Alpha Care Management Services No. 3 Limited

Grenville Court Care Home

Inspection report

Horsbeck Way
Horsford
Norwich
Norfolk
NR10 3BB

Tel: 01603893499

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This unannounced comprehensive inspection took place on 10 May 2018. Grenville Court is a care home registered for up to 64 people. It is set over a ground floor and a first floor, and people have their own rooms and en-suite toilet facilities. There are some communal bathrooms, toilets, lounges and dining areas in the home.

There was not a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The directors of the organisation were working in the home and overseeing the day to day management. They had recently had support from a member of staff who worked at another home as clinical lead, in running the home. This person had left the day before our inspection, and there was a new manager starting on the day of our inspection.

At the last inspection on 13 November 2017 we found seven breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found serious and widespread concerns at this service. At this inspection we found there continued to be widespread concerns, and despite improvements being made in some areas, there was a deterioration in some areas. The provider remained in breach of seven Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the CQC Registration Regulations.

The service was not safe. People were not adequately supported with their health needs and care plans did not always contain proper guidance for staff. There was some poor manual handling and associated care plans were poor. There was not always effective management of people's health needs. This included people's behaviours, falls and pressure areas. There was not always detailed care planning around specific conditions such as diabetes.

There were a number of errors made in relation to medicines administration. People did not always receive their medicines as prescribed, including both oral and topical medicines. There was not always sufficient consistent guidance for staff on how to give PRN (as required) medicines, and staff did not always have sufficient knowledge of medicines they were administering.

There was not always good infection control practice across the home, or management of potential infections.

There were not always sufficient recruitment checks in place to ensure that people were suitable to work in the home. There were not always competent staff available to people when they required support. Competency checks were completed but not always followed up. Staff inductions did not always include enough shadowing experience to gain knowledge of people's needs. Not all staff had a suitable level of English to enable them to communicate properly with people.

People were not always supported appropriately with their meals and therefore to eat enough. Action had not always been taken when people had lost weight.
People's mental capacity had not been assessed for specific decisions, and decisions were not always made with families in people's best interests.

Staff did not always provide personal care to people when it was needed, so their dignity was not always upheld. People were not always protected from improper treatment, and safety incidences were not always reported to safeguarding. The directors did not promote a caring atmosphere within the home.

There was not always enough stimulation and activity provision for people, however there were recent staff recruited for activities. People did not always receive care according to their individual needs and preferences. There was limited information available about people's end of life care wishes.

People's relatives did not always feel comfortable to raise a concern, and they did not always gain suitable resolutions from doing so when they did raise them.
There was poor leadership in the home and a poor morale amongst staff. Staff did not feel comfortable to raise concerns.

The providers had not ensured that CQC were notified of events under the conditions of their registration. This included safeguarding and serious injuries.

The systems in place for monitoring and improving the service were not sufficiently effective and improvements have not been made in a timely manner since the last inspection.

There were systems in place to ensure that safety checks were carried out such as on electrical and lifting equipment. People felt safe with staff and staff were polite to people.

There had been improvements in supporting people to drink and recording this so that it could be monitored.

The overall rating for this service is 'Inadequate' and the service therefore remains in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

Risks to people were not always assessed and mitigated. Risks associated with pressure care, medicines and infection control were not always managed safely.

Safeguarding concerns were not reported to the appropriate authorities.

There were not always staff available to people when they needed support, and safe recruitment procedures were not always followed.

There were systems in place to ensure that equipment used by people was maintained and kept safe.

Is the service effective?

Requires Improvement

The service was not effective.

Staff did not receive the level of training and competency checking they needed.

The service was not compliant with the Mental Capacity Act (MCA) 2005. Decisions were not always made in people's best interests and people were not supported to make decisions where they had variable capacity.

People were not always supported to eat enough, however there were improvements in staff supporting people to drink enough.

There were healthcare professionals regularly involved with people living in the home.

Is the service caring?

Inadequate

The service was not caring.

The directors of the organisation did not promote a caring atmosphere within the home.

People's dignity was not always upheld and they were not always protected from improper treatment.

Care staff were polite towards people, but they did not have time to spend meaningfully with people.

Is the service responsive?

Inadequate

The service was not consistently responsive.

People did not always receive care according to their individual needs and records were not always up to date with people's support needs.

There was not enough stimulation and engaging activity for people living in the home, which was based on their interests.

Relatives did not always feel comfortable to raise concerns and complaints were not always resolved.

Is the service well-led?

Inadequate

The service was not well-led.

There was no registered manager in place and there was inconsistent leadership.

There were not up to date accurate records kept, and audits were not always effective.

There was a poor morale amongst the staff team and a culture where staff did not feel comfortable to raise concerns.

The provider had not notified CQC of events under the terms of their registration.

Grenville Court Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection was unannounced. The inspection was carried out by three inspectors, a medicines inspector 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. A member of the Care Quality Commission (CQC) medicines team looked at how the service managed people's medicines and if the systems in place were safe.

