HC-One Oval Limited

Grosvenor Park Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Grosvenor Park Care Home on 30 April and 8 May 2018 and our visit was unannounced. Grosvenor Park Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided and both were looked at during this inspection.

Grosvenor Park Care Home accommodates up to 57 older people. The service provides personal care and support to people with nursing needs and increasing physical frailty, such as Parkinson's disease, multiple sclerosis and strokes. There is also a rehabilitation service provided for up to 10 people who were non-weight bearing following an operation, with specialised input from a physiotherapist and occupational therapist. We were told that some people were also now living with a mild dementia type illness. There were 49 people living at Grosvenor Park Care Home during our inspection, ten of whom were there for rehabilitation.

The service had a registered manager in place. 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.

Grosvenor Park Care Home was taken over by a new provider in February 2017. This was their first New Approach Inspection and rating.

There were systems and processes to assess and monitor the quality of the service provided. However, we found that audits were not always effective as they had not identified shortfalls in care records, medicine management, staff supervision and staff training. This had the potential to impact on the safety and well-being of people. Risk assessments for people's health had not been reviewed or updated following changes to their care, despite people's needs changing significantly. This was because risk assessments did not always reflect people's mobility changes as they went through their rehabilitation programme or guide staff in how to support people safely. Air mattress settings were not set or checked as per the manufacturers' guidance to ensure they were used safely and for maximum benefit. Medicine management did not always follow good practice guidelines in respect of 'as required' medicines and the use of pain charts. We found that not all lessons learnt from accidents, incidents and mock fire drills had been taken forward to ensure people's continued safety. The programme of training and supervision identified that some staff were not up to date with essential training and that not all staff had received regular supervision. Following the inspection process we received confirmation that this had been taken forward as a priority.

People were supported to make decisions in their best interests. If there was a reason to question a person's capacity the provider assessed their capacity to make their own decisions. Staff and the registered manager had a good understanding of the Mental Capacity Act. Where possible, they supported people to make their own decisions and sought consent before delivering care and support. Where people's care plans contained

restrictions on their liberty, applications for legal authorisation had been sent to the relevant authorities as required by the legislation.

Staff supported people to eat and drink enough to maintain their health and referred people to other healthcare professionals when a need was identified. Visits from healthcare professionals were recorded in the care plans, with information about any changes and guidance for staff to ensure people's needs were met. The service worked well with allied health professionals

Staff had a good understanding of people's needs and treated them with respect and protected their dignity when supporting them. People were very complimentary about the caring nature of staff. People told us care staff were kind and compassionate. One person said, "They are like a family, very kind but also have a sense of humour." Staff interactions demonstrated staff had built rapport with people and they responded to staff with smiles. The atmosphere in the home was warm and friendly and conducive to building and maintaining relationships with others in the home, as well as with family and friends. People's diversity was respected and staff responded to people's social and emotional needs. People told us their needs were met because they were supported and cared for in accordance with their wishes and choices. A person told us "I still have my independence, they encourage me to go out and support me well."

People were supported in a personalised way that reflected their individual needs. A range of activities were available for people to participate in if they wished and people enjoyed spending time with staff. Activities were provided throughout the day, seven days a week and were developed in line with people's preferences and interests. Further ideas for the prevention of social isolation for people who remained in their rooms were being discussed by the management team. Technology was used to keep families up to date if they lived away this was via protected internet access so they could discuss their loved ones' care. There was a complaints policy and form, available to people. Staff were open to any complaints and understood that responding to people's concerns was a part of good care. People received a pain free and dignified death at the end of their lives. Staff supported people with compassion and worked with local hospice teams as required.

People and staff were positive about the culture of the service, staff and relatives felt the staff team were approachable and polite. The staff team worked in partnership with other organisations at a local and national level to make sure they were following current good practice. Maintenance records for equipment and the environment were up to date, such as fire safety equipment and hoists. Policies and procedures had been reviewed and updated and were available for staff to refer to as required. Staff said they were encouraged to suggest improvements to the service. Relatives told us they could visit at any time and they were always made to feel welcome and involved in the care provided. Staff said the management team was fair and approachable, care meetings were held every morning to discuss people's changing needs and how staff would meet these. Staff meetings were held monthly and staff were able to contribute to the meetings and make suggestions. Relatives said the management was very good; the registered manager was always available and they would be happy to talk to them if they had any concerns.

We found one breach 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 this 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

Grosvenor Park Care Home was not consistently safe.

Risk assessments were devised and reviewed monthly. However, management of people's individual safety in respect of skin integrity and mobility were not consistently recorded. Guidelines and records relating to some medicines were not clear and had not ensured all medicines were administered safely and in a consistent way.

