Alpha Care Management Services No. 3 Limited

Grenville Court Care Home

Inspection report

Horsbeck Way
Horsford
Norwich
Norfolk
NR10 3BB

Tel: 01603893499

Date of inspection visit:
06 August 2020
07 August 2020
10 August 2020
11 August 2020
12 August 2020
17 August 2020
18 August 2020
21 August 2020

Date of publication:
21 October 2020

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Grenville court care home is a large residential care home providing personal care to up to 64 older people many of whom are living with dementia. At the time of the inspection there were 59 people living in the home.

The care home is set over two floors each with its own lounges and dining area. People have their own rooms with ensuite facilities. The home is serviced with a large kitchen and a laundry.

People's experience of using this service and what we found
Where people were living with dementia, they were not supported by enough staff who had received appropriate and effective training to best meet their needs. Risks to people's health and wellbeing had not been assessed, managed and mitigated to ensure people were supported effectively to reduce those risks and keep them safe. Medicines were not managed safely and the records to support good administration of medicines were poor.

Staff who had been promoted whilst working at the home had not been through an equitable, safe and fair recruitment process. Staff in more senior posts had not been appropriately assessed to determine they had the skills to deliver the post requirements.

Effective governance and oversight systems were not in place. Quality audits were not developed or used to drive improvements and records of people's needs were poor and in need of review, involving people and their families, where appropriate. The home did not have a positive culture as management did not lead by example and staff were required to contact other professional bodies to drive improvement.

Steps were not taken to ensure productive and effective working relationships were built and sustained with other professional bodies including the safeguarding team. Notifications of specific incidents were not shared with the care quality commission as required.

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

Rating at last inspection
The last rating for this service was Good (17 December 2019)

Why we inspected
We received concerns in relation to the care and support provided at the home. In the four months prior to the inspection we received concerns in relation to staffing, nutrition, pressure areas, dignity, safeguarding and restrictive practice. As a result, we undertook a focused inspection to review the key questions of Safe and well-led only.

We reviewed the information we held about the home, taking into account the COVID-19 pandemic, and determined we could improve the safety and quality of the home by inspecting just the two key questions. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from Good to inadequate. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe and well led sections of this report.

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

During the inspection we had concerns for the safety of people in the home and wrote to the provider. The provider took immediate steps to address the concerns and continues to work with us to improve provision at the home.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Grenville Court 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.

During the inspection we found concerns which led us to contact the provider with a view to potential urgent action. The provider took immediate steps to amend the management team at the home to mitigate immediate risks and keep people safe.

We have identified breaches in relation to how medicines were managed and how risks were both assessed and mitigated, how concerns around people's safety, health and wellbeing were reported and managed under appropriate safeguarding procedures, and how procedures were changed and implemented under best practice guidelines for the COVID-19 pandemic. We also found breaches in relation to ensuring that there were enough suitably trained or qualified staff in post to meet the needs of people and keep them safe in the event of an emergency. This included a lack of robust recruitment procedures specifically when people were promoted to more senior posts once working at the home.

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

During this inspection we wrote to the provider of our intent to take urgent action and the provider gave us an action plan for immediate change. We continued to have concerns about the pace of change and completed a targeted inspection to review the action taken following our concerns. We found not enough action had been taken and we served the provider a Notice of Decision and urgent conditions were put on the provider's registration. This meant the provider had to submit weekly reports to us to assure us they were taking the action required to keep people safe.

Follow up

We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
This focused inspection has found both key questions inspected as inadequate. As a consequence the overall rating for this service has now changed to 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Grenville Court 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.

This was a focused inspection looking at the key questions, safe and well-led. As part of this inspection we looked at the infection control and prevention measures in place. This was conducted as part of our Thematic Review of infection control and prevention in care homes.

Inspection team
This inspection was completed by three inspectors and one assistant inspector. One inspector led the inspection remotely over all days of the inspection. Two inspectors and the one assistant inspector completed a site visit on 6 August 2020. Following this, the assistant inspector and one inspector completed calls to staff and family members of people living in the home.

Service and service type
Grenville Court 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.

The home had a manager who was not registered with the Care Quality Commission. This manager was removed by the provider early into the inspection and replaced with a team of managers. At the time of the inspection the provider was legally responsible for how the home was run and for the quality and safety of the care provided.