As part of the inspection, we reviewed the information available to us about the home, such as the notifications that they had sent us. A notification is information about important events which the provider is required to send us by law. We also reviewed information we received in the form of whistle-blowing and complaints received prior to the inspection. Whistleblowing is a concern bought to our attention by staff about the practices where they work. Prior to the inspection, the provider also completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Prior to the inspection we also sought feedback from a number of professional bodies involved with the service, including pharmacy, district nursing team, the local authority, safeguarding and the Clinical Commissioning Group (CCG).

As part of our inspection we spoke with 14 people using the service and seven relatives. We also spoke with 12 members of staff. We also received feedback about the service from two healthcare professionals involved with the service.

We looked at a selection of care records, including eight people's in detail. We also reviewed the daily records of people's care, and checked certain areas of other people's care plans. We looked at information relating to how the service was run, such as policies, auditing systems and quality assurance systems. We also reviewed the provider's action plan which they sent us prior to the inspection. In addition, we requested some further information from the providers immediately following the inspection.

Inadequate

Is the service safe?

Our findings

During our last inspection in November 2017, we found that the service was not safe for people and it was therefore rated 'Inadequate' in this area. During this inspection we identified further serious shortfalls and the service was not safe. It remains 'Inadequate' in this area.

At our last inspection in 2017 we found that the service was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was due to poor assessment and management of risks to people, and infection control concerns. At this inspection we found the home had not made improvements with regards to safe care and treatment, and remained in breach of this Regulation.

At our last inspection in 2017, we found that risks associated with people's mobility and falls were not always managed. Prior to this inspection we received feedback from two healthcare professionals regarding concerns about the number of falls within the home, and we also liaised with them as part of our inspection. At this inspection, we found that the management of risks to people were not always adequate. For example, mobility care plans did not always contain adequate guidance for staff about how to mitigate the risk of people falling. We saw that when the home had carried out pre-admission assessments of care needs for people they had admitted since our last inspection, falls risks were not always adequately covered. For example, in one pre-assessment, under 'falls history', it said, 'none'. The next page with details given by the social worker stated that the person had fallen three times in the last month and received a falls team referral from the paramedics who had attended to them at home. There was a lack of consideration of this risk. Pre- admission assessments provide an overall view of a person's care needs so that a service can use them prior to admission to ascertain whether they can meet their needs.

For one person living in the home, their relative told us they had fallen from their chair recently. There was no information in their care plan for staff on mitigating their risk of falling. For another person, we received concerns about the staff's management of their mobility prior to the inspection. We looked at their care plan with regards to mobility, and there was no information about how staff could mitigate their risk of falls. The person was mobile with their walking frame and had frequent falls. The incident reports detailing some falls they had were insufficiently detailed, not always completed in a timely manner, and with limited guidance for staff regarding further actions to take. Risks associated with injury to the head such as concussion, were not always properly managed. The provider demonstrated that they analysed the number of falls which occurred each month, and some action was taken when people fell repeatedly, such as referring to the falls team. However, there was no analysis of the location and time of the fall, to check whether there were any trends.

At our last inspection in 2017 we found that some people displayed behaviours which could challenge others. People's care plans did not contain enough guidance for staff about managing associated risk. At this inspection, we found this had not changed and people's behaviour was not always managed appropriately, and people were not always kept safe as a result. For example, there were numerous incidents related to one person's behaviour and there was no evidence that the service had explored the

reasons for the behaviours. Some guidance for staff was in place for them to support the person, however this was not detailed and did not always protect others. The incidents reported to us by staff and relatives continued to present a significant risk of harm to other people.

At our last inspection we saw unsafe manual handling and this continued to be an area of poor practice at times. For example, we saw that one person was supported to move with a stand aid, and they were unable to bear their weight independently for long enough to transfer to the chair. This was not safe practice and the person was at risk of falling, and the staff were at risk on injury. According to the person's care plan, they could use either a hoist or a stand aid, and staff were to assess the day before what equipment to use. This did not provide staff with sufficient guidance to support this person to move safely.

At our last inspection we found some concerns related to the management of medicines. At this inspection we found that improvements in the safety of management and administration of medicines had not been made. Not all prescribed items were kept secure. This presented a risk of misuse or ingestion for people who were mobile and living with advanced dementia. We also found that thickener, which was used to thicken fluids to prevent choking, was being administered out of an open, unmarked box. This is a prescribed item to be given according to the label on the box, to the person to which it is prescribed only. This presented a significant risk that staff could not ensure that it was given appropriately.

We observed that medicines were late being administered which meant that there was a risk that some people were not given medicines as prescribed because they were too close together. The morning medicines round was still underway at 11am, with the next round beginning at lunch time. We found discrepancies in some medicines administration records (MAR). This included for warfarin which is an important cardiovascular medicine and which must be given accurately and appropriately for the safety of people prescribed it. Variable doses were not recorded accurately and there were some gaps in the recording. Medicines associated with higher risk to health if not given accurately were not always recorded properly. For example, records for pain relieving skin patches did not show the area of the body where patches were to be applied or record the removal of patches. This meant there was a risk that the old patch was not always removed, or that the person had remaining patches when the new one was put on, indicating risk that they could receive an inaccurate dosage. It also meant that the patch may not be rotated, causing irritation to skin. We identified gaps in external medicine records. For example, people were not being administered creams when directed by prescribers. This presented a risk for people's skin integrity, especially when at risk of developing pressure areas.

