Mrs J & Mr H Chamberlain & Mrs N Woolston & Mr D Chamberlain & Mr Thomas Beales

Grove Villa Care

Inspection report

24 Mill Road
Deal
Kent
CT14 9AD

Tel: 01304364454

Date of inspection visit:
08 July 2019
09 July 2019

Date of publication:
21 August 2019

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Grove Villa Care is a residential care home and was providing personal care to 12 people with a learning disability at the time of the inspection. The service can accommodate up to 16 people in one adapted building. We have applied a condition to their registration to stop them admitting anyone new into the service without our prior permission.

The service had not been developed and designed in line with the principles and values that underpin Registering the Right Support and other best practice guidance. The provider and registered manager had not ensured people had control over their lives. People had limited independence, were not included in everything that happened at the service. They were not part of the local community. People were not involved in planning and co-ordinating their care and the service was not centred around them.

The service was a large home, bigger than most domestic style properties. It was registered for the support of up to 16 people. This is larger than current best practice guidance. There was a risk that the size of the service had a negative impact on people, there continued to be identifying signs outside of the property and industrial bins which indicated it was a care home. Staff were encouraged to wear a uniform that suggested they were care staff when coming and going with people.

People's experience of using this service and what we found
People continued not to live fulfilled lives at Grove Villa Care. The service rarely applied the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence.

The outcomes for people did not reflect the principles and values of Registering the Right Support for the following reasons. People were not involved in planning their care and had not been supported and encouraged to be as independent as possible. People's care was not centred around them but was planned around what staff wanted or thought was best for people. People were not treated with respect or supported to be an active part of their community.

People were not protected from the risks of harm and abuse. The police were investigating allegations of financial abuse and we found further concerns during our inspection. Some concerns had been raised by staff but there had been a delay in these disclosures being made which put people risk. Action had not been taken to understand people's diverse needs and make sure they were not discriminated against.

People were not 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 supported this poor practice.

The provider and registered manager continued to lack oversight of the service. They had not checked the service met the standards required. The provider's consultant had recognised that the service continued to be in breach of regulations, but action taken to make improvements had not been effective.

Assessments of people's needs, and any risks had not been completed. People had not been supported to plan taking risks and how risks would be managed. People continued to be at risk of falling and choking because staff did not adequately monitor them.

People were not always supported to remain as healthy as possible. Staff had not planned people's care following hospital stays to make sure they did not become unwell again. People's medicines were not always managed safely. Medicines records were inaccurate and staff's ability to administer medicines safely had not been assessed.

People were not always involved in planning and preparing meals. Some people had not been supported to tell staff about the food they liked, and staff had not looked at their cultural needs and preferences.

Staff did not feel supported by the provider and consultant and the relationship between them had broken down. Staff were demotivated, and some felt bullied. The registered manager had not consistently challenged poor practice or held staff accountable. There was no clear philosophy of care based on good practice and staff did what they wanted. Staff had not received the support and guidance they needed to provide good care. Records in respect of people's care were inaccurate in places and were not always held securely.

There continued not to be enough staff to support people, with staffing based on contracted hours and not people's needs. Additional staff had been deployed at times, but this was not consistent to ensure people always had the support they needed to remain safe. Staff had not completed the training they needed to fulfil their role. The registered manager continued not to follow safe recruitment practices.

The service was clean and well maintained. However, action had not been planned to ensure people were safe in an emergency, such as a fire. A process not in place to receive and respond to day to day concerns people had. A process was in place to investigate and resolve any complaints.

The registered manager and provider had not informed CQC of significant events that had happened at the service, so we could check that appropriate action had been taken. The CQC performance rating was prominently displayed.

Rating at last inspection and update
The last rating for this service was Inadequate (published 26 April 2019) and there continued to be multiple breaches of regulation. At this inspection improvements had not been made and the provider was still in breach of regulations.

Why we inspected
The inspection was prompted in part due to concerns received about financial abuse and low staffing levels. A decision was made for us to inspect and examine those risks. We also followed up on action we told the provider to take at the last inspection.

