Alpha Care Management Services No. 3 Limited

Grenville Court Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced comprehensive inspection took place on 4 and 5 October 2018. Grenville Court is a care home registered for up to 64 people. It is set over a ground floor and a first floor, and people have their own rooms and en-suite toilet facilities. There are some communal bathrooms, toilets, lounges and dining areas in the home. At the time of our inspection there were 40 people living in the home, one of whom was in hospital.

There was not a registered manager in post and there had not been one working in the home since November 2017. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A new manager was appointed and started in post on 31 July 2018. This manager had commenced the application process to register with CQC.

This service has a recent history of non-compliance and serious concerns. At the inspection on 13 November 2017, we found serious and widespread concerns, resulting in seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection on 10 May 2018, we found there continued to be widespread concerns, and despite improvements being made in some areas, there was a deterioration in other areas. The provider remained in breach of seven Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the CQC Registration Regulations. This was because the service was not safe. There were a number of concerns around medicines administration, management of people's health needs, care planning, infection control, recruitment, staffing, and consent. Care was not person-centred and leadership was poor.

Following the inspection in May 2018, we met with the responsible person from the new organisation that had taken over the provider, and they shared their action plan with us. We remained concerned that improvements were not being made in a timely manner as we continued to receive complaints and concerns about the service for a few more months. A new manager started in post on 31 July 2018, and agreed to share their action plan and improvements with us on a monthly basis, which they have complied with. We saw that the home was beginning to make improvements from these action plans, and from feedback from the professionals involved with the service such as the local authority quality assurance and safeguarding teams.

At this inspection we found three repeated breaches of Regulations. However, in these areas, improvements had been made, with further improvements needed for the service to become compliant.

There was not always good infection control practice across the home as not all the areas of people's environment were kept clean and tidy, and a contagious infection had not been immediately acted upon.

Environmental hazards and risks to people in their rooms had not always been identified, such as unsecured razors and potentially hazardous substances, although prompt action was taken following the inspection.

There was refurbishment work being undertaken in the home and this had not been risk assessed. There was a risk of people accessing rooms where work was being undertaken and unsafe equipment was being used.

Prescribed creams were still not stored securely presenting a risk of inappropriate use. Instructions for creams were not always available and these were recorded sporadically in some cases.

There were not always enough consistent, competent staff available to people when they required support. This was because there had been a high turnover and the home was using a lot of unfamiliar agency staff, who did not always know people's needs well.

Staff did not always provide personal care to people when it was needed according to their care plans, for example supporting people with showers.

People's capacity to make important decisions had not always been assessed, and when decisions were made, there was no evidence of this being in their best interests.

There were care plans in place which guided staff on how to care and support people. This included with behaviours which some could find challenging, and with end of life support needs.

There were activities available in group sessions and visiting entertainment, however there was limited provision of activities for those who preferred to stay in their rooms or to do activities on a one to one basis.

Oral medicines were stored securely and administered as they had been prescribed. Staff underwent medicines administration training and competency checking.

People were well supported with their meals and therefore to eat enough, with options of meals and three courses available at lunch. Action had been taken when people had lost weight and people's weights were closely monitored. People were also supported to drink at various intervals throughout the day and their intake was monitored.

People's relatives felt comfortable to raise a concern, and they felt the manager was approachable and made efforts to resolve concerns. People, relatives and staff we spoke with were positive about the manager and their ability and motivation to improve the home.

The systems in place for monitoring and improving the service had been greatly improved, however there remained areas for improvement.

People felt safe with staff and staff were polite to people. The manager had reported any concerns to safeguarding authorities when needed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Some risks to people were assessed and mitigated, including those associated with choking, pressure care and manual handling. However, not all risks associated with infection control and people's environment had been identified and managed safely.

There was a high turnover of staff and not always a fully competent, consistent team on duty.

Some areas of the home were not kept clean and tidy and improvements were required to some areas of the environment.

Safeguarding concerns were acted upon and reported to the appropriate authorities.

Is the service effective?

Requires Improvement

The service was not always effective.

Decisions were not always assessed and made in people's best interests and people were not always supported to make decisions where they had variable capacity.

Staff received training and competency checking, however a significant proportion of staff were not familiar with the service or people, affecting their ability to competently deliver effective care at times.

People were supported to eat and drink enough, and were given options.

There were healthcare professionals regularly involved with people living in the home.

Is the service caring?

Requires Improvement

The service was not always caring.

The culture of the home needed further improvement in

embedding a caring way of working with people.

People's dignity was upheld in the main, but further improvement was needed.