Notice of inspection
We notified the home of our intention to inspect the day before the site visit. We did this due to the current COVID-19 pandemic. The short notice period allowed them the opportunity to get information and a room ready for the arrival of the inspection team.

What we did before the inspection
We reviewed information we had received about the home since the last inspection. We sought feedback from the local authority and professionals who work with the home. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their home, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

We contacted the manager and requested information be left available for the inspection team attending the site visit and requested other documents be sent electronically to the inspector. We also requested contact details of family members, staff, and professionals working with the home.

During the inspection
During the site visit we spoke briefly with two people living in the home and we either had telephone or email communication with nine other family members, over the inspection period. We had been liaising with professionals including the local authority safeguarding board and quality team both before and during the inspection.

Whilst on site we spoke with seven members of staff including the manager, area manager, chef, senior carers and carers. We also spoke with eight staff via telephone including domestic and activity staff and had email communication with two staff. We had ongoing email and telephone communication with the area manager and spoke with the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

Whilst on site we looked at six recruitment files, accident and safeguarding records, medicine administration records and all available audits. We looked remotely at 14 care plans and requested other management information to analyse whilst completing the inspection off site. This included meeting minutes, dependency assessments and policy and procedures.

Inadequate

Is the service safe?

Our findings

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

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

Systems and processes to safeguard people from the risk of abuse

- The safeguarding policy was not being followed to ensure people were kept safe.
- People were admitted to the home without an assessment of their needs and identification of any risks to the individual. As a consequence, staff were unable to deliver safe care. Three people who were recently admitted to the home did not have care plans or any records showing how they should be supported. Staff were unaware of one person's continence needs and as a result they were not met. We discussed this information with the area manager and two safeguarding alerts were made by the provider's area manager in relation to people being admitted to the home without any preadmission assessment and care plans
- People at risk of developing pressure ulcers were not protected by regular repositioning and as a result, pressure ulcers developed. Where pressure ulcers had developed, care plans and risk assessments were not completed to ensure staff knew how to support them. When pressure ulcers developed and worsened due to ineffective support, referrals were required to be made to the safeguarding team and notifications should be made to the CQC, we found these had not been completed. Three safeguarding alerts were made by the provider's area manager and CQC where this had occurred.
- Due to the COVID-19 pandemic people discharged from hospital should be discharged following receipt of a negative test. The manager had accepted the discharge of a person admitted to hospital following a fall without a negative test. In line with government guidance where possible people should be isolated to reduce the risk of possible infection transmission amongst other people in the home.
- The manager had decided the person could not understand the need to isolate and in order to protect people in the home changed the training room into the person's bedroom and locked them in this room. There was not an appropriate assessment to determine the deprivation of the person's liberty (DoLS) was lawful. There was not an application to the DoLS team to seek authorisation and there was not an appropriate decision made in the person's best interest to determine this was the least restrictive option. The person was locked in the room for seven days unlawfully. A safeguarding alert was made, following concerns raised by staff to the Local Authority.

People were not protected from harm or abuse as the manager had not safely implemented the provider's policies in this area. This placed people at risk of harm and was a breach of regulation 13 (Safeguarding service users from abuse or improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Risks to people's health and wellbeing were not assessed effectively. When concerns were noted steps were not taken to provide staff with the guidance they needed to mitigate risks and keep people safe. One family member told us, "We have had to have a lot of input to keep [family member] well. I would say the

staff do try but they have a lack of understanding of [family members] needs."
● One person had lost over 30% of their body weight in the 90 days prior to the inspection. Actions had not been implemented to safely monitor the person's risk of malnutrition. The person was not weighed weekly, their food and fluid intake were not recorded or monitored in any meaningful way to determine what they had eaten. Effective monitoring would have allowed staff an opportunity to offer more of the type of food the person would choose to eat. We also found effective and timely advice had not been sought from external professionals to best support the individual. A safeguarding alert was raised by the CQC.
● The home primarily supported people living with dementia. At times people behaved in a way that staff found challenging. Risk assessments were not developed to guide staff on how to best support people at times of heighted anxiety. We noted two people where staff required more guidance. We looked at the risk assessments for the two people and found them to lack the detail needed to support them effectively, safely and in a person-centred way. We made two safeguarding alerts n relation to this.
● Where people were falling the manager had not taken adequate steps to ensure they were safe and people continued to fall. Risk assessments were not updated following falls and some risk assessments did not identify concerns. Body maps were not routinely completed when people were injured and falls diaries were inaccurate. Two family members shared concerns around the ability of the home to support people wo were at risk of falls. One told us, "I have been very concerned in the last five months as I don't seem to be told when [family member] falls, I hear it through the grapevine."
● There were not adequate monitoring systems or analysis of risk areas, to allow the identification of poor practice and any actions required to drive improvement.

