The Grovecare (UK) Limited

# The Grove Residential Care Home

**Inspection report**

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## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |
| Is the service safe? | Requires Improvement |
| Is the service effective? | Requires Improvement |
| Is the service caring? | Good |
| Is the service responsive? | Requires Improvement |
| Is the service well-led? | Requires Improvement |

## Overall summary

We inspected The Grove Residential Care Home on 9 and 10 December 2014. The inspection was unannounced.

At the last inspection on 29 July 2014, we asked the provider to take action to make improvements to the way they assessed and planned care for people, and this action has been completed.

The Grove Residential Care Home provides care for up to 19 older people, some of whom may experience needs related to memory loss. The home has 13 single rooms and three shared rooms and 13 people were living in the home during the inspection.

There was no registered manager in post at the time of the inspection. A registered manager had not been in post since 31 July 2013. The provider had submitted an

# Summary of findings

application to the Care Quality Commission (CQC) in order to register as the manager. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are registered persons who have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

CQC is required by law to monitor the operation of the Mental Capacity Act, 2005 (MCA)Deprivation of Liberty Safeguards (DoLS) and to report on what we find. Staff had been trained and understood how to apply the principles of the MCA, although records were not always completed correctly. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves. At the time of the inspection no-one who used the service had their freedom restricted.

We undertook a Short Observation Framework for Inspection (SOFI) at coffee time in the main lounge and in the dining room at lunchtime. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

People told us they felt safe living in the home and they were treated with respect and dignity. They said they were supported to enjoy activities and interests of their choice and were able to say how they wanted to be cared for. Staff understood how to identify, report and manage any concerns they identified.

People received support to access appropriate healthcare services when they needed to and their medicines were managed safely. They were provided with a variety of foods and drinks. Nutritional planning took account of their needs and preferences.

Staff were appropriately recruited to ensure they were suitable to work with vulnerable people. They were knowledgeable and received training about how to meet people's needs. They delivered care that was planned to meet people's needs and took account of their choices, decisions and preferences.

People said they felt able to raise concerns and knew how to make a complaint if they needed to. They felt staff listened to their concerns and took action to resolve any issues.

We identified some areas of care and support which required improvement such as fire safety arrangements, completion of care records and quality assurance processes. The provider was aware of these issues and had taken steps to address them.

# Summary of findings

## 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 consistently safe.

People felt safe within the home and staff knew how to protect people from abusive situations. People received their medicines in an appropriate and safe manner.

There were enough staff with the right skills and knowledge to make sure people's needs, wishes and preferences were met.

Fire safety arrangements did not fully protect people in the event of a fire.

**Is the service effective?**

Requires Improvement

The service was not consistently effective.

People had good access to healthcare and their nutritional needs were met.

Staff received training and support to meet people's need needs, wishes and preferences.

People who may have lacked capacity to make decisions were not always assessed appropriately.

**Is the service caring?**

Good

The service was caring.

Care was provided in a warm and sensitive manner.

People were treated with dignity and their privacy was maintained. Their choices and decisions about their care were respected.

**Is the service responsive?**

Requires Improvement

The service was not consistently responsive.

People were supported to engage in activities and interests of their choice and maintain contact with family, friends and the local community.

People knew how to raise concerns and make a complaint if they needed to.

Risk assessments based on nationally recognised good practice principles were not consistently completed or kept up to date.

**Is the service well-led?**

Requires Improvement

The service was not consistently well-led.

Systems for gathering views about the service from people who lived in the home and staff members were in place.

People and their visitors were kept informed of developments in the home and could raise issues with the provider.

# Summary of findings

A new system to assess and monitor the quality of the service provided to people was in place. However, it was in its infancy and not yet robust.

# The Grove Residential 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.

The inspection took place on 9 and 10 December 2014 and was unannounced.

The inspection team consisted of two inspectors and an expert 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. The expert by experience who visited this service had experience with older people who may have dementia related needs.

We looked at the information we held about the home such as notifications, which are events that happened in the home that the provider is required to tell us about, and information that had been sent to us by other agencies such as service commissioners.

We spoke with seven people who lived in the home and three relatives who were visiting. We also spoke with two visiting healthcare professionals. We looked at eleven people's care records. We also spent time observing how staff provided care for people to help us better understand their experiences of care.

We spoke with four care workers, 3 non-care based staff and the provider. We looked at six staff files, supervision and appraisal arrangements and staff duty rotas. We also looked at records and arrangements for managing complaints and monitoring and assessing the quality of the service provided within the home.