There was a lack of protocols for the administration of some medicines that were prescribed to be administered 'as required medicines' (PRN). Staff administering them did not know what some PRN medicines were for or when to administer them. For people who were not able to communicate to staff if they required PRN medicines, there was a lack of pain assessment tools in use. There was a lack of records showing why PRN medicines were needed, with some PRNs being given regularly without recorded justification. This included an example of mind altering medicines which can be used to manage people's behaviour. This meant people were at risk of not received medicine when they required it, or receiving it unnecessarily.

There were inconsistencies between care files and risk assessments covering information about PRN medicines currently prescribed. For example, for one person, the care plan stated they were not on any PRN medicines. However, we saw from other records there were two PRNs prescribed. This meant there was a risk that medicines were not always given when needed, or they could be given in error. We also saw that inconsistent information was recorded about people's allergies. For example, we saw that the MAR cover sheet for one person recorded there were no known allergies, but the care plan and risk assessment referred

to a penicillin allergy. This presented a risk of staff not being aware of what allergies people had, and these may not be handed over in a medical emergency.

For a person with limited mental capacity to make decisions about their treatment and who refused to take their medicines, there was written guidance about how to give the person their medicines crushed and hidden in food or drink (covertly). However, we noted a member of staff giving these in a way that was not consistent with this advice. This may have adversely affected the safety of the medicines given.
Oral medicines were stored securely for the protection of people who used the service and at correct temperatures.

At the last inspection we found significant concerns around infection control. We found that significant poor practice remained. We saw that some staff were handling red laundry bags without an apron on, and we went into one bedroom where a red laundry bag had been left on the floor with soiled items in it. Red laundry bags are dissolvable bags used for clinically soiled items and must be handled and disposed of using the correct personal protective equipment (PPE).

We also continued to have concerns about the management of a potential infectious outbreak. We saw that for one person, they had a skin condition which was not yet diagnosed, but saw from daily notes that the GP had recommended extra hygiene precautions such as washing bedding each day. There was no evidence in daily notes that this was being completed, and we saw that the person had received support to have only three showers within the last six weeks. There was a risk that potentially contagious infection was not being managed effectively.

Risks to people associated with developing pressure ulcers were not always managed appropriately. We observed during the inspection that one person was not wearing their prescribed pressure relieving boots, and we looked at their records and found that there was not suitable detail in the care plan about these. We also spoke with staff and found that one member of staff did not know they were currently in use. There was no body map in place to show existing pressure areas and no guidance for staff on how to manage these. We saw that another person was being supported to change position regularly because they were cared for in bed and at high risk of developing pressure ulcers. Records showed they were not always supported with this. The person had developed serious pressure ulcers whilst in the home. No body map was in place for this person to guide staff on how to manage these. The person was prescribed topical cream to treat pressure areas, but records showed that this was not applied as prescribed. We could not be assured that staff were doing all that was practicable to mitigate risks to the person with regard to pressure ulcers.

Risks associated with people's health conditions were not always properly assessed and mitigated. For example, we checked the care plans of one person with diabetes, and this was not detailed with guidance for staff about risks to people's feet, or their blood sugars. Another person with diabetes was having sugary food regularly according to records, however their care plan did not have sufficient detail about their diet. This meant we were unable to ascertain the level of risk to the person as risks had not been identified.

The above concerns resulted in a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The providers had not always gathered the required information prior to employment to assure themselves that staff had a right to work in the UK. Furthermore, there was a lack of transparency around who was working in the home, and when. One staff member was employed in February 2018 without the required right to work documents being held on file by the provider. For another member of staff, we saw from records that they had been dismissed from the home due to changes in the home's sponsorship status.

However, we saw from other records that the person continued to work in the home, and it was not clear under what remit. Neither member of staff was included on any rotas, supervision or training records.

These recruitment files were not made available to us during the inspection, or when we requested them verbally afterwards. Following the inspection, we wrote to the provider requesting the records, which were then provided to us. There was a risk that the provider did not always follow safe procedures to ensure people employed were fit and proper to work in the home.

This constituted a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection the home was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was due to lack of effective training and competency checking for staff, and staff deployment across the home. At this inspection we continued to find that staff did not always receive effective training and competency checking. The service remained in breach of this Regulation.

We received mixed feedback about whether staff were available to people. We received concerns prior to this inspection that there were less staff at weekends than during the week. When we visited the home, we arrived to do the inspection early in the morning, and there was one senior at night covering both floors for 52 people, along with four care staff. Another member of staff told us they felt this was a risk in cases where an incident or emergency occurred.

One relative said, "I have rung [staff] to come and take [relative] to the toilet but no one seems to come. There's even less staff at the weekends." Two further relatives confirmed to us that they regularly asked staff to come into a communal area to support or supervise people. Both said they had witnessed falls in communal areas when there were no staff around. A visiting healthcare professional felt that there were not always enough staff to meet people's needs. Three staff said they often ran short staffed, more so at weekends. We found that the rota did not always reflect who was working, so we were unable to ascertain whether there were enough staff to meet people's needs.