Staff were trained in how to protect people from abuse and knew what to do if they suspected it had taken place.

Staffing numbers were sufficient to ensure people received a safe level of care. Recruitment records demonstrated there were systems to ensure staff were suitable to work within the care sector.

Is the service effective?

Requires Improvement

Grosvenor Park Nursing and Residential Home was not consistently effective.

Not all staff had received training which was appropriate to their job role. Formal systems of personal development, such as supervision meetings had fallen behind and not all staff had received regular supervision.

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Staff had a good understanding of peoples care and mental health needs. Staff had received essential training on the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) and demonstrated a sound understanding of the legal requirements.

People were able to make decisions about what they wanted to eat and drink and were supported to stay healthy. They had access to health care
professionals for regular check-ups as needed.

Is the service caring?

Good

Grosvenor Park Care Home was caring.

Staff knew people well and had good relationships with them. People were treated with respect and their dignity promoted. They were involved in day to day decisions and given support when needed.

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Care records were maintained safely and all associated information kept confidentially.

Is the service responsive?

Good

Grosvenor Park Care Home was responsive.

Care plans showed mostly up-to-date information on people's needs, preferences and risks to their care.

People told us that they were able to make everyday choices, but we saw this happening during our visit. Meaningful activities for people to participate in as groups or individually to meet their social and welfare needs were provided.

A complaints policy was in place and complaints were handled appropriately. People felt their complaint or concern would be resolved and investigated.

Is the service well-led?

Requires Improvement

Grosvenor Park Care Home was not consistently well-led.

Whilst the provider had systems for monitoring the quality of the service and driving improvement, these were not effective at this time. Records relating to the care and treatment provided to people and running of the service were not always accurate or up to date.

Good communication and teamwork was evident. Staff described an open culture where their views were valued.

There was clear leadership and staff understood their roles and responsibilities

Grosvenor Park 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 30 April and 08 May 2018 and was unannounced. The inspection was carried out by three inspectors and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed the information we held about the home, including previous inspection reports and the Provider Information Return (PIR). This is a form in which we ask the provider to give some key information about the service, what the service does well and improvements they plan to make. We contacted the local authority to obtain their views about the care provided. We considered the information which had been shared with us by the local authority and other people, looked at safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we spoke with twenty people who used the service and seven visitors. We spoke with twelve staff members which included care staff, two registered nurses, the maintenance manager and the activity person. In addition we spoke with the registered manager and regional quality manager. We also spoke to a member of the community speech and language team, a GP and following the inspection we spoke with a specialist tissue viability nurse and a member of the community dietician team.

We spent time observing staff providing care for people in areas throughout the home and observed people having lunch in the dining room. We used the Short Observational Framework for Inspection (SOFI) during the day. This is a way of observing care, to help us understand the experience of people who may be less able to tell us about their experiences.

We reviewed a variety of documents which included eight people's care plans and associated risk and individual need assessments. This included 'pathway tracking' six people living at the service. This is where

we check that the care detailed in individual plans matches the experience of the person receiving care.

We looked at five staff recruitment files and records of staff training and supervision. We viewed medicine records, policies and procedures, systems for recording complaints, accidents and incidents and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at Grosvenor Park Care Home. One person told us, "I have no concerns." Relatives confirmed they felt confident in leaving their loved one in the care of Grosvenor Park Care Home. One visiting relative told us, "I think it's a good home, I keep a close eye on things." Another relative said, "I trust staff here." However, we found there were shortfalls which compromised people's safety and placed people at risk from potentially unsafe care.

People's risk assessments did not always reflect their actual needs and some lacked sufficient information and guidance to keep people safe. Personal emergency evacuation plans (PEEPs) were not available. When we asked for PEEPs we were directed to an overview which listed people's names, bedroom number and stated whether they could walk /otherwise, or needed horizontal evacuation. This list was found lacking in guidance for safe evacuation. There was no further information to guide staff in the safe evacuation of each person. Staffing levels decrease in the evening and night time and this was not reflected in the evacuation plan. Staffing levels, especially at night, would not be able to respond to the actions detailed, due to the layout of the home and number of staff. This placed people at risk from failed emergency evacuations. PEEPs were immediately developed and in place by the second day of the inspection .

Evidence was seen of four recent fire drills involving staff (within the last two months). There was evidence that issues were identified on these drills (10/04/2018 and 12/04/2018) such as staff being slow to respond, no member of staff taking control, fire doors being wedged open and a failure to call the fire service. On three out of four drills recommendations were made that staff needed fire refresher training. The registered manager told us this had not yet been actioned. This was taken forward by the area manager on the first day of the inspection. We were advised that under the previous provider there had been two members of staff designated fire wardens, but there was confusion as to whether this arrangement remained in place as staff were waiting to receive HC-One's training and be advised of HC-One's fire policies. This had not ensured people's safety in the event of a fire.

