Alpha Care Management Services No. 3 Limited

Grenville Court Care Home

Inspection report

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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

About the service
Grenville Court Care Home is a residential care home that can provide accommodation and personal care to 64 people aged 65 and over. The care home is run over two floors, each with its own lounges and dining area. People have their own rooms with an en-suite toilet. At the time of our inspection there were 13 people living in the home.

People's experience of using this service and what we found
The care people received had improved since our last inspection. The provider had implemented a new management team and structure to drive improvement within the service.

The provider's governance systems had been reviewed and management oversight increased. Although improvements had been made in this area, we found some shortfalls in risk and medicines management that the provider had not identified and therefore corrected. The provider and manager took immediate action in response to our feedback. However, this demonstrated the revised systems were not yet fully embedded and therefore, further improvements are required. We have made a recommendation about governance and monitoring.

People and relatives told us they were happy with the quality of care provided. During our visit, we observed people were happy and contented. Staff were respectful and demonstrated patience and kindness.

Systems were in place to safeguard people from the risk of abuse. Communication about people's needs had improved. This gave staff the knowledge they required to ensure they could provide people with appropriate care.

There were enough staff to meet people's needs and to keep them safe. The required checks had been made to ensure new staff working in the service were safe to do so.

Since our last inspection, staff had received further training to ensure they were competent to support people living in Grenville Court. They were happy working in the service and felt supported.

The service and equipment people used was clean. Systems were in place to reduce the risk of the spread of infection.

The new management team and provider had instilled a person-centred culture within the service. People, relatives and staff told us they were open and approachable. The management team worked well with organisations for the benefit of people living in the service.

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

Rating at last inspection (and update)
The last rating for this service was Inadequate (published 21 October 2020).

At this inspection we found improvements had been made and the provider was no longer in breach of regulations.

This service has been in Special Measures since October 2020. During this inspection the provider demonstrated that improvements have been made. The service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

Why we inspected
We carried out an unannounced focused inspection of this service on 6 August 2020. Multiple breaches of legal requirements were found. We wrote to the provider after that inspection and asked them to take urgent action to keep people safe. They provided us with an action plan telling us how they would do this.

We continued to receive concerns about the quality of care provided and therefore, conducted a further inspection in September 2020 to check whether the provider had made enough improvement. We found they had not, and legal requirements continued to be breached. We took urgent enforcement action to stop them from admitting people into the service. We also told them to tell us each week how they ensured staff were appropriately trained and competent to provide people with safe care. This information has been received from the provider as required.

We undertook this focused inspection to check whether the provider had made the required improvements and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions of Safe and Well-led which contain those requirements. The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has changed from Inadequate to Requires Improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Grenville Court Care Home on our website at www.cqc.org.uk.

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 the service can respond to COVID-19 and other infection outbreaks effectively.

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

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.

Grenville Court 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. 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 and prevention measures in place. This was conducted so we can understand the preparedness of the service in managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was conducted by two inspectors, one of whom specialised in the management of people's medicines and an assistant inspector.

Service and service type
Grenville Court 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 in place. They were not registered with the CQC at the time of the inspection, but they had applied to do so. This application was being processed.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 12 April 2021 when we visited the service and ended on 19 April 2021 when we provided feedback to the manager and three representatives of the provider.

What we did before the inspection
We reviewed the information we held about the service including notifications the provider had to send us

by law and feedback from the public. We also requested information from the local authority who are a commissioner of the service. We used this information to plan our inspection.

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.

During the inspection
We spoke with three people living in Grenville Court Care Home during our visit, along with five staff and the manager. As most people living in the service were unable to provide us with feedback about the care they received, we spent time within the communal areas, observing how staff interacted with people and the support they received.

We reviewed a range of records. This included four people's care records, two staff recruitment and training files and multiple medicine records. A variety of records relating to the management of the service were also reviewed.

On 13 April 2021, we spoke with three relatives over the telephone to gain their feedback regarding the quality of care provided.

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 where a rating was given, this key question was rated as Inadequate. At this inspection this key question has now improved to Requires Improvement. This meant some aspects of the service were not always safe. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At our last two inspections of this service, the provider had failed to ensure there were robust systems in place to assess and mitigate risks to people's safety. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made and the provider was no longer in breach of regulation 12. However, not all risks to people's safety had been adequately assessed. Not all incidents had been reported as was appropriate to do so. Therefore, improvements are required in these areas.

