Ratan Care Homes Limited

Grove House Residential Care Home

Inspection report

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Coventry
West Midlands
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Tel: 02476335600

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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 inspection site visit took place on 5 April 2018 and was unannounced.

Grove House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The home accommodates 29 people in one adapted building across two floors. On the day of our visit 20 older people lived at the home. The home is located in Coventry in the West Midlands.

We last inspected Grove House in March 2017 and gave the home an overall rating of 'Requires Improvement'. There was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding service users from abuse and improper treatment. This was because where people lacked capacity and had their liberty restricted, referrals had not been made to the local authority to ensure their restriction was lawful; and concerns about abuse had also not always been referred to the safeguarding team. We asked the provider to send us a report, to tell us how improvements were going to be made to the service.

At this inspection on 5 April 2018 we checked to see if the actions identified by the provider had been taken and if they were effective. We found sufficient action had been taken in response to the breaches in the Regulation. However, we also identified a number of areas where standards had not been maintained. This is the second time the home has been rated as requires improvement.

The service had a registered manager. 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.

The provider had not ensured people's medicines were always managed and administered safely and in line with their procedure.

Staffing levels meant staff were not always available to respond to people's requests for assistance, were task focused and there were often times when there was no staff presence in communal areas of the home.

Procedures were in place to ensure risk associated with people's care, the premises and equipment, and emergencies were assessed. However, some risk assessments contained conflicting information. People's care records were personalised and regularly reviewed. However, information documented in care records, and the inclusion of people and relatives in care reviews was not always clear.

Inductions for new staff did not reflect nationally recognised guidance. Staff completed training, including

on-going training, though staff had mixed views about the quality of the training provided. Staff received regular management support through individual and team meetings.

The provider's systems to check monitor and improve the quality and safety of the service provided were not always effective. People and relatives were satisfied with the service provided and the way the home was managed. The provider used feedback from people and relatives to make improvements to the service.

People told us they felt safe living at Grove House. The management team and staff understood how to protect people from abuse and their responsibilities to raise any concerns. Staff recruitment systems reduced the risk of recruiting unsafe staff. People told us they were provided with some opportunities to take part in activities they enjoyed.

People, relatives and professional visitors said care staff were kind, caring and professional. People enjoyed their meals and the range of food available.

The management team had an understanding of the Mental Capacity Act (MCA) and their responsibilities under the Act. Restrictions on people's liberty, where needed, were approved by the local authority. However, some people's consent had not been gained in line with the principles of the Act and where relatives had authorisation to make best interest decisions information was not clearly recorded. Staff gained people's consent before they provided care and support to people.

People were encouraged to make choices about their daily lives, including where they would like to spend their day. When needed, people had access to health care services and staff worked with other health professionals to support people to maintain their health and well-being.

Staff respected people's privacy and dignity and supported people to maintain their independence. People who lived at the home were encouraged to maintain relationships which were important to them. Relatives and friends could visit the home at any time. People and relatives knew how to make a complaint and complaints were managed in line with the provider's procedure.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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 consistently safe.

People felt safe living at the home; however staff were not always available to support people when needed. Medicines were not consistently managed safely and in line with the provider's procedure. Risk management plans were in place. However, some contained conflicting information. The management team and staff understood their responsibilities to safeguard people from harm. The provider's recruitment systems reduced the risk of recruiting unsafe staff.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The induction for new care staff did not reflect best practice guidance. Care staff completed training the provider considered essential to ensure they had the knowledge and skills to deliver safe and effective care to people. Staff had mixed views about the training provided. The registered manager and staff had an understanding of their responsibilities under the Mental Capacity Act (2005). However, consent had not always been obtained in line with the principle of the Act. Staff obtained people's consent before care and support was provided. Care workers supported people with their nutritional needs and to access health care when needed.

Is the service caring?

Requires Improvement

The service was consistently caring.

People, relatives and health care professionals spoke highly of the care staff who they considered to be friendly and kind. Care staff had a caring attitude but did not have the time they needed to provide good care. Care staff respected people's privacy and dignity and right to make decisions and choices. People were supported, where possible, to maintain their independence and relationships that were important to them.