Care plans contained risk assessments specific to health needs such as mobility, continence care, falls, nutrition, pressure damage and a person's overall dependency. Care plans looked at the person's identified risk and included a plan of action to promote safe care. However we found that some people's health, safety and wellbeing was not always assessed and protected. For example, pressure relieving air mattresses used to prevent tissue damage were in use, but were not set at the correct setting for each person's weight as directed by the manufacturer. Pressure relieving mattresses should be set according to people's individual weight to ensure the mattress provides the correct therapeutic support. Staff had also not recorded the setting to be used within the care plan documentation or risk assessments. There were also no systems for checking that air mattresses were set correctly and working. These were discussed with the registered manager who asked the maintenance team to immediately check the identified beds and replace them if necessary. We were able to check that this had been actioned.

People who were at Grosvenor Park as part of the six week non weight bearing rehabilitation contract had professional visits documented by the attending physiotherapist and occupational therapist (OT) team.

However directions to ensure the person's safety following surgery had not been reflected within the care plan and risk assessments. For example when people's mobility had progressed and changed. Apart from the entry from the physiotherapist or OT there was no written guidance for staff to follow as to how the person should use walking aids, sit, use the bathroom or get up from bed. Mobility risk assessments for people had not been changed from non-weight bearing, to weight bearing with mobility aids. Care staff told us, "We receive verbal instructions when changes happen, but it's not written as such in the care documentation." This meant that not all staff would have the same information to ensure that care delivery was consistently safe.

People who lived with diabetes had a care plan that contained a flow chart detailing the action to take in the event of hypoglycaemia (low blood sugar). However there was no record of the person's baseline blood sugar levels or the identification of normal patterns of levels for the individual person. There was also no flow chart for identifying hyperglycaemia (high blood sugar) and what action staff should take. This meant staff would not know what was normal for the person and take the appropriate action to ensure people's safety.

Accidents and incidents had been documented with the immediate actions taken. However there was a lack of follow up or actions taken as a result of accidents and incidents. For some people who had fallen and the fall had been unwitnessed by staff, there was no record of an investigation or a plan to prevent further falls. One person had had multiple falls over the past six months but this was not reflected in the person's care plans or risk assessments with actions to prevent a re-occurrence. This meant that the provider had not always put preventative measures in place to prevent a re-occurrence and protect the person from harm. Therefore there was no learning evidenced from accidents and incidents.

Systems for the management of as required medication were not fully embedded into everyday practice. The management of medicines had not ensured all medicines were administered safely and in a consistent way. Some people were prescribed 'as required' (PRN) medicines. People took these medicines only if they needed them, for example, if they were experiencing anxiety or pain. We found that some people did not have individual PRN guidelines for staff to follow in relation to medicines or medical procedures. These should provide guidance for staff about why the person may require their medicine/treatment, when it should be given and how the effectiveness should be monitored. For example, one person was prescribed a medicine for angina and chest pain, there were no instructions for staff to know when to administer it and there were no pain charts to monitor for the effectiveness of the medicine.

People who were prescribed medicines which prevents blood from clotting need careful monitoring and regular blood tests as the dosage changes on the result of blood tests. Two charts in use by the service to record instructions and provided a safety check for staff had not been completed since 9 August 2017. The registered nurse said it was because the form was the previous provider's and had not been replaced.

One person had not received their prescribed medicine which was due three times a day for one month. This had not been identified by any staff giving medicines. This was referred to the GP for review and has now been discontinued.

The management of skin creams were not consistently followed for staff to follow and record how and when skin creams were applied. The provider could not demonstrate that skin creams were applied to people in a consistent way, or in accordance with prescriptions.

The failure to assess, record and mitigate risks to people's health and safety was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems for ordering, checking orders received, disposal and administration were in place to manage people's prescribed medicines. Medicines were stored correctly and at the right temperature. A list of signatures were retained to allow for identification of staff that had administered medicines on a particular day. Checks were also done looking at whether medicines were stored and administered correctly, any omissions in MAR charts or errors were picked up and action taken. To protect people with limited capacity to make decisions about their own care or treatment, the provider followed correct procedures when medicines need to be given to people. We observed registered nurses giving medicines at three different times and saw staff followed safe practices.

Staff had a clear understanding on how to safeguard people and protect their health and well-being. Staff had received safeguarding training and understood their responsibilities for keeping people safe from the risk of abuse. They were able to give examples of signs and types of abuse and discuss the steps they would take to protect people , including how to report any concerns. The organisation had a whistle-blowing policy that provided guidance for staff on how to report concerns in the workplace. Staff told us they felt confident to whistle-blow if necessary. A member of staff said, "I would report any concerns I had, if dealt with, that would be fine, but if nothing happened, I would go to the local authority and CQC."

