HC-One Oval Limited

Ghyll Grove Care Home

Inspection report

Ghyllgrove
Basildon
Essex
SS14 2LA

Tel: 01268273173

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27 October 2020
29 October 2020
30 October 2020
02 November 2020

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Ghyll Grove Care Home is a residential care home providing personal and nursing care for up to 169 older people. Some people have dementia related needs and some people require palliative and end of life care. The service consists of four houses: Kennett House, Medway House, Chelmer House and Thames House. At the time of our inspection there were 79 people living at the service.

People's experience of using this service and what we found
Effective arrangements were not in place to mitigate risks for people using the service and staff employed at the service. Not all appropriate measures were in place or being followed to prevent and control the spread of infections. Effective arrangements were not in place to protect and prevent people who used the service from abuse or to properly investigate where concerns were raised.

The leadership, management and governance arrangements did not provide assurance the service was well-led. Quality assurance and governance arrangements at the service were not reliable or effective in identifying shortfalls in the service. Governance arrangements, including performance management, roles and responsibilities required improvement. Lessons were not consistently learned to improve the service for people using the service.

People were not always supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

There were enough staff available to meet people's needs. Suitable arrangements were in place to ensure the proper and safe use of medicines.

At this inspection we found improvements had been made relating to staffing levels and the deployment of staff; and the provider was no longer in breach of Regulation 18 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. However, not enough improvement had been made relating to governance and the provider was still in breach of Regulation 17 of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

Rating at last inspection (and update) The last rating for the service was Requires Improvement, [published January 2020]. This service remains rated Requires Improvement. This service has been rated Requires Improvement for the last three consecutive inspections.

Why we inspected
This was a focused inspection based on the previous rating and prompted in part due to concerns raised by the Local Authority in July 2020. A decision was made for us to inspect and examine the risks identified by the Local Authority. A focused inspection was carried out to review the key questions of 'Safe' and 'Well-Led'

only.

We also looked at infection prevention and control measures under the 'Safe' key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID 19 and other infection outbreaks effectively.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Ghyll Grove Care Home on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Ghyll Grove Care Home

Detailed findings

Background to this inspection

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

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak and to identify good practice we can share with other services.

Inspection team
The inspection was completed by four inspectors on 27 October 2020. One inspector was assigned to Kennett House, Medway House and Chelmer House respectively. One inspector reviewed the service's infection control and prevention measures in three out of four houses.

Service and service type
Ghyll Grove 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.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We sought feedback from the Local Authority prior to the site visit and made telephone calls to people's relatives on 14, 15 and 16 October 2020. A variety of records relating to the management of the service were reviewed. We used all of this information to plan and inform our inspection.

During the inspection
We spoke with three people who used the service about their experience of the care provided. We spoke with the interim manager, area director, area quality director, qualified nurses, senior care staff, care staff and housekeeping staff. We also spoke with one healthcare professional. We reviewed a range of records and this included people's care records. We looked at two staff files in relation to their conduct.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at Medication Administration Records [MAR] for 12 people using the service, staff supervision records for four members of staff and quality assurance and governance records.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

At our last inspection in November 2019, suitable arrangements were not in place to ensure enough staff were deployed to meet people's care and support needs. This was a breach of Regulation 18 [Staffing] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. We found enough improvement had been made and the service was no longer in breach of this regulation.

Assessing risk, safety monitoring and management;
• Not all risks to people's safety and wellbeing were being monitored and followed up. Where people had a daily fluid target to be reached each day because they were at risk of dehydration, where this was not achieved, there was no evidence to demonstrate how this was being monitored and addressed.
• The care records for one person recorded they should be weighed at weekly intervals as they were underweight. Information provided following the inspection showed this had not been completed each week as stated and yet the person remained at high risk of losing weight.

Preventing and controlling infection
• Arrangements to assess current and emerging risks presented by the pandemic for people using the service and staff had not been identified and recorded. This demonstrated a failure to assess and support people using the service and staff who may be at increased risk of getting COVID 19.
• Preparatory arrangements to have safe prevention and infection control measures in the event of a COVID 19 outbreak were not initially in place but completed retrospectively because of the inspection.
• We were not assured staff were using Personal Protective Equipment [PPE] effectively and safely.
• We were not assured the provider was always meeting social distancing rules in communal lounges and this required improvement to keep people safe.
• We were assured the provider was admitting people back from hospital safely to the service and preventing visitors from catching and spreading infections.
• We were assured the provider was accessing testing for people using the service and staff at regular intervals.

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

Systems and processes to safeguard people from the risk of abuse
• The provider's arrangements did not ensure all allegations of abuse were investigated without delay and

actions taken to ensure lessons were learned.
• The provider did not act in accordance with the Mental Capacity Act 2005 where people did not have the capacity to consent to COVID 19 testing. The 'best interest' process was not being routinely followed. A 'best interest' assessment determines the person's wishes and whether any restrictions in place are in the person's best interest. A safeguarding concern was raised with the Local Authority by the Care Quality Commission.
• People using the service and those acting on their behalf told us they were safe. Comments included, "I have no worries about [name of relative] being there [Ghyll Grove Care Home] and they seem quite happy" and, "[Name of person using the service] is much safer than if they were at home on their own."

This was a breach of Regulation 13 [Safeguarding service users from abuse and improper treatment] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

Learning lessons when things go wrong
• This inspection highlighted some lessons had been learned and improvements made since our last inspection in November 2019. Suitable arrangements were now in place to ensure there were enough staff available to meet people's needs and the service's medicines management was safe.
• However, recommendations highlighted in November 2019, relating to social activities, care planning and supervision for staff, remained outstanding. Significant improvements were still required to make sure the service was consistently well-managed and led.