Enforcement
We have identified continued breaches in relation to the management of the service, staffing, the protection of people from risks, supporting people to live health lives, involving people in their planning their care and

developing independence at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures:
The overall rating for this service is 'Inadequate' and the service remains 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 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.

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

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 effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Inadequate

The service was not caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Grove Villa Care

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.

Inspection team
This inspection was completed by two inspectors.

Service and service type
Grove Villa Care is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The registered manager was not working at the service on the days of our inspection.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. This included feedback from the local authority and whistle-blowers. We also reviewed notifications we had received from the provider in relation to specific events at the service including safeguarding investigations and injuries. 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 took this into account when we inspected the service and made the judgements in this report.

We used all this information to plan our inspection.

During the inspection
We met everyone who used the service and observed interactions between staff and people throughout the inspection. We spoke with ten members of staff including the provider, senior care workers, care workers and the house keeper.

We reviewed a range of records. This included six people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including minutes of meetings, environmental checks and safety certificates were reviewed.

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 Inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People were not protected from abuse. At the time of our inspection the Police were investigating allegations of financial abuse. When staff supported people to go out for drinks and meals, people paid for staff. On one occasion several people have paid £30.65 each for lunch for themselves and staff. People had paid for equipment which should have been supplied by the provider. During the inspection the provider told us they would reimburse people the money they should not have spent.
- People had not been protected from harm because the registered manager and staff had not recognised safeguarding concerns and acted to protect people. There had been a delay in some incidents being reported by staff and other incidents, such as unexplained bruising, had not been reported to the local safeguarding team for investigation. An incident occurred during our inspection and staff did not know if it should be referred to the local safeguarding team. Almost half of the staff had not completed training in relation to safeguarding.
- Some staff had completed safeguarding training. Staff's understanding of the training had not been checked to make sure they were confident to identify and raise concerns correctly. One staff member told us about the training, "Some of it went over my head".

The provider and registered manager had failed to protect people from harm and abuse. 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.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to assess risks and mitigate risks to people. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 12

- People were not supported to manage their behaviours that challenged, to help them and others remain safe. There had been incidents where people's behaviour had impacted on others, such as one person pinching other people. Incidents of behaviour which challenged had not been analysed to look for possible patterns or triggers. No guidance, such as positive behaviour support plans, had been put in place to enable staff to recognise and respond to triggers and reduce the risk of the behaviour from happening again. This included, an incident which resulted in the police being called to the service.
- Staff continued to use the bed safety rails despite one person not have a history of falls at the service. The person did not use safety rails when they were away from the service and had not fallen. Their falls risk

assessment had been updated and stated that they were awaiting a new bed which would mitigate the risk of falling and bed safety rails would no longer be needed. However, the risk of them being restricted had not been assessed and mitigated.
● Action had not been taken to ensure people were protected in the event of a fire. New personal evacuations plans had been written for people, however these had not been completed by someone with the skills to do this. They did not contain clear guidance for staff about the support people would need at different times of the day. For example, no consideration had been given to the fact that people with hearing impairments would not be able to hear the alarm when they were not wearing their hearing aids.
● One fire drill had taken place since November 2018. People and staff had not had the opportunity to practice and become confident in evacuating the building at different times of day. Checks of fire safely equipment and other services such as gas and electricity were up to date.

The provider and registered manager had failed to assess risks and mitigate risks to people. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
At our last inspection the provider had failed to ensure that persons employed were of good character and to ensure recruitment procedures were operated effectively. This was a continued breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 19
● People continued to be at risk because staff were not recruited safely. Checks had not been completed on staff's conduct in previous caring roles to ensure they were of good character and had the skills and knowledge they needed to fulfil their roles. Shortfalls in relation to the recruitment of one staff member identified at our November 2018 inspection and by the provider's consultant had not been addressed.
● Consistent action had not been taken when staff's practice did not meet the standards required. One previous employee had been referred to the Disclosure and Barring Service (DBS) so they could consider barring them from working with vulnerable adults. However, the provider did not know if another staff member had been referred to the DBS when they were dismissed. The registered manager had not addressed staff's poor practice until recently. In the past month the provider had begun to challenge staff's practice and had followed their disciplinary processes.