A safeguarding document was on display in the staff offices highlighting steps that staff should take if they suspected abuse and telephone numbers of contacts they could call to report any concerns.

We discussed with staff how they made sure people were not discriminated against and treated equally and without prejudice. A senior member of staff told us, "We treat everyone the same, and everyone is treated with dignity and respect." Another staff member said "Staff are mindful of racism or sexism and respect peoples' differences.

Health and safety audits were regularly undertaken by the registered provider to ensure that people remained safe. Environmental risk assessments were carried out regularly looking at access to the home, maintenance and catering. Monthly health and safety checklists looking at the doors, fire safety, first aid, food safety, manual handling, documents, COSHH, infection control, electrical safety were done. We saw current certificates for gas safety, portable appliance testing and electrical safety.
Regular reviews, servicing and repairs were undertaken and recorded for equipment including moving and handling hoists, slings, profiling beds and manual wheelchairs.

There was a business continuity plan which instructed staff on what to do in the event of the service not being able to function normally, such as a loss of power or evacuation of the property.

People were cared for in a clean, hygienic environment. The service and its equipment were clean and well maintained. There was an infection control policy and other related policies to guide staff in the prevention of cross infection. People and visitors told us that they felt the service was clean and well maintained. One person said, " It's is very clean." Protective Personal Equipment (PPE) such as aprons and gloves were readily available. Staff used PPE appropriately during our inspection and it was available for staff to use throughout the service. Discussions took place about the planned refurbishments, which included carpets and bathrooms. These plans had been delayed due to the change of provider and were soon to be completed.

There were enough staff deployed that enabled them to respond to people's needs. Staffing levels were adapted to people's changing needs. The staff were divided into three teams, which reflected the floors of the building.
Staffing levels were assessed daily, or when the people's needs changed to ensure people's safety. The

registered manager told us, "Staffing levels are good, the staff work well." Feedback from people indicated they felt the service usually had enough staff but there were times when they felt more staff were needed. Staff said they felt more staff would be beneficial especially at meal times. We observed throughout the two days that care delivery was given in a timely manner and call bells were answered promptly. There was daily audits of response times to call bells. All calls were recorded and a print out of all calls was available to view. The call bell audit identified the length of time people waited and if over five minutes was investigated as to the reason for delay. Senior staff carried an alert receiver which alerted them if a call bell was not answered and they would investigate and report back to the registered manager. There was also an emergency setting to alert people that someone was still waiting for their call to be answered. We saw that there had been some delays recorded but they were isolated. There were no trends of long or unanswered call times that identified staffing levels were unsafe.

Recruitment systems were robust and made sure that the right staff were recruited to keep guests safe. We reviewed five staff files. A record was kept of all staff Disclosure and Barring Service (DBS) checks. The DBS helps employers make safer recruitment decisions and prevent unsuitable guests working with vulnerable groups. Copies of proof of identity such as passport and national insurance numbers were kept and interview notes were retained along, with two references and their original application form.

Requires Improvement

Is the service effective?

Our findings

People and visitors spoke positively about the home and the care and support provided by the team of staff. Comments included, "I have great faith in the staff," and, "Staff are very good and provide good care." One visitor said, "They (the staff) manage very well."

However, we found that staff at Grosvenor Park Care Home did not consistently provide care that was effective.

Staff and training records were difficult to access during the inspection process because the main training record had remained with the previous provider. Following the inspection we received an up to date record with an overview. This showed that some essential training was behind. For example, 25 % of staff had not had recent moving and handling training, for some staff, their last training had been in 2014. The registered manager was open about the fact that some training needed to be undertaken. The new providers, HC-One, confirmed that training would roll out to encompass HC-One training courses. The registered manager confirmed that her new training computer had been installed so all compliance figures for training will start rising as staff completed courses. This was an area that required improvement.

All staff told us that they felt well supported and felt they could speak to senior staff in the home and that they would be listened to. However not all staff had received regular supervision and this was confirmed by the registered manager who had set up a supervision plan that would address the shortfalls found. Systems for regular supervision and annual staff appraisal had not been established. This was an area that required improvement.

Registered nurses were supported to update their nursing skills, qualifications and competencies. One registered nurse told us she had been supported in attending additional training on palliative care this had included specific training on equipment used to administer medicines via a syringe driver. The registered nurses told us that they had the skills to look after the people living in the home and would access training they felt they needed through the home or externally if required. The registered manager told us staff training had been reviewed with an emphasis on providing further specialist training to ensure the needs of people were appropriately responded to.

