Grove Park Healthcare Group Limited

Grove Park

Inspection report

2 The Linkway
Brighton
BN1 7EJ

Website: groveparknursinghome.co.uk

Date of inspection visit:
10 August 2022

Date of publication:
23 September 2022

Ratings

Overall rating for this service	Insufficient evidence to rate

Is the service safe?	**Insufficient evidence to rate**
Is the service effective?	**Insufficient evidence to rate**
Is the service well-led?	**Insufficient evidence to rate**

Summary of findings

Overall summary

About the service
Grove Park is a hospital that consists of one nursing unit which provides nursing and personal care for up to 31 older people with complex needs, and an acute inpatient mental health service for adults of working age in two wards (nine beds on each). At this inspection, we only inspected the nursing unit and there were 24 people living there.

People's experience of using this service and what we found
People's hydration intake was not being effectively monitored to reduce the risk of dehydration. Incidents were not recorded fully and did not show actions taken to minimise the risk of further incidents. They were also not monitored to identify trends. People had individual risk assessments in place to help manage and minimise risks. There were high levels of agency staff which meant there was a risk of staff not knowing people's needs and risks well.

Staff had not all completed the provider's mandatory training. This meant that staff did not always have the required skills to carry out their roles effectively and safely. Staff had not been receiving supervision or regular team meetings to adequately support them. People's eating preferences and needs were being catered for. Staff told us that this had recently improved and prior to this people who required a special diet was not consistently receiving what they needed. People's physical healthcare was assessed and supported, and people had access to GP's and other healthcare professionals. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests. However; the provider did not consistently record that consent was sought by the person, a next of kin or Power of Attorney.

Quality assurance systems were not robust which meant areas of improvement were not identified or acted upon. There was not adequate management oversight of the service. There were not effective or detailed policies and procedures in place for staff to follow. Managers did not ensure that staff were adequately trained or supported.

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

Why we inspected
We received concerns in relation to the safe care of people on the unit. As a result, we undertook a focused inspection to review part of the key questions of safe, effective and well-led only.

Grove Park was registered with the CQC in February 2022. We inspected the mental health wards in June 2022, but this was the first time we inspected the nursing unit. We did not rate this service at this inspection because we did not look at the key questions in full.

Enforcement and Recommendations
We have identified breaches in relation to safe care and treatment of people, staff training and support and the management processes of the service at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? Insufficient evidence to rate	**Insufficient evidence to rate**
Is the service effective? Insufficient evidence to rate	**Insufficient evidence to rate**
Is the service well-led? Insufficient evidence to rate	**Insufficient evidence to rate**

Grove Park

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 under the Health and Social Care Act 2008.

Inspection team
The team that inspected the service comprised of three inspectors.

Service and service type
The nursing unit at Grove Park 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. The nursing unit at Grove Park is a care home with 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 a registered manager in post.

This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service. We sought feedback from the local authority and professionals who work with the service. We used all this information to plan our inspection.

During the inspection
We spoke with eight members of staff including the nurses, the chef, registered manager, director and the

seconded ward manager.

We reviewed a range of records. This included 10 people's care records and 11 fluid charts. We looked at staff training and supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

Insufficient evidence to rate

Is the service safe?

Our findings

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

This key question has only been partially inspected and was not rated.

Assessing risk, safety monitoring and management

● Records of fluid given to people contained gaps and omissions and did not inform staff of the required amount of fluid somebody was assessed to need during the day. It was not possible to determine whether people's hydration needs had been met. Some records had been checked daily, but we could not see any actions that had taken place in respect to gaps in recording, or if people's hydration was less than their assessed needs. There had recently been an incident where a person had been admitted to hospital due to lack of escalating concerns around hydration. This meant there was a risk of people deteriorating through dehydration. We raised this with the provider who assured us they would be making improvements to monitoring of fluid intake immediately and that procedures and guidance would be in place for staff.

The failure to ensure people's hydration needs were monitored effectively was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We reviewed the provider's incidents and found that few were recorded and were not detailed. We saw that a number of incidents were incorrectly recorded as accidents. The accident forms were not detailed and did not contain information of actions taken following the incident to mitigate reoccurrence. They were also not reviewed for themes and trends to drive improvement within the service.

● Risks arising from people's conditions and choices were assessed, monitored and managed. We saw risk assessments for bed rails, falls and choking. We saw that following identification of risks actions had been taken to mitigate them such as; a falls mat placed in people's bedrooms. People had individual evacuation plans showing the support they would need in the event of an emergency.