The provider did not ensure people were kept safe. Risks were not effectively assessed or managed, placing people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● There were not enough staff to meet people's needs. Due to inaccurate assessments of people's needs the staff required to meet them had not been correctly determined. The dependency tool used, identified people in the home with mostly low-level needs, this was not correct.
● Staff had complained to the CQC prior to the inspection that they could not meet people's needs in a timely way and that people had to wait to receive the support they needed. This included when people needed to be repositioned and to be supported with personal care needs.
● On the day of the inspection site visit people were taken from their bedrooms to the lounge and dining room area. They remained in that area for the duration of the day or until they requested to be moved. There was one activity coordinator to support 59 people and often the support provided was on a one to one basis due to the complexities of people's needs. This meant people were sitting for long periods of time without either stimulation or support.

Staff did not have time to deliver more than what was needed to meet people's basic care needs. The required staff numbers had been incorrectly calculated to ensure enough staff were on duty to meet people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff recruited to post were not done so in a safe and equitable way. The information required under section 3 of the Health and Social Care Act was not routinely gathered. This included information of the previous performance of staff.
● References were not validated and declarations of health care needs were not assessed to determine if any suitable adjustments were required to people's working environment.

● Where staff were promoted once already in post, recruitment procedures were not followed. This included the lack of an advertised post, application and interview process and an assessment of any additional training required for the new post.

Staff were not safely recruited. Information required under schedule 3 was not always available. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● There were not enough trained and competent staff always on duty to administer medicines to people as prescribed. Night shifts would often not have a staff member on shift who had been trained in the administration of medicines. This meant people wouldn't receive their medicines if required.

● We found staff had been administering medicines prior to the receipt of suitable training and their competence being tested. One staff had their competence signed off prior to completing the training.

● People did not always receive their medicines as prescribed, this included medicine to be administered prior to food being administered with or after food and paracetamol being administered in less than four hourly intervals.

● Medicines to be administered as required did not have associated protocols in place to inform staff when people might require the medicine. This was specifically important as people living in the home were at risk of not being able to communicate their needs and express when they may be in pain.

● Medicine Administration Records (MARs) were poorly completed and were not always accurate in relation to how a medicine should be administered.

Medicines were not safely managed, recorded or administered and best practice was not always followed. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● During the pandemic the Care Quality Commission (CQC) completed phone assessments with all services. These were called emergency support framework assessments. Within this telephone assessment we would determine if the service was coping with the risks associated with the COVID19 pandemic. Grenville court's emergency support framework assessment was completed on 11 May 2020. We found during the inspection that information shared with us as part of our emergency support framework assessment was not accurate. This included a lack of risk assessments and that best practice guidance had not been routinely developed and implemented.

● We saw ample pictures on the home's social media page which showed staff not following the guidance for wearing personal protective equipment. (PPE) and staff often being in close contact with people living in the home. One family member told us, "We thought the home were managing well until I saw the social media page and staff were not wearing PPE, I tried to have a discussion about this but got no response."

● Extra cleaning schedules had not been introduced to manage the risk and spread of COVID-19.

● Whilst the home was generally clean, extra precautions including government guidance had not been introduced to manage the COVID-19 pandemic. This included a lack of social distancing and the admission of people from the community or hospital without a negative test result.

● People told us visiting contractors were not told to wear PPE and accessed the home without testing of their temperature or washing their hands.