●Items such as toiletries and denture cleaner that could cause harm if accidentally ingested were stored in locked cabinets within people's rooms. However, the keys to the cabinets remained within the lock which meant people may have been able to gain access to these items. Risks associated with this practice had not been assessed to ensure it was safe. The manager removed the keys and agreed to assess this potential risk for each person living in the home.
●Staff had reported most incidents appropriately and these had been thoroughly investigated and lessons learnt to reduce the risk of the incident re-occurring. However, we identified an incident that had not been brought to the manager's attention. Therefore, no investigation had occurred, and the provider had not taken the appropriate action such as reviewing risks to people's safety. We alerted the manager to this who immediately acted on our feedback and told us they would provide staff with further training in this area.
●Other risks that had been poorly managed at our last inspection had been managed well. This included risks in respect of falls, not eating and drinking enough and developing pressure ulcers. Actions had been taken to reduce risks associated with the premises. This included conducting regular checks in relation to fire safety and on the equipment people used.
●The provider had now ensured staff working on each shift had the appropriate training and competence to meet people's needs and to keep them safe. The people we spoke with told us they felt safe living in Grenville Court. One person said, "Yes, I do feel safe. I know it is not like home, but this is now my home and I am happy and safe."

Using medicines safely

At our last two inspections, the provider had failed to ensure people's medicines were managed safely. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made and the provider was no longer in breach of regulation 12. However, existing monitoring systems would benefit from further improvement to ensure they are fully robust at monitoring that people have received their medicines safely.

●Two people's cream records contained recent gaps which implied they had not received them. We queried this with the manager who assured us the creams had been applied but the records not updated. They told us they would remind staff of the importance of keeping accurate records.
●Not all relevant records had been updated with changes made to people's medicines. This increased the risk of confusion. The manager told us this would shortly be resolved as an electronic medicine management system was being implemented.
●Records showed medicated skin-patches had not been rotated on one person's body in line with guidance. The person had not experienced any harm, but this increased the risk of an adverse skin reaction. Immediate action was taken to resolve this during the inspection.
●Records showed that oral medicines had been given as prescribed and people told us they received their medicines when they needed them. One person said, "They bring it (the medicine) daily. The doctor tells me what to have and they (staff) give it to me. I have a pain killer, so I have no pain."
●Improvements had been made to the information available to staff to help them to give people their medicines safely. Written guidance for medicines prescribed on a when required basis (PRN) was available for all medicines prescribed in this way. Medicines had been regularly reviewed by prescribers to ensure they were appropriate for people.
●Staff authorised to give people their medicines had been trained and assessed as competent to do so.

Systems and processes to safeguard people from the risk of abuse

At our last two inspections of this service, the provider had failed to ensure there were robust systems in place to safeguard people from the risk of abuse. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made and the provider was no longer in breach of regulation 13.

●Systems had been improved to safeguard people from the risk of abuse.
●The staff we spoke with had a good understanding of safeguarding and knew how to report any concerns they had, including outside of the provider if needed.
●Safeguarding incidents had been reported to the relevant authorities as required for independent investigation.
●New systems had been put in place to ensure people's needs had been fully assessed and the care records we viewed demonstrated this. Staff had a good knowledge of how to keep people safe and meet their needs to protect them from the risk of neglect.

Staffing and recruitment

At our inspection in August 2020, the provider had failed to ensure there were enough staff to provide people with safe care. New staff had not been subject to the required checks to ensure they were safe to work within the service. This was a breach of regulations 18 (Staffing) and 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Furthermore, during our inspection in September 2020 the provider had failed to ensure staff had been adequately trained to provide people with safe care. This had resulted in a breach of Regulation 12 (Safe care and treatment) of the Health and

Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made and the provider was no longer in breach of regulations 12, 18 and 19.

●There were enough staff to keep people safe and meet their needs. One person said, "There are enough to look after me. They are on the ball. They know me well and what I like, I have nothing bad to say about them." A relative told us, "When we have gone in there seems to be a lot of staff. They are very well-trained staff and know [Family Member] well and their needs. They can become anxious and they (staff) support them well. [Family Member] is happy there, so we are happy."
●Staff we spoke with told us there were enough staff on each shift to meet people's needs and to keep them safe. We observed this on the day of our visit.
●The provider had ensured staff working on each shift had the appropriate training and competence to meet people's needs and to keep them safe. Staff completed a thorough induction when they started working at the service and all staff received ongoing training.
●Records showed the provider had completed the required checks on new staff before they started working in the service. This ensured they were safe to support the people living there.

