HC-One Oval Limited

Ghyll Grove Care Home

Inspection report

Ghyllgrove
Basildon
Essex
SS14 2LA

Tel: 01268273173

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12 February 2019

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service:
Ghyll Grove Care Home provides accommodation, personal care and nursing care for up to 169 older people. Some people have dementia related needs and some people require palliative and end of life care. The service consists of four houses: Kennett House, Thames House, Chelmer House and Medway House. At the start of our inspection there were 114 people living at the service.

People's experience of using this service:
• Safeguarding procedures were not fully embedded or followed and staff did not always recognise or respond appropriately to abuse.
• Information about risks to people's safety was not consistently identified and recorded.
• People's comments about staffing levels were variable. Staff did not always have the time to give people the care and support they needed. Staff regularly felt stretched, and the focus was on completing tasks rather than on providing person-centred care and support.
• People were not always protected by the service's prevention and control of infection procedures as the premises were not as clean and hygienic as they should be.
• Staff training was not always up-to-date or embedded in their everyday practice. Staff supervision and support was not consistent.
• Not all people were treated with dignity, kindness and respect. Staff routines and preferences took priority over consistent care and meeting people's preferences and wishes.
• People were not routinely supported to take part in social activities, relevant to their interests, preferences or needs.
• Complaints and concerns are not investigated thoroughly and in a timely way, or dealt with in an open and transparent manner.
• People's end of life care needs are not clearly documented.
• People, relatives and staff do not feel the service is always well-led. Governance and performance management arrangements were not always reliable or effective. The culture of the service was not always open or transparent.
• Staff recruitment arrangements were robust to support people to stay safe.
• People received sufficient food and drink throughout the day. The dining experience people received was variable across the service.
• Staff worked collaboratively with others and people were supported to access healthcare service and receive ongoing healthcare support.

Rating at last inspection:
Following the last inspection the rating of the service was 'Good' (Last report published 31 July 2017).

Why we inspected:
This was a responsive inspection, prompted in part by notification of an incident following which a person using the service was placed at risk of harm and abuse. This incident is subject to a police investigation.

Follow up:
We will continue to monitor intelligence we receive about the service until we return to visit as outlined in our inspection programme and schedule. If any concerning information is received we may inspect sooner.

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?

Requires Improvement

The service was not always effective.

Details are in our Effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our Responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our Well-Led findings below.

Ghyll Grove Care Home

Detailed findings

Background to this inspection

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

The inspection was prompted in part by notification of an incident following which a person using the service was placed at risk of harm and abuse. This incident is subject to a police investigation and as a result this inspection did not examine the circumstances of the specific incident. However, the information shared with CQC about the incident indicated potential concerns about the overall management of the service and the management of concerns and complaints. This inspection examined those risks.

Inspection team:
The inspection team consisted of four inspectors on two days [Inspector, Inspector Manager, Assistant Inspector and Bank Inspector]. The inspection team was accompanied by two experts by experience on the first day of inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses care services. In this instance services for older people and people living with dementia.

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

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. However, the registered manager, deputy manager and clinical service manager were not present at the inspection. The service was being managed by a manager from a 'sister' service and they were supported by senior managers from within the organisation.

Notice of inspection:

This inspection took place on the 11 and 12 February 2019 and was unannounced.

What we did:
Before the inspection, we reviewed information we had received about the service since the last inspection. This included details about incidents the provider must let us know about, such as abuse; and we sought feedback from the local authority and other professionals involved with the service.

During our inspection visit, we spoke with 16 people using the service, 18 relatives and 12 staff including senior managers from within the organisation. We observed the support provided throughout the service. We looked at records in relation to people who used the service including 12 care plans and 12 medication records. We looked at records relating to recruitment, training and systems for monitoring quality.

Inadequate

Is the service safe?

Our findings

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

People were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; using medicines safely and preventing and controlling infection.
• Staff did not ensure risks for people were followed to safeguard them from harm. For example, the care plans of people assessed as being at risk of developing pressure ulcers detailed they should be regularly repositioned to prevent the development of pressure ulcers however, records showed staff were not regularly repositioning them in line with their care needs.
• On Medway house, where people were at risk of developing pressure ulcers, they did not always have their body repositioned as the moving and handling equipment was broken. Staff told us equipment from Kennett house was borrowed but this was not always available and staff did not always have the time to get it.
• Four out of five beds on Medway house did not have suitably fitted bedrails in place to ensure people's safety and wellbeing.
• Although an observation tool was being used to record information about a person's behaviour, staff did not correctly use this record to describe what occurred before the behaviour was displayed and to identify possible triggers.
• Staff did not consistently apply good infection control practices to meet current standards and national guidance. Premises [Chelmer, Medway and Kennett] were not clean or hygienic. Call alarm facilities and equipment such as bedframes, mattresses and hoists were dirty. Some items of furniture, carpets and floors were stained and required a 'deep clean'.
• Malodours relating to urine and faeces were observed on Chelmer, Medway and Kennett house's during both days of inspection.
• Improvements were required as there were unexplained gaps on medication administration records on Kennett house.
• Where people had a medicated adhesive patch to deliver a specific dose of medication through the skin, the site of application was not always recorded to show this was rotated.
• On Chelmer house, proper infection control practices were not adopted by the member of staff administering medication. The member of staff was observed to place medication from its original container directly into their hand before giving the person their medicine.