The provider and registered manager had failed to ensure that persons employed were of good character and to ensure recruitment procedures were operated effectively. This was a continued breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection the provider had failed to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet service user's needs. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 18
● There were not enough staff deployed with the skills, knowledge and experience to meet people's needs. Staff deployment was not based on an assessment of people's needs and events at the service. Before our

inspection we were informed staff were taken away from caring duties to take part in training and not replaced. We found this was correct and staff had not been allocated time away from care duties for training. There continued to be reduced levels of staff at the weekend, with two staff supporting 12 people on the Saturday before our inspection.

● Staff were not always available to support people. During our inspection two people missed a morning activity they enjoyed because three staff were in the office chatting and other staff could not leave because people would have been at risk.

The provider and registered manager had failed to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet service user's needs. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

At our last inspection the provider had failed to ensure the proper and safe management of medicines. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 12

● People's medicines were not managed safely. Staff had not read the provider's new medicines policy issued in June 2019. Shortfalls identified in medicines audits had not been addressed and continued. For example, there continued to be gaps in medicines administration records (MAR). The record of staff signatures had not been completed since October 2018, some staff had left, and new staff had started. This made it hard to track who had signed to confirm medicines had been administered.

● The provider told us staff had completed medicines training since out last inspection, however there were no records of who had completed this training. Staff competence to administer medicines had not been assessed as required by the March 2019 medicines audit. We observed staff gave people their medicines safely, however other areas of medicine management were not safe.

● People were at risk of harm because guidance in relation to their medicines was inaccurate or incomplete. For example, one person was prescribed two pain relief medicines containing paracetamol. No guidance was in place about not giving them together or the maximum daily dose as taking too much paracetamol can cause liver damage. Another person was prescribed pain relief patches. No guidance was in place about where to apply the patches and records of where they have been applied had not been kept. Applying the patch in the same place can reduce the effects of the medicine.

The provider and registered manager had failed to ensure the proper and safe management of medicines. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong

● Accidents were not thoroughly investigated to prevent them happening again. The provider's analysis had identified, 'People who use this service are vulnerable to accidents' and a third of the incidents recorded in March and April 2019 were unexplained cuts, marks and bruising. Incidents such as a person having unexplained bruising to their neck had not been thoroughly investigated and staff had not considered discussing it with the local authority safeguarding team.

● Action had not been taken to learn from accidents and incidents. Incident forms were completed when people fell, however, action had not been taken to reduce the risk of them falling again. An analysis of accidents and incidents in March and April 2019 had been completed in May 2019. It required staff to follow

up referrals made to the occupational therapy team for two people. Records of any action taken, or advice provided had not been recorded and used to reduce the risk of people falling again.

● People continued to be at risk of falling as they were not always supported to use the mobility aids prescribed to them. We observed a person with a history of falls pushing a wheelchair, rather than using their walking aid. This increased their risk of falling. A member of housekeeping staff supported the person to use the correct aid.

Preventing and controlling infection

● People were not consistently protected from the risk of infection. We observed one person put a salt pot in their mouth. Staff took this from the person and placed it back on the table. The salt pot was not washed after this incident.

● Most staff who supported people with their personal care had not completed infection control training. Only one staff member had completed food hygiene training, however all the staff prepared food for people.

● Cleaning schedules were in place and followed. The service appeared clean and was odour free. Personal protective clothing such as gloves and aprons were provided, and we observed staff using these.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Inadequate. At this inspection this key question has remained the same. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Supporting people to live healthier lives, access healthcare services and support
At our last inspection the provider had failed to design care with a view to achieving service users' preferences and ensuring their needs were met. This was a continued breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 9

