The Grange Care Centre (Eastington) Limited

The Grange Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Overall summary

The inspection was unannounced. This is the first inspection of the service since the registered provider altered the legal entity of the company. When we last visited the service in December 2013 there were breaches of legal requirements in respect of the care and welfare of people and the care records. We have checked during this inspection that the required improvements have been made to meet the relevant regulations.

The Grange Care Centre is registered to accommodate up to 75 predominantly older people who are living with dementia. The service is divided into four separate units called St George's, Adelaide, Victoria, and Hardwicke. All units provide nursing accommodation. At the time of our inspection there were 63 in residence.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

There was confusion regarding the management of the service. Relatives were not clear on the role of the registered manager and referred to another senior

Summary of findings

manager as being the first person they would talk to if they wanted to raise issues or discuss their relative. There were systems in place to monitor the quality and safety of the service but these were not overseen by the registered manager or the registered provider.

Staffing levels were compromised when staff took their lunch breaks together and potentially placed people at risk. This left one staff member to look after a group of people. The arrangements to supervise people required improvement.

The registered manager and staff team were knowledgeable about safeguarding issues, took the appropriate actions when concerns were raised and reported promptly to the relevant authorities. All staff received safeguarding adults training. The appropriate steps were in place to protect people from being harmed.

Risks were assessed and appropriate management plans were in place. The premises were well maintained and all maintenance checks were completed. Concerns that were raised with us previously regarding staffing levels at night had been addressed. Medicines were administered to people safely by the nurses and there were robust systems in place to ensure people received their medicines as prescribed.

Staff were provided with opportunities to develop their knowledge and skills to enable them to carry out their roles and responsibilities. There was an essential training programme that all new staff completed and a programme of refresher training. Care staff were encouraged to complete nationally recognised qualifications in health and social care.

Staff understood the principles of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS): they knew how to apply this to their role. The MCA provides the legal framework to assess people's capacity to make certain decisions. When people were assessed as not having the capacity to make a decision, best interest decisions were made and involved others who knew the person well. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty.

People were provided with sufficient food and drink and those people who were identified at risk of malnutrition or dehydration were monitored. There were measures in place to reduce or eliminate that risk. Arrangements were made for people to see their GP and other healthcare professionals as and when they needed to do so.

The staff team had good, kind and friendly relationships with the people they were looking. Relatives told us the staff were kind and friendly and always made them welcome when they visited. Staff paid attention to ensure that people's privacy and dignity was maintained at all times.

People were looked after in a way they preferred and did not cause them undue distress. Care and nursing staff provided support that met their specific needs. Relatives, or others who acted on their behalf were encouraged to express their views and opinions about the way people were looked after.

Summary of findings

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 fully safe.

People were protected from being harmed, and staff took the appropriate action to safeguard them. However, the arrangements in place to enable staff to take lunch breaks meant that people were left unsupervised for significant periods of time.

Risks to people's health and welfare were well managed.

The recruitment of new staff followed robust procedures and ensured only suitable staff were employed.

Medicines were managed safely.

Is the service effective?

Good

The service was effective.

People were looked after by staff who had the necessary knowledge and skills to meet their needs. Staff followed the Mental Capacity Act 2005 where people who lacked capacity to make a decision and made application under the Mental Capacity Act Deprivation of Liberty Safeguards where appropriate.

People were provided with food and drink that met their individual requirements.

People were supported to see their GP and other healthcare professionals as and when they needed to do so.

Is the service caring?

Good

The service was caring.

People were treated with respect and kindness and were at ease with the staff who were looking after them. The care staff had good relationships with them and talked respectfully about the people they looked after.

People were looked after in the way they wanted and staff took account of their personal choices and preferences. People were able to make decisions about how they were looked after where possible.

Is the service responsive?

Good

The service was responsive.

People received the care they needed. Their care needs were reviewed and kept up to date. There was a varied programme of activities appropriate for people living with dementia.

Those who acted on behalf of people living in the home were encouraged to make comments and have a say about how their relative was looked after.

Summary of findings

Is the service well-led?

The service was well-led but there was confusion about who the registered manager was. People, relatives and staff were positive about how the service was managed.