There was a high turnover of staff within the home. All of the relatives and staff we spoke with reflected this, and it was recognised by the directors. One relative said, "There are too many staff changes. I've seen three new ones today." We saw from records that this had affected one person's behaviour, and the GP had suggested to keep to the same staff if possible to minimise distress for them.

Some people were at risk of social isolation. One person told us the activities were not their type of thing. Their relative elaborated on this, saying that they had once played skittles but felt this was childish for their relative. One member of staff told us, "There's not enough stimulation. [People] become unhappy looking. They sleep during the day and not at night." Another member of staff felt that some people displayed more distressed behaviour because of a lack of stimulation and familiar staff. We saw that a relative visited the two communal lounges upstairs and we saw that people were animated, laughing and engaging with the visitor, and this was not seen at any other time during the day with staff.

The above concerns constituted a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always protected from the risk of abuse because the providers did not follow safeguarding procedures. We received concerns prior to the inspection from members of the public and whistle-blowers,

that staff were not encouraged to report safeguarding or concerns by the directors of the organisation. We also received feedback prior to the inspection from a healthcare professional involved with the home, that bruising and aggressive behaviour was not managed and reported appropriately. This was also reflected in concerns received from members of the public. We received information from safeguarding authorities about several incidents which were not reported by the service.

One relative told us that during a visit three weeks prior to the inspection their relative was found with a black eye and bruises. Another person, confirmed by their relative, told us they were bullied by other people living in the home. We saw records of incidents which were not reported to safeguarding. These included recent unexplained bruises, medicines errors, physical altercations, serious pressure ulcers, and an incident where one person was found in the car park, where they were not safe. When people had behaviours which some could find challenging, for example, violence, sexually inappropriate behaviour or verbal abuse, this had not been reported. Staff we spoke with did not all have a good knowledge of safeguarding and how to report concerns, or what different types of abuse there were. Two members of staff we spoke with confirmed altercations between people, and said action had not been taken to report it to safeguarding authorities. The above concerns constituted a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection in 2017 we found that the checks in place for legionella and water safety were not adequate, as there was no legionella risk assessment. At this inspection we found that although water temperatures were monitored since our last inspection, there was still no legionella risk assessment. An up to date test had been carried out for legionella and there were no concerns found. We found that equipment used for lifting people had been serviced properly. There were checks in place for electrical equipment. There were systems in place to ensure that safe processes were followed in the event of a fire. However, for people who lived in the home, their Personal Evacuation Plans (PEEPs) did not always consider how dementia this may affect some people's ability to respond to an emergency.

All of the people we spoke with told us they felt safe with the staff. Two relatives said they felt their family member was safe because they had equipment in place to alert staff when they moved around in their bedroom, for example pressure mats. This helped people to minimise risk of falling unsupervised whilst in their bedrooms.

Requires Improvement

Is the service effective?

Our findings

During our last inspection in November 2017, we found that the service was not consistently effective for people and it was therefore rated 'Requires Improvement' in this area. During this inspection we again identified shortfalls and the service was not always effective. It remained 'Requires improvement' in this area.

At our previous inspection in 2017, we found that the home did not have an adequate mix of staff deployed across the home and they were not always competent. At this inspection we remained concerned about this and they continued to be in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Three relatives and two people told us not all staff were able to communicate in English. One person said, "I find it difficult to understand some of the carers because they are from other countries and English isn't their first language." Another said, "My speech isn't very good and I find it difficult to get people to understand me anyway and because there's so many overseas [staff] here, it's worse." One relative told us, "[Staff] speak to each other in their own language and their English isn't good enough." They gave an example of when they asked to go to the laundry room to find some clothes which had gone missing, and the staff member did not understand.

Prior to this inspection we received concerns from both whistleblowers and health professionals regarding the competence of staff working in the home. During our inspection we found that staff were not adequately trained and supervised to ensure that they were competent to provide effective care to people using the service. For example we observed poor infection control practices, poor manual handling, errors in the administration of medicines and poor communication skills. We looked at the training records and found that not all staff had received training in key areas such as the Mental Capacity Act 2005 (MCA), food hygiene and infection control. Two members of staff had no records of training and were carrying out competency assessments of other staff, such as for medicines administration.

We spoke with two members of staff and they told us that they had received e-learning training but did not feel this was as effective as face to face training. Three members of staff including the latter, told us that new staff did not get the opportunity to do enough shadowing of more experienced staff to learn how to do the job and get to know people enough to support them effectively. A further staff member said, "[New staff] could put people at risk if they don't know what they're doing, or upset them if they get things wrong." They also gave us an example of a new staff member being sent out to escort someone to a hospital appointment, when they did not know the person.

We spoke with a member of staff who was not able to communicate with us in English. Another staff member gave an example of a difficulty they had in communicating with one member of staff who was not proficient in English, as they had not understood questions about people's care. The concerns we received prior to the inspection included comments that not all night staff were able to communicate effectively in English. This meant that there was a risk that people would not have their needs met by some staff, because

they did not have sufficient understanding of the English language in order to carry out their duties effectively.

