Soundpace Limited

Grovewood Residential Home

Inspection report

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Wirral
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out this unannounced inspection of Grovewood Residential Home on 25 and 26 September 2018. Grovewood 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. Grovewood accommodates up to 32 people in one adapted building.

The home is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At this time of this inspection, the home did not have a registered manager.

We inspected Grovewood on 26 and 30 October 2017 and found breaches of Regulations 11, 12, 15, 17, 18 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to complete an improvement action plan to tell us how they planned to address the breaches of regulations but we did not receive an action plan.

In response to concerns CQC received, and the lack of an improvement plan, we inspected Grovewood again on 28 February and 7 March 2018. We found that all of the breaches were repeated. We asked the provider to complete an improvement action plan to tell us how they planned to address the breaches of regulations, and issued a Warning Notice with regard to Regulation 17. The service was rated inadequate and placed in special measures.

During this inspection we found continued breaches of Regulation 11, 12, 15, 17, 18 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found breaches of Regulations 13 and 20A, and Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The premises and equipment were not always maintained in a safe condition, and people were not adequately protected from the risk of infection. Some rooms did not have a consistent supply of hot water. A central heating boiler had been deemed unsafe by British Gas in August 2018 and no action had been taken. The home's fire risk assessment and personal emergency evacuation plans were out of date. We saw a number of areas that were not adequately maintained. We had many concerns over standards of cleanliness and the age and decay of the building and the furniture in it.

The provider had not ensured that robust recruitment procedures were followed including the relevant checks. We asked the acting manager if any new staff had been recruited since our last inspection and we were told that there had not. We then found that four staff members had been recruited. Two did not have adequate references.

Incidents that had put people at risk had not been referred to the local authority for investigation under safeguarding procedures.

Mental capacity assessments were not in place for most of the people living at the home. This included people who were living with dementia; people who had a 'do not resuscitate' order which they had not consented to; and people who had devices fitted to their beds to prevent them from falling out of bed.

Staff had not received appropriate support, supervision and appraisal. In two files we looked at we saw that that the staff had been subject to disciplinary action yet both staff members had only received one supervision session in the last six months and neither supervision session referred to the issues of performance where improvements were required. Supervisions and appraisals had been improved since our previous inspection but were still inconsistently offered.

We saw staff meeting minutes that were very confrontational and did not encourage a learning or supportive culture for staff to develop within. We were very concerned at some of the language used and the tone of the communication and did not feel that it was conducive for a positive working environment.

Record keeping across the service had improved but was still not good. For example, during the inspection the acting manager and other members of staff spent a lot of time trying to find documents such as service user guides and complaints records.

The acting manager told us that the provider visited the home about once a month and was always available by phone. We saw records of provider visits in April and May 2018 but none since. We found no evidence of any checking or monitoring by the provider, for example of the staff recruitment and supervision records or the state of the environment.

Some audits were in place to monitor the quality and safety of the service. However, the audits did not identify or address the concerns we found during this and previous inspections. Audits consisted mainly of the acting manager or staff auditing their own work.

Infection control self-audits had failed to identify the issues found by the NHS infection prevention and control inspection in July 2018. Cleaning and laundry daily checklists did not refer to the issues that were clearly visible in the environment.

At this inspection we found that despite concerns raised at our previous inspections, and the action plan we received from the provider, no significant improvements to the overall provision of the service for the people living at the home had been made or sustained. This demonstrated the management systems at Grovewood were inadequate.

The provider did not display their most recent performance rating either in the premises or on their website.

The provider had not notified CQC of safeguarding incidents or of Deprivation of Liberty authorisations for people living at the home.

At our inspections in October 2017 and February 2018 we found that no written information about the service was available for people living at the home and their families or for people interested in going to live at the home. Since then, the manager had produced a 'Residents Guide'. However we found that this contained misleading information, for example reference to the National Care Standards Commission which was disbanded in 2004.

During the inspection we saw that there were enough staff on duty and people's requests for assistance were answered promptly. We observed that staff supported people in a friendly, caring way. A programme of staff training had been implemented. The service had a part-time activities organiser and a variety of social activities was provided. The kitchen had a five star food hygiene rating and people appeared to enjoy their meals.