Staffing and recruitment
• We did not review the provider's recruitment practices and procedures at this inspection as no concerns were previously highlighted in November 2019.
• Relative's comments about staffing levels were variable. Relatives told us there had been lots of staff changes and staff always seemed to be very busy. Comments included, "Staff always seem to be running about" and, "Staff are always busy, they [service] use a lot of agency staff."
• Staff told us there were occasions whereby staffing levels were not always maintained. This referred specifically to both Kennett House and Medway House.
• Observations demonstrated some people's personal care was not completed until midday or close to when the lunchtime meal was served at 12.30. Staff told us the impact on people using the service meant some people remained in bed until lunchtime and did not have their toileting needs or continence products provided in a timely manner.
• Although the above comments were made from relatives and staff, the deployment of staff was appropriate to meet people's needs at the time of our inspection.

Using medicines safely
• We looked at the Medication Administration Records [MAR] for 12 out of 79 people living at the service. These were in good order, provided an account of medicines used and demonstrated people were given their medicines as stipulated by the prescriber.
• Observation of the medication rounds showed these were completed with due regard to people's dignity and personal choice. For example, people were asked if they wished to have pain relief medication and their decision was respected.
• Staff involved in the administration of medication received training and had their competency assessed.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection in November 2019, effective arrangements were not in place and did not provide assurance the service was well-led, that people were safe, and their care and support needs could be met. Quality assurance and governance arrangements at the service were not reliable or effective in identifying shortfalls in the service. This was a continued breach of Regulation 17 [Good governance] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014. At this inspection we found not enough improvement had been made and the provider remained in breach of this regulation for a third consecutive time.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Continuous learning and improving care

• Effective arrangements were not in place to assess, monitor and improve the quality and safety of the service. The Local Authority completed a visit to the service in July 2020 to verify compliance with their action plan. The Local Authority were unable to 'sign-off' the actions recorded as the provider had failed to pick up the issues and concerns raised relating to people's safety and wellbeing.

• Discussions held between the service's management team and the provider between November 2019 and July 2020, portrayed an unrealistic and inaccurate depiction of the service. Information recorded the management team were confident the service was moving in the right direction and actions from the Local Authority would be met. The provider failed to verify this, ensuring lessons were learned and the stated improvements made.

• Regardless of the previous registered manager being formally supervised on four occasions and the provider undertaking eight 'home visits' to the service between November 2019 and July 2020, there was a significant failure at both service and provider level to effectively identify and manage risks and to ensure people's safety and wellbeing.

• A 'Recovery Plan' was put in place in September 2020 to address the Local Authority's action plan and to reflect the findings found at our last inspection. Updates provided to the Local Authority and Care Quality Commission failed to validate all objectives set. Comments recorded which required further action had not always been followed up.

• The incidence of safeguarding concerns at Ghyll Grove Care Home had increased significantly since our last inspection in November 2019. Since July 2020 and up until this inspection, the Local Authority reported

there were 18 open safeguarding concerns under review and investigation. This demonstrated effective arrangements were not in place to monitor and improve the quality and safety for people using the service.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
• The service does not currently have a registered manager in post. Since 2 September 2020, an interim manager has been in place and they are supported by the provider's representatives.
• Not all relatives spoken with knew who the previous registered manager was or who was currently managing and overseeing the service in the interim. Comments included, "I didn't know who the previous manager was or what their name was, so I'm not really too bothered about this one" and, "To be honest, with all the changes I never know who is actually in charge, so the confidence isn't really there."
• This was also reiterated by staff spoken with following the site visit. When asked who was managing Ghyll Grove Care Home, one staff member referred to the previous registered manager. The member of staff was unaware who the interim manager was or the role and responsibilities of the Area Director and Area Quality Director.
• Support for staff from the management team was inconsistent and information to support staff's performance was unreliable or not completed.
• Not all staff felt valued, supported or appreciated by the provider, particularly by the interim management team. Staff told us this was exacerbated because of a lack of communication and staff not being clear about the management team's role and responsibilities. Staff told us they received good support from the individual house manager's and most qualified nurses.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• Relatives told us they had not seen their family member's care plan or been involved in providing information. One relative told us, "I saw the care plan initially, but it was a long time ago. I don't recall having a review of [relative's] care for over two years." Other comments included, "I really don't know about the care plan, we have never really been asked" and, "Ghyll Grove have never asked us about [name of relative] care plan."
• Care plans viewed did not demonstrate involvement from people using the service or those acting on their behalf.
• We did not look at the provider's other formal arrangements for engaging and involving people, the public and staff on this focussed inspection.

Effective arrangements were not in place to assess and monitor the quality of care provided, to ensure compliance with regulations. This was a continued breach of Regulation 17 [Good governance] of the Health and Social Care Act 2008 [Regulated Activities] Regulations 2014.

Working in partnership with others
• Information available showed the service worked in partnership with key healthcare organisations. A healthcare professional told us staff communicated well, were informative and acted on feedback and advice provided.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Effective arrangements must be in place to mitigate risks for people using the service and staff employed at the service. Appropriate measures must be put in place to prevent and control the spread of infections.

The enforcement action we took:

We imposed conditions on the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Effective arrangements must be in place to protect and safeguard people using the service. Providers must act in accordance with the Mental Capacity Act 2005.

The enforcement action we took:

We imposed conditions on the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective arrangements must be in place to assess and monitor the quality of the service provided and to ensure compliance with regulatory requirements.

The enforcement action we took:

We imposed conditions on the provider's registration