People had been supported to live healthy lives and had access to health and social care professionals. People at risk of developing pressure wounds had received appropriate care. One person at risk of skin breakdown had a pressure damageWaterlow risk assessment in place, this that had been completed accurately. A Waterlow assessment is a tool that gives an estimated risk for the development of a pressure sore in a given patient. Where any marks to skin were noted they were recorded on body maps and photographs were taken to document the potential wounds. There were mental health plans in place to support people living with dementia or anxiety. These contained guidelines for staff to follow to alleviate their anxiety. Guidance from professionals had been followed by staff. One person had lost weight and experienced problems with swallowing safely and had been referred to the dietician. There person had was a nutrition care plan in place and this reflected the advice from the dietician. We observed that the specialist

advice was followed in practice by the staff team during two meal services. People had access to a GP, dentist and an optician and could attend appointments when required. Care plans demonstrated that a wide range of professionals were involved in people's care. We reviewed one person's care plan and saw that they person had been seen by healthcare professionals on three occasions over the past two months.

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. People were being asked their consent via consent forms in care plans for issues such as sharing of information with other health professionals. Where people could not consent mental capacity assessments and best interest decision meetings were carried out. One person at risk of malnutrition was being weighed but the person did not recognise they were at risk and did not want to engage with professionals, or strategies, to maintain a healthy weight. The registered manager arranged a MCA assessment and the person was found to lack capacity around this decision, and a best interest meeting with the presence of medical professionals and family was held. All parties agreed that a referral was to be made to the dietician in the person's best interest and this decision was reviewed monthly. People had been referred to the local DoLS office appropriately.

People's needs were assessed and their care was planned to ensure their needs were met. There were holistic assessments of people's needs prior to a service being provided. There was good use of nationally recognised assessment and management tools including for pressure wounds, malnutrition, pain management and wound care. The care plans were seen to have been reviewed at least monthly and the progress notes were sequential, detailed and signed by their authors. In each person's file there was a section that gave background information such as their current family members and their contact details, their past occupations, where they lived and their present interests. There was also information about their preferences such as the time of going to bed, preferred meals and the gender of care staff to attend them. Although we could not find information about protected characteristics, staff described how issues such as ethnicity and sexual lifestyle choices were assessed when they arrived at the home.

Staff had developed systems for organising work and for communicating information between staff. Each shift began with a handover and staff were allocated people to look after and specific roles. This included either assisting in the lounge areas or supporting people supporting people in their own rooms. Staff breaks were also recorded to ensure effective allocation of staff. Handover sheets were used to communicate individual needs and appointments. The staff handover demonstrated that staff were knowledgeable about people and their individual needs. They reminded people of these needs, for example it was documented that one person had not being drinking and needed encouragement. Daily records and charts were used to communicate how people's needs were being attended to. We have already identified some shortfalls in care documentation, but we also saw some other clear instructions for staff to follow such as two hourly checks at night on a person who was unwell, and 30 minute checks on a person who needed closer supervision to prevent falls. These were documented to demonstrate they had been completed.

People had been supported to eat and drink enough to maintain a balanced diet and good health. People at risk of malnutrition or dehydration had their food and fluid intake monitored with food and fluid charts,

and these had been completed accurately. At mealtimes we observed that food was presented well. Trays were seen to be taken to people dining in their bedrooms and these were covered with plate protectors and placed in easy reach of people. These trays were neatly laid out to encourage people to eat. We observed that people in their bedrooms who required support to eat their meals were supported well and without delay. People with complex needs in relation to their eating and drinking were assisted by staff in a calm and relaxed manner. There were choking assessments completed and dietary supplements, fluid thickeners, and fortifications were seen to be in use.

Staff worked together to ensure that people received consistent and person-centred support when they moved from or were referred to the service. Pre-admission assessments were conducted at people's homes or previous placements and also were invited to visit the home for the assessment. When people were transferred to hospital, the person was sent with all their medicines along with transfer documentation which held information such as allergies, medical history, capacity, mobility, any injuries, what jewellery people may be wearing, if they had epilepsy, their current weight, and whether the person was prescribed warfarin. The registered manager would ensure that the next of kin was contacted to inform them and also ensure that medicines charts and any instructions on resuscitation were sent. When accepting new people to the service the registered manager ensured a discharge summary was sent from the hospital or care setting and check medicines had been returned and any changes were reflected in paperwork.

People's needs were met by the adaptation, design and decoration of the premises. Lifts were available to all areas of the building so people's' independence was promoted at all times. Each floor of the building had a security coded exit system to keep people safe, people who were able to make the decision to leave their floor were provided with a key card and could leave at anytime. The building was a large older style building with large communal areas and wide corridors, ideal for people who used mobility aids including scooters. The home was overall well decorated but was in need of updating and redecorating in certain areas, this which had been identified and planned for. Communal areas were comfortable and included a library room, activity room, a large dining area and lounge. Bedrooms all had an ensuite facility and there were also communal bathrooms.