The home's complaints procedure was displayed and the acting manager had kept records of complaints they had received since our last inspection.

The overall rating for this registered provider is 'Inadequate'. This means that it has been placed into 'Special Measures' by CQC. The purpose of special measures is to:
• Ensure that providers found to be providing inadequate care significantly improve
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

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.

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.

At our last two inspections we found that parts of the premises were not clean. At this inspection we found that some areas were not clean and hot water was not available in some parts of the building.

At our last two inspections we found that the required checks had not been carried out before new staff were employed. At this inspection we found that some progress had been made however not all of the required checks were in place.

Accidents and incidents were logged but did not always show action taken to help prevent reoccurrence.

People's medicines were managed safely.

Is the service effective?

Inadequate

The service was not effective.

At our last inspection we found that parts of the premises were not well-maintained. At this inspection we found some improvement to the maintenance of the premises, however many areas were worn and shabby.

People's mental capacity had not always been assessed to determine whether they required a Deprivation of Liberty Safeguard application.

Since our last inspection, staff had completed a programme of training, however records of staff supervision and support were not satisfactory.

Is the service caring?

Requires Improvement

The service was not always caring.

The staff employed at the home were kind, caring and good-humoured.

People were not provided with a pleasant environment to live in.

Is the service responsive?

Requires Improvement

The service was not always responsive.

We found some improvement to people's care files but this was inconsistent.

A varied programme of social activities was provided.

The home's complaints procedure was displayed and records of complaints received were in place.

Is the service well-led?

Inadequate

The service was not well led.

The home did not have a registered manager.

The provider did not have effective quality monitoring systems, and in the absence of a registered manager, we found no evidence of quality monitoring by the provider.

The provider had not fulfilled their obligation to inform the Care Quality Commission (CQC) of certain events affecting the health and wellbeing of people.

Grovewood Residential Home

Detailed findings

Background to this inspection

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

We undertook an unannounced inspection of Grovewood Residential Home on 25 and 26 September 2018. The inspection was undertaken by two adult social care inspectors and an inspection manager.

Before the inspection we contacted Wirral Council Quality Monitoring department to ask if they had any concerns about the service. We looked at all of the information that CQC had received about and from the service since the last inspection.

During our inspection we spoke with one person who lived at the home and observed the care and support provided to other people in communal areas. We spoke with the acting manager and five other members of staff. We looked at all parts of the premises. We looked at a range of records including care records for three people, medication storage and records, staff files and training records, premises records, and records relating to the quality checks undertaken at the service.

Inadequate

Is the service safe?

Our findings

During our inspections in October 2017 and February/March 2018, we found breaches of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Fit and proper persons employed. This was because the provider had not ensured that robust recruitment procedures were followed including the relevant checks. During this inspection we found that although some improvements had been made, there were still shortfalls in the staff files and the service remained in breach of Regulation 19.

We asked the acting manager if any new staff had been recruited since our last inspection and we were told that they had not. We then found that four staff members had been recruited. Two not have adequate references. A maintenance person had been recruited but the acting manager did not consider them to be a staff member. We explained that they were a staff member and that the same safe recruitment procedures applied. We asked to see their staff file and were told that they did not have one. On the second day of the inspection the manager had put together a staff file for this person and we saw that pre-employment checks had been carried out..

During our inspections in October 2017 and March 2018 we found breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment. This was because the premises and equipment were not always maintained in a safe condition; the management of medicines was not safe; people were not adequately protected from the risk of infection.

At this inspection we found continued areas of concern. At the last inspection in March 2018 we found that hot water temperatures were not always maintained and some people did not have hot water in their bedrooms. The acting manager told us that repairs had been made but the issue was ongoing and was not yet resolved. During the inspection we tried to wash our hands in two different sinks in two toilets and in both the water was cold. Hot water temperature checks carried out on 20 August 2018 recorded no running hot water in room 4F, and water temperature at 18 degrees in room 7F and the staff toilet. Only one bedroom had hot water at the recommended maximum temperature of 42 degrees. We also noticed that the list of water outlets tested did not cover all areas, for example the laundry, kitchen and bathrooms were not included.

