people and do all that is reasonably practicable to mitigate any risks. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People had not been provided with sufficient fluids. Appropriate risk assessments and monitoring documents had not been completed to monitor people's food and fluid intake.
- Where people required specialist diets, appropriate risk assessments were not in place. Care plans contained conflicting information in regard to the consistency of food people required.

The provider failed to ensure people's nutritional and hydration needs were being met, monitored and recorded. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Infection control

● People were not protected from the risk of infection. Best practice in relation to infection control was not followed. Clear cleaning schedules were not in place.

● The provider had failed to implement and follow COVID 19 guidance to reduce the risk of infection. For example, social distancing was not being followed and PPE was not being used appropriately

● Infection control audits were not in place. Inappropriate items had been stored in a toilet and appropriate waste disposal bins were not always in place, which increased the risk of contamination.

The provider failed to ensure risks were assessed and guidance implemented in relation to the prevention and controlling the spread of infections. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

At our last inspection we recommended the provider consider current guidance on the storing and recording of medicines and to update their practices accordingly. The provider had not made improvements.

● Medicines had not been administered safely.

● Staff with the required medication training were not always on duty. This had resulted in staff, who had not received appropriate training or had their competencies assessed, were administering medication.

● Instructions provided by other professionals with regard to medicines had not been followed. For example, a hospital discharge note stated a certain medicine was not to be administered; staff continued to administer this medication against the hospital's medical advice.

The provider failed ensure the proper and safe management of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● Appropriate processes were not followed in relation to employing staff. Where agency staff had been used, appropriate recruitment checks had not been completed and an induction had not been provided. The provider had no information about the agency workers' skills or the training they had completed.

● The provider was unable to provide any evidence about how they ensured safe staffing levels. People's dependency levels had not been reviewed since October 2019.

● Rotas showed that there was not always appropriately skilled staff on duty.

Failure to deploy a sufficient number of suitably qualified, competent, skilled and experienced staff was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

● Systems and processes were not in place to ensure lessons could be learnt when things went wrong.

● Accidents and incidents had not been fully recorded or investigated by management.

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

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

At the last inspection we made a recommendation about ensuring effective systems to monitor and improve the service were in place. The provider had failed to make these improvements.

- The provider did not understand quality performance, risk and regulatory requirements.
- Quality assurance processes were not in place. The lack of systems and processes in place to identify concerns or shortfalls within the service placed people at increased risk. For example, lack of care planning and risk assessments, poor management of medicines and failure to ensure appropriate infection prevention control measures were in place.
- The previous manager left their post in January 2020. A new manager had been appointed but they had failed to address the significant shortfalls within the service.
- The provider failed to ensure there was effective and competent management arrangements in place. They had a lack of oversight of how the service was being run. They did not have monitoring systems to identify significant shortfalls within the service.
- The provider had not visited the service for over two months during the COVID 19 pandemic. Despite this, they did not consider implementing additional governance checks to allow them to monitor the service remotely.

The provider failed to ensure systems and processes were in place to assess, monitor and improve the service. This was a breach of Regulation 17, (good governance), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care

- Shortfalls had been highlighted to the provider at previous inspections, but appropriate action had not been taken to improve the service.
- Investigations and auditing of incidents and accidents were not always robust, fully completed or managed appropriately to mitigate future risks to people.

The provider had failed to reduce or remove risks where possible which had a negative impact on people using the service. This was a breach of Regulation 17, (good governance), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

● A person-centred culture was not promoted. Staff told us the service had started to deteriorate when the previous manage left the service.

● Staff did not feel supported within their roles. They had not been provided with sufficient training to ensure they had the skills and knowledge they needed. They expressed concerns over the lack of management within the service.

● People and staff's personal data had not always been stored securely in line with the General Data Protection Regulation (GDPR). People's care records were stored in an unlocked office and staff personnel files were stored in an unlocked filing cabinet.

The provider failed to maintain securely, records in relation to people who used the service and staff employed. This was a breach of Regulation 17, (good governance), 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

● The provider had not been responsive to issues and concerns. They had failed to be open, honest, and apologise to people when things went wrong.

● The provider failed to report concerns in relation to COVID 19 to the local authority in a timely manner to enable appropriate, additional support to be provided.

The provider failed to seek and act on feedback provided or concerns raised. This was a breach of Regulation 17, (good governance), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● The provider did not effectively involve and engage with people. Care plans and risk assessments only contained basic information which meant their views and preferences were not always taken into consideration. Care plans had not been updated to reflect people's current needs and wishes.

● Professionals visiting the service expressed concerns over the care and support people were receiving.

● Guidance from other professionals had not always been followed, which put people at increased risk of harm.

Failure to ensure the care and treatment was appropriate, met people's need and reflected people's preferences was a breach of Regulation 9, (person-centred care), 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 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure the care and treatment was appropriate, met people's need and reflected people's preferences

The enforcement action we took:

Notice of proposal to cancel the providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to assess the risks to the health and safety of people and do all that is reasonably practicable to mitigate any risks. They also failed to ensure the proper and safe management of medicines.

The enforcement action we took:

Notice of proposal to cancel providers registration

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 The provider failed to establish and operate systems and processes effectively to prevent abuse of service users and they failed to investigate and report any allegations of abuse

The enforcement action we took:

Notice of proposal to cancel providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider failed to ensure people's nutritional and hydration needs were being met, monitored

and recorded.

The enforcement action we took:

Notice of proposal to cancel providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Inadequate systems and processes to assess, monitor and improve the service meant that lessons failed to be learnt. The provider had failed to reduce or remove risks where possible which had a negative impact on people using the service.

The enforcement action we took:

Notice of proposal to cancel providers registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to deploy a sufficient number of suitably qualified, competent, skilled and experienced staff

The enforcement action we took:

Notice of proposal to cancel providers registration.