Most staff were caring, but some were task-focussed.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive care according to their individual needs.

There were activities within the home as well as visiting entertainment, but there was not always enough for people on a one to one basis, which was based on their interests.

Relatives felt comfortable to raise concerns and these were responded to appropriately.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was no registered manager in place and there was inconsistent leadership.

There were not up to date accurate records kept, and audits were not always effective.

There was a poor morale amongst the staff team and a culture where staff did not feel comfortable to raise concerns.

The provider had not notified CQC of events under the terms of their registration.

Grenville Court Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection was unannounced held over two days. The inspection was carried out by three inspectors, a medicines inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

As part of the inspection, we reviewed the information available to us about the home, such as the notifications that they had sent us. A notification is information about important events which the provider is required to send us by law. We had not requested a Provider Information Return on this occasion. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We reviewed information we received in the form of whistle-blowing and complaints received prior to the inspection. Whistleblowing is a concern bought to our attention by staff about the practices where they work. Prior to the inspection we also sought feedback from a number of professional bodies involved with the service, including pharmacy, district nursing team, the local authority, safeguarding and the Clinical Commissioning Group (CCG).

The majority of people living in the home were living with dementia and as a result of this, were not able to give us feedback about the care they received. As part of our inspection we spoke with one person using the service, one visiting friend and ten relatives. In addition, we received written feedback from a relative immediately following the inspection visit. We also made observations of care and interactions throughout our inspection visit. We spoke with eight members of staff including two heads of care, a care worker, a senior care worker, two kitchen staff members, the activities coordinator and the manager. We also received feedback about the service from healthcare professionals and the local authority, who were involved with the service.

We looked at a selection of care records, including eight people's in detail. We reviewed the daily records of people's care, and checked certain areas of other people's care plans. We looked at information relating to

how the service was run, such as policies, auditing systems and quality assurance systems. We also reviewed the provider's action plan which they sent us prior to the inspection. In addition, we requested some further information from the providers immediately following the inspection.

Requires Improvement

Is the service safe?

Our findings

During our last inspection in May 2018, we found that the service was not safe for people and it was therefore rated 'Inadequate' in this area. During this inspection we identified that although improvements had been made in some areas, further improvements were still needed. It was therefore rated 'Requires Improvement' in safe.

At our last two inspections we found the service to be in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was due to poor assessment and management of risks to people, and infection control concerns. At this inspection, despite significant improvements made, there continued to be a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Further improvements were needed to ensure people received a safe service.

At our last inspection in May 2018, we found that the management of risks to people were not always adequate. At this inspection we found that improvements had been made in this area, however there remained some risks to people. On walking around the home, we saw that many ensuite toilets contained potentially hazardous substances and items, such as razors. This had not been identified as a risk to people, including people who had demonstrated self-harming behaviours in the past. These items also posed a risk to those living with dementia who may have impaired recognition and recall. Items such as denture cleaner tablets and aerosol air fresheners, as well as toiletry items could pose a risk to people if accidently consumed or misused. These items had not been included on any environmental risk assessment so it was not clear whether a risk to people had been identified.

By the end of our inspection visit the manager had ensured that all razors were locked away. They also told us that they were awaiting locks for the cabinets which had been installed since our last inspection. However, we saw that some of these had locks, but remained unlocked anyway. The manager told us it would take some time to instil this way of working with staff, as they had been keeping these items in this way for some time.

There was not always good security of the building and environment. We had some concerns around the security of the front door. There were no risk assessments in place for work taking place in the home. There was a risk that contractors working in the home could leave doors open and people could get in or out of the building, as there was no evidence that the contractors had been debriefed about specific safety needs of the people living in the service with dementia. There were contractors coming in and out of the home who were working in some rooms and replacing carpets. We found a blade on a window sill of a bedroom which was currently being worked on, which may have been used for cutting carpets. The room was unlocked and unattended on two occasions through the morning when we checked, and this blade was still there. Later, we brought it to the manager's attention and the blade had gone, however it remained unaccounted for, as we were not able to ascertain who had taken it.

We found that the rooms where a carpet underlay had been laid, had a strong chemical smell. The manager told us the chemicals used were non-toxic, but we saw from records that one person said they felt dizzy

because of the smell. We observed that one person was incontinent and there was urine on the floor in their room. There was urine on the floor both when we arrived to carry out our inspection, and later when we checked after 3.5 hours. We were concerned that the carpet was yet to be laid, but there had been urine on the underlayer. There was no risk assessment which had considered issues associated with people's continence, smell and disorientation whilst the flooring in their rooms was being changed.