People's care and support needs were not provided in a safe way and risks to people were not recorded. Medication and infection control practices and procedures were not always followed. This demonstrated a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse; learning lessons when things go wrong.
• Safeguarding policies and procedures were in place and staff had received safeguarding training. However, this was not embedded into their everyday practice. One member of staff told us concerns were raised with

the management team in December 2018, because a person's rights were not being recognised or promoted by a family member. No evidence was available to show the management team had recognised this as abuse, responded to the allegation or followed required procedures to ensure the person's civil liberties were protected. This had not been followed-up by staff.
• Where a safeguarding concern had been raised and investigation reports completed, it was unclear how conclusions and outcomes were reached as supporting documentation to evidence the management teams findings were not routinely available.
• Not all investigation reports had been forwarded to the Local Authority or Care Quality Commission in a timely manner despite numerous requests. During October and November 2018, concerns were raised about the care and treatment of one person living at Ghyll Grove Care Home. The management team were requested to undertake an internal investigation and to provide a report to the Local Authority and Care Quality Commission. The investigation report was forwarded to the Local Authority in January 2019 and received by the Care Quality Commission in February 2019 after a further request.
• The above demonstrated staff did not always recognise concerns or incidents. When things go wrong, reviews and investigations are not always completed in a timely manner, sufficiently thorough or demonstrate learning from events.

Effective arrangements were not in place to protect people from abuse and improper treatment. This demonstrated a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment.
• People's comments about staffing levels were variable. No concerns were raised on Thames House about staffing levels. One person told us, "There are normally carers around if I need help, so staffing isn't an issue for me." However, other comments were less favourable. This referred specifically to Chelmer, Medway and Kennett house's. One person on Medway house told us there was no point using their call alarm facility to summon staff assistance. They stated, "No point, they [staff] don't come." A relative on Medway House stated, "There is not enough staff and they don't have the time to talk to [family member]." Relatives told us staffing levels on Kennett House were very poor, with staffing levels not always being maintained and high usage of agency staff; the latter impacting significantly on the quality of care people received.
• Suitable arrangements were not in place to ensure there were enough staff to give people the care and support they need. Staff did not have the time to sit and talk with people. Staff were regularly felt stretched and under pressure, with the focus on completing tasks rather than providing person-centred care and support.
• People received personal care later than they wished resulting in some people remaining incontinent and soiled. People were not receiving regular baths or showers and some people were left in bed for no apparent reason. Staff stated there were insufficient staff available to support people being brought into communal lounge areas. The latter was improved on the second day of inspection following a discussion with the registered provider.
• Although people's dependency needs were assessed, this was not always accurate. This resulted in people's dependency needs on Kennett house being miscalculated by the management team over a significant period of time and insufficient staffing levels deployed.
• Staff rosters for the period 11 January 2019 to 12 February 2019 were requested for each house, but not all rosters were available for Kennett and Thames house. Rosters provided for Kennett house were not accurate.

Effective arrangements were not in place to make sure there are sufficient staff to support people to stay safe and meet their needs. This demonstrated a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

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

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience.
• Not all staff had completed the provider's online training. Not all training attained was embedded in staff's practice and this suggested not all staff had the necessary skills and required competencies relevant to their role. For example, most staff had completed safeguarding training and were able to recognise what constitutes poor practice. However, staff had not raised concerns about colleagues poor practice or where the management team had failed to address staffs or others concerns and had not always been raised with the registered provider or external agencies.
• Not all newly appointed staff had received a robust induction.
• Staff told us they did not feel listened to, valued or supported by the existing management team or the organisation. Comments included, "I definitely do not feel feel valued or supported. We [staff] do the best we can, but we are not appreciated", "Not all of the time and not by management" and, "I do not feel valued or supported, there is no appreciation at all."
• Staff had not received regular supervision and there was no evidence to show the qualified nurses or the clinical service manager had received 'clinical' supervision in line with the registered provider's policy and procedure. Not all staff had received an annual appraisal of their overall performance.