There was a programme of regular audits in order to monitor the quality and safety of the service however it was not possible to evidence that the registered provider and registered manager had an oversight of how things were going. There was no recorded systems in place to learn from any accidents, incidents or complaints.

Requires Improvement

The Grange Care Centre

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, and to provide a rating for the service under the Care Act 2014.

This was the first inspection of The Grange Care Centre since the provider re-registered the service with new company details in September 2014.

The inspection team consisted of two adult social care inspectors 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. Their area of expertise included nursing care and in particular dementia care.

Prior to the inspection we looked at all the information we had about the service. This information included the statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law. We would normally review the Provider Information Record (PIR) and previous inspection reports before any inspection, but because of the company change, the PIR had not been completed. We would have used the key information in the PIR to plan our inspection using, taking account of what they told us the service did well and the improvements they planned to make. When The Grange Care Centre was last inspected in December 2013 under the previous registered provider, improvements were required in meeting people's care and welfare needs and the care records.

We contacted six health and social care professionals as part of the pre-inspection planning process. This included GPs, specialist nurses, the commissioning and quality assurance team and an adult social care team manager from Gloucestershire County Council.

During the inspection we spoke with 11 people who lived at The Grange, nine visitors, 17 staff including the registered manager, five nurses, eight care staff and four ancillary staff. Not every person was able to express their views verbally. We therefore undertook a Short Observational Framework for Inspection session (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not tell us about their life in the home.

We looked at 10 care records to check that people's care needs had been assessed and they were provided with the care and support they needed, nine staff recruitment files and training records, staff duty rotas and other records relating to the management of the home.

Requires Improvement

Is the service safe?

Our findings

People who lived in the service were not able to tell us whether they felt safe. However they did say "I am quite okay here and they (staff) say I don't have to worry about a thing", "They all look after me very well" and "Yes of course, I have lived here a very long time and the staff are around to help me". Relatives or visitors felt that their loved ones were protected and secure and made the following comments: "I love the homely atmosphere" and "I feel so much better now I know they are happy and settled in The Grange". One relative whose spouse had moved to the service in the last couple of weeks said "I feel so much happier now that my relative is out of hospital. I have no concerns about their safety when I leave to go home".

Several relatives raised concerns about the availability of staff after lunch, one person said: "Sometimes there are no staff about, they all disappear, its probably their break time". Staff who worked 'long days' (7.30am – 8pm) took their lunch break from 1-2pm. The staffing available on each unit during this time was limited. On one unit, during this time, we observed one person touching another. There were no staff in this communal area to supervise people. In this instance the person stopped the interaction and walked away. This was discussed with the registered manager who acknowledged that staff breaks were an issue and agreed to review how this part of the day could be staffed more effectively.

There was no system in place to calculate the numbers of staff required to meet the collective needs of people. We were told that staffing numbers were increased when people were unwell or when the number of people living in the home increased. However, in practice staffing levels were arranged on numbers only (ie 1:5). Staffing rotas confirmed each unit was staffed separately. Care and nursing staff were allocated to work within specific units but could be moved to other units if needed. The nurses organised their own rotas and the team leaders completed the care rotas for day duty.

The night duty rota was organised by the administrator. During the day there were two or three nurses on duty plus three or four care staff per unit. Some staff said they would like to have more staff on a daily basis to enable them to "really provide more person centred care". Over night there were two nurses and minimum of four care staff on duty. We had concerns raised with us last year about staffing levels at night and at that time the registered manager advised us they had increased staffing numbers. Staff rota's we looked at confirmed there were two nurses and five care staff for most shifts on duty.

Agency staff were being used to cover vacant shifts. At the time of the inspection there were vacancies for one full time and one part time nurse for night duties and two full time care staff for day duty. Shifts also needed to be covered for staff who were on long term sick leave and maternity leave. A number of the agency staff were 'block booked' to cover shifts and were therefore familiar with the people they were looking after and the procedures in the service.

As well as the care team, the staffing team consisted of administrative staff, a training officer, catering staff, housekeeping and laundry staff, activities organisers and the maintenance team. The staff team were led by the registered manager and the clinical lead nurse. All staff confirmed they believed the staffing numbers meant they were able to provide safe care to people. One nurse said there was a good balance of experience and expertise within the team, with a combination of general and mental health trained staff.

