Lancashire County Council

Grove House Home for Older People

Inspection report

Highfield Road
Adlington
Chorley
Lancashire
PR6 9RH

Tel: 01257481442
Website: www.lancashire.gov.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Grove House Home for Older People is registered to provide accommodation and personal care for up to 47 people. The home is set in its own grounds and accommodation is provided across two floors. The home is divided into four areas known as Willow Court, Elm Court, Cedar Court and Oak Court. There were 31 people living in the home at the time of the inspection.

People's experience of using this service and what we found
The provider's systems failed to identify that care and treatment was not always provided in a safe way. Audits and checks were not effective in identifying risks to people's health and safety. Staff practice was not always effectively monitored.

Whilst people told us they were happy living in the home, care and treatment was not consistently provided in a safe way. We found two people's support documentation, including their risk assessments had not been updated to provide staff with current guidance about their care. One person had experienced two falls in the home which had resulted in significant injuries and a substantial change in their needs. However, these events did not prompt a review of their support plan or risk assessments. As a result, staff were carrying out complex care activities and a specialist healthcare task with no guidance or oversight. This placed the person at high risk of unsafe and inconsistent care. Two people required support for positional changes, however, most of their daily care monitoring charts were not completed and it was unclear what checks and positional changes had taken place. There was no evidence to demonstrate the management team had checked the charts to ensure appropriate care was provided.

Whilst staff had access to training and appropriate policies and procedures, there was a delay in reporting a safeguarding issue to the local authority. Medicines were not always managed appropriately, there were no protocols seen to guide staff in the administration of 'as necessary' medicines and at the time of the inspection, staff told us they were applying an external cream which had been brought into the home by the district nursing team. There were no details or instructions about the application of the cream on the person's medication administration record.

The home had a satisfactory level of cleanliness. Although the provider had appropriate arrangements for routine maintenance and repairs and some areas had been refurbished, the wallpaper was badly scuffed in many bedrooms making it difficult to clean walls. At the time of the inspection, remedial work recommended on the electrical safety check in 2018 had not been carried out. Following the inspection, the provider confirmed immediate safety issues had been addressed at the time and a planned and coordinated electrical update would be carried out in June 2021.

There were sufficient staff on duty and the provider had suitable arrangements for the recruitment of new staff. However, three staff spoken with were unsettled and they felt communication with the management team could be improved. The provider had considered the staff morale and had recently carried out a staff survey.

The provider had failed to notify the commission without delay of two incidents where people had incurred serious injuries. This matter will be considered separately from the inspection process.

We asked the provider for details and evidence of their checks and audits of the service over the last six months. This information was provided after the inspection. Whilst the information received demonstrates the provider had carried out checks and audits, our findings showed people remained at risk from inconsistent and unsafe care.

The provider had appropriate arrangements for the management of people's finances. All records checked were complete and up to date.

Following the inspection, we received an action plan from the provider which set out their response to the inspection findings. We will check improvements to the service on our next visit to the home.

Rating at last inspection
The last rating for this service was good (published 17 March 2019).
We also carried out an unrated targeted inspection to look at the infection prevention and control measures in place (published in 8 April 2021).

Why we inspected
We received concerns related to the management of medicines and finances and the management of the home. As a result, we undertook a focused inspection to review the key questions of safe and well-led. We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively. We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection. We have found evidence the provider needs to make improvement. Please see the safe and well-led sections of this full report.

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

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

During this inspection, we have identified breaches in relation to Regulation 12 – Safe care and treatment and Regulation 17 – Good governance.

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

Follow up

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Grove House Home for Older People

Detailed findings

Background to this inspection

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

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

Inspection team
The inspection was carried out by one inspector.

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

The service had a manager registered with CQC; the manager was also the owner. This means they are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service, including information from the provider about important events that had taken place at the service, which they are required to send us. We considered feedback from the local authority including the safeguarding team.

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 observed how staff provided support for people to help us better understand their experiences of the care they received. We spoke with four people living in the home, four members of staff, a housekeeper, an operations manager and area co-ordinator for cleaning services, a senior operations manager and the registered manager.

We reviewed a range of records. This included two people's care records and risk assessments, two medication records and one staff member's recruitment records. A variety of records relating to the management of the service were also reviewed. We walked around the service to observe the environment; we did not look at all areas.