When we looked at staff records, we saw that some issues with staff competency had been identified by the provider. For example, two members of staff had their competency in manual handling checked and significant concerns had been identified. However, no further training or competency checks had been carried out to ensure that their practice improved. This meant that people continued to be exposed to the risk of poor manual handling. When we looked at records of medicines errors we found that action had not always been taken to further supervise the staff member, or retrain them. We found that for one member of staff administering medicines, they had made some recent errors and had not had their competency checked since March 2018. This meant that people continued to be exposed to the risk of being given their medicines incorrectly.

The above concerns constituted a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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). Some people had DoLS authorisations applied for within the home, and two of these had been authorised.

At our last inspection in 2017 we found that mental capacity assessments had been carried out, however these were not decision specific and not always carried out as required by the MCA. We were also concerned that the home had taken no further action following concerns we identified with regards to the MCA during our previous inspection. It was not clear that decisions relating to people's care had been made in people's best interests, because these had not always been recorded. We therefore could not establish who had been involved in the making of these decisions.

Decisions such as people having pressure mats, equipment, PRN medicines and personal care interventions, where relevant, were not clear. This is because the service had not ensured that decision-specific mental capacity assessments were carried out. For example, for some people whose records stated they generally 'lacked capacity', staff recorded that some people refused PRN medicines, or personal care, but there were no specific capacity assessments in place, and no best interests decisions. This meant that it was not clear whether people understood what or why they were refusing or accepting care, or whether staff understood this. Therefore, we could not be assured that decisions for people who lacked capacity, were made in their best interests. We could not be assured that people who were regularly refusing personal care interventions were not at risk of neglect because their capacity was not assessed properly and care was not always given in people's best interests. Furthermore, not all staff had training in MCA.

One relative gave us an example of an important decision involving their relative that had been made without their involvement. The person's level of capacity had not been assessed in line with this decision. The service had applied for DoLS applications for some people without assessing their capacity first. The care records we looked at for people who were living with dementia stated they did not have capacity,

however no specific decisions were documented. There was therefore a risk that people were not being supported to make decisions if they were able, including those some may consider unwise. For people who were lacking in or had variable capacity, there was a lack of processes to ensure that people received good safe care in their best interests.

There was CCTV in use throughout the home in the communal areas. There was no evidence that people's consent had been sought for this, or that it was in people's best interests.

The above concerns constituted a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection in 2017, people were not always properly supported to have enough to eat, and consequently the service was in breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We remained concerned about the level of support people had to enable them to eat, at this inspection. However, some improvements had been made and the provider was no longer in breach of this regulation.

We had concerns that people were not always properly assisted to have their meals. A relative we spoke with described finding their relative in their bedroom with a plate of food out of reach, and another recent occasion where they were left in a communal area with a full plate of food, which had gone cold. A member of staff also told us they had recent concerns when they found that one person had not eaten their lunch and this had been left in their bedroom and not noticed by staff. During our inspection we saw some instances where people had been left with unfinished meals. For example, we visited one person in their bedroom and found they had an unfinished breakfast plate there. The person's care plan stated they required assistance with their meals. We saw from records that concerns had been addressed with one member of staff about their practice with regards to supporting people to eat.

We also saw that some people's care plans stated they should be offered snacks regularly, and the snacks to be left within reach, people were not always provided with this in communal areas of the home. We observed one of these people in the communal lounge at different times during the day and they did not have snacks within reach. We looked at the food and fluid records for this person and there was no record of snacks being offered routinely. There were two people whose records we looked at in detail who had lost a significant amount of weight, and had not been referred to a dietician. One person who had lost a lot of weight had no food diary put in place, so there was no way for staff to monitor what they were eating in order to take further action, or report it to the dietician. This put them at further risk of malnutrition. We saw that when people had been refusing their meals for a few days, this was not always handed over during the verbal staff hand over between shifts. There were three people we identified from records who were regularly refusing meals recently, and it was not handed over to the following shift. There was a risk that this information may get missed and people continued to refuse their meals without further action being taken. It was not clear from the records what action was taken when people refused their meals, for example, if something else was offered instead.

There had been some improvements made in the recording of fluids. Two relatives told us they had concerns around staff supporting their relative to eat and drink enough. We looked at people's records and found that people were regularly offered drinks. There was a target fluid intake for people on the handover sheet which staff used, however there was no guidance in place for providing further support to people when they were not drinking enough. We saw that when people were regularly refusing to drink, it was recorded on the fluid chart for staff to encourage them regularly.

Two relatives told us the drinking water left in their relative's bedroom was rarely changed by staff. One told us they had kept a close eye on this recently and would be concerned to give their relative any as it had been there for over a week on occasions. Another said, "[Relative] had a drink in their room with a film on the top." This indicated that there was a risk not everybody was drinking enough.

We saw that the choice given to people with regards to food had improved. We observed that staff gave people choices of food and drink, and these choices were respected, for example, people were able to have what they wanted for breakfast. People were positive about the food they received, one saying, "The food is lovely. I have a pureed diet." Another said, "I do get a choice at mealtimes and I have to say the food is really enjoyable." We also spoke with a member of staff in the kitchen who was able to tell us how they prepared different types of meals.

The service did not always sufficiently support people to move between services. We received information from a healthcare professional prior to the inspection as they had concerns about the handover received from another care home from Grenville Court. The person concerned had complex needs associated with their dementia and there was no information handed over about their behaviour. We received two complaints related to people living in the home prior to the inspection from members of the public that the service had not supported their relatives appropriately in their move to a different service.