Not all staff received appropriate training, induction or supervision to fulfil the requirements of their role. This demonstrated a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet.
• We asked people about the food they received at Ghyll Grove Care Home. People's comments were positive and included, "The food is good, it's warm and tasty" and, "I look forward to the meals and there's a good choice. If you don't like what's on offer, they'll [staff] find something for you."
• The dining experience for people on Thames House was observed to be positive. This was in contrast to the dining experience on Chelmer, Medway and Kennett house. On Chelmer house people were not routinely offered the opportunity to sit at the dining table for their meals. The lunchtime experience for people on Medway house was chaotic as staff were trying to support people in the communal lounge and those who remained in their room. Observations showed that without significant input from people's relatives at mealtimes on both Medway and Kennett house, staff would struggle to assist people to eat and to receive their meal in a timely manner. Staff confirmed they relied heavily on relatives to assist at mealtimes.
• People were not routinely prompted to wash their hands or to have their hands cleaned with wipes before eating. One person on Kennett house was given sandwiches at teatime, however the staff member failed to notice that the person's hands were covered in faeces. Although this was highlighted by us, no initial

attempt was made by the staff member to encourage the person to use the bathroom or to wipe the person's hands. We had to intervene with a senior manager to urge the member of staff to take our concerns seriously. The member of staff was indecisive and stated, "I've tried to get [person using the service] to wash their hands twice already."
• Where people were at risk of poor nutrition, their needs were assessed and appropriate healthcare professionals were consulted for support and advice.

Staff working with other agencies to provide consistent, effective, timely care; supporting people to live healthier lives, access healthcare services and support.
• The service worked with other organisations to ensure they delivered joined-up care and support. People had access to healthcare services when they needed it.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law.
• People's needs were assessed and this included their physical, mental health and social needs.
• People's protected characteristics under the Equalities Act 2010, such as age, disability, religion and ethnicity were identified as part of their needs assessment.

Adapting service, design, decoration to meet people's needs.
• Ghyll Grove Care Home is a purpose-built care home consisting of four individual houses. People had access to a small garden but these were not always as secure as they should be and there had been incidents whereby people had accessed the garden without staffs knowledge.
• There was sufficient dining and communal lounge areas for people to use and choose from within the service. People had personalised rooms which supported their individual needs and preferences.
• Improvements to Kennett house were being made to make this more 'dementia friendly'.

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

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 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 with appropriate legal authority. 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, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

• Staffs understanding of MCA and DoLS and how this impacted on people using the service was variable.
• People's capacity to make decisions had been assessed and these were individual to the person. However, where people had a sensor alarm mat in place, no information was available to show this had been discussed with the person or agreed to confirm it was in their best interest to have this item of equipment.
• Where people were deprived of their liberty, applications had been made to the Local Authority for DoLS assessments to be considered for approval and authorisation.

Requires Improvement

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.

People did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; equality and diversity.
• People's comments about the care and support they received was variable. Though some people and their relatives felt the care and support provided was good [Thames and Chelmer House] others did not [Medway and Kennett House].
• Comments on Thames house were favourable. One person told us, "There's lots of banter and teasing. One of the carers walks by, taps me on the head and walks off. I'll catch them one day. It's just general mucking about. Everyone tries to be friendly, we laugh a lot." One relative told us, "The carers chat to [family member] even though they [staff] get little back in return."
• People did not always feel they were treated with care and kindness or feel listened too. This was attributed to inadequate staffing levels at the service, high usage of agency staff and staff not having the time to spend with them.
• People and those acting on their behalf told us they did not receive proper personal care, regular baths or showers. Information available suggested people's comments were accurate. One relative told us, "[Relative] doesn't like asking for things and likes to stay in their room. Sometimes they'd like a bath more often, they [staff] do not bath them often enough." One person who lives at Ghyll Grove Care Home was observed to a have a build-up of plaque on their teeth. They told us that it was "terrible" living on Medway house and stated, "They [staff] talk to me alright but they don't ask permission to wash me, they do it automatically. They don't brush my teeth, I haven't got many. They don't have time to really talk to me."
• Though people had a good rapport and relationship with the staff who supported them, not all people were supported and cared for by a consistent team of staff or received person-centred care.
• Not all people living on Kennett house were given the opportunity to spend time within the communal lounge and it was stated to us by relatives and staff that people were regularly 'rotated' during the week rather than this being their personal choice. Records for one person showed over a seven week period only one occasion whereby they had been supported to sit within the communal lounge. There was no obvious rationale for this decision by staff. One relative told us, "I've asked staff why [relative] is sitting in bed and they [staff] say they're not on the list to get out of bed."

Supporting people to express their views and be involved in making decisions about their care.
• People and their relatives were given the opportunity to provide feedback about the service through the completion of annual questionnaires in May 2018 and by leaving comments on an external website.
• Most relatives confirmed they had been involved in the pre-admission assessment process and seen their family's care plan.

Respecting and promoting people's privacy, dignity and independence.
• Though people received support with their personal care in private and staff were discreet when asking

people if they required support to have their comfort needs met, people were not always treated with respect and dignity as evidenced within the findings of this report.

