Care Management Group Limited

Grange Court

Inspection report

115d Hilperton Road
Trowbridge
Wiltshire
BA14 7JJ

Tel: 01934429448
Website: www.achievetogether.co.uk

Date of inspection visit:
14 August 2019
19 August 2019

Date of publication:
28 October 2019

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Grange Court is a residential care home providing personal care to five people with autism at the time of the inspection. The service can support up to six people. One person was receiving care at another home, supported by staff from Grange Court. This support was planned to remain in place until two days after the inspection. Four people were living at the home at the time of the inspection.

Grange Court accommodates people in an adapted residential property. There were communal lounge, kitchen, dining and garden spaces at the home. Two people had adapted self-contained 'flats' with a bedroom, kitchenette and living space.

The staffing and governance of the home meant people living at Grange Court did not receive appropriate care and support in line with the principles of Registering the Right Support. Registering the Right Support aims to ensure people who use the service can live as full a life as possible and achieve the best possible outcomes. The principles reflect the need for people with learning disabilities and/or autism to live meaningful lives that include control, choice, and independence.

People's experience of using this service and what we found
At this inspection we found the service continued to be in breach of Regulations 17 (Good Governance) and 18 (Staffing). In addition, evidence found shows the service to now also be in breach of Regulation 12 (Safe and Treatment).

There were not enough suitably experienced staff to meet people's needs. There were staff who had left the service since the previous inspection or had requested to 'step-down' from senior roles. The home was staffed with a mix of permanent staff, agency staff, and 'service support team' staff. The service support team are employed by the provider and work on short-term contracts around three-six months at different services. The provider's head of recruitment had been assigned to improving the staffing levels at the home.

People did not receive consistent care and support from the number of staff they were funded for and assessed as needing. The home received payments for the staffing levels from the local authority but failed to provide this as per their agreements. There were examples of people declining in their motivation to engage in activities and also their physical appearance. These examples linked directly to the service not having enough staff. We reported our concerns to the local authority. They advised us reviews of people's care and how their needs were being met would take place.

Staff told us they felt or had at times felt unsafe working at the home. Staff had received serious injuries resulting in hospital admissions. Staff told us they felt for one person it was not possible to follow the behavioural support plan, to reduce the likelihood of injuries occurring. They said this was because the person could anticipate what they were going to do and this left staff feeling vulnerable and at risk of sustaining injuries.

Records showed one incident since the previous inspection was potentially triggered by a member of agency staff not knowing the person and their routine well enough to support them. The management review of the incident had not been documented to identify whether appropriate practice was followed. Staff told us of other times when the actions of staff who did not know the person well had caused escalations in behaviours. These had led to people and staff being put at risk.

Body maps and injury records for one person following an incident were not consistently maintained. It was unclear what injuries the person sustained and how these were monitored. There was also a lack of clarity about what permanent marks the person had. This meant the person was at risk of not having new injuries identified.

Staff felt the manager valued their work but felt the provider did not. They had mixed feelings about initiatives being put in place to try and improve staff retention.

Staff felt there were communication issues at times between the manager and staff team.

Although feedback was given at the previous inspection about shortfalls in record keeping, measures had not been put in place to address this and the shortfalls continued.

A recently appointed quality improvement manager had been assigned to work with the service and mentor the manager. The manager expressed concerns this would lead to shortfalls being brought to their attention, which they would not be able to address due to the staffing challenges.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection (and update)
The last rating for this service was Requires Improvement (published 23 July 2019)

The provider completed an action plan after the last inspection to show what they would do and by when to improve, this was received in the expected timeframe. Due to receiving two whistle-blower concerns about the service since the previous inspection, this focussed inspection was started one day before the action plan was received.

Continued breaches of regulations since the last inspection were identified.

Why we inspected
This focussed inspection was prompted by whistle-blower concerns about staffing levels and provider level leadership of the home. Because of the concerns raised by the whistle-blower's and the evidence found at the previous inspection, we inspected the key questions of Safe and Well-Led only. Ratings from previous comprehensive inspections for those Key Questions were used in calculating the overall rating at this inspection.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will use this meeting and the findings from this inspection to consider enforcement action we may take.