People were supported to access healthcare such as chiropodists, GPs, community nurses and other teams, such as mental health and speech and language therapy when required. Staff did not always follow recommendations given by other health care professionals, for example with regards to pressure care. We found that healthcare professionals maintained significant input at the home to support staff. This helped to ensure that people received timely healthcare.

There had been some improvements since our last inspection in the environment. There were hand washing facilities in the dining areas for staff, and the kitchen section was separated from the dining area upstairs. There were also decorations on the walls which had different textures so people could gain sensory feedback from them. People were able to have personalised bedrooms with some of their own bedding or items if they wished. There was a pleasant garden with furniture available for people to use if they wished, one person telling us they enjoyed this.

Inadequate

Is the service caring?

Our findings

During our last inspection in November 2017, we found that the service was not caring and it was therefore rated 'Inadequate' in this area. During this inspection there had been some improvements in some areas, but we identified deterioration in others. We again identified serious shortfalls and the service was not caring. It remains 'Inadequate' in this area.

At our last inspection in 2017, the provider was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people's dignity was not upheld, and at this inspection we found this continued to be the case. We found at the last inspection that people's continence was not always managed appropriately. At this inspection we found that recording associated with supporting people with continence had improved. However, we concluded that in practice, people were still not always supported to maintain a suitable level of personal hygiene and cleanliness. In some cases, a lack of support with personal care such as continence support and showering had impacted on their wellbeing and safety. For example, one person had sustained a chemical burn to their skin due to their continence not being managed appropriately. This was identified by the district nurse during a visit and it had not been previously identified by staff. The person required full support with their continence. We looked at the records of daily care provided and saw that they had received support with showers four times in the last six weeks.

Prior to the inspection we received some complaints from members of the public about the care provided to their relative with regard to their continence and personal care. We also received some complaints via whistle blowing about the personal care provided to people. During the inspection one relative said that they asked care staff to support their relative with their continence, and this was not done. We found that some people's care plans contained contradictory information or insufficient detail to guide staff on the support people required with regard to their continence. For example, one person's care plan stated they had occasional continence difficulties, however stated that they wore continence protection, but could use a toilet independently. There was no guidance for staff on how to support the person with their continence. They had also not been supported to shower for 17 days prior to the day of our inspection visit, when they were supported to shower. This meant that people were not always supported to uphold their dignity.

We also spent time with one person in their bedroom and found that their bedding was soiled. Their relative told us a member of staff had gone around to check the rooms, but had not looked under the duvet. Another relative who we gained feedback from immediately following the inspection stated they had very recently found their relative's bed, bathroom and clothes in a soiled state. A third relative told us that recently they had found their relative in a wet bed.

We observed staff in a communal area asking another member of staff to check people's pads. This did not uphold their dignity. People were not always supported to wash according to their care plans, and limited information was available as to what action to take if they refused continually. We saw that one person was unshaven with dirty hair and fingernails, and was wearing dirty glasses. We saw from records that they were not supported to wash as per their care plan. For another person, they had sores on their feet. We spoke

with a visiting healthcare professional who advised that their feet should be washed twice a day. We checked these records and found this was not always done.

In the afternoon we saw one person in their bedroom with a plate of sandwiches on the table, but there was a strong malodour in the room which was not conducive to eating. Although there was an improvement in the cleanliness of people's bedrooms and bedding since the last inspection, we observed some rooms with soiled bedding, and a strong malodour.

Consequently the provider remains in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection we received one comment from a relative saying that staff spoke to each other around people and relatives in their own languages. This was in addition to a whistleblowing concern we received prior to the inspection which also told us this was the case. This did not support people's communication and wellbeing because it did not include people in what was going on. Furthermore, it could be disorientating for those living with dementia.

It was clear from speaking with people and staff that staff did not always have time to spend with people in a meaningful way. One person said, "The carers do what they need to do and so I don't get into conversations with them. It's a bit sad it's that way but that's how it is." This was closely reflected by three more people we spoke with. Another person, in reference to staff not speaking English, said, "It makes me a bit sad and lonely."

We received many concerns in the form of complaints and whistle-blowings prior to the inspection, that the directors of the company did not always have a caring approach. The complaints we received since the last inspection included accounts of the directors telling families that their relative would be moved if they raised concerns, and that they had been seen to shout at both relatives and staff members in communal areas. Four staff members we spoke with as part of the inspection also confirmed this was the case. This did not promote a caring atmosphere within the home.

The attitude of staff towards people had improved since our last inspection. We received one complaint about staff's attitude from a member of the public prior to the inspection, which was a single incident. The people and relatives we spoke with told us that the care staff were caring and spoke to them nicely. All of the people we spoke with felt they could approach staff if they needed to. A relative said, "Staff are open and friendly, I can see by [family member's] response when they smile at [family member] and how [family member] smiles back." However, another relative told us they felt the care provided was simply task-oriented. We observed some interactions over lunch time where carers showed warmth and empathy with people. However, staff did not always adapt their communication to enable people to understand properly. For example, they gave multiple choices verbally all in one go. They did not always communicate in a way that supported people living with dementia to make choices.