Is the service responsive?

Requires Improvement

The service was consistently responsive.

People's care records were personalised though some information was not clearly recorded. Care staff had a good understanding of the needs of people they supported. People were provided with some opportunities to engage in activities. People and, where appropriate, their relatives were not always involved in reviewing their care. People and relatives knew how to make a complaint and complaints were managed in line with the provider's procedure.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The provider's systems to monitor, review and make improvements to the quality and safety of service were not consistently effective. The registered manager did not always have the time needed to fulfil their management responsibilities. People, relatives and health care professionals spoke positively about the service provided and the way the home was managed. Care staff received the support and guidance they needed from the management team to carry out their roles.

Grove House Residential 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.

The inspection visit took place on 5 April 2018 and was unannounced. The inspection team consisted of two inspectors 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 service.

Before our visit we looked at the information we held about the home, for example statutory notifications the provider had sent to us. A statutory notification is information about important events which the provider is required to send to us by law.

We used information the provider sent us in the Provider Information Return (PIR). This is information we require provider's to send us at least once annually to give us some key information about the service, what the service does well and improvements they plan to make. During our inspection visit we found some of the information contained in the PIR did not accurately reflect how the home operated.

During our inspection visit we spoke with five people, three relatives of people and four staff, including care staff and catering staff. We also spoke with the registered manager and deputy manager and three visiting health care professionals.

We looked at three people's care records and other records related to people's care, including medicine records, daily logs and risk assessments. This was to see how people were cared for and supported and to assess whether people's care delivery matched their records. We reviewed three staff files to check staff were recruited safely and were trained to deliver the care and support people required. We also looked at records

of the checks the provider and management team made to assure themselves people received a good quality service.

Requires Improvement

Is the service safe?

Our findings

At our previously inspection 'Safe' was rated 'Requires Improvement. We found a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding service users from abuse and improper treatment. This was because on some occasions people had not been referred to the local authority when there had been a concern about possible abuse. This meant we could not be sure allegations of abuse were being investigated correctly in line with safeguarding policies and procedures.

At this inspection we saw the provider had made the required improvements for us to remove the breach of the Regulation. This was because records confirmed the registered manager had made safeguarding referrals to the local authority where people were identified as at risk, or possible risk of harm. They told us, "We learnt from the last inspection. Now I ensure referrals are completed." Records also showed actions had been taken as recommended by the local authority as part of plans to protect people following safeguarding enquiries.

However, areas where the home had previously performed well, now required improvement, and areas which we had previously identified as requiring improvement had not improved.

Medicines were not consistently managed and administered safely.

Previously, we found where people were prescribed medicines on an 'as required' (PRN) basis information was not available to inform staff what the medicine had been prescribed for, and when it should be given. At the time of our inspection visit, the management team gave assurance they would devise 'protocols' to ensure staff had the information needed to support people to take these medicines as prescribed.

During this visit medicine administration records (MARs) showed one person was prescribed PRN medicine to reduce anxiety and another person for pain relief. When we asked to see the protocols for these medicines the registered manager confirmed they were not available. They said, "It's my fault there are no protocols. I have been really busy. It's on my to-do-list." Despite these omission staff told us they understood when these medicines should be given.

The PIR informed us only trained staff administered medicines and regular observations of their practice were completed to ensure staff remained competent. We found senior staff who administered medicines had received training to enable them to administer medicine safely. However, records showed two senior staff had not had their administration practice checked by the management team to ensure they continued to administer and manage medicines safely. The registered manager told us, "This is an oversite on our behalf. We need to tighten up. So we will be doing competency checks every three months."

Some people were prescribed creams and lotions to be applied directly to their skin (also known as topical applications). Care staff told us they were responsible for applying these when they supported people with their personal care. This was reflected on MARs which read, 'Apply with personal care'. However, there was no record to show when these creams had been applied. When we asked care staff what training they had

received in relation to topical applications they told us they had not been trained. This meant we could not be assured topical applications were being applied safely and as prescribed.