We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Enforcement
We have identified breaches in relation to the leadership of the home. This was a breach of regulation 17. Also, the safety and quality of care people received and the staffing levels. This was a breach of regulation 12.

Since the last inspection we recognised that the provider had failed to ensure people were supported by suitable staffing arrangements. This was a breach of regulation 18. Full information about CQC's regulatory response to this is added to reports after any representations and appeals have been concluded.

Special measures
The overall rating for this service is 'Inadequate' and the service is in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

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

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Grange Court

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection team consisted of one inspector,

Service and service type
Grange Court 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 service had a manager in post. Their application to register with the Care Quality Commission was in progress. Registering 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.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We reviewed information we held and had received about the service to plan our inspection.

During the inspection
We reviewed records relating to accidents and incidents, medicines administration, and the staff handover

files. We looked at information and records relating to four people's care. We also looked at records relating to the safety and management of the service. We spoke with eight members of staff, also the nominated individual, the home manager, area director, and registered manager of another of the provider's services. The registered manager from the other service had been at the home when we inspected. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

After the inspection
We reported our concerns about people not receiving the care they were funded for to the local authority locality, safeguarding and commissioning teams.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Staffing and recruitment

● At our comprehensive inspection in June 2019, the provider was found to be in breach of Regulation 18 due to shortfalls in how the home was staffed. These shortfalls related to not being able to ensure there were enough suitably experienced or skilled staff to meet people's needs. The breach of regulation 18 continued at this inspection.

● Staff and the provider told us the home had been having difficulty recruiting and retaining staff. Since the previous inspection there had continued to be 13 full-time staff vacancies.

● We found two people frequently did not receive support from the two staff they had been assessed as needing and were funded to receive. Records showed one person did not receive support from two staff for 34 days between 1 June 2019 and 12 August 2019. A second person did not receive support from two staff for 26 days between the same date range. Both people were funded by local authorities to receive this support each day and relied on this support to access the community.

● Staffing shortfalls directly impacted people being able to access the community using their own vehicles. Staff told us of one person who liked to go out each day in their car, the person had not been consistently supported with their preferred routine due to a lack of staff who could drive. For another person, staff told us they had stayed in the home for the entire weekend before the inspection, with only brief trips to the garden or the neighbouring home to collect items. Staff said the person would ask to go out, but they would have to say, "Not today." Not being supported to follow their preferred routines and independence in the community increased the risk that people would become frustrated or anxious. As a result, they may place themselves or others at risk of harm.

We found evidence people were placed at risk of emotional harm due to the impact of not having enough suitably experienced, skilled and competent staff. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At this inspection we did not review staff recruitment files as no concerns had been found at the previous inspection. Recruitment checks included gaining character and employment references. Staff also had disclosure and barring service (DBS) checks in place. The DBS helps employers make safer recruitment decisions by preventing unsuitable people from working with vulnerable people.

● The home had an appointed coordinator with their preferred staffing agency. Agency staff had received the appropriate mandatory training. Those who attended the home on a regular basis received supervision meetings to discuss what was working well and what was not.

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

● This inspection and the previous inspection were prompted by whistle-blower concerns sent to CQC. Whistle-blowing is the process of speaking out about poor practice. Since the June 2019 inspection, we received two further whistle-blowing notifications. These both raised concerns about staffing shortfalls, the risk of people being harmed, and that staff had been harmed. Lessons had not been learned and whistle-blower's felt their concerns were not acted upon by the provider, to reduce the likelihood of recurrence. Whistle-blower's did not feel the provider was taking suitable action to address concerns.

● Records showed that staff were experiencing serious injuries at work. The nature of injuries staff sustained since the previous inspection varied. These included being head-butted, having a piercing ripped from the skin, having their hand stabbed with a fork, and receiving forceful blows to the head. Staff told us their protective headwear had been removed by people during incidents of escalated behaviours and one staff member was too small to wear the protective clothing layer. Staff were at risk of receiving further injuries.

● One staff member who had sustained injury was allocated to work with the person on their first day back at the service after the incident. While a check was made with the staff member that they were happy to work with the person again, a formal debrief of lessons learned did not take place until the afternoon of that day. Despite the serious nature of injuries staff were receiving, the home was not following best practice guidance to ensure lessons were being learned and staff well-being was also being supported. Staff told us they had felt unsafe while at work, because of the culture of expecting injuries to occur.