Requires Improvement

# Is the service safe?

## Our findings

People told us they felt safe living at the home. One person said, “I feel safe and contented.” Another person told us, "I’m safe here. They look after me well.” A visiting healthcare professional told us, “Staff are very helpful and caring and people are safe and secure.”

Staff were able to tell us how they would recognise the signs of potential or actual abuse and how they would report their concerns. They told us, and records showed they had received training about how to protect people from abusive situations. Our records showed that the provider and staff had worked with external agencies to address any concerns for people’s safety that had been raised.

Staff mostly provided care in a way that minimised risks for people. For example, we observed staff using hoists to help people transfer between seats. Two staff carried out the transfers and gave people explanations and reassurance to help them feel safe during the procedures. Staff checked people were safe and comfortable before they left them. We also saw staff supported people appropriately to use equipment such as walking frames and bed rails, and made sure they had access to call bells should they need assistance.

We found, however, several bedroom doors had been propped open with objects such as chairs, a bath towel and wedges. We brought this to the attention of a member of staff who removed the objects and closed the doors The provider told us they had been in contact with the local fire authority and planned to install appropriate door closures and seals. We confirmed this with the local fire officer.

We looked at the recruitment files for six members of staff employed in various roles. We found that before they had been offered employment at the home checks on areas such as employment history and references from previous employers had been carried out. Checks had also been made through the Disclosure and Barring Service (DBS) to ensure they were safe to work with vulnerable people.

Although we received differing views from staff about whether or not there were enough staff on duty to meet people’s needs, we saw that people received care and support when they needed it and in an unhurried manner. People who lived in the home told us there were enough staff to meet their needs. One person said, “When I call staff at night or day they come immediately or inform us if they are engaged.” Another person said, “At night staff attend and give us whatever we require.”

The numbers of care and non-care staff on duty reflected the staff rota. However the provider who was acting as the manager, and the administrator who was also trained and worked as a member of care staff, were not included in the rota. Both the provider and the administrator were carrying out duties within the home during the inspection, however some staff were not clear about their roles. The provider told us they would add their names and duty days to the rota in future so that staff were clear about who was on duty.

Staff carried out medicines administration in line with good practice and national guidance. They also demonstrated how they ordered, recorded, stored and disposed of medicines in line with national guidance. This included medicines which required special control measures for storage and recording. Staff who administered medicines told us, and records confirmed, they received regular training about how to manage medicines safely. One person told us, “I get my medication on time.” Another said, “I can have a pain killer when I need one, they’re [staff] very good.”

Where people received homely remedies their GP had signed an agreement and this was kept with the person’s medicines care plan. Homely remedies are medicines that can be bought over the counter without a prescription such as cough mixture.

Requires Improvement

# Is the service effective?

## Our findings

People told us that staff understood what they liked and needed. One person said, "I'm satisfied, I don't know about the rest." Another person said, "They are very good, they look after us well." A relative said, "It's a very good place, the best place for [my relative]. He gets his needs met."

Some staff had lead roles for areas such as medication management, infection control and first aid. One member of staff told us they had recently been given a lead role as dignity champion. Records showed staff had received training about these subjects to enable them to fulfil the roles. The records showed staff had also received training about subjects such as diabetes, moving and handling and dementia care to enable them to meet people's individual needs.

The training plan for the coming year included subjects such as nutrition and skin care, risk assessing and equality and diversity. Throughout the inspection we saw staff providing care and support for people which demonstrated they applied this training in the appropriate ways. For example, staff used hoists safely and took care to monitor people's blood sugar levels where necessary. Staff told us they received regular supervision which helped them to review their performance and we saw that appraisals had been arranged for the coming year.

Staff had received training about Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) and further training was planned. They were able to demonstrate an understanding of the subjects when we spoke with them. They told us how they would follow DoLS principles if anyone needed their freedom restricted and how they would seek authorisation. A person who lived in the home told us, "It's not regimental, staff do not tell me to do anything, I like freedom and I have it."

We saw that staff used MCA principles when providing care. For example, wherever possible they helped people to make their own decisions and choices about what support they wanted. Where people were unable to do this choices or decisions had been made in the person's best interest and staff explained what they were going to do and why in a reassuring and positive way.

People had given their consent for areas of their care such as the safe use of bed rails, sharing personal information with other health and social care professionals, taking prescribed medicines and using their photograph for identification purposes. Where people were unable to give their consent best interest decisions had been taken in order to keep them safe.