Staffing and recruitment

● There were a number of vacancies within the service. Managers told us that recruiting staff was an issue and they were actively recruiting to try and fill these vacancies.

● The service had high levels of agency staff. Managers told us this was approximately 50-60%. This meant that there were not always staff on shift that knew people and their needs well.

● There were sufficient numbers of staff on shift to support people with their personal care and daily activities. We saw staff went about their tasks in a calm, professional manner. Staff we spoke with told us people did not have to wait too long for staff if they needed assistance.

Insufficient evidence to rate

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.

This key question has only been partially inspected and was not rated.

Staff support: induction, training, skills and experience

- Staff had not all completed their mandatory training such as; safeguarding, moving people safely, fire safety and communication in dementia. This meant there was a potential risk to people and staff safety because staff were not adequately trained to fulfil their role. The provider had booked a schedule of training for staff so they could complete their mandatory training and were in the process of starting some e-learning training to get staff trained.
- Staff told us they had not received supervision since starting at the service. We asked the provider to see evidence of staff supervision and only one record for one person's supervision could be found. Staff meetings had not been regularly held since the service opened. This meant that staff were not adequately supported or monitored to see if they were competent in their roles or if they needed support in certain areas or training.

The failure to ensure staff were adequately trained and supported was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

- DoLS had been applied appropriately, however; we did find that one person's application was not sent off for two weeks after they arrived at the nursing unit.

● Consent was not always recorded fully or appropriately. Some forms for consent to treatment had not been signed. Some forms for consent for bedrails had been signed by a nurse and not by the person, next of kin or a person that has Power of Attorney.

Supporting people to eat and drink enough to maintain a balanced diet

● Kitchen staff were aware of and catered for people's individual nutrition needs and preferences. This included preparing meals for people living with conditions that meant they needed to have foods prepared in a certain way. Staff told us this was a recent improvement and previously people's dietary requirements were not consistently met. Staff offered people choices of menu. We saw staff effectively supporting people with their meals.

● We saw there was easy access to fluids around the unit. Bedrooms had jugs of water for people to access or they could ask for a drink if they were unable to get this themselves. We observed staff offering drinks to people.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● Recognised tools were used for assessing people's needs in line with best practice. This included skin integrity care and assessing for the risk of malnutrition. Where people had increased risks in these areas, there were plans in place to minimise the risk of this occurring.

Supporting people to live healthier lives, access healthcare services and support

● People had access to healthcare services but until two weeks prior to inspection this had not been easy to access. The provider had joined a local primary care group. This meant two local GP surgeries were accessible and there was now a weekly GP drop in for people to be able to access. This meant referrals to healthcare services, such as mental health, occupational therapy and speech and language therapies, were easier and faster.

Insufficient evidence to rate

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.

This key question has only been partially inspected and was not rated.

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

- The registered manager did not have much involvement with the nursing unit. During the inspection, we found that the nursing unit did not have a unit manager. A manager from another care home was covering, but on a part time basis. The acting unit manager told us when no manager was on the unit that the responsibility fell with the nurses on shift. This meant there was a lack of effective leadership with no one being fully accountable for the day to day safety and quality of the service and no clear oversight of the risks, issues and performance.
- The provider did not have effective processes to have oversight and monitor the quality of the service. We identified that audits had not been being carried out to identify areas for improvement in the service. This meant that leaders had not clearly identified areas for improvement within the service such as, fluid charts not being consistently completed or signed, or that staff were not being effectively supported or trained.
- Policies relating to the service showed that the fluid charts should be audited. This was not happening. There were no details for staff to follow with regards to what to do if a person is not taking fluids or when to escalate this. There was no incident management policy which meant staff did not have guidance on when and what to report as an incident.

The failure to ensure the service was effectively monitored to ensure safety and drive improvements was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager told us they had just recruited a unit manager that was due to start in post within the next month. A deputy manager was also being recruited.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure there were appropriate procedures and policies in place to guide staff effectively on how and when to escalate concerns with regards to people's food and fluid. The provider did not ensure all people were consuming safe amounts of fluid.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective governance processes in place to ensure it assesses, monitors and improves the safety and quality of the services as needed. Leaders did not ensure they had clear and robust oversight of the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure all staff working with people had undertaken the required training to ensure they are competent to deliver safe and good quality care. Staff did not receive regular supervision and appropriate levels of support from managers