Requires Improvement

Is the service responsive?

Our findings

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

People's needs were not always met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control; end of life care and support.
• People's care records did not fully reflect or accurately detail people's care and support needs or provide sufficient guidance for staff as to how people's needs were to be met.
• People's comments relating to social activities on Thames house were positive. Comments included, "We do a bit of dancing and I get my nails done. There's not a lot going on but I've no complaints and I never get bored." This was in contrast to Chelmer, Medway and Kennett houses. One relative told us, "They've [people using the service] got no activities, they are non-existent, it's really poor. I've been told there are several activity coordinators, but they are never here."
• People on Chelmer, Medway and Kennett house's received limited opportunity to participate in meaningful social activities. Throughout the inspection there was an over reliance on the television and playing music. Records to evidence activities provided were poor and concurred with our findings.
• Staff told us there were people using the service that were judged as requiring end of life care. Although there was no evidence to suggest people were not receiving appropriate care, no information was recorded relating to their pain management arrangements and how the person's end of life care symptoms were to be managed to maintain the person's quality of life as much as possible.

Improving care quality in response to complaints or concerns.
• Systems were in place to record, investigate and respond to any complaints raised with the service. Improvements were needed to ensure all supporting documentation was in place to evidence how outcomes had been reached. Relatives confirmed not all of their concerns were listened to, taken seriously or addressed by the management team.
• Compliments were available to capture the service's achievements.

Requires Improvement

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

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility.
• We identified shortfalls in the quality of leadership and management and this impacted on people using the service, the quality of care and support people received and staff employed at Ghyll Grove Care Home.
• Prior to the inspection it was evident that poor leadership had created a negative culture at the service leading to a lack of openness and transparency. Staff did not feel listened to, valued or supported by the registered manager or other senior team members. A significant number of staff spoken with were candid and expressed concern regarding the management team, their management style, the impact this had on staff morale and the level of care and support provided to people using the service.
• The registered provider's quality monitoring arrangements were not effective in identifying the concerns found at this inspection.
• Though many audits and checks were in place and completed at regular intervals, these checks failed to address the areas for improvement as highlighted throughout this report.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements.
• A manager was in post and they were registered with the Care Quality Commission.
• None of the existing management team were present at the time of the inspection. The service was being managed by senior managers employed by the registered provider because of concerns raised relating to one person using the service in January 2019.
• Relatives and staff told us they had raised issues with the registered manager, deputy manager and clinical service manager. However, they went on to say that little action was undertaken to address these and in particular, staff told us they had stopped reporting concerns as there was little point.
• The management team had failed to act on concerns from the Local Authority, Care Quality Commission and others. Not all concerns had been shared with the registered provider.
• The registered manager, deputy manager and clinical service manager had not received regular formal supervision. Though a member of the management team was being performance managed, there was no evidence to show actions and timescales highlighted to monitor their performance had been followed-up to ensure the required improvements had been made.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics.
• Arrangements were in place for gathering people's views of the service they received and those of people acting on their behalf. Though a response to the survey results was completed, this did not reflect all of the

findings, particularly where the results scored 'poor' or 'very poor.' For example, 23% of relatives found the outcome of complaints to be 'poor' or 'very poor'. No information was evident to show how this was being addressed and improved.
• Staff meetings were held to enable the management team and staff the opportunity to express their views and opinions on the day-to-day running of the service. Where issues were raised, an action plan had not always been completed detailing how these were to be monitored and addressed.
• Relatives meetings were held for family members to feel involved and to provide on-going support and information. Where issues were raised, an action plan had not always been completed detailing how these were to be monitored and addressed.

Effective arrangements were not in place to ensure compliance with regulatory requirements and to monitor the service. This demonstrated a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care; working in partnership with others.
• Once the registered provider was made aware of the concerns that prompted this inspection, immediate actions were taken to mitigate risk and reduce future recurrence.
• Senior management presence was increased within Ghyll Grove Care Home. For example, the management team were deployed to work alongside staff on Kennett house to provide effective support and role modelling.
• Additional staff deployed across the service to plug staffing shortfalls, to enable people to have a bath or shower and to enable people to access the communal lounge areas.
• Recruitment of new staff at all levels to reduce the use of agency staff and to provide consistency for people living at the service.
• Changes to the home environment [Kennett house] to make this more 'dementia friendly' and to ensure the premises were clean and compliant with infection control practices.

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 12 HSCA RA Regulations 2014 Safe care and treatment Not all people using the service received care and treatment that was safe and improvements were required to the management of medicines.

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 Suitable arrangements were not in place to protect people from the risk of abuse or to effectively investigate any allegation of abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective arrangements were not in place to assess and monitor the quality of care provided, to ensure compliance with requirements.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of staff must be deployed to meet people's care and support needs.