Staff did not always follow the provider's medication procedure. For example, the procedure stated all eye drops must have the date of opening recorded on the bottle and the date of disposal recorded on the MAR which should be four weeks from the date of opening. Disposal dates are important because eye drops may not be safe to use after this time. We saw prescribed eye drops in the medicine fridge which did not have the name of the person they were prescribed for, or the date they were opened. We raised this with the registered manager who took immediate action to remove and replace the eye drops.

Some MARs did not reflect stocks of medicine in the medication trolley. For example, we saw three open bottles of liquid medicine prescribed to treat constipation. These items were not recorded on people's MARs. This meant we were unclear if the items had been discontinued, or if they were being administered. We spoke with the registered manager who immediately contacted the prescribing GP. The registered manager confirmed the items had been discontinued and removed them from the trolley.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

Other MARs showed medicines had been administered and signed for at the specified time. Most contained photographs of people to reduce the risks of medicine being given to the wrong person. Where people were prescribed pain relief patches, body maps had been completed to ensure these were applied in line with manufacturer's instruction. Medicine which required additional controls were securely stored and had been administered in line with the providers procedure.

People told us they felt safe living at Grove House and most said staff were available when needed. One person explained they felt safe because staff were always around. However, two people commented on staffing. One said, "I know there's a problem with staff shortages. They seem to look after me ok." Another told us, "Sometimes I ask for something and they say 'no, I'm too busy."

The registered manager confirmed the provider had reduced staffing levels the week before our visit to three care staff during the hours of 8am to 9pm. This was because the number of people had reduced to 14. However, on the day of our visit 20 people lived at the home, but the number of staff had stayed at the reduced level of three staff.

Staff told us that whilst they could just about manage people's personal care needs with the lower number of staff, the changes did not reflect people's needs. They went on to tell us that many people in the home required the support of two staff each time they needed personal care. This meant that when staff had 20 people to care for (which they did on the day of our visit) and one person required personal care; two of the three staff on duty might have to support that person, leaving one member of staff to support the remaining 19.

During our visit care staff were very busy and their engagement with people was focussed on completing 'tasks'. For example, we saw one person pressed their call bell asking for their lunch, and another person pressed their call bell to request a drink, whilst two care staff supported another person with their personal care. The registered manager and deputy manager had to step in to support staff ensure people's needs were met. The registered manager commented, "The resident's needs must come first. It does mean that other things [management tasks] slip."

We were in the dining room at the start of the lunchtime meal service. Initially there were no staff available to welcome or assist people to their chairs. We saw one person left standing in the dining room because the seat they usually chose was taken and the person did not know where to sit. People who were seated waited almost half an hour for their lunch to be served. There were no staff available to reassure people or tell them people lunch was on its way, and no attempt was made to engage people in other activities while they waited for their lunch.

Twenty minutes later when staff did arrive there was very limited interaction between people and staff and the meal time experience was disorganised. For example, when some people were eating their meal the deputy manager spent time moving chairs around so other people could be seated and staff asked people if they would like a serviette after lunch had been served. We saw five of the 12 people eating in the dining room were not offered drinks. Food looked and smelt appetising.

We shared our observations of the lunchtime service with the management team, who told us this was not what 'normally happened'. The registered manager told us, "It's probably because there are more residents."

We asked the registered manager how they assessed how many staff were needed to support people safely and to ensure people received care and support when they needed it. They told us, "I don't have a formal way of determining staffing levels but this is something I am going to develop." They added, "I will be speaking to the provider about increasing staffing."

Staff told us that as well as managing on reduced levels of staff they also struggled at times because there were not enough permanent staff to cover the rota. The registered manager told us they had to employ agency staff to make sure there were enough staff to keep people safe. A member of staff told us, "The problem is we have to keep showing them [agency staff] what to do and we are already rushed." The registered manager said they were trying to address this by requesting the same agency workers and on-going recruitment campaigns.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

The provider's recruitment policy and procedures minimised risks to people's safety. The provider ensured, as far as possible, only staff of suitable character were employed. Prior to staff working at the home, the provider checked their suitability by contacting their previous employers and the Disclosure and Barring Service (DBS). The DBS is a national agency that keeps records of criminal convictions. Staff confirmed they were not able to start working at the home until all pre-employment checks had been received by the registered manager.