The provider had not ensured the service was following government guidance and implementing best practice to reduce the risk and spread of COVID-19. This was a breach of regulation 12 (Safe care and

treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

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

- In recent months there had been a high staff turnover and lots of new staff employed. Staff did not receive the support and leadership required to develop an open and transparent culture which would achieve the best outcomes for people.
- In the three months prior to the inspection the Care Quality Commission (CQC) received concerns from five members of staff working at the home. Concerns included, a lack of staff, a lack of training, a culture where staff felt undervalued and staff felt they were not meeting the needs of people living in the home as they would like.
- We had spoken with the manager each time concerns were raised and they had given us assurances issues were dealt with and people were in receipt of good quality person centred care. When we inspected, we found this was not the case. Whilst completing the inspection it was clear that records were being updated and amended at the time of the inspection. This did not reflect an open and transparent approach.
- We shared our concerns with the provider who took immediate action to remove the manager and their deputy. An interim management team was put in place who have worked well with the CQC at making the immediate changes required.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Previous forms of communication and sharing information with families had ceased when the manager started. This included regular emails, phone calls and a quarterly newsletter. More formal feedback including questionnaires and care reviews had not taken place.
- Records for people's care were not always accurate and were regularly contradictory. Families were frustrated at the lack of contact from the home in relation to their loved one's care and changing needs. One person told us, "The home does not communicate well, the manager is not approachable and we are not told important things. Every time we ring, we are told different things that we did not know about." Staff also shared concerns in relation to a lack of accurate and available information on people's needs and wishes.
- Where people had tried to contact the manager to request feedback or seek formal response to questions it was not received or was delayed. We saw some communications which were not effective at answering questions posed and were at times dismissive of families concerns. When we asked family members about how they raised concerns, one family member told us, "They were never listened too, that is why I came to CQC." Another told us, "There doesn't seem to be a complaints procedure, they just always go to the

manager and it's up to them how they are dealt with, the office door always used to be open and could just have a chat, now it's always closed."

Working in partnership with others
● The provider had not assured themselves the manager was sharing information requested from professional stakeholders. This included the safeguarding team, Local Authority quality team and care quality commission. Information was primarily requested by stakeholder groups to support people needs and ensure they were kept safe.
● We found initial responses to concerns appeared to be robust, but when we asked for evidence to support responses or further detail information was not always received or there was a delay in receiving the information. The safeguarding team had been waiting over a month for information to initially investigate safeguarding concerns.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care
● The manager had not introduced any effective audits or a quality assurance process to ensure the provision of services was in line with the requirements of the regulations and met people's needs.
● Audits which were completed were not effective at identifying concerns and where any issues were identified they were not addressed or managed though an effective governance procedure.
● Team meetings and supervisions did not take place to share quality improvement concerns with staff and the provider did not have oversight to assure themselves the home was managed effectively.

The provider did not have an effective governance system. Audits were not completed to ensure best practice and that the regulations were being followed. Records held were not accurate or were incomplete. The provider did not ensure the home liaised with and worked with other professionals to meet the needs of people in the home and feedback was not sought in a meaningful way from staff, people in the home and their relatives on the quality of the services both delivered and provided. This was a breach of regulation 17 (Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The CQC did not receive notifications as required under the provider's registration. Since the inspection the area manager and inspector had raised a total of seven safeguarding alerts. This gave the commission some assurance the interim management team was beginning to promote the best interests of people living in the home

The provider was not submitting notifications to the care quality commissions as required in line with the requirements of their registration. This was a breach of regulation 18 (notification of other incidents) of the Health and Social Care Act 2008 (Registration) Regulations 2012.

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	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider was not submitting notifications to the care quality commissions as required in line with the requirements of their registration. This was a breach of regulation 18 (notification of other incidents) of the Health and Social Care Act 2008 (Registration) Regulations 2012.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Staff were not safely recruited. Information required under schedule 3 was not always available and the provider's policy was not followed This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not have time to deliver more than what was needed to meet people's basic care needs. The required staff numbers had been incorrectly calculated to ensure enough staff were on duty to meet people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 The provider did not ensure people were kept safe. Risks were not effectively assessed or managed, placing people at risk of harm. Medicines were not safely managed, recorded or administered and best practice was not always followed. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Notice of Decision to add conditions to 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 People were not protected from harm or abuse as the manager had not safely implemented the provider's policies in this area. This placed people at risk of harm and was a breach of regulation 13 (Safeguarding service users from abuse or improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Notice of Decision to add conditions to the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have an effective governance system, Audits were not completed to ensure best practice and the regulations were followed and records held were not accurate or were incomplete. The provider did not ensure the service liaised with and worked with other

professionals to meet the needs of people in the home and feedback was not sought in a meaningful way from staff, people in the home and their relatives on the quality of the service both delivered and provided.

This was a breach of regulation 17 (Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Notice of Decision to add conditions to the provider's registration