- People were not supported to remain as healthy as possible. Some people were at risk of becoming unwell because their health conditions were not well managed by staff. For example, one person had been to hospital three times since February 2019. They were admitted to hospital in July and were diagnosed with severe constipation. Daily records for the four days before their admission described signs they maybe unwell. Staff had not referred the person to their GP or other healthcare professionals for advice.
- Following the person's discharge from hospital, care had not been adequately planned, recorded and monitored to ensure any changes in their health were identified quickly. Recognised monitoring tools, such as the Bristol stool scale had not been used to identify signs the person was becoming constipated. Exercises staff were to support the person to complete to help manage their condition had not been consistently recorded. Guidance was not in place about how staff would identify the signs that the person was in discomfort or pain and the person continued to be at risk of becoming unwell.
- Another person had been admitted to hospital twice. In March 2019 a physiotherapist advised staff complete exercises with the person three times a day to them becoming unwell again. This care had not been planned and guidance was not available for staff to refer to. The exercises had not been completed consistently as some staff did not know how to do the exercises. Staff told us, "I think they are supposed to have them twice a day" and "Not all staff were trained by the physiotherapist. I wasn't, so don't do the exercises".

The provider and registered manager had failed to design care with a view to achieving service users' preferences and ensuring their needs were met. This was a continued breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Supporting people to eat and drink enough to maintain a balanced diet

- People were not supported to maintain a healthy weight. One person had put on a significant amount of weight in between September 2018 and March 2019. No action had been taken to identify the cause of the weight gain. Action had not been taken to advise the person about healthy eating, so they did not put on

any more weight. Staff told us the person's key worker was responsible for monitoring their weight. Their key worker no longer worked at the service and this role had not been delegated to another staff member.
● Robust care plans were not in place to ensure people drank enough each day. Each person had the same recommended daily fluid intake, regardless of what was usual for them, their weight and any health conditions. The amount people drank was not monitored to make sure they drank enough. This was especially important as the weather at the time of our inspection was very warm.
● We observed people were not given choices about what they would like to eat or drink in ways they understood. The menu was small and did not contain pictures of meal choices to help people make decisions. When people enjoyed the occasional takeaway or meal out, action had not been taken to ensure that everyone was able to make informed choices about what they ate.
● Some people had been supported to share their views about foods they would like to be added to the menu at a residents meeting. However, not everyone had been able to share their views and action had not been taken to ensure everyone's views and preferences were known and added to the menu.

Staff working with other agencies to provide consistent, effective, timely care
● The provider and registered manager were not working with healthcare professionals to ensure people's health and individual needs were met. Where professionals had given advice and support this had not always been responded to or actioned to help people remain well.
● People's decisions not to follow the advice of healthcare professionals had not always been recorded. Strategies to keep them as safe were not followed consistently. One person did not follow the speech and language therapy recommendations to eat a soft diet. To reduce the risk of them choking, staff were required to monitor them while they ate. We observed the person eating without staff supervision. The person coughed frequently while eating.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
At our last inspection the provider had failed to design care with a view to achieving service users' preferences and ensuring their needs were met. This was a continued breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 9
● Changes in people's needs continued not to be assessed when they returned from hospital stays. Two people had recently returned to the service following a stay in hospital. An assessment of their needs had not been completed before they returned home so the registered manager could plan their care with them and be assured staff could continue to meet their needs.
● Assessment tools recommended by the National Institute for Health and Care Excellence (NICE) had not been used to assess people's needs. For example, the Waterlow scale pressure ulcer risk assessment had not been used to assess the risks of people developing skin damage. The Malnutrition Universal Screening Tool had not been used to assess the needs and plan the care or people at risk of losing weight.
● Action had not been taken since our last inspection to assess people's skills. This was needed to ensure staff knew what people were able to do for themselves and could plan the support they required to achieve their goals.

The provider and registered manager had failed to design care with a view to achieving service users' preferences and ensuring their needs were met. This was a continued breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staff support: induction, training, skills and experience

At our last inspection the provider had failed to ensure staff were appropriately trained and competent to carry out their roles. This was a continued breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 18

● People were at risk because staff did not have the skills and knowledge to provide effective care. Two new staff had begun working at the service since our last inspection. Both worked alone at night and neither had completed the provider's induction process to ensure they had a knowledge of people and their needs. Staff's competence had not been assessed to make sure they had the skills they required before working alone with people and they had not signed to confirm they had read people's care plans.

