Peak Care Limited

Grove House

Inspection report

Moor Road
Ashover
Chesterfield
Derbyshire
S45 0AQ

Tel: 01246590222
Website: www.peakcare.co.uk

Date of inspection visit:
20 June 2022

Date of publication:
25 August 2022

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Grove House is a residential care home providing accommodation and personal care to up to 31 people in one adapted building. The service provides support to older adults, some of whom are living with dementia. At the time of our inspection there were 22 people using the service.

People's experience of using this service and what we found
The service was not safe. People were not consistently protected from abuse and improper treatment as allegations of abuse were not always identified or referred appropriately. People were at risk of injury as a result of poor falls management. Risks to people's health and safety had not been sufficiently assessed or mitigated and care plans were not always in place to guide safe practice. Lessons were not always learnt following incidents. There was a risk people may not receive their medicines as prescribed because safe medicines practices were not followed. Staff did not always use personal protective equipment (PPE) effectively to reduce the risk of infection.

There were not enough staff employed to ensure the safe and effective running of the home and staff were not always deployed effectively. Staff did not always have adequate training to meet people's needs and there was a lack of formal systems to support staff and manage performance. Feedback about the quality of the food was poor and there was a risk that fluctuations in people's weight may not be identified. Although people were supported to access support from external health professionals, care plans did not contain up to date information about their health needs. The environment was pleasant and well maintained.

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

The home was not well led. Although people and their relatives were generally positive about individual staff members, the culture of the home was not person centred. Governance systems and audits were not effective in identifying or addressing areas for improvement. The provider did not have sufficient oversight of the operation of the home, consequently poor practices had been allowed to develop. Feedback from people, staff and families was not used to drive improvement at Grove House.

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 good (published 11 January 2019).

Why we inspected
The inspection was prompted in part due to concerns received about leadership and management of the home. A decision was made for us to inspect and examine those risks.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment, safeguarding, staffing, consent and governance at this inspection.

Immediately after the inspection visit, we wrote to the provider and asked them to take action to address our most serious concerns. Although the provider responded with details of action they were taking, we were not assured that all risks were mitigated. 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 overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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 well-Led findings below.

Is the service effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Grove House

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.

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 inspection was conducted by an inspection manager and an inspector. An Expert by Experience also made calls to people's families as part of the inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Grove House 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 House 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 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 no registered manager in post. The previous registered manager had left the service in 2021, the provider had been trying to recruit to the manager post with no success. Recruitment was ongoing at the time of our inspection.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used all this information to plan our inspection. We did not request a provider information return (PIR) before this inspection. 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.

During the inspection
We spoke with two people who used the service and the relatives of eleven people. We also spoke with three senior carers, three members of care staff and a member of the catering team. We spoke with the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of written records including five people's care plans, staff recruitment and training records and information relating to the auditing and monitoring of service provision. We undertook observations of care and support.

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 good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People were not consistently protected from abuse and improper treatment.
- The provider had failed to identify and refer safeguarding incidents. The provider had undertaken an investigation into concerns raised about poor practice, some of the concerns indicated unsafe, neglectful practices. Despite this, the provider had not referred the concerns to the local authority safeguarding adults team to enable an independent investigation.
- The provider had failed to identify, investigate or refer other safeguarding incidents, such as a person who left the service unsupervised and an incident where a person was left unattended by staff and fell.
- During our inspection we were concerned several people did not have sufficient care plans in place and were at risk of having their needs neglected. As a result, we made referrals to the local authority safeguarding adults' team.

The provider had not protected people from abuse and improper treatment. This was a breach of regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

- People were at risk of injury as a result of poor falls management. Risks had not been sufficiently assessed or mitigated and care plans were not always in place to guide safe practice.
- One person had fallen 18 times in the past six months, there was no falls risk assessment and their care plan did not reflect the level of risk. Although a sensor mat had been implemented, we saw them alone in their room with the sensor mat tucked under the bed, which meant it would not be effective.
- Another person had multiple factors that increased the risk of them falling, and they had recently fallen twice. Despite this they had no falls risk assessment or care plan.
- Other risks, such as, skin integrity, were not always assessed or planned for. One person had skin damage to their legs. Their care plan said their skin was in 'good condition' and there were no details to guide safe staff practice.
- Failure to assess and mitigate risk placed people at risk of harm.

Learning lessons when things go wrong

- People were exposed to the risk of harm as lessons were not always learned following incidents.
- One person had recently left the home unsupervised. There was no investigation into this incident and consequently, no learning to prevent future risk. Their care plan did not contain any information about the risk of them trying to exit the building unsupervised and there were no mitigations documented to reduce risk.

● There was no evidence of learning from themes and trends of falls to reduce recurrence. For example, one person had fallen from their bed or chair 12 times in a four week period. Despite this, their care plan did not reflect the risk of them falling from their bed or chair and there were no mitigations in place to reduce risk.

