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 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 10 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
At this inspection we found improvements in the way the environment was managed around reducing the risks that could contribute to people's falls and improvements to fire safety. However, there were still concerns around the way people's assessed needs were recorded, and how they were supported by staff.

There was not always clear learning from events which placed people at risk of harm.

Staffing levels were inconsistent and there was a large turnover of staff. This meant agency staff were used. There was a lack of complete recruitment processes which put people at risk of being cared for by staff unsuitable for their roles. Staff rotas were not clear. We could not be assured shifts were covered by sufficiently trained and competent staff.

At our last visit we found people's medicines were not safely managed. We found some improvements at this inspection but there were still concerns over safe medicines practice.

The provider had increased their oversight of the service. However, there were concerns raised from staff about the lack of support and a culture of bullying by the provider, this had led to several staff leaving the service.

Although work had been undertaken to improve quality monitoring processes the processes need embedding before we can make any judgements on how effective they will be.

People we spoke with felt safe with the staff who supported them. The service was clean, and staff followed good infection prevention and control practices.

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 2 February 2022)

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations.

Why we inspected
We carried out an unannounced focused inspection of this service on 10 November and 17 December 2021. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve the need for consent, safe care and treatment, safeguarding people, recruitment practices and governance processes

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe 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 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, staffing, staff recruitment and quality monitoring processes.

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.

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.

We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the 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 'Inadequate' and the service remains 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.

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?

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.

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.

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was not a registered manager in post.

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 11 members of staff including the providers, seven members of care staff, a cook and two housekeepers.

We reviewed a range of records. This included six people's care records and multiple medication records. We looked at 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 three 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 our last inspection we rated this key question Inadequate. At this inspection the rating remained the same. This meant people were not safe and were at risk of avoidable harm
At our last inspection the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The risks to people's safety were not assessed and actions to mitigate risks were not in place. At this inspection although there had been some improvements around the management of environmental risk there were still concerns around the risks to people's safety and the provider remained in breach of this regulation.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong;
● People were not always supported in line with their assessed needs. Some people's care plans were not complete or reflective of their needs. There was not always clear learning from events.
● People did not always have equipment in place to support them with their mobility. One person required a frame to support them when walking around their bedroom. This was not in place when we visited the person in their room. The person used furniture to support them to get from the bed to their chair. They were unsteady and at risk of falling mobilising in this way. At the last inspection the person we saw the person had sustained several unwitnessed falls and required a walking frame to support them. This continued lack of staff oversight of the person's needs showed a lack of learning from events and continued to put the person at risk of further falls.
● Records did not always show if people had been repositioned in line with their assessed needs. One person's care plan showed they should be repositioned three to four hourly. However, the person was under the care of the district nurse due to the deterioration of their skin integrity, they had requested the person to be repositioned every two hours. The care plan had not been updated to reflect this. Daily records showing checks on the person recorded there were periods of up to six hours when the person was lying in one position without being moved. This put the person at risk of further skin damage.
● A further person who had been at the service since August 2021 did not have a complete care plan in place. This had been highlighted at our last inspection. The provider told us they had completed the plan but had not printed this off the computer. On the second day of our inspection the care record still did not contain the person's full care plan. These concerns put people at risk of receiving care which did not meet their needs.

Using medicines safely
● When we last visited the service, people's medicines were not being safely managed. At this visit although we saw some issues we raised had been addressed, there were still concerns around the safe management of controlled medicines.

● We found there were several discrepancies related to one person's medicine administration record (MAR) and the controlled medicines register. The register showed the person had only received half the number of tablets they should have received for six days, but their MAR showed staff had signed to say both doses had

been administered to the person on those days. There were also discrepancies in the running totals of medicines written in the controlled medicines register which had not been clearly investigated or monitored by the provider. This left people at risk of not receiving their medicines in line with their prescription and meant lessons from these errors had not been learned.

The above issues are a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Providing safe care and treatment.

● However, provider had made improvement to the environment since our last inspection. For example, at the last inspection the fire alarms had not been tested regularly due to a fault in the system which prevented staff from switching the alarm off following the test. This had been rectified and there were records of weekly tests being carried out.
● The second floor of the service had been decommissioned by the provider as the evacuation equipment could not be used safely on this floor. Unused rooms on this floor had been locked and a cupboard housing a hot water tank with exposed pipes which had been unlocked at our previous inspection putting people at risk of potential burns was kept locked
● Since our last inspection when we identified a risk of people living with dementia and mobility concerns being able to access the two staircases at the service. The provider had installed stairgates so people would only access the stairs with support from staff.