The provider had systems to minimise risks related to the premises and equipment, such as periodic safety checks of water, fire equipment, and electrical equipment in line with safety guidance.

There were also procedures to identify potential risks related to people's care. We saw risk assessments had been completed and care was planned to manage and reduce risks. For example, some people were at risk of falling and could injure themselves. Where this was the case, the risk had been identified and information was included in people's care plans so staff knew what actions to take to keep people safe.

However, risk assessments were not always clear. For example, one person had been assessed as being at 'extreme' risk of falls, but elsewhere in their care plan, the risk had been described as 'very high.' Another

person's care plan included a falls risk assessment, where the risk was described as 'high'. However, in other sections of the person's care plan, the risk of falls was recorded as 'moderate.' Accurately recording the correct assessed risk level is important as it determines the different action needed to manage and reduce the risk. Whilst staff knew the level of risk and what actions to take, the registered manager acknowledged this could cause confusion for staff, particularly where agency staff who were not familiar with people were used.

Emergency plans were in place if the building had to be evacuated, for example in the event of a fire. Staff demonstrated they understood the provider's emergency procedure and the actions they needed to take in the event of an emergency. We saw people had personal emergency evacuation plans in place (PEEPs). PEEPs provide staff and the emergency services with the information needed to support people safely in the event of a fire, or other emergency situation.

However, PEEPs we saw were all due for review in February 2018. Whilst the registered manager assured us there had been no changes, they agreed they would review these guidelines to ensure they were up to date.

Staff had attended training in safeguarding vulnerable adults and demonstrated they understood the different types of abuse a person may experience, and their responsibilities to report any concerns. Care staff were able to give us examples of what might be cause for concern, what signs they would look out for and what action they would take. We saw posters displayed around the home advertising the providers confidential help line which people, staff and visitors could use to escalate concerns if they felt these had not been addressed.

The home was clean and tidy. Our discussions with care workers assured us they understood their responsibilities in relation to infection control. One said, "It's important to wear gloves and aprons when providing personal care. We only use them once then throw them away in the yellow bags."

Requires Improvement

Is the service effective?

Our findings

At our previous inspection, in March 2017, 'Effective' was rated as Requires Improvement. We found the provider had breached Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding service users from abuse and improper treatment. This was because referrals under the Deprivation of Liberty Safeguards (DoLS) had not been made to the local authority when a person's liberty had been restricted and the person did not have the mental capacity to consent to the restriction. During this visit we found the provider was no longer in breach of Regulation 13, but improvements were still required.

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 Mental Capacity Act 2005 (MCA). The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards.

The registered manager demonstrated a basic understanding of the legislation in relation to DoLS. Records confirmed where restrictions on people's liberty had been identified, the registered manager had made DoLS applications to the relevant authorities so they could be legally authorised. This protected people who could not make all of their own decisions, by ensuring restrictions were proportionate and were not in place without the relevant authorisation.

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.

Care plans included detailed information for staff on the level of support people needed to make day to day decisions. However, where relatives had the legal authority to make 'best interest' decisions this was not always clear. The registered manager told us they had requested evidence from relatives of any decision making powers they had been granted but most had not responded. They assured us they would address this.

Staff had completed MCA training and understood the need to gain people's consent before providing care and support. However, records showed consent had not always been sought in line with legislation. For example, we saw two people had signed to say they consented to the delivery of care and to have their photograph taken. However, the capacity assessments in their care plans informed us they did not have capacity to agree to their care, and DoLS referrals had been made. We raised this with the registered manager, who explained people had signed consent when they had capacity to do so, but confirmed they could no longer give informed consent. They assured us they would consult with the relevant people to make decisions on whether or not, for example consenting to photography was in their best interests.

