

Groveswood House

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Inspection report

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25 October 2018

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Ratings

Overall rating for this service	Inadequate ●
Is the service safe?	Inadequate ●
Is the service well-led?	Inadequate ●

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service in January 2018. Breaches of legal requirements were found. After the comprehensive inspection the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches found.

We undertook this focussed inspection to check the provider had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Grovewood House on our website at www.cqc.org.uk.

The inspection took place on the 24 and 25 October 2018 and we inspected the service against two of the five questions we ask about services: Is the service safe? and Is the service well led?

At this inspection, we found the provider had not fully addressed the issues from the last inspection and they continued to be in breach of regulation 12, safe care and treatment with a further breach being found in relation to good governance, regulation 17.

No risks, concerns or significant improvement were identified in the remaining key questions through our ongoing monitoring or during our inspection activity so we did not inspect them. The ratings from the previous comprehensive inspection for these key questions were included in calculating the overall rating in this inspection

Grovewood House at one time was the local vicarage and is set in a rural location on the edge of a small village in Northumberland. It accommodates up to 28 people over two floors. At the time of the inspection, 23 people lived at the service.

Grovewood House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single packages 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 in relation to the key questions, 'safe and well led'

There was a registered manager in place. A registered manager is a person who has registered with the CQC 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 the time of the inspection there were some issues with the provider registration which were being dealt with separately by the CQC.

Although people and staff felt that the service provided safe care, we found a number of issues which needed to be addressed.

The management of medicines was inadequate and required improvement. For example, regarding administration, storage and recording.

Although we found the service was clean and tidy and people also deemed the service was clean, we found issues with infection control in connection with the use of aprons and gloves in the kitchen areas.

Record keeping needed further improvements. Some care plans, risk assessments and other monitoring records, were either out of date or not in place at all.

Accidents and incidents were not always fully recorded and reported to the correct authorities, including the local safeguarding team and the CQC.

Staff did not always follow safe moving and handling procedures, by failing to place the brakes on a wheelchair during transfer of a person. We have made a recommendation about this.

Fire safety procedures were in the process of being updated, including staff training and monitoring within the home. The local fire authority will be returning to the service in November to ensure they are fully completed.

Audits and checks had not identified all the concerns we had during the inspection. The service had the continued support from a quality assurance organisation. However, from the last two reports provided by this organisation, it appeared that advice given had not always been followed in a timely manner. Issues identified earlier in the year with regards to medicines for example, were still being raised in August and October and had not been rectified.

Correct recruitment procedures continued to be followed, with suitable checks being made on potential staff. Enough staff were employed to meet people's needs.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to safe care and treatment and good governance. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this service is now 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. 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?

The service was not safe.

Medicines were not managed safely.

Accidents and incidents were not always reported correctly.

Risks people faced in their daily lives were not always assessed and potential for harm reduced.

Safe moving and handling procedures were not always followed.

There was enough safely recruited staff deployed at the service to support people safely with call bells being answered quickly.

Inadequate ●

Is the service well-led?

The service was not well-led.

Audit and governance systems were not always effective. The service had continued to breach regulations from our last inspection and other areas of the service had failed to fully meet people's needs in a safe manner.

Record keeping needed further improvement. Issues raised during internal and external checks had failed to be fully addressed.

A registered manager was in place and we received positive comments about them.

People and staff felt the culture and atmosphere was positive and links with the local community were maintained.

Inadequate ●

Groveswood House

Detailed findings

Background to this inspection

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

The inspection was prompted by concerns shared with the Care Quality Commission from the local authority contract monitoring team. They had recently visited the service and found some issues, including medicines management.

We undertook the unannounced, focussed inspection on 24 October and completed it on 25 October 2018. The team consisted of an adult social care lead inspector, a pharmacist inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection, we reviewed the information we had received from the service, including notifications. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales. We also contacted the local authority safeguarding and commissioning teams, the local fire authority, infection control care home leads for the area and Healthwatch. Healthwatch is an independent consumer champion which gathers and represents the views of the public about health and social care services.

On this occasion we did not ask the provider to complete a Provider Information Return (PIR) due to the short timescales in planning. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with 14 people who lived at the service. We also spoke with the registered manager, deputy manager, two cooks, one senior member of staff who also worked some of their hours as an activity coordinator and four care and domestic staff at the service.

We reviewed three people's care records and medicines records for all the people living at the service. We

also reviewed records in relation to the management of the service, including audits and health and safety information.

Is the service safe?

Our findings

At the last inspection we found a breach in Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in connection with safe care and treatment, particularly in relation to medicines. Although the provider had sent us an action plan and said they would be meeting the regulations by May 2018, we found issues with medicines management continued and other areas of concern were also found.

People were not always observed when medicines were administered which meant there was a risk of people not receiving their medicines as prescribed. On the first day of our inspection we observed three people taking medicines unobserved by staff. This was not in line with their care plans.

Records relating to medicines in the home were not always accurate or in place. For example, one person was prescribed two medicines but there was no record to evidence these had been administered. We also found for another person who was prescribed a strong painkiller and a medicine for nausea, that there were no medicines administration records (MAR) to record these. One person's MAR chart was currently in use with dates of August and September despite the inspection taking place in October.