After the inspection
We continued to seek clarification from the provider to confirm evidence found. We looked at and considered the provider's action plan sent to us after the inspection.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated good. At this inspection, this key question has deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

- People were at high risk from inconsistent and unsafe care. We looked in detail at two people's care and treatment and the records associated with their support. We found that people's risk assessments did not reflect their current needs.
- One person had experienced two falls which had resulted in serious injuries and a substantial deterioration in their health and wellbeing. However, the person's care plan and risk assessments had not been reviewed and updated to reflect the significant change in their needs. Consequently, staff told us they were carrying out care activities including complex moving and handling and a specialist healthcare task without any written guidance or oversight. One member of staff said, "We don't know what we are doing." The person also required the use of a catheter; however, their care plan and risk assessment had not been updated to provide staff with clear guidance on how to monitor and manage the person's catheter care.

- Risks were not effectively monitored and managed. The provider had implemented a monitoring chart to provide an overview of the care delivered each day. However, despite both people requiring positional changes and their skin monitored, most of their daily charts in respect to skin integrity had not been completed. There was also no evidence to demonstrate the management team had checked the charts and taken any action to mitigate the high level of risk.

The provider had failed to assess the risks to the health and safety of people receiving care and treatment and failed to do all that is practicable to mitigate the risks. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our visit, the registered manager gave assurances the issues would be addressed, and we received an action plan following the inspection. However, the people considered in detail during the inspection had been put at risk of harm and there was no evidence to indicate care documentation and practice would have been reviewed at the time of the inspection, without our intervention. We will therefore check any action taken on our next inspection of the home.

- Safety checks had been carried out on the installations and equipment; however, at the time of the inspection, there was no evidence seen to indicate the remedial work recommended on the electrical safety check conducted in 2018 and had been completed. The registered manager explained this work was to be carried out as soon as possible and this was confirmed in the provider's action plan. Further to this matter, the provider informed us after the inspection, all immediate actions raised in the 2018 safety check were repaired at the time and a planned and co-ordinated electrical update would be carried out in June 2021.

Systems and processes to safeguard people from the risk of abuse

● People were not fully protected from harm and abuse. Whilst staff and the management team had access to appropriate training and policies and procedures in respect of safeguarding vulnerable adults, we noted one incident had not been reported to the local authority safeguarding team in a timely manner. This is important to enable the local authority to prompt or have oversight of any investigation. Following the inspection, we raised a safeguarding alert in respect to one person's care with the local authority.

● We checked the arrangements for the management of finances and found all balances checked corresponded accurately to the records.

● People told us they were happy living in the home, and they had no concerns about their safety. During the pandemic, the provider installed a visitor pod to allow people to see their family and friends in a safe way.

Learning lessons when things go wrong

● Accidents and incidents had been recorded and entered onto a database. The registered manager carried out a monthly analysis of the data and discussed any themes at the management meetings.

● The systems used to prompt an update of people's care plan and risk assessment documentation following an accident were ineffective.

Using medicines safely

● Medicines were not always managed safely. Whilst appropriate records had been maintained for the administration of medicines, we noted there were no protocols to guide staff on the administration of medicines prescribed 'as necessary.'

● Staff told us they were using an external cream as part of a specialist healthcare task, which had been brought into the home by the District Nursing Team. There was no record of the cream on the person's medication administration record and no guidance on how this cream was to be applied. According to the provider's action plan, this situation was clarified with the district nursing team, following the inspection.

● We saw medicine audits had been carried out along with stocks checks, however the audits seen at the time of the inspection had failed to identify the shortfalls identified at the inspection. Following the inspection, we were sent a copy of the senior operations manager's audit dated 12 April 2021. The audit had identified a lack of protocols for medicines prescribed "as necessary." However, our findings demonstrated this issue had not been rectified by the date of the inspection.

Preventing and controlling infection

● The registered manager had implemented infection prevention and control measures which included the use of PPE. We noted all care staff were wearing PPE appropriately during the inspection.