Preventing and controlling infection

At our inspection in August 2020, the provider had failed to ensure there were adequate systems in place to protect people from the risk of the spread of infection. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made and the provider was no longer in breach of regulation 12.

●We were assured the provider was promoting safety through the layout and hygiene practices of the premises. The home and equipment people used was clean. In the main, staff used good practice. For example, they were observed washing their hands regularly however, one staff member wore jewellery which may have made hand hygiene less effective and another did not wear gloves when assisting a person to eat in line with good practice. We have signposted the provider to guidance in these areas.
●We were assured the provider was preventing visitors from catching and spreading infections, was meeting shielding and social distancing rules and admitting people safely to the service.
●We were assured the provider was using PPE effectively and safely and was accessing testing for people using the service and staff.
●We were assured the provider was promoting safety through the layout of the premises and was making sure infection outbreaks could be effectively managed.
●We were assured the provider's infection prevention and control policy was up to date.

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 where a rating was given, this key question was rated as Inadequate. At this inspection this key question has now improved to Requires Improvement. This meant the service management and leadership was inconsistent and required further improvement.

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

At our last two inspections, the provider had failed to ensure there were adequate governance systems in place monitor and improve the quality of care people received. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made and the provider was no longer in breach of regulation 17. However, some audits and checks had not been fully effective at identifying potential issues for investigation. Therefore, further improvements are required to ensure the new systems put in place are fully effective in this area.

●The manager told us people's daily records were checked by senior staff to ensure any incidents had been reported for investigation. However, we found an incident had not been identified through this check and therefore, no investigation had taken place to ascertain if any shortfalls needed to be rectified.
●Senior staff checked the environment regularly to ensure safety. They had not identified that keys had been left in locked cabinets containing potentially hazardous items that may have posed a risk to people's safety.
●The rating from the last inspection was not displayed on the provider's website to ensure the public were informed. They immediately rectified this when we brought it to their attention however, this shortfall had not been identified through their existing governance systems.
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We recommend the provider reviews their current governance systems to ensure they are fully robust at identifying potential issues.

●The manager conducted regular analysis, and this had been effective at driving improvement within areas we had found serious shortfalls at our last inspection. This included monitoring that people had eaten and drank enough for their health, reducing the risk of people developing pressure areas and ensuring staff understood people's needs so they could provide them with safe care.
●Representatives of the provider regularly visited the service and conducted reviews of the care given. This had helped drive improvement within the service as had the introduction of a new management structure and team.
●The provider and manager had worked well with external authorities such as the local authority, to

improve the care people received.

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; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics;

At our last inspection in August 2020, we found there was not an open and inclusive culture within the home. People had not received care based on their individual needs and communication with people and relatives was poor. This had resulted in a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made in these areas and the provider was no longer in breach of regulation 17.

●People and relatives we spoke with were happy with the quality of care provided and told us things had improved since the new management team had been put in place. One person told us, "I am happy here. It's a nice home. [Manager] comes to speak with me most days. They are really nice, and the staff are kind and respectful." One relative said, "[Manager] has sent out a letter and we have had more communication from the home." Another relative said, "Communication has been better since [Manager] has been there, as there is more structure."
●There was a culture of openness where people, relatives and staff felt listened to and comfortable to raise concerns if needed. A relative said, "I have not had to raise a concern but [Manager] seems approachable and I feel I could go to them and they would listen. It feels nice and well run."
●Staff we spoke with were happy working in the service. They said they had been fully engaged in any changes made and had been supported well during the pandemic. They added communication to them had improved. For example, regular meetings had been held to ensure they understood their role and important issues had been discussed to enhance their knowledge and learning.
●The new manager was experienced and demonstrated a good understanding of the duty of candour and regulations. They had been open and transparent with people and relatives when things had gone wrong. We found the manager to be open and responsive to our feedback during the inspection.

At the inspection in August 2020, the provider had failed to notify us of incidents that we should have been told about by law. This was a breach of regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009.

Enough improvement had been made and the provider was no longer in breach of regulation 18.

●The provider and manager had ensured that incidents had been reported as is required. This included incidents of actual or alleged abuse, serious injuries and when people had passed away.