● The home was staffed daily with a mix of permanent, agency and temporary staff. The temporary staff were employed and trained by the provider and based at the home on three-month contracts, although in that time they may work at other services. The temporary nature of these roles could mean people were supported by staff who may not consistently know them well. We received mixed feedback from staff and the provider about the competencies of agency and permanent staff. It was evident there were potential shortfalls in staff competencies regardless of whether they were permanent or temporary in their contract at the home.

We found evidence staff had been harmed and the varied competencies of staff put people at risk of harm. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● Staff told us how they would identify if a person was at risk of abuse and all staff knew there were risks to people's safety and wellbeing at the home, at the time of the inspection.

● Staff felt they could approach and raise concerns with the home manager, area manager and area director. They also knew the provider had a whistle-blowing procedure. Staff knew they could raise concerns with CQC and the local authority.

Using medicines safely

● Staff felt there were not enough medicines trained staff available. They told us at times there were only two medicines trained staff in the home and this led to delays in administration. Staff also were mindful that in the event of medicines being needed to be administered in an emergency, it may be difficult to receive this support in a timely manner. We raised this with the home manager who informed us it had been assessed as safe to have two members of medicines trained staff available. They advised us this was the minimum requirement and they were in the process of signing-off agency staff to administer some medicines.

● Records of medicine administration showed people received their prescribed medicines. Medicines were stored securely and administered by trained staff.

Preventing and controlling infection

- The home was free from unpleasant odours and was clean throughout.
- Staff had access to personal protective equipment (PPE) to reduce the likelihood of cross-contamination. This included gloves and antibacterial hand-gel.

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated 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.

The provider and their support of the service

- We had received whistle-blower concerns about the home and the provider's support in providing adequate staffing since April 2019. In August 2019, we continued to receive further whistle-blowing concerns that staffing had continued to not improve. The concerns raised related to staffing impacting the safety of people and staff, as well as the quality of care people receive.
- We contacted the provider following receiving whistle-blower concerns in July 2019, but the response we received from the provider did not address all concerns we had raised. In the response we received from the provider, we were also told people would only go without their two-to-one staffing needs being met if the staffing was at a critical level. The response neglected to advise us of the extent that the critical staffing levels were being operated on.
- For the two people who were frequently without their required staffing levels, the extent of this information had not been communicated to their relatives or the funding authority. We advised the provider to act promptly and inform people's relatives of the frequency of the missed support. Following our inspection, we also notified the local authority of how staffing was impacting people who were not receiving their two-to-one support.
- We raised concerns at the inspection about two people not receiving the two-to-one support they were funded for. We were advised this had been a historic decision by the provider to avoid having a higher ratio of agency staff in the home than those employed by the provider. This meant people's needs were not being prioritised when considering staffing levels. Following this feedback, the provider agreed to schedule adequate staffing to meet people's assessed needs.
- There had been a change in the expected provider level support for the home manager, to help with their induction to the service. There had been a temporary manager in post, with an expected handover period of working with the newly appointed home manager for three months. This had not happened as planned. This meant the home manager had not been able to shadow support staff shifts. They were not able to get to know people as well as they needed to. The area director was not aware this part of the home manager's induction had not happened and told us they would put plans in place for mentoring the home manager.

We found evidence staff had been harmed and people were at risk of harm. There was a lack of good governance from the provider to support the service in sustaining improvements when concerns were first identified. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Some actions had been taken by the provider following our June 2019 inspection. These included