Staff had good awareness of safeguarding issues and told us they would report any concerns they had about people's safety to the nurse on duty or the clinical lead nurse. Staff were able to tell us what constituted abuse and how they might recognise if a person was being harmed. They were aware they could report directly to Gloucestershire County Council safeguarding team or the Care Quality Commission.

Safeguarding training was included in the essential training programme, all staff had to complete this and was delivered via teaching sessions. The last session had taken place in November 2014 and the training officer was aware of which staff members were slightly overdue to complete their refresher training.

The clinical lead nurse had raised safeguarding alerts with the local authority when there had been concerns and was able to talk about actions that had been taken in the past. Key staff had completed a management of safeguarding level two training course with an external provider and there were plans for team leaders to attend a foundation safeguarding training course.

Requires Improvement

Is the service safe?

Risks assessments were completed for each person in respect of the likelihood of developing pressure ulcers, falls, continence, risks of malnutrition and moving and handling tasks. Where a person needed the staff to support or assist them with moving or transferring from one place to another a safe system for moving and handling activities was devised. These set out the equipment required and the number of care staff to undertake any task.

We saw other person-specific risk assessments had been completed, for example the risks associated with a person's unpredictable or challenging behaviour. In this case, the staff team had also received specific risk assessment training. Bed rail assessments were completed to determine whether they were safe to be used when the person was in bed. In the majority of cases they were considered to pose a greater risk and were not used. In this event the bed was kept at its lowest level with a soft mat by the side of the bed. Personal emergency evacuation plans (PEEP's) had been prepared for each person: these detailed the level of support the person would require in the event of a fire.

Any maintenance requests the staff team were aware of were recorded in a 'requests book' and this was checked on a daily basis. Tasks were either addressed by one of the maintenance team or external contractors were called in. Checks of the fire alarm system, fire fighting equipment, fire doors, hot and cold water temperatures were completed regularly and records maintained. All specialist hoisting equipment, baths, the passenger lift and the call bell system were serviced regularly and maintained in good working order. The kitchen staff recorded fridge and freezer temperatures, hot food temperatures, food storage and kitchen cleaning schedules.

Staff files were checked to ensure that safe recruitment procedures had been followed. Each of the files evidenced that robust recruitment procedures had been followed. Where there were gaps in employment history, this had been explored satisfactorily. One care workers written reference had been completed by a family member. Nursing & Midwifery Council checks had been completed for all nurses.

The recruitment policy had been due for review in August 2014 – this had not been completed but had already been identified by the registered manager. The policy stated that "There must be at least two interviewers at all times". Most interview notes were completed by one, and a staff member confirmed interviews for care and support staff were completed by just them. Nurses were interviewed by two senior staff and this was confirmed in one nurse's personnel file.

Criminal Records Bureau (CRB) checks, now called Disclosure and Barring Service (DBS) checks had been carried out for all staff. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they were previously barred from working with adults.

People were not able to look after their own medicines and these were administered by nurses at the prescribed times. All medicines were stored in locked medicine trollies or within locked cupboards. The room and fridge temperatures where medicines were stored were checked on a daily basis. Suitable arrangements were in place for storing those medicines which need additional security. Records showed that these medicines had been looked after safely.

Medicines were re-ordered every four weeks to ensure people's medicines were always available for them. When new supplies were delivered they were checked against the MAR charts and the prescriptions to ensure they were correct. The nurse signed in how many medicines were received.

We spent time with a nurse who was administering morning medicines to people in two units. The pharmacy provided printed four weekly medicines administration record (MAR) charts for staff to complete when people had taken their medicines. Where MAR charts were handwritten, the entry had been countersigned by another nurse in order to prevent errors. Charts would be handwritten if new medicines had been prescribed during the four week period, or changes had been made to the prescription.

If people required their medicines to be crushed or to be given covertly this was detailed on the MAR chart. Instructions were also detailed about how the person liked to take their medicines. Examples included 'likes to take tablets from the spoon', 'tablets all at once from the pot' and 'likes to take tablets one by one'. Some people were prescribed time-specific medicines and these were administered as prescribed. Where people were prescribed

Requires Improvement

Is the service safe?

medicines to be administered as and when needed (called PRN medicine), in all instances the nurse had not recorded the reason the medicine had been given. This may make it difficult to analyse the effectiveness of the medicine.