Good

Is the service caring?

Our findings

We observed many caring interactions between staff and people during our inspection. There was a relaxed atmosphere within the home and we saw people approach staff for support and company throughout the inspection.

People preferred names were used on all occasions and we saw warmth and affection being shown to people. The atmosphere was calm and pleasant. There was chatting, laughter and use of appropriate humour throughout the day. The inspectors were introduced to people and to staff. Staff took time to explain the purpose of our visit to people and sought their consent for us to speak with them. Staff told us how each person preferred to communicate and shared any special methods of communication. Staff also told us of how they supported those who cannot verbally express themselves, "We monitor their response to open questions and learn how they express themselves." We were told by staff 'when (name) does this', 'it means this' and then they detailed how they support the person, It was acknowledged that this could feature more prominently in care plans to guide staff and health professionals. One care worker said, "We communicate in different ways with different people, one of our people uses pen and paper and also brings us books with the words on, it's their particular way to communicate and it works really well."

Understanding peoples' specific ways of communicating also meant staff ensured people were able to consent to and be involved in decisions about their care. For example, one person communicated by nods and staff ensured that they maintained eye contact and spoke slowly to ensure that picked up head and eye responses. One staff member said, "They can't talk but can still tell us what they want. We make sure we ask questions clearly, in a way that only needs a yes or no." Staff spoke about people in a caring and respectful way. Care plans reflected how staff should support people in a dignified way and respect their privacy. People and their families or representative were involved in developing their care plan. Records showed where appropriate, people relatives and advocates signed documents in support plans to show they wished to be involved in the plan of care.

Staff understood the importance of confidentiality. They told us, "You need to protect confidentiality. I do not talk about anything to do with work outside of work or share with other people" and "We seek permission to share personal information. People' support records were kept in locked cabinets in the staff office and only accessible to staff. Each person's support plans detailed the importance of people maintaining their independence where possible. For example, people were supported to be in relationships and to go out with family and friends." Staff told us that people were encouraged to be as independent as possible. One member of staff said, "If you did all for them you'd take away their independence and it might mean they can't return to independent living."

People were supported to express their views and make informed choices about their care. We observed staff supporting people throughout the inspection, they took their time when giving people the information and explanations they needed and the time to make decisions. Preferences in relation to their personal care were recorded, for example, how they liked to take their bath and what were their preferred times for waking and going to bed. There were instructions for staff to refer to, advising them on the level of support required

and where people were able to do tasks independently. Where people needed prompting, the level of prompt was recorded. This allowed people to maintain a level of independence and have some control over aspects of their lives. Risk assessments and decision making pathways were used to allow choice and enable the development of people's independence. One person told us that they had chosen to live at Grosvenor Park because they had stayed for short holidays and knew they would support them to be independent as possible and still go out on the sea front and meet friends.

People' rights to a family life were respected. Visitors were made welcome at any time and were able to have meals with their loved ones if they chose to. There were items of interest from the provider on notice boards, such as their vision and values, newsletters, details of events that had taken place, the weekly activities programme, health information booklets and advice about advocate services. Information on the use of advocacy services was available and the registered manager confirmed staff worked in partnership with Independent Mental Capacity Advocates (IMCA) when required. An advocate is someone who can offer support to enable a person to express their views and concerns, access information and advice, explore choices and options and defend and promote their rights.

Good

Is the service responsive?

Our findings

People told us that staff listened and responded to their personal wishes and their health needs. One person told us, "They listen to what I want to do and do everything they can to make it happen." Another person said, "When I got a sore leg, they immediately sorted me out with a Drs appointment and I got antibiotics."

People received care in the way they wanted and their care plans contained personalised information. We saw detailed plans which told staff how to meet people's individual needs. For example, continence care was identified and a plan of action for staff to follow was in place. People's continence needs were explained in their continence care plan. These identified the exact support each person required on a day to day basis, as well as the support they needed when they were incontinent. Care plans detailed what type of incontinence aid was to be used what to say to the person if they were upset following incontinence, and people's preference for the gender of the care staff. We observed throughout our inspection that people were supported to use the toilet in a dignified and responsive way.

People living with dementia had their needs planned for within their care plan. One person living with dementia had limited speech, was frequently not oriented to place or time and had at times declined staff assistance. The person's care plan had identified a brief trigger point where the person would be seen to become restless with heightened anxiety. By being aware of this presentation staff had learnt to distract the person and incidents and altercations had been better managed. It was identified that the person liked to walk, so staff moved them to another part of the home that staff could monitor them more easily. By supporting the person in this way staff had been able to reduce unwitnessed falls. This was not fully documented in care plans but all staff were aware of the need for being vigilant.