We found that prescribed creams were not always properly recorded. The records we saw for topical creams were filled out on some days, and not others, and there were not always instructions for staff on the records about how, where, and when these should be applied. For others, we saw there were instructions and body maps in place but this was not consistent throughout the home. Therefore, there was a risk that people were not always receiving these as prescribed, and this included medicines to help prevent skin conditions and pressure ulcers.

There was improved communication amongst the staff team which meant that new risks and changes in people's care were passed on to staff on the next shift in handover, as well as during a daily meeting, involving the manager. We listened to the morning handover and found that the information given to staff was not always disseminated to all staff who were on shift, and there was not always detailed information given. This was especially important as a significant proportion of the staff currently working at the home did not know people well. Where a person had a new pressure area, and another an infectious condition, not all staff were aware of this.

Some safety checks had fallen behind schedule, for example monthly bed rail checks had not been carried out since June 2018. These checks are important to ensure that equipment remains safe to use, and ensure that risks associated with injury, entrapment or falls from bed are mitigated.

There remained concerns around infection control. One person had contracted an infectious condition and not all the staff on duty had been made aware, and there was not an immediate response to this information. This meant there was an infection control risk as staff were not immediately aware what precautions they needed to take to prevent the spread of infection. We raised this with the manager who took prompt action, including necessary items such as clinical bins and Personal Protective Equipment (PPE) for staff, put in the person's bedroom.

For one person who had been moved out of their room pending the flooring being changed, we saw that the toilet brush had been moved onto the top of the toilet cistern, on which was also stored their toothbrush and other personal items. This did not demonstrate a responsible approach to hygiene.

We saw that most of the communal bathrooms were used for storing dirty laundry in separate bags, and in one communal toilet upstairs there was underwear hanging over the radiator. In another one, there was a disused collapsed airflow mattress. A visiting friend we spoke with said, "There have been pads left in the bathroom in amongst the laundry. That's not good is it?" In another bathroom we saw an old, rusty toilet frame. We ascertained that there were still improvements needed to the management of laundry in terms of where it was kept and keeping the bathrooms clean and tidy.

Despite some improvements made, there continued to be a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Further improvements were still needed to ensure people received a safe service.

Two relatives told us they felt staffing levels had improved under the new management, and we saw this reflected in a quality assurance questionnaire. Although there were enough staff on duty according to

people's assessed needs, and this was reflected on the staff rota, there was not yet an established staff team in place. Prior to the inspection we received a whistleblowing where we were told that the standard of care was lowered because there were not enough consistent staff. At this inspection, we found that there were enough members of staff on duty to support people. There had been a high turnover of staff since our last inspection. The home was currently interviewing for 14 care positions, and the manager told us they tried to get consistent staff from the agency they used whenever possible. Staff we spoke with told us it was difficult working with so many agency staff and it affected the care people received because it slowed the shifts down.

At our last inspection in May 2018 we found the provider was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because they were not ensuring people were safeguarded from the risk of mistreatment. At this inspection we found that improvements had been made and the provider was no longer in breach of this regulation. Staff were encouraged to bring forward any safeguarding concerns they may have, and the manager had reported any concerns to the appropriate authorities, and worked with them where needed.

At this inspection we found that improvements had been made to people's care plans about managing risk associated with behaviours which others could find challenging, or was violent. At this inspection we found that people were better supported and reassured, and there were less incidences related to people's behaviours. Information was available in people's care plans for staff to guide them around providing people with reassurance.

Improvements had been made in safe manual handling techniques. Staff had also received up to date practical training in manual handling. We saw that risks to people in relation to choking were mitigated and staff, including care staff and kitchen staff, understood people's needs in this area.

For people who were at high risk of developing pressure ulcers, staff supported them to change position regularly. However, it was not clear how long was acceptable for people to be seated in a chair when identified at high risk. We noted that one person was staying in a specialist chair for up to four hours and we could not find direction around this, as they were advised to reposition every 2 hours when in bed. Most people had equipment in place when required, for example specialist pressure relieving boots and cushions. However, one person's pressure mattress was not the one that was described in the care plan.

We found that equipment used for lifting people had been serviced properly. There were checks in place for electrical equipment. There were systems in place to ensure that safe processes were followed in the event of a fire. However, for people who lived in the home, their Personal Evacuation Plans (PEEPs) did not always consider how dementia may affect some people's ability to respond to an emergency. Shortly after the inspection the manager sent us the legionella policy and associated risk assessment. There were systems in place such as water temperature control, descaling and flushing, to minimise the risk of legionella. The manager also booked a sampling test to take place after our inspection.