Where a person had legally appointed someone to act on their behalf a copy of the legal document this was in the person's care file. We saw that people's representatives and staff had acted in their best interests for wishes related to issues such as end of life care.

However, we found that mental capacity assessments and best interest checklists were not always completed correctly. For example, the decisions to be made were not always recorded; where mental capacity assessments had been carried out these had not always been followed up with a best interest checklist; one care file recorded a person was not able to make a decision but there was no evidence that a mental capacity assessment had been carried out.

People told us they enjoyed the food they received in the home. One person said, "The food is very good, he [the chef] does me beef which I quite like." Another person said, "I am offered tea, coffee or food at night if I want it."

A four week menu plan was in place. The chef said that meals were cooked to suit people's preferences and needs and the menu served as a guide to make sure people had what they liked and needed. The chef knew which people required additional dietary support for needs such as swallowing problems, diabetes and weight loss and we saw how the lunch time meal was adapted to meet those needs. Although no-one in living in the home at the time of the inspection had specific cultural or religious dietary requirements the chef was confident they could cater for those needs appropriately if required. There was a good amount and range of foods in stock, including meal supplements for those who required them.

We observed the lunchtime meal and saw people had ample portions of fresh, home cooked food, choices for each course and extra helpings when they asked for them. Records showed that staff had received training about nutrition and food hygiene.

Cold drinks were freely available to people and staff made hot drinks for people at regular intervals and when requested. Records showed that staff monitored what people ate and drank and sought healthcare advice where

Requires Improvement

# Is the service effective?

necessary. However, one person had been assessed as needing support with weight loss. Although a care plan and a monitoring system were in place there was no evidence that a nutritional risk assessment had been carried out.

People had access to health care professionals, such as their doctor, dentist and optician. One person said, "I can see my GP any time and the nurse comes and goes."

A visiting healthcare professional told us that they had a positive relationship with the care staff. They said that care staff were always friendly and aware of peoples' healthcare needs. They said, "When I first visited here they showed me round. If I ask them a question they always have an answer." Another visiting health professional said, "Staff always remember when I'm coming and have everything ready for me."

Records of health professionals visits were kept in people's care files and showed what treatments and interventions a person had received. We found that staff responded effectively in an emergency situation. For example, a person's care file reflected the emergency actions staff took when they collapsed with chest pains.

Good

# Is the service caring?

## Our findings

People told us they liked the staff who supported them. One person said, "The staff are good and I'm treated with dignity and can make my own decisions." Another person told us it had been suggested they move nearer to their family but they said they would not move from The Grove as they were very happy there. They told us staff encouraged them to maintain their independence with walking and helped them to settle to sleep well at night.

A relative said, "Staff are always very friendly and helpful." Relatives told us they were welcomed into the home and we saw staff offering refreshments to one relative when they arrived.

Healthcare professionals told us they thought people were happy and well cared for. One healthcare professional said, "It's a nice place, welcoming and warm. I hear them [staff] talking with people all the time in a nice, friendly way."

People were treated with kindness and warmth by a caring staff team. They were relaxed in the company of staff and sought them out when they wanted to chat. There was a friendly and happy atmosphere and preparations were underway for Christmas, which people told us they were looking forward to.

Staff ensured people's privacy and dignity were maintained. For example, they made sure people's clothes were adjusted for dignity when they used the hoist, they spoke with people discreetly or in private when discussing care needs and used the forms of address that people preferred. Care plans promoted good practice for maintaining people's privacy and dignity when supporting them with care needs such as continence, hoist transfers and bathing.

People's care records were stored safely so as to maintain confidentiality. However, when staff handed over to the next shift of staff their discussions took place in part of the main corridor of the home. Although staff took care to speak discreetly this area of the home was used by people and their visitors which meant there was a risk confidential information could be overheard.

People chose where to spend their time, using the lounge, dining area and their bedrooms as they wished. Some people were supported to go out with relatives or have relatives visit with them. Some people chose to eat their meals in their own rooms and staff supported this. Staff provided individual support to people who required assistance with eating and drinking.

Staff asked people if they were ready to receive care and support before they provided it. They provided the care and support in a sensitive manner. For example, they explained what they were doing and engaged with people throughout the processes.

Requires Improvement

# Is the service responsive?

## Our findings

At the last inspection of the home on 29 July 2014 we found that there was a breach of Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010. This was because assessment of people's needs, care planning and delivery of care were not always carried out in a way that protected their welfare and safety.