Using medicines safely
● Medicines were not managed safely.
● People had not always received their medicines as prescribed. There were insufficient systems in place to order medicines in a timely way. This had resulted in a person's pain medicine running out several times which placed them at increased risk of experiencing avoidable pain and distress.
● There was a risk medicines may not be effective due to a failure to follow administration directions. One person was prescribed a medicine that should not be taken at the same time as other medicines, however, records showed this medicine had been administered at the same time as at least three other medicines.
● Poor recording increased the risk of medicines errors. There was no evidence that handwritten medicines records were checked by a second member of staff and staff had made changes to medicines records without signing or dating them.
● The medicines room did not promote good hygiene practices, there was no hot water or soap available at the handwashing sink. Furthermore, equipment used for the administration of inhalers had not been cleaned and was in an unhygienic state.

Preventing and controlling infection
● People were exposed to the risk of infection as PPE was not used effectively or safely. Throughout our inspection we observed staff not wearing masks, or not wearing them as intended, such as under their nose.

Systems were not in place to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Despite our findings, the majority of people's families felt their relatives were safe and that medicines were managed safely.

● 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 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.

Staffing and recruitment
● There were not always enough staff to meet people's needs and ensure their safety. We received variable feedback from people and their families about staffing levels. Whilst some relatives told us staffing levels were okay, others commented that staffing could be "stretched."
● Records showed multiple falls had occurred in communal areas, unwitnessed by staff. This indicated that staff were not deployed effectively to ensure people's safety.
● Although the provider had a system in place to determine staffing levels, this had not been updated in recent months. Staff described some people has having "complex" needs but they were rated as 'low' need

on the staffing tool. This meant we were not assured that staffing levels were based upon individual needs.
● Staff told us that the absence of a management team had put additional pressure on the team as they were having to run and manage the home as well as delivering care.

There were not enough staff to ensure people's safety. This was a breach of regulation 18(1), (Staffing), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Safe recruitment practices were not always followed. Although the provider had undertaken Disclosure and Barring Service (DBS) checks, there were some gaps in records. The source of references was not always verified, identification was not always held on file and interview records did not demonstrate that there was a robust interview process in place. This posed a risk that the provider may recruit unsuitable staff.

Visiting in care homes
● People's families told us they were able to visit their relation when they wished. A relative commented, "There are no restrictions on visiting. They've been very good with visiting."

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The 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 MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- There was a risk people's rights under the MCA may not be upheld.
- Where people were unable to consent to aspects of their care, such as the use of movement sensors, their capacity to consent had not been assessed and there was no evidence that decisions made were in their best interests or the least restrictive option.

There was a risk people's rights under the MCA may not be upheld. This was a breach of regulation 11, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- There was a risk people's human rights may not be upheld.The provider had not ensured DoLS applications had been made when people were deprived of their liberty.
- During the inspection the staff team were unable to provide information about who required a DoLS and if applications had been made. Following inspection, the provider advised us that 12 people required a DoLS, but only one DoLS was in place. Others had not been applied for or had expired.

The provider had not applied for DoLS when people were deprived of their liberty. This was a breach of regulation 13(5) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

● People did not always receive safe and effective care as staff did not have adequate training or supervision.
● Many staff did not have training in key areas. None of the staff had up to date training in falls management, this was a concern given the high numbers of falls at the service. Despite supporting several people with dementia, none of the staff had up to date training in dementia or communication. We found staff did not have a good knowledge of key areas, such as, mental capacity.
● Some staff were documented as having attended up to 12 training sessions on a single day. This included areas such as moving and handling and medicines, which require in depth training. Some staff were not on the training record so the provider was unable to evidence if they had up to date training.
● Training did not always lead to competency. Although most staff had training in areas such as medicines management and safeguarding, we found that staff did not demonstrate good, safe practice in these areas.
● Staff did not have regular, formal supervision of their practice. Staff told us they did not have supervision meetings and there were no records of staff having had recent supervision. This meant there were limited opportunities to monitor staff performance and provide support.

The provider had not ensured staff were competent. This was a breach of regulation 18(2), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were assessed prior to their admission to the home, however, this information was not always used to develop care plans. Consequently, the only information staff had about some people was a preadmission assessment. This posed a risk of inconsistent and unsafe support.
● Nationally recognised tools were available, but not always used effectively or updated to reflect people's changing needs. For example, a skin integrity risk assessment had been completed for one person, but the score had not been totalled so there was no overall score to inform care planning.

Supporting people to eat and drink enough to maintain a balanced diet
● We received poor feedback about the quality of the food and there was a risk that fluctuations in people's weight may not be identified.
● One relative told us, "[Relative] doesn't like the food. It's very institutionalised. It's boring; the same things all of the time." We saw a survey conducted in 2021, in which people left comments such as 'meals are often cold' and 'I leave most of my meals as I don't enjoy them.' There was no evidence that action had been taken to address this feedback.
● People were weighed regularly, but there were multiple records and people's weights differed between the different records. There had been no audit of people's weights for several months which posed a risk that fluctuations may not be identified or acted upon.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● There was a risk people may not receive effective support in relation to their health.
● Some people did not have any information about their health needs in their care plans and other care plans had not been updated to reflect changes in people's health needs. This posed a risk staff may not know how to support them.
● People were supported to access advice and support from specialist health professionals when needed. However, as care plans were not up to date, advice from health professionals was not always in care plans.