We looked at nine MARs and found 54 gaps where there should have been a staff signature to show the medicine had been administered. For example, one person who was prescribed a regular inhaler for the treatment of asthma showed 34 missed doses in October with no explanation. Another person was prescribed a medicine for pain, which had recently been changed from being administered on a 'as required' basis to a regular basis. However, staff had not responded to this change and were not administering it as prescribed.

Topical medicines (creams or ointments) were not managed well and we could not be assured people had received them as prescribed. Out of the 14 topical medicines records we reviewed, 13 lacked detail to ensure staff applied them correctly. Staff signed MAR's to record creams had been applied without always witnessing the application. One recording showed a medicated gel had been signed for, despite staff confirming that no application had taken place. One person had two topical medicines in their room that were labelled for another person. We also found staff did not always have training for applying medicated creams.

'As required' medicines (intermittent medicines used, for example, in pain relief) were not managed safely to ensure people received them as they should. Nine out of 10 records had no guidance for staff to follow, including in relation to signs or symptoms for staff to look for if a person was in pain for example. This is particularly important for people who may not be able to communicate their needs to staff.

Temperatures in both the medicines fridge and room were recorded to be above the recommended ranges to keep medicine safely stored. For example, the medicines room showed recordings of 27.7 degrees in all of September and October (maximum 25 degrees) with no action taken. The medicines room was not fully secure and was being inappropriately used. During the inspection staff entered the medicines room via an external door, sometimes after a smoking break. All staff also had access to the medicines room from the

kitchen as it was used to store care plans, other records and various other items.

People self-administering their own medicines at the service were not supported safely to do this and this was not in line with the providers medicines policy. For example, one person who was using their own inhaler for breathlessness, had no risk assessment in place. Therefore, we could not be sure this person was being safely supported.

Other risk assessments to mitigate against the avoidable risk of harm to people were not always in place or updated regularly, including those in relation to the environment in which people lived. For example, a downstairs toilet regularly used by people was situated on an incline. Handles had been placed on either wall to support people, but no risk assessment was in place to ensure that everyone could still manage this safely and if any other control measures were needed.

Two rooms which contained equipment with the potential to harm people, including chemicals and maintenance tools were not fully secure. Both rooms had bolts in place which people who were mobile could reach. This had been raised as an issue in August 2018 from a visit by the local authority contracts monitoring team, but continued to be the case.

Systems and processes to protect people from abuse were not always followed. Accidents and incidents were not always monitored, reported or recorded fully to ensure that remedial action was taken and concerns addressed. For example, one incident of a safeguarding nature had not been reported to the local authority safeguarding team or the CQC. We discussed this with the registered manager who said, "This was not reported to me. Yes, this should have been reported. I have already spoken to the staff about this." We also found no investigation report into this incident.

People were not always protected from the risk of infection. The service was clean and tidy with no odours at all. However, we found an issue with infection control. Staff, including the registered manager and deputy manager continued to use kitchen areas without personal protective equipment (gloves or aprons) even after we had discussed this issue with the management team.

The local fire authority had recently visited the service in early October and found issues which needed to be addressed. These included updating staff training in fire safety, maintenance of escape routes and testing of equipment. We found that some actions had been taken and some planned to take place. The local fire authority was due to revisit the service in November to follow up on these outstanding actions.

These issues constitute a breach of Regulation 12 Health and Social Care Act (Regulated Activities) Regulations 2014, in relation to safe care and treatment.

Despite the issues we found, people told us they felt safe living at the service and could not think of anything to improve it. Comments from people included, "Yes, I feel safe. The doors are always locked and staff are friendly - it's like a family really" and "Yes, I feel safe. The ambience of the place is good, very safe." The service had a calm atmosphere and all the people appeared happy and relaxed.

We observed a moving and handling procedure in which the care staff had not placed the brake on the wheelchair in use, although we confirmed in the person's records that other procedures were followed.

We recommend the provider review their moving and handling procedures to ensure staff follow safe procedures in line with best practice.

Recruitment procedures were in place to ensure that any potential staff were safely employed, including reference requests, identification checks and Disclosure and Barring Service (DBS) checks. DBS undertake criminal screening of potential employees to ensure they are suitable to work with vulnerable adults or children.

There were enough staff on duty to address the needs of people living at the service. Comments from people included, "I like the homeliness here. Staff are very good. Staff talk to me all the time"; "Yes, staff do come quickly. I have heart trouble and sometimes I need help quickly...they (care staff) are there straight away" and "I have to press my buzzer several times every day. They (care staff) are always there in a couple of minutes."

During observations, lounge areas remained under supervision and emergency call bells were answered promptly when activated. Staff told us there was enough staff, but that on occasions it could be busy. The deputy and registered manager both assisted in the service with people's needs, including supporting people during meal times. We observed staff chatting to people throughout the inspection and carrying out their duties in an unrushed and steady paced manner.

Is the service well-led?