At our last two inspections we found serious concerns related to the management of medicines. At this inspection we found that improvements had been made in this area to make the administration of medicines safer for people. Recording, competency checking and administration of oral medicines had improved.

Records for oral medicines were in place with prescribed instructions for staff on how to administer them. We found improvement in the quality of record-keeping around medicines which showed that overall, people received oral medicines as prescribed. We noted some minor discrepancies in the records, however,

most had already been identified by audits.

We observed the latter part of the morning medicine round and noted that people received their medicines on time by staff that followed safe procedures. Staff who handled and gave people their medicines had been provided training and had their competence assessed to ensure they managed people's medicines safely. Oral medicines were stored securely for the protection of people who used the service and at correct temperatures.

Supporting information was available for staff to refer to when administering medicines. There was personal identification and information about known allergies and medicine sensitivities. There were additional records in place to ensure safety. For example, for people prescribed skin patches, there were also additional records to show where on their bodies they were applied, but records did not confirm the patches were later removed before the next patch was applied to ensure safety.

When people were prescribed medicines on a when-required basis, there was written information available to show staff how and when to give them to people to ensure they were given appropriately, however, we identified some that needed further detail to give staff clearer indication when the medicines were needed. Care notes showed when prescribers had made changes to people's medicines.

Where needed, the service had consulted with and obtained written guidance from the pharmacist about how to give people their medicines crushed and hidden in food or drink (covertly). However, when new medicines had been prescribed the advice was not always obtained and recorded.

Staff were recruited with some checks in place. For example, they had DBS (Disclosure and Barring Service) check, which helped to contribute to assessing whether they were suitable to work with people. However, in some cases the applicants had not filled out the application forms including any employment gaps. The manager had only been in post a short time and they explained that they would be carrying out thorough checks on new staff, and we saw that more thorough checks had been completed when the new manager had recruited new staff.

The manager completed a monthly review of all incidents and accidents within the home and took appropriate action to further mitigate risks or make onward referrals if required.

Requires Improvement

Is the service effective?

Our findings

During our last inspection in May 2018, we found that the service was not consistently effective for people and it was therefore rated 'Requires Improvement' in this area. During this inspection we found that further improvement was still required and it remains 'Requires improvement' in this area.

At our previous inspection in May 2018, we found that the home did not have an adequate mix of staff deployed across the home and they were not always competent. This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A significant proportion of staff working on each shift were agency staff who were not always regular and did not know people's needs well. This was demonstrated to us on the morning we arrived to do our inspection, when we asked an agency staff member questions about one person, and observed their interaction with them. The person did not understand the person's needs, and they were not able to answer questions about people's care. This was their second shift in the home and they were working with one other care staff member on the ground floor. They also did not know any of the door codes to the downstairs bathrooms or the rooms where the care plans were kept, which meant they would not have access if needed. Another agency staff member working with two staff on the first floor said this was their fourth shift.

The home was unable to demonstrate that there were enough competent staff deployed to meet people's needs safely and responsively due to such a high level of unfamiliar staff working in the home. Some feedback we looked at from relatives also confirmed this, one saying, 'some staff appear to have no knowledge of [people's] needs.'

However, a large proportion of the staff team were working with an agency. When we arrived for our inspection we spoke with a member of agency staff and observed their interaction with one person. It was clear that they did not know the person, or their needs, and the person had to wait for another member of staff before being attended to. This staff member confirmed that this was their second shift in the home, and another agency staff member on the same shift confirmed that it was their fourth shift. The permanent staff we spoke with confirmed that they felt it was difficult having a high number of agency staff. One member of staff said, "[Agency staff] can slow the day down which then impacts on people's care." They did go on to say that there were some regular staff who come from the agency which helped consistency.

There had been some advances in staff competency, which included agency staff undertaking the home's manual handling training where possible. However, people still did not always receive the person-centred care they required because there was not always a thorough understanding of individual needs associated with people's conditions. One relative said, "I don't think there's enough person-centred care." They said that although their relative often refused a shower due to the manner in which living with dementia had affected them, if reassured, they could easily be persuaded to have a shower. It was included in this person's care plan that they should be supported to have a shower regularly, and this was not delivered by staff. We checked the daily records for the month prior to our inspection and the person had not had a shower. The person's relatives also pointed out that staff did not often support the person to clean their teeth, and they

said they felt this was basic care. For example, a relative told us that staff did not always understand how to communicate with their family member in an encouraging way, which supported them to participate in personal care such as having a shower. On the morning we arrived to do the inspection we observed that one person had been incontinent in their room, and we listened to an interaction with the staff member who went to them on two occasions following this and they were not offered, or encouraged, to have a shower. A senior member of staff who had been on during the night and support people to get up in the morning confirmed that nobody had had a shower, because they all refuse. These examples further demonstrated a lack of understanding of people living with dementia and their communication needs.