The service was meeting the accessible information standard and people's care plan documentation was written in a way they could understand. There was however limited evidence to show that people were actively involved in the review of their care plans, other than staff taking into account their observed reactions to the care they had received. From talking to some people however they confirmed they were involved and consulted about their care plan. Care plans could be further developed to allow larger print and be more user friendly and this was an area that the registered manager was taking forward with new care documentation. The registered manager said that pre-admission assessment and review paperwork sometimes was totally dependent upon consultation with people's relatives and this was then included in the person's care plan.

There was a monthly planner that showed that a range of activities which took place both in house with the coordinators and through external entertainers who called at least twice a month. We saw evidence of both small group and one to one activities. The small group activities seen included a quiz and word game and also singing and gentle exercises. There were also morning sessions where one of the activities coordinators read from the daily newspaper and led a discussion about world events. Activities had been organised responsively when needed. We reviewed the care plan for one person and saw that their hobbies and interests had been identified as gardening, TV, films, music and walking. The person's daughter had contacted the registered manager to state that their mother seemed tearful and requested if staff could

support the person to go out of the service. The next day there was a response from the registered manager stating they would ask the activities coordinator to speak to the person and the person was promptly taken to a garden centre and had photos taken to share with their family.

A number of person centred events were seen where people received individual assistance from an activities coordinator. There was a normal range of celebratory activities at Easter and Christmas and birthday arrangements included the person receiving a card and a gift from the service. We observed an activity session where people participated in a quiz and another session where people were reading the newspapers and discussing current affairs. The staff knew people very well and told us what they liked doing and the music they loved to listen to his was specifically special to those people who remained in their rooms. There was a calm and gentle atmosphere thought the home.

There was a complaints handling policy that allocated tasks to be completed based on a risk assessed traffic light system. The registered manager told us they managed all complaints in the first instance, but some higher rated items had to be signed off by a nominated senior manager. All complaints, incidents and safeguarding alerts had to be entered onto the provider's electronic recording system. There was also a paper tracker kept by the registered manager that listed the status of the investigation of each complaint. Each complaint then had all of its papers collected in a wallet that sat behind the tracker. The system was organised and well recorded. The entries showed that suitable steps had been taken to investigate individual complaints including reviewing written care records, observations and interviews with staff. The registered manager was sharing information appropriately with the local authority safeguarding adults team: a safeguarding referral had been made for the most recent complaint that concerned unexplained bruising. In each complaint there was evidence that the 28 day timescale for any initial response had been met and that each complaint had been concluded with a polite letter from the provider to the complainants.

People were supported to have a pain free, comfortable and dignified death. We reviewed the care plans for three people who were receiving palliative care near the end of their life. Palliative care is any care or treatment to relieve pain without dealing with the cause of the condition. One of these people had a do not attempt resuscitation (DNAR) notice in place that had been completed by their GP. DNAR stands for Do Not Attempt Resuscitation. A DNAR form is a document issued and signed by a doctor, which instructs medical teams not to attempt cardiopulmonary resuscitation (resuscitation after a heart attack). They had been seen by a wide range of medical professionals to ensure that they received appropriate support and care at this time. Anticipatory medicines had been prescribed and were supported by an appropriate PRN protocol. Anticipatory medicines are used in palliative care to enable the person to have their symptoms managed in their care setting without being admitted to hospital.

People's preferences and choices for their end of life care and where they wished to die, were clearly recorded, kept under review and acted on. People were able to record their future wishes and plans in a future decisions care plan. This named the person's next of kin, whether anyone held a lasting power of attorney, whether there was an advance decision or living will in place, whether there were any other relatives or friends that the person wanted involved in their care, anyone the person did not want involved in their care and whether any advocates were involved. There were also plans for where people would like to be cared for when they became unwell and if there were any treatment decisions they would or wouldn't want. People were encouraged to think about their final days and whether they would like a priest or religious minister to visit them, or if there were any important objects they would want to have close to them. Choices were set out for any arrangements after people had died such as whether they wanted to consider organ donation, what type or burial or cremation they would like and what funeral service they had planned, including preferred funeral directors.

Requires Improvement

Is the service well-led?

Our findings

People and visitors told us they thought the service was, "Well-led" and that there was an, "Open culture" and, "They could talk to the manager and the staff if they had a problem."

There was an experienced registered manager who had been in post for seven years. She was supported by the senior management of HC – One. The deputy manager's post had recently become vacant and the organisation were actively seeking a replacement to support the registered manager. People and visitors knew the registered manager by name and one visitor said she was, "Very approachable and always available."