Adapting service, design, decoration to meet people's needs
● The service was adapted to meet people's needs.

● The home was well presented and in a good state of repair. There were several communal areas that were homely and inviting. People had the use of a small garden area that we saw them enjoying during our inspection.

● There were renovations underway to improve the home, this meant that some people did not have access to an adapted bath. The provider explained this was for a temporary period and there were accessible showers available to people.

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 good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- People were not always at the heart of the service.
- Whilst people and their relatives were generally positive about individual staff members, the culture of the home was not person centred. The provider was not aware of institutionalised practices that developed at the home, such as people being allocated set days for bathing and only being offered one bath or shower a week.
- Some families were concerned about changes in the staff team, they did not feel they had been given adequate information about the changes. A relative told us, "There has been quite a turnover of staff to be honest. A lot have gone. I don't know if they've replaced them all. The residents find that unsettling." People's relatives also told us that communication could be difficult because quite often the phone was not answered.

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

- There were not enough staff to oversee the safe and effective running of Grove House. At the time of our inspection there was no registered manager or deputy manager. Senior carers were running shifts and trying to manage the home; they told us they were stretched and unable to make the required improvements without additional time and support.
- Governance systems were not effective. Audits did not always identify issues and some audits had not been undertaken. For example, medicines audits had failed to identify widespread issues and there had been no care plan audits, so missing and out of date information had not been identified.
- The provider did not have effective oversight of the operation of the home. In the absence of a registered manager, the provider had relied upon the staff team to run the home. The provider did not undertake any formal audits of staff practice and consequently they had failed to identify and address issues with performance.
- The provider had not ensured accurate and up to date records were in place. Two people who had moved into the home two months before our inspection did not have care plans in place. This meant there was no guidance to inform staff support and posed a risk to people's health and welfare.

Continuous learning and improving care

- The provider had failed to implement an effective system to learn from adverse incidents and improve care.

● There was no evidence of learning from themes and trends of falls to reduce recurrence. In 2022, 24 falls from beds and 31 falls from a chair were documented by staff. These patterns had not been identified and the fall risk assessment template did not cover the risk of falls from chairs or beds, which meant that these risks were not assessed or mitigated.
● Swift action was not taken to improve care when concerns were found. Despite identifying significant concerns about the conduct of some staff, the provider had not completed an audit to identify the impact of the poor practice. This meant the provider was not aware of the extent of issues and they had not developed an action plan to address the concerns.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● There were limited opportunities for people, families and staff to provide feedback and influence the development of the service. Where feedback was provided this was not always used to drive improvement.
● There had been some recent meetings for people living at the home, records showed activities and food were the main topics of discussion. However, there was no clear action plan developed to address issues raised in these meetings. Similarly, people raised widespread concerns about the quality of food in a survey conducted in 2021, but there was no evidence this had been addressed and people continued to express concerns about the quality of food.
● People's families told us there had not been any recent relatives meetings and they were not invited to share their views in surveys. A relative told us, "I've not been asked my opinions or not been invited to relatives' meetings."
● Staff told us there had not been any recent staff meetings and we saw there had not been a staff survey for over a year.

The provider had failed to implement and operate effective systems to ensure the quality and safety of the service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Despite our findings, overall, people and their families were positive about the staff using words such as 'gentle', 'kind' and 'lovely' to describe them. Relatives told us they felt their family members were well cared for, by staff who knew them well, in a homely environment.
● There were a range of activities available that people could choose to get involved in and these considered people's diverse needs. For example, there were specific groups to cater to the needs of males and females.

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; Working in partnership with others
● Although there was evidence that the provider had informed people's families about incidents such as falls, the failure to investigate incidents to identify any staff wrong doing meant the provider was unable to fully meet their duty of candour.
● Although the home worked with external organisations such as GPs and district nurses in relation to people's individual care needs, there was no evidence of any wider partnership working to improve care.

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 11 HSCA RA Regulations 2014 Need for consent There was a risk people's rights under the MCA may not be upheld. Where people were unable to consent to aspects of their care their capacity to consent had not been assessed.

The enforcement action we took:

We served a warning notice telling the provider when they must become compliant by.

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's health and safety had not been sufficiently assessed or mitigated and care plans were not always in place to guide safe practice. Lessons were not always learnt following incidents and medicines were not managed safely.

The enforcement action we took:

We took urgent action to impose conditions on the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not consistently protected from abuse and improper treatment as allegations of abuse were not always identified or referred appropriately.

The enforcement action we took:

We took urgent action to impose conditions on the registration of the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems and audits were not effective

	in identifying or addressing areas for improvement. The provider did not have sufficient oversight of the operation of the home,

The enforcement action we took:

We served a warning notice telling the provider when they must become compliant.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough staff employed to ensure the safe and effective running of the home and staff were not always deployed effectively. Staff did not always have adequate training to meet people's needs and there was a lack of formal systems to support staff and manage performance.

The enforcement action we took:

We served a warning notice telling the provider when they must become compliant by.