Although new staff had an induction which included shadowing more experienced staff, we saw a new member of staff working alone with people when we inspected, and had concerns that they did not demonstrate a good understanding of dementia. They told us they were shadowing, however at this time, they were following some instructions given to them but were working alone.

We ascertained that there was not a fully competent staff team deployed throughout the home to deliver care according to people's needs. Further cultural improvements within the staff team were required to embed and sustain ways of working effectively.

There continued to be a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities).

At our last two inspections we found a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities). At this inspection the provider was no longer in breach of this Regulation. However, they were aware that further improvements were still needed with regard to the MCA.

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's mental capacity had not been assessed for specific decisions, and decisions were not always made with other relevant persons in people's best interests. We were told by several members of staff that many people refused to have showers, however there were no records to support this, and no best interests' decisions about people's capacity in this area. There was no evidence of consultation with people and relevant others around their rooms. For example, whether replacing their carpets, moving them into other rooms, or accommodating them in their rooms with a strong chemical smell, before the work was finished, was in their best interests. For some people, this had caused disorientation and distress and it was not clear that a best interests assessment had been made for these people, who were living with dementia.

We recommend the provider sources guidance about best practice regarding best interests decisions and mental capacity assessments.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Some people had DoLS authorisations applied for within the home, however the new manager was awaiting feedback from the DoLS team as they did not have all of the records around who had previous applications in from the previous providers.

Staff confirmed the manager carried out supervisions with them. The manager told us they would carry out supervisions after three months with new staff, and they had not yet completed appraisals with staff. We saw that staff had their competencies checked, and any issues identified, for example with medicines administration. Since the new manager had been in post staff underwent additional training including practical manual handling, safeguarding, first aid and the MCA.

Staff were able to demonstrate how they had worked with external professionals to try different approaches with people to ensure their wellbeing as much as possible. For example, reviewing medicines and referring to other teams where needed.

The person living in the home we spoke with told us, "The food's excellent but I'm not a fussy eater, I eat most things. We get cold drinks." A relative explained, "I definitely feel more satisfied. [family member's name]'s on a soft diet. I've spoken to [staff] about it and they gave me this leaflet which explains all about it. I found it very helpful. I come every day from mid-morning to mid-afternoon and help with [family member]'s lunch. The new manager suggested I had my lunch with [family member] to encourage them to eat. It's so much better for both of us. The food's great and [family member]'s eating so much better. We sit at the table together. I feel I'm being looked after too."

A member of staff told us, "Mealtimes are definitely better, there's much more option." We also spoke with the kitchen staff and found that they were knowledgeable about different people's dietary needs and how to prepare their meals. We observed the mealtime, where people were offered choices of three courses, which were nicely presented and appetising. The mealtime was unrushed and staff supported people to eat. We saw that there were photographs of the options available on the board, and staff also showed people what the options were at lunchtime. This better empowered people living with dementia to choose their meals.

A relative told us, "Yes [relative's name]'s looked after well. They're putting on weight too." People's monthly weights showed that many people who had a low weight were gaining weight, and appropriate action was taken when people were losing weight. This included fortifying their diets and referring to a dietician.

We did see that throughout the day whilst jugs of squash were available in communal areas, to help people to stay hydrated, they were not always offered around to people who did not have capacity to get it for themselves. There were many people sitting without a drink within reach, although they were offered hot drinks regularly at various intervals throughout the day. Staff recorded people's food and drink. However, there was not an individual fluid target for people so we were unsure what the information recorded was being used for, and how.

A relative told us, "The doctor comes into the home regularly and the staff call them when needed." We also saw from records that staff supported people to access healthcare such as a dietician, nurse or speech and language therapist. However, there was one person who we could not see from their records when they had last seen a chiropodist, as they had significant support needs associated with their feet. We fed this back to a head of care.

The person living in the home we spoke with told us, "I like going into the garden for the quiet and for the fresh air." We saw that the garden was accessible and secure for people living in the home. There were some improvements in the environment, such as the upstairs dining room, in which the tables were elegantly laid. In other areas, people's environment needed improving, such as the communal bathrooms where there was equipment and laundry being stored.

Requires Improvement

Is the service caring?