We saw that staff respected privacy and entered rooms with a prior knock on the door. This was also confirmed by a relative.

We had mixed views of how staff involved relatives in people's care when appropriate. One relative we spoke with said that the home had had a meeting with social services without them being invited. Despite this, the minutes of the meeting had given the impression this relative was in attendance, however they told us this was not the case. During this meeting they also covered incidents the person had been involved with which the relative had not been made aware of previously. The home had not made them aware that the person

living there had gone from a temporary position there to a permanent one, and they were not consulted about this.

One relative said they felt they were more involved and consulted when the previous acting manager was in the home, however they had since left. We saw during the inspection that two staff members went through details of people's care plans with relatives. The relatives we spoke with told us staff contacted them if there was an incident in relation to their family member.

Inadequate

Is the service responsive?

Our findings

During the last inspection in November 2017, we found that the service was not responsive and was therefore rated, 'Inadequate' in this area. At this inspection, the service remained 'Inadequate' in this area.

At our last inspection we found that personal care was not provided in line with people's preferences and there was a lack of stimulation for people. Staff did not adapt care plans in line with people's changing needs and care was not always delivered in line with people's care plans. Therefore the service was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we continued to have concerns, and the service was still in breach of this Regulation. They were also in breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because they did not always resolve complaints effectively.

At our last inspection we raised concerns with the provider about personal care for people, especially with regard to health needs. For one person who we had raised concerns about on our previous inspection, we continued to have concerns about the way they were cared for. They were still not receiving personal care as per their care plan and in line with their individual needs.

Care plans did not always contain accurate and up to date information. People's health needs were not always covered sufficiently in their care plans, and were not always attended to by staff. For people who had visual or hearing impairment staff did not always support them as needed. For example, one relative told us they had requested repeatedly that staff support their family member with their hearing aids, and staff were still not providing this support. Where staff had noted a change in people's health or mobility, this was not always added to the care plan and further recommendation sought where needed. For one person, care staff had reported the person was unable to sit up on the shower chair. They therefore gave a bed bath but a week later they were supported to have a shower. There were no further notes about whether the person sat safely on the shower chair and there was no further review. Where people had needs associated with pressure areas and diabetes, care plans were not always updated to reflect current needs. Staff were not always able to tell us accurate information about people's current needs. The concerns brought to our attention about new staff not always shadowing enough, teamed with high turnover, meant staff did not always know people's needs.

People's emotional and mental wellbeing was not always supported. We continued to have concerns that people's behaviour was not always being well managed in practice. This is because we received feedback that staff were not always available, and that some people's behaviour had a negative impact on others and this was not always managed. Pre-assessments did not always contain sufficient information and guidance about people's behaviours.

We received some information from a healthcare professional prior to the inspection about whether the service properly assessed people and were able to meet their needs. We looked at three pre-admission assessments for people who had been admitted into the home since our last inspection. These did not contain enough detail for the home to ascertain whether they could meet people's needs or not. For

example, for one person, it said they became agitated during personal care, and no further information about why this was and what could be done to mitigate this. It also said on the pre-admission that the person was registered blind, but with no further information. It stated the person had no capacity and no assessments were done. Despite this, in the communication section of the pre-admission, it stated 'communicates', with no information about how. It said the person required two staff for assistance, but again no further information. The information given by the social worker was not used to assess whether the home was suitable for the person and whether staff could meet their needs. We concluded that the pre-admission assessments were not detailed enough for the service to properly assess whether or not they were able to meet people's needs, and what level of input they required.

We saw that many people remained alone behind closed doors throughout the day. There was no evidence of one to one sessions taking place with these people in line with their preferences, and no evidence that preferences had been taken into account when planning activities. This included when they were identified in their care plan as being at risk of social isolation. There was no activities provision for the weekend.

There were no detailed end of life care plans in place. It was not clear how the service was meeting people's needs and preferences and consulting their families with regard to their end of life care requirements.

One relative told us, "All [family member's] clothes are named but [family member] will be wearing someone else's and vice versa." Two more relatives confirmed that their family member's clothes went missing. We saw that this was previously raised in complaints from people's relatives, and we also identified this as a problem during the last inspection. This area had not improved sufficiently and people's belongings were not always respected.

The above concerns constituted a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some staff and relatives told us that they did not always feel comfortable to raise a concern or complaint. We received feedback from two members of the public prior to our inspection stating that the directors had asked their relatives to leave the home following the family raising concerns with CQC or making a complaint to the providers. We also received information from a whistle-blower prior to the inspection who confirmed this was the case.

Two relatives told us they had bought certain things to the staff's attention that they wanted to be done, and stated this had not been resolved. One person said, "I feel [staff] are reasonably approachable but nothing seems to be done." Another stated they had found the previous acting manager helpful, but the staff had not continued with what they agreed. One member of staff told us, "[The directors] don't want to hear anything negative." We looked at records of concerns and complaints. These were not always fully investigated and signed off by a staff member who had resolved the compliant.