People were confident care staff had the skills and knowledge needed to support them effectively. One

person described care staff as 'very capable'. A relative told us staff who worked at the home were knowledgeable and professional.

Care staff told us they completed an induction when they started work at the home. This included working alongside an experienced staff member, and completing training the provider considered essential to meet the needs of people who were living at the home. One staff member described their induction as 'good'. The added, "Everyone [management and staff] was really helpful."

However, the provider's induction was not devised in accordance with nationally recognised guidance for effective induction procedures. This was because new staff had not completed the Care Certificate as part of their induction. The Care Certificate was introduced in 2015 and assesses staff against an agreed set of standards during which they have to demonstrate they have the knowledge, skills and behaviours expected of specific job roles in social care sectors. The registered manager told competing demands on their time had 'delayed' the introduction of the Care Certificate. They told us they would speak with the provider about this.

Care staff had mixed views about the training they received. One told us, "The training we get is fine." Another told us they did not feel they gained from refresher training because of the way it was delivered. They said, "The trainer just reads from the board, so it's difficult to concentrate and I don't feel I learn." They added, "We never get asked to give feedback about training." A third commented, "The training is really good, they explain things, they always have time for you if you aren't sure about anything."

Records showed most of the training staff needed to refresh their skills and knowledge was up to date; this included moving people safely, equality and diversity, management of infection control and health and safety. Staff also completed training in other areas related to people's individual needs, like understanding how to support people's care if they were at risk of developing pressure ulcers. . We saw the home had retained its accreditation to The React to Red scheme for three years. This is a pressure ulcer prevention scheme run by health and social care partners. Homes have to meet and maintain certain standards to achieve accreditation.

Prior to people moving to Grove House the management team completed an initial assessment of their needs and expectations to ensure these could be met. This included people's life style choices, beliefs and preferences. Some records showed people and their families had been involved in the process.

People told us the food provided by the home was good, was readily available and that there was always a choice. One person said, "Its good quality." Staff demonstrated they understood people's dietary likes, preferences and specialist requirements. For example, one staff member told us of people whose drinks needed to be thickened to reduce the risk of choking (drinks sometimes need a thickening agent added to help the liquid move more slowly and reduce the risk of it going into a person's lungs). Kitchen staff explained how they 'fortified' meals by adding cream, full fat milk and butter to increase the calorific intake for people who had, or were at risk of weight loss.

Records showed people were weighed regularly where they were at risk of weight loss, and that referrals were made to dieticians to ensure people were safe. However, one person who was identified as being at 'high risk' had not been weighed since October 2017 because it had been identified they were too unwell and it would cause them distress. We discussed this with the deputy manager, who agreed other methods (such as measuring the person's arm circumference) could be used which would reduce any distress or discomfort for the person whilst monitoring risk.

People received support to maintain their health and wellbeing. One person told us, I had an eye test a few months ago. The doctor comes here. I haven't needed a dentist. The chiropodist also visits." A relative said they 'always' received a telephone call from the home to update them when their family member had been visited by the doctor. They told us they thought this was 'very good.' Care records showed people were supported to access medical professionals on an on-going and routine basis, as well as when their needs changed or their health deteriorated.

Staff worked in partnership and maintained links with a range of health professionals. A health care professional who regularly visited people at the home told us they found staff to be approachable and helpful. They added, "I have never had a problem when I visit." Another visiting professional commented, "Staff and the manager are very co-operative, very engaged and very professional." The registered manager told us, "Good relationships with other professionals benefit everyone but most importantly the residents."

We checked to make sure people's needs were met by the design and decoration of the home. The provider had made some adaptations to the home to better support people. For example, radiators had been covered and, where radiators were on corridor walls, grab rails had been fixed to the wall around the radiator so people could hold onto the rails to steady themselves without having to touch radiators. The registered manager told us further improvements were planned as part of the home's rolling refurbishment programme. This included replacing carpets which were showing signs of wear and tear.

Requires Improvement

Is the service caring?