The quality of care and support given to people was regularly reviewed. A wide range of audits were completed frequently. Despite having these management systems and quality audits, we identified some areas that required further development and improvement.

There were systems to assess the quality of the service provided or to monitor and mitigate risks to people, however these were not always effective in bringing about improvements. For example, medicines audits had been carried out but failed to identify the shortfalls found at this inspection. This meant that people were not always protected from potential risk of medicine errors. The provider had not ensured all records relating to the service were accurate, complete and up to date. Risk assessments and care plans for people had not been updated to reflect changes to mobility as they progressed on the non –weight bearing programme. Risks for those that lived with diabetes had not been fully explored with actions to take if their blood sugars were high. Pressure relieving equipment was provided for some people who had been identified as at risk from skin breakdown but these had not been set correctly to the manufacturers' instructions and no checks had been undertaken. There were gaps in staff training and staff supervision which meant not all staff had had the necessary training to meet the needs of the people who lived at Grosvenor Park Care Home. The proactive nature of the actions being undertaken and the need to further embed practices of the new provider at the service was not a breach of regulation but an area of practice in need of improvement.

Records and documents pertaining to the running of the service which included health and safety checks were all up to date and available at the service. Organisational policies and procedures were available to all staff and reviewed regularly so they reflected changes to legislation and reflected current good practice guidance. Staff told us they had access to policies and procedures, for example, whistle blowing, safeguarding, infection control, health and safety. Staff told us they had read them, and knew they were kept in the staff office to refer to when needed. One staff member said, "I would read the policy if I needed to."

The registered manager was aware of their responsibility to comply with the CQC registration requirements. They had notified us of events that had occurred within the service so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken. They were aware of the statutory Duty of Candour which aimed to ensure that providers are open, honest and transparent with people and others

in relation to care and support. The Duty of Candour is to be open and honest when untoward events occurred. The registered manager confirmed that all incidents that had met the threshold for Duty of Candour had been reported to people's relatives.

The provider sought feedback from people and those who mattered to them in order to improve their service. The registered manager had ensured relatives who were unable to visit the service regularly were posted out a form. People who came for rehabilitation or short respite care were also asked to complete a questionnaire sharing their views on their stay. Feedback was also gained from people by annual satisfaction questionnaires and by regular resident meetings. People shared their views about the resident meetings and the management team. People told us, "Yes the staff listen to me, the manager does visit us and I like living here," and, "I have no complaints, everything is pretty good."

There was an open culture at the service. The registered manager was visible and worked at the service 9am until 5pm, five days a week. The registered manager told us that they had an open door policy which had really supported the home to be able to rectify any concerns before they become bigger issues and offer support in any areas where it may be needed. People knew the manager and thought she was helpful, nice and approachable. One person said, "Honest and knowledgeable." A visitor said, "We were initially worried when we were told it was changing owners but to be honest nothing has changed apart from the name."

Staff told us they enjoyed working at the service. Staff told us, "Very happy here, well supported, some training still to do, I think I'm due my moving and handling training soon," and "I like working here, good team and great residents." Staff meetings happened regularly and staff found them helpful as they discussed what was happening within the organisation, any issues and new messages from the provider. One staff member said, "Meetings are really important to us as a team." Minutes from these meetings evidenced staff discussed care delivery, team work, new ideas, new staff, outcomes of audits, the use of equipment, room checks, and the importance of call bells being within reach. Staff told us they felt supported by the management. One staff member said, "The manager is very approachable and supportive." A second staff member said, "It's very family orientated here. I feel comfortable asking for anything." The manager attended staff handovers on a regular basis to gauge staffing levels against people's needs and a staff member said, "It's good to have the manager at handovers because then she picks up on things and understands our challenges."

We saw evidence that the service worked effectively with other health and social care organisations to achieve better outcomes for people and improve quality and safety. The health and social care professionals we contacted did not express any concerns at the time of our inspection. The registered manager had a good working relationship with the local services and was working effectively in partnership with key organisations. The registered manager described a close working relationship with the local authority safeguarding adults team and told us that they had received good support and advice from the team. Relationships with local GP surgeries were positive and staff at the service were communicating well and reporting concerns appropriately. There were close links to local health teams such as physiotherapy, occupational therapy and dieticians. The service had been sharing appropriate information and assessments with other relevant agencies. The registered manager and provider were aware of the changes to data protection coming in to force and there was a strategy in place to ensure compliance with the changes.

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 Risks to people's safety were not being adequately identified and addressed in a timely way. Regulation 12(2) (a) (b). People's medicines were not safely managed or consistently administered as prescribed. Regulation 12 (1) (2) (g).