● On a tour of the premises we noted the standard of cleanliness was satisfactory. Although some areas would have benefited from additional cleaning, for instance, people's bedroom carpets. We also noted some personal items belonging to the staff had been stored incorrectly in one bathroom. Although the provider had appropriate arrangements for routine maintenance and repairs and some areas had been refurbished to good effect, the wallpaper was badly scuffed in many bedrooms making it difficult to clean walls.

● There were established arrangements for visitors entering the home and for the admission of new people.

Staffing and recruitment

● The registered manager completed a dependency assessment each week to monitor the staffing levels and had access to some flexible staff hours. We observed there were enough staff on duty during the inspection.

● We looked at one new staff member's personnel file during the inspection and noted the provider operated an appropriate recruitment procedure, which included all necessary regulatory checks.

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.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- People were at risk because the provider had not always ensured sufficient oversight of the service. Audits and checks were not always robust and had not picked up on many of the issues and concerns identified during our inspection.
- In February 2021, a care plan audit identified one person's plan required updating; however, this was not carried out. The person later had two falls in the home, which resulted in a significant change in their needs. Despite marked changes in their health and wellbeing their support plan and risk assessment documentation had not been updated to provide staff with guidance about their care. As a result, staff were carrying out activities which had not been appropriately planned and risk assessed. This situation placed the person at high risk of unsafe and inconsistent care.
- The management staff had carried out medicines audits, however, the audits had failed to identify the lack of written procedures for medicines prescribed 'as necessary'. Following the inspection, we were sent a copy of the senior operations manager's audit dated 12 April which highlighted a lack of protocols. However, our findings showed this issue had not been rectified at the time of the inspection.
- Some staff told us they felt unsupported and not listened to by the management team. We noted they had reported a cause for concern about a person's health on two occasions during handover meetings to a member of the management team. However, we checked the handover records and found these concerns had not been recorded. It was therefore unclear if any action had been taken.
- Monitoring records had not been consistently completed in respect of two people's positional changes and checks on their skin integrity. There was no evidence seen to demonstrate the management team had audited the forms to check appropriate care had been provided.
- A safeguarding alert had not been made in a timely manner following incidents in the home. This prevented the local authority from carrying out investigations to ensure appropriate measures had been put in place and the person was safe.
- We asked the provider for details and evidence of their checks and audits of the service over the last six months. Whilst the information received demonstrates the provider had carried out checks and audits, our findings showed people remained at risk from inconsistent and unsafe care.

The provider had failed to operate effective systems and processes to assess, monitor and improve the quality and safety of the service and had failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of people using the service. This was a breach of Regulation 17 of the Health and

Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had failed to notify the commission without delay of two incidents where people had incurred serious injuries. This matter will be considered separately outside the inspection process.

Following the inspection, the provider sent us an action plan, which covered their response to the issues raised during the inspection. However, given the high level of risk identified, we would have expected these matters to have been proactively identified and addressed, without our intervention. We will check improvements on our next visit.

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

- The provider had not always promoted a positive culture which was open and empowering. Whilst staff spoken with told us they worked well together, they felt morale amongst the staff team was low and communication with the management team could be improved. The provider had given consideration to staff morale and had carried out a staff survey in March 2021. They had also ensured information was displayed on notice boards in respect of staff well-being and falls. Additionally, staff had access to an extensive range of policies and procedures and were given opportunities to attend meetings.
- Staff members told us information and concerns were not acted on in a timely manner. This had the potential to impact on people's outcomes as well as their health, safety and welfare. Two staff spoken with referred to the pressure of work during the pandemic.
- The registered manager told us they understood the duty of candour and their responsibility to be open and honest when something went wrong.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- People were consulted about the service. We saw residents' meetings had been held on a monthly basis and a consultation exercise had recently been held in the home. The registered manager explained they were in the process of collating the results. Whilst, the provider had not carried out an annual satisfaction survey since November 2019, they explained after the inspection this was due to the pandemic and resources had been diverted to support the management of this situation.
- The registered manager confirmed the staff had good working relationships with other social care and health care professionals and members of the local community.

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 The provider had failed to assess the risks to the health and safety of people receiving care and treatment and failed to do all that is practicable to mitigate the risks.(Regulation 12 (1) (2) (a) (b)).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to operate effective systems and processes to assess, monitor and improve the quality and safety of the service and had failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of people using the service. Regulation 17 (1) (2) (a) (b)).