During this inspection, we saw that improvements had been made to the way in which care was assessed, planned, delivered and reviewed. Care records identified needs and risks, said how they should be addressed and we saw staff provided the appropriate support and care. For example, concerns regarding weight loss had been identified for one person. Records showed staff monitored their nutritional intake and we saw they had requested healthcare involvement when the person had needed it. We found the provider was no longer in breach of the regulation, however improvements were still required. For example, we found specific risk assessments for needs such as nutrition and pressure area care were not consistently completed. These assessments help to maintain a consistent approach to care based on nationally recognised good practice principles.

We observed a handover from the morning shift staff to the afternoon shift staff. Changes in people's needs were clearly communicated. Events that were due to take place in the afternoon were confirmed.

People, their relatives and visiting health professionals told us staff knew people's needs, likes and preferences well. We saw examples of this during lunch when we observed staff making sure people were served with the food portions and the types of drink they preferred. The chef told us they had updated menu options to include things people said they liked such as stuffed chine and fried potatoes. One person said, "We get what we want, if we change our minds we'll get something else."

People told us they were supported to take part in hobbies and interests of their choice. People told us they liked knitting, reading and watching TV and we saw them doing these things. We also saw that staff helped people to maintain contact with family and friends and have access to the local community.

People were encouraged to spend their time how and where they wished. The activity coordinator said, "Some people choose not to mix, so I try to involve them in one to one activities, such as crosswords, knitting and their life story." During the inspection people decided they wanted to join in with an impromptu dance session. Two people told us they really enjoyed it.

One person told us they thought more could be done by way of organised activities. The provider acknowledged that improvements could be made in this area and had arranged training for the activity coordinator.

People told us they knew how to make a complaint. One person said, "I am quite at liberty to complain if I have a complaint. I can complain and I am listened to." Another person said, "I would know if I need to complain but the carers are good."

The complaints procedure was on display in the main reception area and was accessible to people and their visitors. Records showed that the provider had not received any complaints directly to the home since our last inspection.

However, we had received concerns which we addressed with the provider. For example, concerns were raised with us about people not being able to bathe due to a broken bath hoist. The provider took appropriate action and during this inspection we saw the hoist was in working order. The provider also told us that they had begun planning the refurbishment of this bathroom to provide more bathing options for those who did not wish to use the bath hoist.

Requires Improvement

# Is the service well-led?

## Our findings

The provider told us there was a quality assurance and audit system within the home. However there was no clear, recorded evidence to demonstrate the outcomes of audits or any actions that had been taken in the year prior to this visit. The provider recognised that the audits and checks had not always been robustly recorded and therefore did not fully support early identification and resolution of issues.

The provider was aware of the issues we found during this inspection such as gaps in risk assessment processes; gaps in the recording of MCA and DoLS needs and fire safety and had recently taken steps to address the issues. For example, senior staff told us they had been allocated extra time away from care based shifts to enable them to fully review and update care plans and risk assessments. We saw this taking place during this inspection.

The provider had developed a new system for quality assurance within the home. The system covered areas such as care file recording, medication arrangements, infection control and fire safety arrangements. However, we could not assess the impact of the system upon the provision of services as it was in it's infancy and not yet robust.

A registered manager had not been post in since 31 July 2013. An acting manager had been employed but left the home before completing their registration with us. The provider was currently acting as the manager of the home and had applied for registration with us.

Staff told us they knew who to go to for assistance and demonstrated they knew what each of their roles were within the team. However, we received differing views about communication with the provider. Some staff said they felt there had been a lack of communication of information and they did not feel their views were listened to. Others said there had been issues but now things were improving and they felt able to approach the provider to discuss their views.

The provider acknowledged that changes in the management arrangements had impacted upon levels of support and communication and had taken steps to address them. For example, recent staff meeting records showed that staff had been given the opportunity to discuss issues and receive information about developments within the home. Records also showed the provider had arranged for training sessions about effective communication skills.

The majority of people who lived in the home, their relatives and health professionals, we spoke with said they felt informed about developments within the home. They said they felt able to speak with the provider and resolve any issues they had. Records showed the provider met with people regularly so they had an opportunity to voice their opinions.

The provider had a system for gathering the views of people and their relatives by way of an annual survey. They told us they had reviewed the systems in light of issues regarding communication and would now be carrying out more specific surveys across the year about topics such as menu planning and activities provision. A staff survey had also been introduced; the results of which had not yet been collated.