Our findings

At our previous inspection we found the service provided was caring. During this inspection whilst we saw staff had a caring attitude, they were not consistently providing good care because they were rushed and task focused.

People and relatives told us staff were friendly and kind. One person said, "The staff are all very nice to me." Another commented, "The staff are fantastic they can't do enough for you. It's brilliant here it's like one big happy family." A health care professional told us staff were polite and respected people's wishes. They added, "They are very good with people."

From speaking with care staff it was evident they cared about the people in their care and wanted to do their best. One told us, "Every day I really look forward to starting my day by saying hello to the residents." Another said, "The most important thing for me is the residents. Making sure they are having a good life. The life they want. If I can make sure they are happy and comfortable I have done a good job." However, staff explained they did not always have the time they needed to support people in the way they needed.

During our visit, care staff demonstrated their caring and sensitive approach to their work. For example, we heard one member of staff speaking to a person who was anxious. The person apologised because they thought they were keeping the staff member from other duties. The staff member replied, "I have as long as you need. What's important is that you are ok." We saw they remained with the person until they were satisfied the person was less anxious.

However, we saw at other times, when rushed, staff became task focused. For example, a staff member served mid-morning drinks to people in the lounge but did so without speaking to people other than to ask if they wanted a drink and staff were not available to support people throughout the lunchtime meal service.

People were encouraged to maintain relationships important to them. People told us their visitors were welcome at any time. One said, "I have lots of visitors. There are no restrictions." We saw care staff greeted relatives in a friendly manner. One relative told us they were always offered a drink and biscuits when they visited and went on to described how, on one occasion, the cook had given another family member some stew to take home because they were not feeling well.

People had personalised their rooms with pictures, photographs and soft furnishing of their choice. When speaking about their bedroom one person said, "Look at my beautiful home." People told us they were able to make everyday choices and decisions and staff respected the decisions people made. One person said, "I get up when I want and I go to bed early by choice."

Staff understood the importance of respecting and ensuring people's privacy and dignity was maintained. We saw two staff assisting a person to transfer from their wheelchair to an easy chair with a hoist. Staff maintained good communication throughout. For example, staff said things like, "And down we go now," and, "Let's just bring your head forward a little so the bar isn't in the way." Staff also ensured the person's

dignity was maintained by adjusting the person's clothing during the manoeuvre.

Care staff understood the importance of encouraging people to be as independent as possible. One told us, "We don't do things to the residents. We do things with the residents." Another described how one person was able to get dressed most days without assistance. They added, "I always ask [person] if they need help but I know they like to do it if they can." Staff knew increased independence contributed to people's well-being.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in March 2017 we rated this key question as 'Good'. At this inspection visit we found staff were not always available to respond to people's requests for assistance in a timely manner. People and relatives were not always involved in care planning and people's emotional and social needs were not always met.

People told us care staff who supported them understood their individual needs and said they were satisfied with the service they received. One person said, "They look after us well, it's a happy place." Another person, living at the home on a temporary placement told they like the staff and home so much they hoped they could stay permanently.

Staff demonstrated they had a good knowledge of people's individual needs, and were able to tell us how people preferred their care and support to be provided. For example, one staff explained some people enjoyed their own company and spent time in their bedroom, whilst other people liked to sit and chat in the communal lounges. They added, "If [person] isn't in the lounge you know they're not well."

Care staff attended a daily handover meeting at the start of their shift to exchange information about people at the home. Staff told us this assisted them in keeping up to date with people's health and care needs. Handover records were used to communicate important messages and listed key information about each person that lived at the home.

Care plans detailed people's needs and preferred routines which supported staff to provide personalised care. For example, what people preferred to drink and what items of clothing they liked to wear. Care files contained information about people's life histories, their likes and dislikes, cultural and religious motivations. Where people had specific needs, for example around communication there was guidance for staff on how best to support the person.

We saw care plans had been regularly reviewed. However, they did not show how people, their relatives and/or representatives had been involved in the review process. When we asked people and relatives about their involvement in planning and reviewing their care we received mixed responses, "I don't remember discussing my care at all." and "Yes, there has been a meeting."