Whilst we were checking the equipment safety records we saw that a warning notice had been issued by a British Gas Engineer who had visited the home a month before our inspection. The notice stated that a boiler was unsafe to use. We asked the acting manager about this and they said they had no knowledge of the warning notice and that the provider did not know about it either. The notice was signed by a staff member from the home. We telephoned British Gas and they explained that the notice deemed that the boiler was over 35 years old and was unsafe and that the provider used it "at risk" as there were also flue and ventilation issues. During the inspection the acting manager spoke with the provider and they agreed that the boiler would be replaced. It was of significant concern that they were not aware of this issue until we noticed it in their premises safety records.

We looked at the fire risk assessment for the building and saw that it was four years old and had not been updated or reviewed. The acting manager told us that they had reviewed it but could not find the documentation to show this. The personal emergency evacuation plans for people living at the home were out of date and some had not been updated for four years. This was of considerable concern because the accommodation was over three floors and many people had mobility problems and had to use stair lifts to get access to and from their bedrooms. It was not possible to see how people could be evacuated safely in the event of an emergency.

Before the inspection we received information regarding an infection prevention and control audit that had been carried out by NHS staff on 11 July 2018. The overall score was 69% which indicated that improvement should be an organisational priority. Particular areas of concern were staff knowledge, the environment in general, and the laundry. Following this, two senior members of staff had attended infection control training; cleaning schedules had been put in place; and adapted toilet seats had been replaced. Improvements to the laundry room had been started but were incomplete and the current arrangements did not meet the requirements for safe infection control.

During the inspection we had many concerns over standards of cleanliness and the age and decay of the building and the furniture in it. We saw old, stained chairs that people were sitting in, stained carpets and in one bedroom the carpet was badly fitted, ripped and a serious trip hazard. We also saw rotting windows and a pile of rubbish at the side of the home that would be a good breeding ground for rodents. We also saw a complaint from a relative made in August 2018 which mentioned staff carrying cake to a person's room in their hands, and the person's hands not being washed after using the toilet. During the inspection we observed that staff giving out biscuits to people did not offer the container, but handed the biscuits to people.

We looked at the 'Monthly statistics and review of accidents/incidents' that had been completed by the acting manager for the months of June, July and August 2018. The audit for June stated that 12 accidents had occurred but only 10 were listed. The section 'Number of residents involved in accidents/incidents' was answered "2", but there were at least eight different names. The 'Number of residents who fell' was answered "0", but there were at least five people who had fallen. The 'Number of resident injuries sustained was answered "2" but with no evidence of what type of injury or how serious. The response to the section 'actions taken/considered' section was "No pattern determined in this audit. All singular incidents.", however the records showed that one person had sustained three falls.

The audit for July 2018 showed that three people had more than one fall, but the 'action taken' only referred to one of these people. Both the July and the August audits showed that almost all of the falls had occurred between 8pm and 8am, but we saw no evidence that this had been recognised or addressed.

These are continued breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The accident/incident records, and other documents we looked at showed a number of incidents that had occurred since our last inspection where people who lived at the home were at risk. We asked the acting manager to show us their safeguarding records but none were produced. These incidents had not been identified as safeguarding concerns and had not been referred to the local authority or notified to CQC.

This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safeguarding.

During our last two inspections we found that people's medication was not always managed safely. At this inspection we found that improvements had been made and people's medication was stored safely and administered as prescribed. A portable hand-washing unit had been put in the medication room.

During the inspection we saw that there were enough staff on duty and people's requests for assistance were answered promptly.

Inadequate

Is the service effective?

Our findings

During our inspections in October 2017 and February/March 2018, we found a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Need for consent. This had also been identified at the inspection carried out in September 2016.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

During this inspection, staff we spoke with said that most people living at the home had a DoLS in place, but this was not the case. DoLS records were not clear but showed that four of the 22 people living at the home had a DoLS authorised. Two additional authorisations had expired and it was unclear if they had been renewed. Mental capacity assessments were not recorded in the electronic care files we looked at so it was unclear how decisions were made regarding which people needed a DoLS application to be made on their behalf.