● Staff had not been supported to develop the skills they needed to support people. The provider's training audit found training had not been planned to ensure all staff had the skills they needed. The registered manager had booked some staff on training twice and some had not completed training. Training records showed that staff continued not to be supported to develop basic skills. We observed staff did not support and encourage people to make decisions about their care and be as independent as possible.

● A process was not in place to develop staff's skills to enable them to apply for promotion. Decisions to promote staff were not based on an assessment of their skills and knowledge against a list of requirements for the role. Staff who had been promoted had not received an induction into the role to support them to develop their skills, including leadership skills. One staff member had been promoted without the provider's agreement and the provider's consultant had raised concerns about the skills of other staff to lead shifts.

● Staff still did not receive regular supervision to reflect on their practice, discuss any concerns they had and plan their development needs. Staff's poor practice had gone unchallenged by the registered manager and continued. The provider's consultant had completed two comprehensive supervisions in the past month, when they identified concerns with staff's practice. An appraisal process was not in operation.

The provider and registered manager had failed to ensure staff were appropriately trained and competent to carry out their roles. This was a continued breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Ensuring consent to care and treatment in line with law and guidance

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● People were not supported to make decisions in ways which suited them. For example, we observed one person being asked to choose between five different cereal boxes at breakfast. Staff did not follow guidance in the person's care plan to offer them two choices at a time.

● People's capacity to make decisions, including decisions about how they spent their money and how their care was provided had not been completed. There was a culture that staff knew what was best for people and made decisions on their behalf.

● Staff did not have a good understanding of the MCA, including best interest decisions or unwise decisions.

For example, the provider's consultant informed us staff did not understand people with capacity were able to make unwise decisions and staff were not able to force them to receive care. This included making someone get out of bed in the early hours of the morning to go to the toilet.

● Some people had DoLS authorisations in place, while others had expired. The consultant had completed an audit of DoLS authorisations in June 2019 and had applied for seven new DoLS authorisations where the previous ones had expired. The failure to reapply for DoLS authorisations before they expired left people at risk of being unlawfully restricted.

Adapting service, design, decoration to meet people's needs

● The service had not been designed in line with registering the right support. People had not been involved in choosing furniture and decoration for communal areas. Furniture had not been chosen with people's needs in mind and we observed staff struggling to support people to move close to the table for meals and activities.

● People's names were displayed on their bedroom doors; however, people had not been involved in making the signs and they were not displayed at a height everyone could see. One person's name was written on a torn piece of paper and stuck to their bedroom door well above their eyeline.

● People's bedrooms were personalised. They were decorated as people wished and contained personal items such as pictures, souvenirs and ornaments.

Inadequate

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

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 people were not treated with compassion and there were breaches of dignity; staff caring attitudes had significant shortfalls.

Ensuring people are well treated and supported; respecting equality and diversity
At our last inspection the provider had failed to ensure people felt supported and failed to ensure people were treated with dignity and respect. This was a continued breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 10

- People were not consistently treated with respect. We observed staff wearing gloves to support people at meal times. There was no evidence that staff and people were not at risk from the spread of infection. People were supported at home and in the community by staff wearing uniforms or aprons. Being supported by staff dressed in this way made people standout from others in their community and marked them as different. The provider and staff had not considered wearing these garments was disrespectful
- Staff did not always speak with people or refer to them in respectful ways. For example, staff told us about how the 'fed' people, rather than describing how they supported them at mealtimes. Staff also shortened people's names or called them by their full name. People had not agreed for their names to be shortened or to be addressed using their full names.
- People had not been given opportunities to chat about their lifestyle choices, sexual orientation or gender identity so their responses were could be respected. Staff were not aware of our guidance about relationships and sexuality in adult social care services.
- We observed some kind interactions between staff and people. One person became distressed several times and staff responded to the person calmly and patiently. Some staff demonstrated a caring attitude towards people. One staff member sat with a person massaging their hands and asking them if they slept well the night before.