introducing a quality improvement manager. While we received concerns during the inspection about how improvements could be implemented or sustained, the role was yet to have the opportunity to take effect.
● Staff had received consultation from a senior management team in the two weeks prior to inspection. The provider sought staff input as to how the staffing situation could improve. Staff told us initiatives such as a bonus scheme had already been trialled seven months prior to the inspection and staffing had not improved at that time. Following these consultations, staff were offered a bonus for payment before Christmas, subject to various conditions, including not taking more than three days off work sick.
● Staff were sceptical of what benefit these consultations would have and shared mixed views with us. The area director explained they valued staff contribution and told us the provider was taking their concerns seriously. One staff member said, "I know I am not important to them. I am just a number." Another said, "[The amount we are paid] shows they don't value what we do or the risks we face. Staff are ending up with serious injuries. I am not surprised people don't want to work here. I don't know why [the provider] can't see it." A different staff member told us, "I have thought about leaving. I am so close to doing it. I am only staying because I worry what will happen to the people who live here if the staff continue to leave."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Shortfalls in staffing prevented people from receiving consistent and person-centred care to achieve good outcomes. One person who did not consistently receive their two-to-one staff support was unable to work towards a personal goal of having their hair cut. At the previous inspection we were shown a person-centred communication tool to help them achieve this positive outcome. At this inspection we were told that had been put on hold, due to staffing shortfalls. Staff told us the person's hair had become matted and difficult to clean. Although there were plans to introduce this support again, these were yet to take place.
● Staff spoke with enthusiasm about wanting to deliver person-centred care, but knew they were unable to help people achieve their full potential. Staff told us they valued working at the home and being able to make a different to people's lives. However, they felt their ability to do this was not supported by the provider and staffing at the home.

The shortfalls in staffing impacted the culture in the service. The shortfalls in staffing meant there were risks to people's health, safety and emotional well-being. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
● There was an embedded culture of expecting to receive injuries at work. Staff told us the behavioural support plans for two people were not kept as up to date as they could be. They told us the people's needs changed from week to week. They said one person appeared to know the deflection moves staff would use to exit situations where the person made physical contact with them. One staff member said, "The reality of the situation is, you end up just trying your best to get out. It took too long for the staff to come to me a while ago to help and [person] head-butted me." All staff we spoke with told us they felt the level of behaviours they were required to support people with was not reflected in the support they received from the provider.
● There were discrepancies between what different staff told us and what the home manager told us about whether there were enough suitably trained staff to 'shift lead' on weekends. A shift lead staff member is responsible for running the home in the absence of the home manager. They allocate staff to work with different people. Two staff described staff who were not trained as shift leaders working in this role as "being set up to fail". The home manager told us they had wanted to "empower" staff members. However later in conversation agreed with us that allowing the staff member to shadow a shift leader would have been more

suitable.

We found evidence staff had been harmed and people were at risk of harm. There were insufficient systems in place to monitor risks, learn lessons and ensure good governance. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care

● At the previous inspection the home was found to be in breach of Regulation 17 (Good Governance) in the key question of Effective. This was because of the systems, assessments and records in place to monitor the quality of care and ensure people's up to date needs were in their care plans. The home continues to be in breach.

● Learning outcomes from the previous inspection had not been acted upon with immediate effect. Written and verbal feedback was given at the inspection on 13 June 2019, which included poor record keeping. In checking records relating to people's safety, we also saw records which had been reported on previously had not improved. These included records of people's fluid intake. This evidenced a lack of action to act upon concerns which could be addressed with appropriate communication and monitoring.

● We found a further example of poor record keeping, which meant a person's potential injuries could have been missed. We found accident records and body maps for one person following an incident of behaviours where they had hit their knee against a wooden cupboard had not been maintained correctly. The record stated the staff member would record the injuries on a body map, but this had not happened. Two weeks later there were new knee injuries recorded on a body map, but with no corresponding accident record to state how these had occurred. We asked one staff member about this and they told us the person always had swollen knees. The home manager checked records of the person's 'permanent marks' and found there were no entries relating to the person's knees. The home manager informed us they would make a GP appointment for the person and would review documentation relating to their permanent marks.

Risks to people's safety and well-being continued to be present since the previous inspection and there was a lack of action being taken. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; working in partnership with others

● Staff told us they felt the home manager was "trying [their] best", however they also felt the home managed was under "extreme pressure." Staff told us the home manager thanked them for their work. They said they knew the home manager valued them and they felt the home manager also wanted to do the best to support staff well-being. The home manager told us, "There has been a negative culture here for some time. I hope the staff can see I do listen, and I do thank them for their work."

● People continued to be supported for visits home to see their family and people's relatives could visit the home or receive communication via telephone and email.

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

● Since the previous inspection we did not see evidence of events which required the provider to act upon their duty of candour. However, the provider understood their responsibility to act upon the duty of candour.