Our findings

In the last inspection the 'well-led' key question was 'required improvement'. We deemed that although some improvements had taken place further improvements were required. Timely efforts had not been made to ensure the service was safe and governance monitored fully, which further impacted on the overall key question 'well-led' and we now deemed this to be inadequate.

There was a registered manager in place who had worked at the service since 1994, being promoted to manager in 2000. They, along with the deputy manager assisted with the inspection on both days of our visit.

At the last inspection an organisation had been appointed to support the service to meet the regulations. This continued to be the case. We found information from the organisation alerting the provider of ongoing issues was not acted upon swiftly. During review of recent reports to the registered manager, which were compiled by the organisation, we noted ongoing concerns had been raised which had not been fully addressed, particularly in relation to medicines management. The reports highlighted the same issues which we found during our previous inspection. These issues should have been addressed by the end of May 2018 which was when the provider wrote to the CQC to say they would be meeting all regulations.

Actions from audits had not always been recorded when issues had been found or subsequently addressed. We found that audits and checks had not always highlighted the issues we had, during our inspection. For example, medicines stock checks were in place, however we found one bottle of a strong pain-killer had expired in April 2018 that was still in stock.

Policies and procedures were found to be mostly out of date and in need of review, with the majority being dated either 2016 or 2015. The provider also had a medicine policy in place for staff to follow which was not fit for purpose and did not cover all aspects of medicine management. For example, the policy contained no information about topical medicines, fridge monitoring or when required protocols. After the visit to the service the registered manager provided us with an updated medicine policy. However this continued to be missing the examples listed above.

Record keeping in the service had improved in parts since our last inspection but there continued to be gaps. For example, not everyone had a care plan in place for medicines. One person who had specific dietary needs had no care plan in place to support staff. Information held in kitchen areas regarding people's dietary needs were not fully up to date. However, we saw no evidence to suggest people had received an incorrect diet.

Fire monitoring records were not always kept up to date with checks completed including, for example, fire alarm tests and fire lighting checks. These gaps in record keeping made it unclear if people had been as safe from harm as they should be in line with fire safety measures. The local fire authority had also seen these issues during a visit in October and intended to revisit the service in November to check all issues had been addressed.

Care review meetings with people and their relatives took place and were recorded in care records. However, there were no overall 'service user' meetings or surveys issued to collate the views of people and their relatives on feedback about the service to continually aid service improvement.

Complaints information was not displayed in the home where people and visitors could gain access to. This had been raised in a recent visit by the local authority contracts monitoring team in August and continued to be the case.

These issues constituted a breach of Regulation 17 Health and Social Care Act (Regulated Activities) Regulations 2014, in relation to good governance.

One safeguarding incident was not reported to the CQC in line with the providers and registered managers legal obligations. This is being dealt with outside of the inspection process and we will report on this at a later stage.

Although meetings and surveys had not been undertaken fully for people or their relatives, the registered manager had an open-door policy to address any issues raised. People told us they could speak to the management team whenever they needed. One person said, "I have just got to ask and I can have a word. Look, the door is open there (managers office door) but she is often around anyway to talk to." From observations, staff had a culture of person centred care for people and we overheard many positive conversations taking place between staff and the people they cared for.

People and staff, we spoke with were complimentary about the management team including the registered and deputy managers. One person said, "I know the manager. She is very nice. She is always about and helps during the day." Another person told us, "The manager has been in touch with my niece to ask her to sort my house out so I can go home." A staff member told us, "The manager and (deputy manager name) are always on the floor helping, they support the staff when it's needed."

Staff worked well as a team. One person said, "They seem to work well together. They know each other well and staff do their best" and "Yes, they do work well as a team. They all help us do what we need to, when you've lost everything." One staff member confirmed, "Yes I think we all work well together. We have handovers for the next shift coming in twice each day and we share information then."

Links with the local community had been established. One person told us, "Sometimes the children come in from the local school to sing carols for us at Christmas." This was reinforced by a member of staff who said, "Children from the local nursery make mince pies for the residents and come and sing carols for them and have a drink of juice with them. The residents love this." A staff member also told us, "We have links with Alnwick Gardens. We take residents there on trips and they take part in 'Elderberries' and 'Singing for the Brain'. Residents love taking part in this. We also have links with local churches. Priests will come in to do one to one prayers or sometimes we have a service for everyone in the lounge." One staff member told us, "I think we have a good rapport with residents. I love them!"

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The provider had not maintained people's safety in connection with medicines management, assessing and mitigating all risk to people, infection control procedures and safeguarding people fully from abuse.</p> <p>Regulation 12 (1) (2) (a)(b)(c)(d)(g)(h)</p>

The enforcement action we took:

We have taken action against the provider and issued a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The provider had not ensured that robust quality systems or processes were fully established and operated effectively to monitor the service appropriately, including people's safety.</p> <p>The provider had not fully sought feedback from the people or relatives living or involved with the service.</p> <p>The provider did not have full, complete records for all people living at the service.</p> <p>Regulation 17 (1) (2) (a)(b)(c)(d)(ii)(e)(f)</p>

The enforcement action we took:

We have taken action against the provider and issued a warning notice.