

Rethink Mental Illness

Grove Court

Inspection report

100 Lancaster Road
Newcastle Under Lyme
Staffordshire
ST5 1DS

Tel: 01782628983
Website: www.rethink.org

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

About the service

Grove Court is a residential care home providing personal and nursing care to up to 12 people. The service provides support to people with mental health support needs. At the time of our inspection there were 9 people using the service.

People's experience of using this service and what we found

Quality assurance systems in place were not always effective at identifying concerns and looking for ways to improve the quality and safety of care. Risks were not always assessed and planned for, which could leave people's health and wellbeing at risk. Despite this, staff generally knew people well. Medicines were not always managed safely. Some improvements had been made to the cleanliness of the service; however, the home was still being refurbished and this was not yet completed. Some records were poorly completed and did not evidence people were always being kept safe. Overall, people had a good relationship with staff, however, 2 staff used some inappropriate language to refer to a person and this had to be challenged.

There were enough safely recruited staff and staff had appropriate checks in place. Staff felt supported in their role. There were no restrictions on visiting. The registered manager and provider were aware of their duty of candour. The registered manager was responsive to feedback. The service worked in partnership with other organisations and professionals.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service generally supported this practice.

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 requires improvement (published 16 June 2023).

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 undertook this focused inspection to check the provider 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. This inspection was also prompted by a review of the information we held about this service.

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 requires improvement. This is based on the

findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'All inspection reports and timeline' link for Grove Court on our website at www.cqc.org.uk.

Enforcement

We have identified breaches in relation to assessing and reducing risks to people's health and wellbeing, medicines management and quality assurance systems at this inspection.

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

We will request an action plan from 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

<p>Is the service safe?</p> <p>The service was not always safe.</p> <p>Details are in our safe findings below.</p>	<p>Requires Improvement ●</p>
<p>Is the service well-led?</p> <p>The service was not always well-led.</p> <p>Details are in our well-led findings below.</p>	<p>Requires Improvement ●</p>

Grove Court

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 Health and Social Care Act 2008.

Inspection team

The inspection was carried out by 2 inspectors.

Service and service type

Grove Court is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Grove Court is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager

This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was 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 who work with the service. We asked Healthwatch if they had any feedback to share. Healthwatch is an independent consumer champion that gathers and represents the views of the public

about health and social care services in England. They did not have any information to share. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection

We spoke with 2 people who used the service during the inspection. We also spoke with 5 members of staff including mental health support workers, the registered manager and a Head of Service from the provider. We also spoke with 1 visiting health professional and completed observations of care in communal areas.

We reviewed 4 people's care plans and risk assessments along with multiple people's medicines and medicines records. We looked at 2 staff members recruitment files. We also reviewed audits, policies and procedures.



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 requires improvement. The rating for this key question has remained requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At our last inspection systems in place were ineffective in identifying safety issues and concerns. This placed people at risk of harm. This was a breach of regulation 12(1) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Some improvements had been made at this inspection. However, people were still exposed to risk which resulted in a continued breach of regulation 12.

- Risks to people's health and wellbeing were not always assessed and mitigated. Lessons were not always learned when things had gone wrong.
- One person had fallen, however there were no accident or incident forms completed, no body maps and the risk falls posed for the person had not been reviewed or their plan updated. There had also not been learning from the incident.
- People were at risk of potential injury from the maintenance and design of their living environment. For example, the window in 1 person's bedroom was not restricted and there were exposed hot radiators and pipes throughout the home. This meant people were at risk from falls from height and scalds.
- Some of these concerns had been identified at the last inspection and while some steps had been taken to reduce the risk, these had not been fully effective.
- The home was being refurbished so there were works on going. One person was at risk from fire while in their room and a risk assessment was in place for this. However, the registered manager explained the fire-retardant items from the person's room were no longer in place due to the refurbishment works. No alternative measures had been put in place to mitigate this, until we fed back our concerns.

The provider failed to adequately assess, plan, and mitigate risks to people's health and wellbeing. This was a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

- Medicines were not always managed safely.
- Guidance for 'when required' medicines were not always in place, or not always detailed enough to guide staff to know when the medicines were needed.
- A person who needed a 'when required' medicine had incorrect guidance in place for staff to follow. It stated the person would ask for their medicine, or respond they wanted it when asked by staff. However, other care plans indicated the person may not request medicine due to their mental health. This meant there was a risk this person may not receive their medicine when needed.
- Medicines were not always stored appropriately so the provider could not be sure they remained safe and effective to use. Some medicines were not refrigerated despite the packaging indicating they needed

refrigerating.