Two people had wedges used on their beds to prevent them from falling out of bed. These are a form of restraint and there were no consents or risk assessments in place. The manager later told us that one of the two people was able to consent and they had completed a mental capacity assessment for the other person. We also saw that some people had a "do not resuscitate" decision in their care notes which was signed by their GP. There was no evidence that this had been discussed with the person and that they had agreed, or that if the person was unable to participate in the decision making, a best interests discussion had taken place. The decisions had not been reviewed.

These are repeated breaches of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Need for consent.

During our inspections in October 2017 and February/March 2018, we found breaches of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Premises and equipment. We saw a number of areas that were not adequately maintained. During this inspection we had many concerns over standards of cleanliness and the age and decay of the building and the furniture in it. We saw old, stained chairs that people were sitting in, stained carpets and in one bedroom the carpet was badly fitted and ripped. We could see that some carpets had been replaced and bathroom flooring replaced since our last inspection but the environment was very shabby and not at an acceptable standard for people to live in. Some of the towels and facecloths were in poor condition. Several doors and some furniture in people's

bedrooms was also damaged and scruffy. This meant that people were living in a poor and potentially unsafe environment.

This was a repeated breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspections in October 2017 and February/March 2018, we found breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Staffing. This was because staff had not received appropriate support, training, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

At this inspection we saw that a programme of staff training had been implemented. However we continued to have concerns about the support available for staff. In two files we looked at we saw that that the staff members had been subject to disciplinary action yet both staff members had only received one supervision session in the last six months and neither supervision session referred to the issues of performance where improvements were required. We saw that supervisions and appraisals had been improved since our previous inspection but were still inconsistently offered. We saw that one person had a supervision session and an appraisal within their first two months of employment when there were no issues of concern.

We also saw minutes of two staff meetings that were very confrontational and did not encourage a learning or supportive culture for staff to develop within. We were very concerned at some of the language used and the tone of the communication and did not feel that it was conducive for a positive working environment. This was communicated to the acting manager.

These examples are continued breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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People we spoke with were happy with their meals. One person said "Food is sound, we get a choice, we get an alternative if needed." Lunch on the first day we visited was mince and mash, followed by egg custard. Most people were enjoying this but we noticed that some people had chosen to have sandwiches. Staff we spoke with, including the chef, had a good awareness of people's dietary needs and choices. The kitchen had received a five star food hygiene rating in May 2018.

Requires Improvement

Is the service caring?

Our findings

At our inspections in October 2017 and February/March 2018, we found that no written information about the service provided was available for people living at the home and their families or for people interested in going to live at the home. The provider said they would make copies available but they had not done this.

The acting manager had put together a 'Residents Guide', however this needed to be revised. The guide referred to the 'registered manager' which the home did not have. It also referenced the National Care Standards Commission, which was disbanded in 2004, and the Care Standards Act 2000, which was superseded by the Health and Social Care Act 2008. We also considered that the document was not clearly written to make it easy for people to understand.

One person told us "I'm happy here, no problems, I come and go as I please. They know me really well. If I had any problems I'd go to [acting manager's name]". We observed staff supporting people in the conservatory, where most people spent the day. We observed that relationships seemed friendly and familiar. Staff supported people in a caring and considerate way. For example, one person fell asleep and spilled their drink and they were supported discreetly to go and change their clothing. People had walking aids close by to enable them to mobilise independently. Some people chose to spend their time in a quiet lounge and a small number preferred to stay in their own room.

We noticed that war-time music was being played in the background and questioned whether people had chosen this and if it was appropriate to the age of most of the people living at the home.

We found that people's dignity was not respected because they did not have a pleasant environment to live in, for example people were sitting in chairs that were visibly dirty and had bedrooms with peeling wallpaper and stained carpets.

There were no restrictions on visiting but during the inspection we did not meet any friends or relatives visiting. A church visitor came into the home to say a prayer with people who wanted to.

The confidentiality of people's personal information was protected by documents being kept in locked filing cabinets in the office or on a password protected electronic system.

Requires Improvement

Is the service responsive?

Our findings

The home's complaints procedure was displayed on a noticeboard near the front door. There was also information about complaints in the Residents Guide. The information in the Residents Guide was many years out of date as it referred to "the Liverpool office of the National Care Standards Commission" which closed more than 10 years ago. It did not inform people of their right to make a complaint to, or raise a concern with, the local authority and gave no contact details for Wirral Council.