Care files were securely stored so people could be confident their personal information was kept private.

People and relatives had mixed views about the activities and support available to enable them to follow their interests and hobbies. Comments included, "We do activities and someone sings to us. They take us out for meals and we have church lunches." "They play some games now and again. I enjoy some of them. I don't go anywhere." and "A man comes playing the organ and guitar, I like the music. We have quizzes as well and keep fit." A relative commented they had only seen activities taking place at the home on one occasion.

The home had a dedicated staff member who was responsible for planning and supporting people with activities four days a week. Care staff told us when the homes activities co-ordinator was not on duty, like on the day of our visit, they tried to provide activities but they could not always do this as they were busy providing care to people. Another commented, "We take people out into the garden, plant plants that kind of thing. We also have a big box with lots of library books in so we take that round a bit like a mobile library."

However, we did not see any activities taking place during our visit and there was no information displayed in the home about planned events and activities so people knew what was on offer to them. The registered manager told us activities was an area they needed to develop. They added, "We have such a wide range of residents [people] with different interests this definitely needs looking into."

We checked how complaints were managed by the home. People and relatives told us they knew how to make a complaint and would feel comfortable doing so. One person said they would tell staff if they had any worries. Discussion with staff demonstrated they understood their responsibilities to support people to share concerns and make complaints.

We saw the provider's complaint procedure was displayed in the home and a 'comments and concern' book was available in the front reception. Records showed the home had received two complaints since our last inspection which had been managed in line with the provider's procedure. The home had also received numerous thank you cards. One read, "Mom had the privilege of staying with you…couldn't have been anywhere better. She told everyone she was happy there."

The registered manager told us they kept their knowledge of current social care issues updated. They explained they did this through reviewing the Care Quality Commission website, subscribing to a social care magazine and discussion with the provider. They told us the provider was arranging training to ensure the registered manager was familiar with recent changes to the data protection law.

The registered manager told us there was no one living in the home at the time of our inspection who was in receipt of end of life care. People's wishes for care at the end stage of life had been considered as part of their care planning and, where people did not have capacity to make decisions regarding this, the provider had consulted with others to make decisions in people's 'best interests'.

However, people's end of life wishes were not always clear. For example, one person's care file contained two Do Not Attempt Resuscitation (DNAR) forms, one almost completely blank, and the other very detailed. We were concerned this could cause confusion, especially for agency staff and may result in the person's wishes not being respected. We discussed this with the registered manager who acknowledged this should have been identified when care plans were last audited and removed one of the DNAR forms.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection in March 2017 we rated this key question as 'Requires Improvement'. This was because we could not be sure the management team understood the legal requirements and their responsibilities to protect people. During this inspection visit whilst some improvements had been made we identified other areas where improvement was required. The rating remains Requires Improvement.

The home had a registered manager. 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.'

The registered manager was supported by a deputy manager and senior care workers. The registered manager told us they also received some support through weekly visits from the provider. They added, "[Provider] is always contactable by phone if I need them."

The management team's oversight of the home did not assure us that people were always cared for safely, and that the quality and safety of the service provided was maintained and improved. For example, the providers 'Monthly Quality Control & Management Review' completed by the registered manager and approved by the provider had not identified the induction for new staff did not include completion of the Care Certificate.

We found audits and checks to assess and monitor the quality of the service provided had been completed but were not always effective. For example, weekly and monthly audits of medicines had not identified the range of medicine management issues we found. This meant the provider had not assured themselves medicines were being safely managed in line with their procedures.

Some quality auditing processes were not sufficiently detailed to enable them to be effective. For example, the audit tool used to check care files showed the date the file had been reviewed and that all required sections of the care plan were on file. There was no further detail to confirm the content of care files were up to date, issues had been identified and actions taken. We saw the latest audit contained care files we had reviewed but the inconsistencies we found had not been identified or addressed. This meant staff did not have accurate information about people's needs and wishes to enable them to provide care and support safely.