Supporting people to express their views and be involved in making decisions about their care

- People continued to be isolated within the service and were not supported to be part of their community. One person's care plan said outings were very important to them. Daily records confirmed they had not been out of the service for eight consecutive days. The provider was unaware about this. The consultant told us, "This is not good for [the person], being stuck in doors for so long". No action had been taken to ensure the person went out when they wanted.
- People were not involved in planning what happened at the service. The routines were not flexible to most people's choices and people were supported when staff decided and not when they wanted. Only one person was able to decide when they got up and had breakfast, other people had to wait for staff to support

them and no routine had been established to support people to understand when they would be supported.
● One person had asked staff to put a film on in the lounge and several people were watching it. During the film another staff member turned the volume down saying, "It's too loud, it is giving me a headache". They then stood in front of the television while they threw a ball to other people, interrupting people watching the film. Later, another staff member came into the lounge and asked the person if they wanted the volume turned back up and they said they did.
● Action had not been taken to support everyone to communicate their needs and preferences. For example, one person was not supported to use the communication cards recommended by their speech and language therapist. We also observed staff respected a person's decision not to act on advice given to them. The staff member gave them time to express the views before trying to help them again.

Respecting and promoting people's privacy, dignity and independence
● People's privacy was not consistently protected. For example, the registered manager had taken records relating to people's care out of the service and these had been returned by their relative. There was a risk personal confidential information about people would be accessible to the public.
● People were not supported to be as independent as they wanted to be. People's independent living goals had not been discussed with them. Staff did not consistently encourage and support people to do things for themselves, including preparing meals and drinks.
● People had been not been asked if they preferred a male or female carer. Records stated that people had chosen their key worker. However, communication strategies had not been used to support people to make the decision about their keyworker in ways that suited them best, such as photographs and observations of people's preferences. People had not been offered a new key worker when staff left and changes in people's needs had been missed.

The provider and registered manager had failed to ensure people felt supported and failed to ensure people were treated with dignity and respect. This was a continued breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Inadequate

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

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 services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
At our last inspection the provider had continually failed to design, with service users and their representatives, care which met their needs and preferences. This was a continued breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 9
Not everyone had a person centred plan which was accurate and reflected their goals and abilities.
● People's care plans were not up to date and accurate. The process of reviewing and rewriting people's care plans continued. Information about people's care needs, wishes and preferences was difficult to find. Some plans contained contradictory information about people's support, while others had missing or out of date information. For example, we observed staff supporting a person to stand in a particular way. Staff told us it was importance the person was supported in this way. Details of the manoeuvre were not included in the person's support plan and there was a risk the person would not receive consistent support.
● Staff were responsible for writing people's care plans. They had not received training to fulfil this role and had received contradictory guidance from different members of the management team about how to do this. People had not been involved in developing their plans despite telling us at the last inspection they wished to be involved. One person had requested a copy of their care plan in February 2019 but had not been provided with a copy.
● People had goals recorded in their records however, these were not detailed or meaningful to them. People's goals included, to maintain a healthy weight, become more independent in their personal care and have their bedroom decorated. Guidance had not been put in place about how these goals would be achieved and the support people would need. Goals had not been reviewed to assess if people were making progress towards achieving them.
● Activities and opportunities to be involved in the community were limited. Some people relied on going out to regular day centre activities, while other people relied completely on staff to arrange activities for them. The activities offered to people had little purpose and were not based on hobbies people enjoyed.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● The provider and registered manager had not ensured that information was available to people in ways they understood. Such as large print or pictures. There was information for people on a notice board in the corridor, however this was not displayed at a height most people could see and was not in an accessible format.
● Objects of reference were not used to help people understand what would be happening. Objects of reference support understanding of spoken language and help people understand daily routines. For example, people were sat at the same tables for meals and activities, tables were not laid and objects, such as cutlery or crockery were not used to inform people it was a meal time.