- Staff were not always following safe medicine administration processes. For example, the staff who signed the Medication Administration Record (MAR) to say a medicine had been given, were not always the same staff giving the medicine to the person.

The provider failed to follow safe medicines management which could put people at risk. This was an additional breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

At the last inspection we identified concerns with the cleanliness of the home. This was a breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we saw action was being taken so the provider was no longer in breach of Regulation 15.

- The home was being refurbished throughout, which would make surfaces easier to clean. However, this was not yet completed. Therefore, we will check this again at our next inspection.
- Staff told us they received infection control training and we saw the appropriate use of Personal Protective Equipment (PPE).

Visiting in care homes

There were no restrictions on visiting in the home.

Systems and processes to safeguard people from the risk of abuse

- People were not always protected from the risk of abuse.
- We found 1 instance of an unexplained bruise being identified and recorded by staff. However, an appropriate referral had not been made to the local safeguarding authority.
- Some staff we spoke with were not clear on the different types of abuse which could occur. All staff told us they would report their concerns, however if staff were unable to recognise abuse, the provider could not be assured they would take appropriate action.
- Despite this, people told us they felt safe and other safeguarding referrals had been made.

Staffing and recruitment

- There were enough safely recruited staff to support people. However, the provider was not using a structured way of calculating how many staff were needed to evidence staffing levels remained appropriate.
- Despite this, there were enough staff to support people. The staffing numbers had been adjusted during some days of the refurbishment to assist with the preparing of people's rooms for refurbishment.
- Staff had their suitability to work with people who used the service checked. This included checks on criminal records with the Disclosure and Barring Service (DBS). This helps providers make safer recruitment decisions. Employment history, reference and staff identity was also checked.

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

- We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met. Other professionals were often involved in the decisions about people's support. However, some improvements were needed to ensure up-to-date decision specific mental capacity assessments were available.

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 requires improvement. The rating for this key question has remained 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

At our last inspection, governance systems were not robust enough to demonstrate safety was effectively managed. This was in breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider remained in breach of Regulation 17.

- Following the last inspection, the provider sent us an action plan about how they planned to address the concerns we found at that time. The provider failed to follow their own action plan.
- The medicines audits had failed to identify the multiple concerns we found during our inspection, such as issues with storage, 'when required' medicines information and medicines practices by staff.
- The care file audits lacked structure, so it was not always clear what was being checked and these checks were not always in place. Care plans sometimes did not always fully assess and mitigate risks to people.
- There was confusion about the monitoring of 1 person's weight. The person's weight was not consistently recorded and when it was suspected they could have lost weight, this had not been checked. Systems in place had failed to recognise this.
- Some records were of poor quality, or had recorded there was an issue, but this had not been acted upon. For example, freezer temperature records were in place however these indicated the freezer was too warm in comparison to the limit set on the document. This had been the case for a number of months, and this had not been identified or dealt with. Food temperature records were poorly completed with multiple missing entries. Handover records were not always clear as they were not always dated, or not clear which shift handover was being given.

The provider failed to establish and operate effective quality assurance systems to assess and mitigate risks to people. This was a continued 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; Engaging and involving people using the service, the public and staff, fully considering

their equality characteristics

- The culture was not always positive. Two staff referred to a person in language which was no longer considered appropriate, and we had to explain this to them.
- Despite this, we observed people had a good relationship with staff. Some staff had been there a long time and people had got to know them well. Staff were aware of those who chose to practice a religion and supported people with this.
- Staff told us they felt supported in their role and felt included in the running of the service. There were also staff meetings. One staff member said, "I've been able to put my point across. [The manager has] always respected me, they've always took on board what I think, and [the team leader]. They are very much approachable. They've got good standards." Another staff member said, "[The registered manager is] 100% approachable. They'll help you out when needed. They're strict but fair."

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 registered manager and provider were aware of their duty of candour. Concerns were looked into and responded to.
- Notifications were submitted as necessary, and the previous rating was being displayed, as required.

Working in partnership with others

- The registered manager was open to feedback and eager to make improvements. They were responsive to feedback.
- A visiting professional told us the staff were able to give them 'fantastic' information about a person who needed support and the referral for their input had been appropriate.
- The local authority had also carried out visits to the service which the registered manager engaged with.

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 Risks were not always fully assessed and mitigated. Medicines were not always managed safely.

The enforcement action we took:

Notice of proposal to impose conditions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance systems were not effective at identifying concerns or areas for improvement.

The enforcement action we took:

Notice of proposal to impose conditions.