At the last inspection we found that complaints were not always effectively investigated and resolved. The complaints system was not effective and did not always lead to service improvement. This continued to be the case at this inspection. We reviewed the complaints received this year, and found they had not always been investigated or resolved effectively. The majority of the complaints were not upheld, and it was not clear who had dealt with complaints as they were not always signed off. The records of complaints received did not always include evidence that the service had liaised with families or apologised when poor care had been identified by family members.

The above concerns constitute a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

Some people said they felt there was enough to do. One person said, "I like singing and I enjoy listening to the music they play and I can join in." Another said, "I like doing my own thing, but I do join in the exercises." However, one person said, "I spend my time looking out of the window and honestly there's not much to do." The directors told us they had organised tickets to a dementia event taking place at the theatre, which several people were going on. We saw that staff carried out some activities with people during our inspection, including a game and some exercises. There were new staff employed to focus on activities provision within the home.

During the inspection we observed the communal areas of the home throughout the day. The television in the main lounge upstairs was on for the day nobody was observed looking at the screen during the many observations that took place during the day. There was some music on in another lounge, which one relative told us was recent and felt it was a positive thing.

Inadequate

Is the service well-led?

Our findings

During our last inspection in 2017, we identified widespread and significant shortfalls in the way the service was led and it was rated 'Inadequate' in this area. At this inspection, we continued to find that the service had serious shortfalls in leadership. Therefore it was still rated, 'Inadequate' in this area.

At our last inspection the service was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because audits were not effective in identifying concerns and taking action. At this inspection we found the service continued to be in breach of this Regulation. Furthermore, the service was in breach of Regulation 18 (CQC Registration Regulations), because they had not sent in the required notifications to us.

There was poor leadership in place and no registered manager or deputy manager. We received several whistle-blowings which included the lack of leadership in place this year. This had an impact on staff and meant they received inconsistent direction. We saw that disciplinary action had been taken against staff in some instances which did not include putting people's safety at risk, for example, not tidying a bathroom immediately after use. However, where staff made a medicines error, there was no further action. This demonstrated a lack of consistent staff management and leadership.

We requested information from the directors during our inspection visit, which was not provided immediately, so we followed this up with a formal request for the information, which was then supplied to us. The directors were not able to answer questions as to the reasons staff were working in the home and not recorded on the rota, and why their recruitment records were not immediately available to us. This demonstrated to us not only a lack of oversight of the systems in place for recruitment, and lack of knowledge as to who was working for them.

Since our last inspection there was increased observation of staff competency, and we saw that some issues had been identified. However, these were not always appropriately acted upon. We found that where medicines errors were brought to our attention both prior to, and during the inspection, systems had not been put in place to rectify these and mitigate the risk of this reoccurring. Furthermore, action had not been taken consistently with regard to staff members making the errors.

There was increased oversight of people's daily care in terms of ensuring they were eating and drinking, in that information was being recorded by staff. However, where people were not eating and drinking enough this was not always handed over to the following shift and action had not always been taken when concerns were identified. There was also increased recording by staff of people's personal care provided. However, action was not always taken when people were not receiving care according to their current needs. Gaps in records were not always identified.

Contemporaneous records were not up to date and accurate. This included people's care plans and staff rotas. Care plans were not updated with current needs. Staff rotas did not reflect who was working when, and therefore there was a lack of accountability for work completed. Some staff who had been working in

the home were not included in any training records.

Following the last inspection, we met with the directors of the organisation and asked them to provide us with their service improvement plan. We reviewed this in line with the previous inspection findings. At this inspection we found that although some improvements had been made in terms of the environment, not all of the required improvements had been made in order for the service to provide consistently good care to people.

There was a lack of transparency and openness within the culture of the home. It was clear that people, relatives and staff were not encouraged to raise any concerns. We received several whistleblowing complaints prior to the inspection who stated that staff felt they were persecuted for raising concerns with the directors of the organisation. During our inspection, five members of staff confirmed that this was the case. They felt they would be in trouble if they raised concerns. Two staff members confirmed that immediately following conversations with us during the inspection, one of the directors approached them to ask what was said. One member of staff called us the day after the inspection to say they had been dismissed for raising concerns. We found that concerns raised by relatives were not always acted upon. We also found prior to the inspection, that many concerns reported to safeguarding authorities had been reported either anonymously, or by healthcare professionals, and not by staff in the home. Furthermore, we found during the inspection several concerns which we reported to safeguarding authorities. This demonstrated that the directors did not promote an open, positive or reflective culture in which the service learned and improved from shortfalls.

There were ineffective governance arrangements and due to the continued failure to make and sustain the necessary improvements, we do not have confidence in this care provider to deliver a good service.

The above concerns constituted an ongoing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were several safeguarding incidents as well as a serious injury which were not notified to us according to the Registration Regulations 2009. This meant we were unable to follow up concerns and be assured that people were kept safe and further risks were mitigated.

The above constitutes a breach of Regulation 18 of CQC Registration Regulations 2009.

There had been some attempts to gain feedback from people and their relatives since our last inspection, when there was an acting manager in post. However, inconsistencies in management had meant that meetings had not been carried out regularly for people and families. There were surveys in place, some of which had provided some positive feedback for the home. However, complaints and concerns were not always acted upon and learned from in order to improve the service provided and to take people's views and experiences into account.