End of life care and support
● Some action had been taken to support people and their relatives to begin to consider their end of life preferences. However, on at least one occasion a relative had disagreed with a person's choice. Staff had not been challenged the decision and supported the person to advocate their views to make sure their wishes were listened to and respected.
● No one living at the service was at the end of their life, however, staff should know about people's preferences including any cultural or spiritual needs, where they would like to be cared for and who they want with them, so they can ensure everything is in place to support them as they wish.

The provider and registered manager had continually failed to design, with service users and their representatives, care which met their needs and preferences. This was a continued breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns
● The provider's process to listen to and respond to complaints had not been followed. We found three staff had complained to the registered manager about another staff member. Clear records of the action taken by the registered manager to resolve the complaints had not been kept. It was not clear if the concerns had been addressed in accordance with the provider's disciplinary and grievance process.
● People had not been supported to raise day to day niggles or grumbles. Any concerns people had raised had not been recorded so the provider could ensure they had been acted on.

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 Inadequate. At this inspection this key question has remained the same. 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
At our last inspection the provider had failed to maintain accurate and complete records. 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 not enough improvement had been made and the provider was still in breach of regulation 17

- There continued to be a lack of leadership. The registered manager was on leave and the provider was at the service. They did not lead the staff team to ensure people received the care they needed. Staff ignored some instructions given by the provider and consultant. For example, when instructed to stop checking money, two senior carer staff continued with this task while people sat alone and unoccupied in another area of the service.
- The provider did not understand the principles of registering the right support. The registered manager had not ensured the principles underpinned the service people received. People were not supported to live as full a life as possible and achieve the best possible outcomes.
- Governance at the service was poor. The provider and registered manager did not operate clear and transparent processes to account for their decisions, actions and performance. The provider was unable to tell us about how the service ran day to day or what improvements had been made. Records of actions and decisions had not been maintained, for example, if staff who had been dismissed had been referred to the Disclosure and Barring Service. The registered manager had not been held accountable for their lack of action to improve the service.
- Records around people's care continued to lack detail and this made it difficult to determine when people's needs had changed and what action had been taken. There continued to be a risk deterioration in people's health would not be identified quickly.
- Action taken previously to ensure we were notified of significant events at the service had not been effective. We found the registered manager and provider had failed to notify us of important events, including safeguarding concerns. The latest CQC rating was displayed on a notice board in the entrance hall.

The provider and registered manager had failed to maintain accurate and complete records. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
At our last inspection the provider had failed to seek and act on feedback from service users and other relevant people on the services provide, for the purposes of continually evaluating and improving the services. 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 not enough improvement had been made and the provider was still in breach of regulation 17
● People, their relatives, staff and other people involved with the service had not been asked for their views to inform the development of the service. The process of gathering people's views the registered manager previously told us was planned for July 2019 had not begun. The provider did not know if this was planned.
● Meetings to gather people's views, wishes, concerns and suggestions had not been held often. Action had not been taken to make sure everyone was able to share their views, including those who were not able to share their views in a meeting.
● No action had been taken to obtain staffs views of the service. Staff told us suggestions they made and concerns they raised with the registered manager, including about the use of people's money, were not listened to or acted on.

The provider and registered manager had failed to seek and act on feedback from service users and other relevant people on the services provide, for the purposes of continually evaluating and improving the services. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care
At our last inspection the provider had continually failed to operate systems to assess, monitor and improve the quality of the services provided and reduce risks to people. 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 not enough improvement had been made and the provider was still in breach of regulation 17
● The provider continued to lack oversight of the service and the multiple breaches of the Health and Social Care Act had not been resolved. They had employed another consultant to advise them, who had spent approximately two weeks at the service. They also identified the breaches of regulation continued and had begun to suggest changes. These had not been implemented by the registered manager and staff team. At the time of our inspection the consultant was supporting the provider to follow their disciplinary process in relation to this.
● The consultant had completed an audit of the service in June. They had begun to develop an action plan, which the registered manager was required to complete with timescales and responsible staff. This had not been completed despite the provider requesting it. Therefore, no plan was in place to make the improvements and check they were effective. We observed the consultant was trying to support improvements in an adhoc way. However, these were not completed as there was no consistent effective leader in place.
● A system had not been established to check the quality of the service and the provider and was not aware of some of the shortfalls we found. The provider told us they were not confident the registered manager completed regular checks of the service and used them to make improvements. The consultant had begun to audit people's care records. They had completed one and shared the required improvements with the registered manager. No improvements had been made to the person's care plan and the person continued

to be at risk of not receiving safe and consistent care.