The acting manager had recorded complaints received May, June and July 2018, which was an improvement, but we saw no evidence that the complaints were followed up to ensure that people were satisfied with the way their complaint had been addressed.

People's care notes were recorded on an electronic system which was accessed through laptops in the office and tablets for the care staff. At the time of the inspection, the acting manager was having difficulty with access to the IT system and was waiting for support with this. Some staff had problems with logging in to the system and this meant it was not clear who had made the records of personal care given. One member of staff told us "The on-line system isn't really the best."

We looked at the care files for three people and found some good, personalised information. However, this was not always comprehensive. For example, one of the care plans we looked at was not completed for sections including: preferred sex of carer, details of GP, details of funeral director, resuscitation status. Another person had no record of their likes/dislikes in food. The weight monitoring chart for the other person was clearly unreliable as it showed the person's weight falling from 8st 0lbs on 28/5/18 to 6st 14lb on 12/6/18; and increasing from 7st 3lb on 7/8/18 to 8st 4 lb on 8/9/18.

Staff we spoke with had good knowledge of the people living at the home and said they received updates of any changes to people's needs during shift handovers.

The service employed an activities organiser for three half days a week and they provided a variety of group activities such as baking, quizzes and games, and taking people out on a one to one basis for shopping or leisure trips. An activities noticeboard in the dining room showed a varied programme, but also had pictures that people had coloured in which did not look age-appropriate. Care staff we spoke with said they organised social activities on other days of the week including games, reminiscence and singalongs.

Inadequate

Is the service well-led?

Our findings

During our inspections in October 2017 and February/March 2018, we found breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good governance. The registered manager had left the home in 2017 and we were concerned about the workload of the acting manager.

Since our last inspection, an additional senior care assistant and an office assistant had been recruited to support the acting manager. Record keeping across the service had improved somewhat but was still not good. For example, during the inspection the acting manager and other members of staff spent a lot of time trying to find documents such as service user guides and complaints records, and the acting manager was unable to access records we asked to see that were on the electronic system.

The acting manager told us that the provider visited the home about once a month and was always available by phone. We saw records of provider visits in April and May 2018 but none since. We found no evidence of any checking or monitoring by the provider, for example of the staff recruitment and supervision records or the state of the environment.

Staff we spoke with told us they felt supported by the acting manager and could go to them with any problems or suggestions. However, we saw minutes of two staff meetings that were very confrontational and did not encourage a learning or supportive culture for staff to develop within. We were very concerned at some of the language used and the tone of the communication and did not feel that it was conducive for a positive working environment.This was communicated to the acting manager.

A meeting for people living at the home and their relatives was held on 5 March 2018, but there was no evidence of any more recent meetings to update families or to ask their views of the service.

Some audits were in place to monitor the quality and safety of the service. However, the audits did not identify or address the concerns we found during this and previous inspections. Audits consisted mainly of the acting manager or staff auditing their own work.

Infection control self audits had failed to identify the issues found by the NHS infection prevention and control inspection in July 2018. Cleaning and laundry daily checklists did not refer to the issues that were clearly visible in the environment. We looked at a fire safety audit that had been completed by the acting manager in August 2018. One question was "Are whistles, gongs or air horns in place?" This was answered "yes", although none of this equipment was in place. Another question was "Are all external fire doors linked to the fire alarm system?" This was also answered "yes", but no alarm went off when we went out into the back garden.

At this inspection we found that despite concerns raised at our previous inspections, and the action plan we received from the provider, no significant improvements to the overall provision of the service had been made or sustained. This demonstrated the management systems at Grovewood were inadequate. These are

repeated breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good governance.

During this inspection we found breaches of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Requirement as to display of performance assessments. This was because the provider did not display their most recent performance rating either in the premises or on their website.

During this inspection we found breaches of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009: Notification of other incidents. This was because the provider had not notified CQC of safeguarding incidents or of Deprivation of Liberty authorisations for people living at the home.

We found good records of a number of night visits/spot checks by the acting manager. Weekly medication audits completed by senior care staff appeared comprehensive and the management of medication had improved.