Our findings

During our last inspection in May 2018, we identified serious shortfalls and the service was not caring. At this inspection we found that improvements had been made in this area and the service is now rated, 'Requires Improvement' in this area.

At the past two inspections the provider was in breach in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people's dignity was not upheld. At this inspection we found that improvements had been made and appropriate action had been taken when people had been subjected to undignified care delivery. The service was no longer in breach of this Regulation. However, further improvements were needed to embed and sustain a caring culture within the home.

At our last two inspections we found that people were not well supported with needs associated with their continence, and this affected their dignity. At this inspection we found this had improved, but further improvements were needed. People were not always supported to uphold their dignity. We checked a sample of people's daily records spanning over the last month prior to the inspection and found that two people had received one shower over the last four weeks. Out of all 40 people, nobody had received more than two, and some had received none, according to the records. In all the care plans we looked at, it stated that people wanted to be supported to maintain their personal hygiene. We observed during our inspection visit that several people had dirty, unkempt hair which appeared greasy.

We saw that staff still did not always respond to people in a caring, dignified and timely way when they required support associated with their continence. On the other hand, a relative who gave us written feedback immediately following the inspection said they noticed staff supporting people more often to go to the toilet and they felt this area of support had improved.

We found that although improvements had been made to this area, that people sometimes received task-focused care. In part, this was because many staff were not familiar with people. A relative we spoke with confirmed that not all staff were caring but some were excellent. One member of staff we spoke with said, "For some [agency staff] they lack the care, they do the task and that's all." We observed many interactions with people throughout the day, and whilst they were mostly caring, there were some that were more task-focussed. We observed that some care staff adapted their communication to interact with people in a caring way. For example, crouching down to speak to people so at their level sitting down. Others were more impatient in their tone and did not always interact with people in a caring way that demonstrated understanding of their needs associated with dementia. The questionnaire feedback we reviewed demonstrated that relatives did not consistently feel that staff had a good understanding of people's needs.

Relatives we spoke with told us that staff knocked before entering rooms, and we saw that staff only carried out personal care behind closed doors, preserving people's privacy and dignity.

The person living in the home who we spoke with said, "Oh the [staff] are very good. If you want anything

they'll get it for you". However, we saw that not everybody was supported with their personal care according to their care plans, many of which stated that people should be supported to maintain their previous level of personal hygiene. When they had not been supported to do so, this affected their dignity negatively.

People were encouraged to visit when they wanted. A relative confirmed, "I always feel welcome. They [home] have an open-door policy." This was closely reflected by other relatives we spoke with.

One relative told us they felt that staff supported their family member in becoming more independent. They said, "When [relative's name] first came in here they were in a wheelchair. They've [staff] got [relative] walking round now. They push the tea trolley sometimes, [relative] loves that – all smiles."

A relative explained that they were more involved in the review of their family member's care, saying, "Yes, it's important for me to know what's going on." This was closely reflected in what other relatives told us.

Requires Improvement

Is the service responsive?

Our findings

During the last inspection in May 2018, we found that the service was not responsive and was therefore rated, 'Inadequate' in this area. Some improvements had been made, however further work was needed, leading this area to be rated, 'Requires Improvement' at this inspection.

At our last two inspections in we found that the service to be in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we saw that there were attempts to make improvements, however significant improvements were still required. Therefore, the provider was no longer in breach of the regulation.

There was one member of staff employed dedicated to the provision of activities. However, one staff member told us, "[People] need more stimulation." They said that the activities coordinator was often caught up in other work, such as helping in the kitchen, and did not always have time to do many activities with people. The staff member gave us an example of when they had supported a person to do a jigsaw puzzle. They said it clearly gave the person a sense of accomplishment which enhanced their wellbeing. They told us they felt there was not enough one to one activity time available for people who preferred to stay in their bedrooms at Grenville. We saw that some people sat for long periods of time without meaningful interaction, both within communal areas and in their rooms.

Prior to the inspection we received a whistleblowing which stated that people did not receive personal care, such as hair washing and showers, as they should. We found that people continued not to receive the personal care they required. The person who we spoke with living at the service said, "The staff do help with the shower but I hate showers and would much prefer a bath." One staff member did not know if there was a working bath in the building and said that it would be beneficial for many people if they could have a bath. We spoke with several relatives who said people continued not to receive enough personal care. On the day of our inspection the senior in the morning confirmed that nobody who was up had had a shower. Records did not demonstrate that people received regular showers, despite that they were specified as a care requirement in their care plans.