The providers PIR stated, 'Accidents and incidents are recorded, monitored and analysed for trends and patterns'. We found accident and incidents were not always investigated and clearly recorded. For example, we saw one person had a dressing on their leg. They told us they had sustained a tear to their skin caused by a staff members long nails. We found the skin tear had been recorded on a body map but there was no accident/incident report. When we raised this with the registered manager we found they were not aware of the possible cause of the injury and told us they would investigate.

Care records for another person showed they had fallen out of bed. However, there was no corresponding incident form. A body map for a third person showed they had had 'marks' on their arms and legs. The person's care records indicated these could be associated with a medical condition. However, there was no information to show this had been confirmed. The registered manager told us the marks were not bruises so they had not been concerned. They acknowledged these needed to be assessed and immediately arranged for a health professional to visit the person who confirmed the marks were consistent with an existing medical condition.

The provider had not ensured there was a system in place to ensure required staffing levels were identified and changed in line with the needs of people who lived at the home. The registered manager told us because the management team supplemented staffing they had not always had time to focus on auditing, monitoring and improving the service. They assured us they spoken with the provider about this, and would do so again following our inspection.

This was a breach of Regulation 17 Health and Social Care Act (Regulated Activities) Regulations 2014. Good governance.

Other audits identified areas for improvement and the action needed. For example, a Health and Safety audit completed by an external consultant identified some staff training was not up to date. The registered manager told us dates had been agreed for staff and the management team to attend training.

People and relatives were complimentary about the way the home was managed and the service provided. Comments included, "[Registered manager] is very good, she listens and is always available." "I am really well looked after. I couldn't ask for anything better." and "It's lovely here…The manager is great."

Professional visitors were also positive about the registered manager and about how the home was run. One told us, "I would put my mother here. [Registered manager] and [deputy manager] are very competent."

Staff told us they felt supported and valued by the management team who they described as 'approachable and helpful'. In addition to daily contact staff were supported through regular individual and team meetings. We saw the registered manager had 'thanked' staff for all their hard work during a recent outbreak of a gastrointestinal illness. They told us, "I was so proud of the staff. They worked so hard." A care staff member told us, "It's nice to be appreciated." However, care staff told us they did not always feel valued or supported by the provider. One said, "I don't think they understand the residents [people's] needs and how hard we work because they wouldn't have cut staff numbers."

The provider invited people and relatives to share their views about the quality of the service and any areas where improvement could be made through an annual survey. The latest survey from 2017 showed relatives were satisfied with the service provided. We saw the provider had analysed the outcome of the survey and used the feedback received to make improvements. For example, menus had been changed in response to people's comments about the type of food they preferred and a lounge was being refurbished because relatives wanted a private spacious area to meet their family member's.

The registered manager was not familiar with the 'Accessible Information Standard' [AIS]. The AIS aims to make sure that people who have a disability, impairment or sensory loss get information that they can access and understand and any communication support they need. They acknowledged this was not something they had yet considered at Grove House, but assured us they would attend to this as they completed the review and update of all care plans.

The registered manager demonstrated they understood their responsibilities and the requirements of their registration. For example, they had ensured appropriate assessments were completed where a person's liberty may be restricted and notified us about important events and incidents that had occurred. The registered manager also shared information with local authorities and other regulators when required, and kept us informed of the progress and the outcomes of any investigations into concerns.

We saw the provider had met their legal responsibility to display the latest rating we gave them within the home and on their website.

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 Regulation 12 (1) (2) (g) HSCA RA Regulations 2014. Safe care and treatment The provider had not ensured the proper and safe management and administration of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 17 (1) (2) (a) (c) (f) HSCA RA Regulations 2014. Good governance The provider had not ensured they had effective systems in place to assess, monitor and improve the quality and safety of the service provided. The provider had not ensured nationally recognised guidance was followed for the induction of new staff.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 (1) HSCA RA Regulations 2014. Staffing The provider had not ensured sufficient numbers of staff were available to meet people's need.

The provider did not have a systemic approach to determine the number of staff needed to meet people's needs.