Staffing and recruitment
● The number of staff at the service was not always enough to provide consistent, safe care for people. We requested staff rosters between 21 February and 20 March 2022. We were only supplied with one roster for the week of 14 to 20 March 2022; this roster showed there were not enough staff to provide safe support for people. The lack of further rosters for the previous three weeks meant we could not be assured shifts at the service were covered by sufficiently trained and competent staff.
● The number of staff on duty at night was one member of waking staff and a further member of staff who undertook a sleep-in shift. A few people at the service required two members of staff to support them with their care, including one person who required two hourly repositioning and continence checks. This meant the sleep-in person would be woken every two hours to provide support for people. Rosters showed times when staff undertook a sleep-in shift and a 12-hour day shift back to back. This meant staff effectively worked a 24-hour period. This is not safe practice and put people at risk of harm.

These concerns meant the provider was in breach of Regulations 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Insufficient number of suitable staff were deployed in the service.

At our last inspection the provider was in breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. As the lack of complete recruitment processes, such as lack of references put people at risk of being cared for by staff unsuitable for their roles. At this inspection the provider remained in breach of this regulation.
● The provider had used family members to work as care workers without undertaking Disclosure and Barring Service (DBS) checks. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

This was a continued breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Lack of safe recruitment processes.

Systems and processes to safeguard people from the risk of abuse
When we previously visited the service, the provider was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The systems and processes in place to safeguard people from abuse were not robust. Staff lacked safeguarding training. At this inspection the provider had made improvements and was no longer in breach of this regulation.

● People we spoke with felt safe with the staff who supported them.
● Staff had received safeguarding training to support them in their roles and were aware of their responsibilities in protecting people from abuse and risk of abuse.
● The provider had processes in place to respond to any safeguarding incidents or concerns.

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 meeting shielding and social distancing rules.

● 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 accessing testing for people using the service and staff.

● 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.

● People were supported to see their families and the provider operated an appointment system to ensure people were safe and followed government guidance on care home visiting.

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 has remained the same. 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.
When we last visited the service, the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The lack of oversight of the quality monitoring systems impacted on the quality of care people received. Although we saw there had been some improvements in this area there were still further improvements required and the provider remained in breach of this regulation.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● There remained a lack of oversight of people's care. Although there had been work undertaken on improving the content of people's care records to ensure staff had the information to manage risks to people in a safe and person-centred way. These improvements had not gone far enough.
● There had been a large turnover of staff at the service over the previous weeks and as recorded in our safe section of this report, some people's care plans did not have the most up to date or comprehensive information in place. This meant staff supporting these people lacked guidance to support people in a safe and person-centred way.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care
● Although the provider had worked to make improvements in their quality assurance processes people remained at risk of receiving unsafe care due to the lack of consistent record keeping and clear oversight of the service.
● When we last inspected the service there was a lack of effective systems in place to assess, monitor and mitigate risks to people. There was a lack of oversight from the provider and there was no registered manager in post. This had impacted on the quality of care people received. At this inspection we saw the provider had introduced quality monitoring processes which would improve their oversight of the service. However, these processes were new and required embedding before we can make a judgement on how effective they are in improving the quality of people's care.
● The provider's records relating to agency staff were inconsistent and they were unable to provide us with evidence of agency staff profiles to show their training was up to date.
● The provider was unable to provide us with staff rosters from the 20 February 2022 to 13 March 2022. As a result we could not be assured the provider had provided enough staff to support people and as reported in our safe section Information we received from the local authority teams visiting the service during this time showed there were days when staff had worked a 24-hour period. This lack of clear oversight of staffing meant people were at risk of receiving unsafe care.

● The service did not have a registered manager in post. However, the provider was working to recruit one.

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

● We had received statutory notifications from the service as they were required by law to report to us.

● Relatives told us if there had been any events, such as their family member suffering a fall, the staff did let them know of events and how the person was being supported.

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

● The provider did not always communicate with relatives or support staff effectively.

● Staff we spoke with told us they felt unsupported and unappreciated by the provider. The majority of staff felt there was a culture of bullying. One staff member told us they had recently left the service as they had been pressured to work excessive hours. They told us they had undertaken up to 80 hours in a week. They felt they were not meeting people's needs. A further member of staff who had also recently left the service, told us if the provider rang them to undertake extra shifts and they didn't answer their phones straight away they would get text messages or voice mails "telling them off" for not responding.

● Staff told us when they raised concerns about the standard of care to the provider via a letter, they were blamed and not supported.

● Relatives we spoke with told us the communication had not been consistent. One relative told us it took a long time to get through on the phone and emails took a long time to be answered. Relatives felt the provider had been slow to make them aware of the changes which had taken place at the service in the last few months. One relative told us communication had improved in the last few weeks, and further correspondence we received via the service from relatives supported this statement.

Working in partnership with others

● The provider worked with the local community nurses and the GP to manage people's care.

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 12 HSCA RA Regulations 2014 Safe care and treatment The risks to people's safety were not assessed and actions to mitigate risks were not in place. Medicines were not managed safely

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment practices were not always safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was not always enough staff to ensure they were deployed to safely meet people's needs.