Some people had moved bedrooms due to changing flooring throughout the home, but we saw that for one person, their toiletries and toothbrush had been left in their original room, whilst they had been moved, so it was not clear how this person was receiving personal care.

At the inspection in May 2018 we found a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because they did not always resolve complaints effectively. We found at this inspection that improvements had been made and there were no formal complaints made. Relatives we spoke with told us the manager had responded to any concerns they raised in a timely way, resolved these as far as possible and communicated with them to ask for their views.

Relatives we spoke with told us about a quiz night held at the home when the new manager started in post. They were positive about this night, saying they enjoyed it with their relatives, and that it was a good

opportunity to give feedback about the service. One relative said, "On that night [staff] put so much effort in, it was so nice to come here and have a nice evening with [relative]." They confirmed that the new manager had held further relative's meetings whilst in post and this helped them feel reassured. They said they felt confident to raise any concerns, and that they would be acted upon appropriately.

The person living in the home told us, "I get up and go to bed when I want. I like all the staff." They went on to say, "I enjoy the activities here. I like joining in with things. I went down to the craft thing which was on earlier. We were painting – I like doing things, it's no good sitting in my room on my own is it? The staff come and ask me if I want to go down and if I do, they take me in the lift." Another relative told us the service had held a BBQ in the garden during the summer.

The activities coordinator told us about their plans and how they selected activities to do with people, based on what they enjoyed. They said the home had weekly visiting entertainment, which we saw from records had been frequented by some people living in the home. This included music and animals such as birds of prey and mini donkeys visiting the home. The activities coordinator carried out group activities with people such as arts and crafts. On the day of our inspection we observed a crafts session taking place, where people were making things for Halloween – people appeared to enjoy this, one exclaiming, "I can't paint, but this is fun!" The activities coordinator appeared to have a good rapport with people. The person living in the home told us there was a church service where they sang hymns. A relative confirmed, "There is a church service here twice a week. The organ in the dining area gets wheeled out for the hymns."

Relatives confirmed they were kept informed about their family member's care or any incidents that occurred. One said, "[Staff member] telephoned me recently to keep me updated – things feel to me like they're definitely on the 'up'."

Some relatives told us, and feedback from questionnaires that we looked at, confirmed some views that although the manager was responsive to concerns, some communication was lost when reiterated to staff. This meant that concerns had needed to be raised again to ensure the manager kept responding. This was not a sustainable solution to ensuring people received person-centred care.

Some relatives told us they were in discussions with the manager about their family member's end of life care. They said, "Oh yes, I'm very much involved. We've recently been discussing DNR." We saw that some people had care plans in place around advanced decisions, which depicted some preferences for people towards the end of their lives. For example, whether they would go to hospital or not, or who should be consulted about end of life if people's relatives had not wished to discuss it as part of the care planning. Where needed, other health professionals had been involved in discussions around end of life care.

Requires Improvement

Is the service well-led?

Our findings

At the inspection in May 2018, we continued to find that the service had serious shortfalls in leadership. Therefore, it was rated, 'Inadequate' in this area. At this inspection we found that improvements had been made and it was now rated, "Requires Improvement" in this area.

We found that breaches of 12, 11, 10, 9 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 had been repeated twice in November 2017 and May 2018. At this inspection of 4 October 2018, we found repeated breaches of Regulations 12, 11, 9 and 17. Improvements had been made in all of the areas, but further improvements were needed to ensure compliance with the Regulations.

At our last two inspections the service was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because audits were not effective in identifying concerns and taking action. At this inspection we found the service continued to be in breach of this Regulation, but had made important improvements.

There had not been a registered manager working in the home since November 2017, and therefore no consistent leadership throughout this time. The new manager was applying to register with CQC.

There was poor management and oversight of the risks associated with the redecoration work which was being undertaken in the service. Members of the inspection team identified many risks to people which had not been found and mitigated.

The provision of personal care to people, and the staff attitude about people refusing showers, had not improved. The heads of care and the manager had not identified that people had not received showers for a long time, and were not receiving the care outlined in their care plans.

Despite improvements in communication within the staff team, further improvements were needed to the oversight of this. Staff were not always up to date with people's needs and new risks to people, and agency staff were not always made aware of information they needed.

Significant improvements had been made in the oversight of this service, however we do not have a suitable time period over which the service has been able to demonstrate sustainability. There was not a comprehensive line of accountability in the service. For example, the heads of care were not always clear on what records they should be checking and they did not always know people's up to date care needs. The manager told us they had had one day off since they started in post, but that they felt well-supported by the organisation. We saw that the systems were not yet fully embedded and a new culture not yet established amongst the staff team. The service required more time to complete this work.