The provider and registered manager had failed to operate systems to assess, monitor and improve the quality of the services provided and reduce risks to people. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● The provider and registered manager had not developed a clear vision and a set of values for staff to follow. People were not involved in planning their care or what happened at the service. Staff made decisions for people based on what they thought was best. People were not respected as individuals and their differences were not supported and celebrated.

● The culture at the service was not centred around people and how to support them to live fulfilled lives. Staff told us they liked working at the service and supporting the people. However, staff's friendships with each other came before providing a good quality service for people. For example, staff spent time talking to each other rather than spending time supporting and encouraging people.

● The relationship between some staff and the provider and consultant had broken down and staff told us they did not feel supported by the provider. They told us they felt supported by the registered manager. However, a culture of constructive criticism and challenge had not been developed and staff did not respond positively when asked to reflect on and change their practice. The lack of openness to change from some of the staff team, prevented positive changes being made to people's lives.

● Staff did not work well as a team to fulfil their roles and responsibilities. For example, one person was supported to an appointment by a staff member. The appointment was cancelled. When the provider asked the staff member if they had made another appointment while they were there, they replied, "It's not my job. It's a senior's job". They had not considered that not making the appointment could delay the person receiving treatment.

● The consultant had begun to support staff to understand their roles and responsibilities at staff meetings. They had also started discussions with staff about areas where they had strengths and agree responsibilities with them. For example, one staff member would be taking the lead on auditing people's finances and another overseeing the care of people at risk of choking.

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

● The provider had informed people's relatives about the enforcement action we were taking to cancel their registration for Grove Villa Care. They had told them if our action was successful the service would close, and people would need to move to alternative services.

● Following our inspection, the provider made the decision not to challenge our enforcement action. They informed people, their representatives, staff and service commissioners the service would be closing and worked with them to support people to move to alternative accommodation in a planned way.

Working in partnership with others

● The registered manager had not worked with the local safeguarding team to protect people from harm and abuse. The local authority safeguarding lead regularly spoke with the registered manager and had not been informed of the safeguarding concerns we found during our inspection.

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 9 HSCA RA Regulations 2014 Person-centred care The provider and registered manager had continually failed to design care with a view to achieving service users' preferences and ensuring their needs were met. 9(1)(a)(b)(c)(3)(a)(b)

The enforcement action we took:

We cancelled the provider's registration for this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider and registered manager had continually failed to assess risks and mitigate risks to people. The provider and registered manager had continually failed to ensure the proper and safe management of medicines. 12(1)(2)(a)(b)(d)(f)

The enforcement action we took:

We cancelled the provider's registration for this location.

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 The provider and registered manager had failed to protect people from harm and abuse. 13(1)(2)(3)

The enforcement action we took:

We cancelled the provider's registration for this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider and registered manager had continually failed to maintain accurate and complete records. The provider and registered manager had continually failed to seek and act on feedback from service users and other relevant people on the services provide, for the purposes of continually evaluating and improving the services. The provider and registered manager had continually failed to operate systems to assess, monitor and improve the quality of the services provided and reduce risks to people. 17(1)(2)(a)(b)(c)(e)(f)

The enforcement action we took:

We cancelled the provider's registration for this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider and registered manager had continually failed to ensure that persons employed were of good character and to ensure recruitment procedures were operated effectively

The enforcement action we took:

We cancelled the provider's registration for this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider and registered manager had continually failed to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet service user's needs. The provider and registered manager had continually failed to ensure staff were appropriately trained and competent to carry out their roles. 18(1)(2)(a)

The enforcement action we took:

We cancelled the provider's registration for this location.