We looked at the most recent report from the area manager's visit to the home on 11 September 2018. They had identified some areas which needed further work to improve. For example, the prompt updating of electronic care records. We also looked at a previous report from 12 June 2018 where significant problems

were found, which reflected our findings from the last inspection on 10 May 2018. We could see from comparing the two reports that significant improvements had been made, however on the most recent one there was no mention of personal care delivery. This demonstrated that the checks were not always thorough enough as they did not identify all ongoing concerns. Furthermore, they had not supported the manager to identify and mitigate the risks to people associated with the environmental work.

Therefore, there remains a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager had carried out many checks of the service whilst they had been in post, and identified further areas which required improvement. This included some areas of the environment which required further work, such as the clearing of the smoking area outside, and testing of electrical devices in people's rooms. The manager was monitoring people's weights closely and taking any action needed. The manager had completed a recent infection control check and had identified some areas for improvement, such as bathrooms needing a deep clean. It also identified some further areas for improvement, such as replacing some furniture and equipment.

The manager had carried out a recent nutrition audit in September 2018 which identified further improvements needed around the provision of soft diets. It also identified that improvements had been made since the previous audit carried out two weeks prior. This demonstrated that the manager was checking whether action had been taken on identified areas for improvement.

Audits were in place to enable staff to monitor medicine stocks and their records to help identify areas for improvement. We saw a system available for reporting and investigating medicine incidents or errors, to help prevent them from happening again.

It had been identified in the most recent action plan the manager had sent us, that further competency checking and embedding of inductions for agency staff were needed. They had also identified the need for further individual risk assessments to be carried out with people. They had not, however, identified the need for risk assessments prior to work taking place to refurbish the home.

Following the inspection, the manager gave us assurances that they had taken action on the areas we found for improvement, such as the topical creams administration and daily records. They also said they were introducing a new checking system to ensure that people received baths or showers at least weekly.

At our last inspection in May 2018 the service was in breach of Regulation 18 (CQC Registration Regulations), because they had not sent in the required notifications to CQC. At this inspection the service was no longer in breach, as the manager had sent us notifications required, including historical ones where they were able.

Everyone we spoke with was positive about the new manager in post. One relative said, "I am pleased to say things have improved in the last two or three months." This was closely reflected by all of the relatives and the visitor we spoke with. One relative said they felt the new manager was highly motivated and determined to improve the home. The relatives we spoke with told us that the manager had been responsive to concerns raised, however they felt it would take time to fully embed a new culture in the home. They said that although the manager acted on feedback, at times staff did not always keep it up so they had to raise the same concerns again. A member of staff told us, "It's not at the stage where I would have my relative in [the home] but I can definitely see improvements."

We found that some staff described the manager as, "Strict" and "Firm but fair", and on one occasion heard

them explain to a member of staff something they wanted to be improved. However, all the staff we spoke with as part of the inspection were positive about, and had confidence in, the manager and described it as a much improved place to work.

The relatives we spoke with all said the manager was always visible around the home, and approachable. One said, "[The manager] gave me his mobile number and said I could call him anytime." However, when asked if they were kept informed of changes in the service, one relative answered, "Not really. It would be nice to be told what's happening."

We saw from records, for example the latest report prior to our inspection from a visit from the local authority, that the manager was working effectively with stakeholders and other professionals to improve the service. This included working with the community nursing team, safeguarding, local authority and pharmacy.

There were plans for improving the service in place, and the manager communicated with CQC and the local authority regularly to inform them of what progress was being made towards improvements and making the service safer. There was also a plan to change the electronic care planning system in the new year which would enable staff to more easily enter records on the system, as well as improve the accessibility of information for both staff and the manager.

The management structure within the home also consisted of a deputy manager, who was focussing on sustaining improvements in medicines administration, and a head of care for each floor. One head of care told us that it was in their remit to check daily records, and we identified that this needed further work in some areas, such as topical medicines application and fluid targets. We brought to the manager's attention that daily records were difficult to audit because there was a lot of information recorded in different places within them, and not always consistently done. The heads of care told us they worked well together and oversaw the seniors. However, one head of care said due to the shortage of permanent staff, their job was difficult. The home was actively recruiting into care staff positions.

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 Risks to people were not always adequately assessed and mitigated. Infection control practices were at times poor. 12(1), (2) (a) (b) (d) and (h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not yet embedded systems and processes that effectively assess, monitor and determine risks to people and maintain accurate, complete up to date records. 17(1), (2) (a) (b) and (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not always competent and available to support people. 18 (2) (a)