Where people were prescribed creams or ointments, the treatment was applied by the care staff. A separate creams chart was used to record the application. One nurse told us at the end of their shift they checked with the care staff that the creams had been applied and records had been completed.

Good

Is the service effective?

Our findings

People told us "Staff are always bustling around and doing everything for us", "They seem to know what they are doing so I let them get on with it" and "It is comforting to know that the staff are about and will help me if I need it. I was unwell a while back and the staff helped me get better". One relative said "I can no longer look after my relative, and the staff have taken on that role and seem very committed to getting it right. They have asked me for lots of information about their life. This is to help them settle in".

All staff spoken with confirmed they had an induction training programme to complete when they commenced in post, and that they received regular supervision and appraisal. During the induction period new staff spent time with the training officer and were monitored on a weekly basis. Practical skills monitoring was delegated to team leaders who worked with new staff members. Care staff had a common induction standards work book to complete, have an appraisal after 12 weeks and again at six months.

Staff told us that training was offered and encouraged. All staff had to complete a programme of essential training relevant to their role and then had refresher training on an on-going basis. One nurse told us, in addition to the essential training that all staff had to complete, they had completed venepuncture (taking blood samples), male catheterisation and manual handling assessor training. A shift leader told us they had completed parts one and two in dementia care.

Other staff said they were provided with any training needed to support them in their roles. One nurse had completed additional training to enable them to provide tissue viability and wound care guidance for the rest of the staff team and was also scheduled to receive a supra-pubic catheterisation update. Their view was that the team were supported to keep updated with regard to best practice and that the clinical lead nurse was supportive and encouraged their training and development.

There was a commitment by the provider to have a team of staff wth suitable skills and relevant qualifications. Thirty-two out of 56 care staff had achieved a health and social care qualification, four staff were in the process of working towards their qualifications and nine more were about to be enrolled on a course.

Staff were supported to carry out their duties to do their jobs. They received a handover report at the start of their shift. We observed a handover at 7.30am on the second day, given by the night nurse, to all the nurses and care staff coming on duty. The nurse reported about a newly admitted person, changes in one person's condition and people they had concerns about. We noticed that not all the care staff listened in full to the report. Staff were allocated the people they would be caring for by the team leaders. Staff told us if they had been on leave and needed more information they got this from their colleagues. Communication books were maintained on each unit, one for care staff and one for nursing staff.

Staff meetings were held regularly. These included those for night staff , senior care staff and senior meetings with the clinical lead nurse, nurses and the registered manager. Staff also had a supervision meeting with either a team leader, nurse or clinical lead nurse on a two monthly basis.

Nurses and care staff were able to tell us about the Mental Capacity Act 2005 (MCA). MCA legislation provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make decisions for themselves. Their understanding of the Deprivation of Liberty Safeguards (DoLS) was good. DoLS is a framework to approve the deprivation of liberty for a person when they lacked the capacity to consent to care or treatment. The safeguards legislation sets out an assessment process that must be undertaken before deprivation of liberty may be authorised. It details arrangements for renewing and challenging the authorisation of deprivation of liberty. Ninety per cent of the staff team had received their training on MCA and DoLS. One staff member said "We wouldn't assume people don't have capacity, we always assume they can make decisions" and "Sometimes people refuse personal care, they have the right to do this, we just wait and usually there is a 'window' when people are more receptive".

Mental capacity assessments had been completed for all day to day activities for each person. The assessments were reviewed after any changes in the person's needs or as required. Nurses talked with us about the MCA forms and DoLS applications that had been submitted and authorised. Although the Care Quality Commission had

Good

Is the service effective?

been notified when DoLS applications had been submitted they had not notified us when authorities were granted. The registered manager said they were unaware of this change in procedure.

One nurse explained that a person had an MCA assessment completed because of the need to administer covert medication. A record of the assessment and the best interests decision made along with the GP and the family was in the person's care records. One person had been assessed as needing constant supervision and was therefore supervised by a carer 24hrs per day. The care plan was clear and detailed how the supervision was to be undertaken, i.e. discreetly, but always within sight of the person.

Staff were clear about the use of restraint. They told us they would not restrain people to deliver personal care. They told us they would not physically restrain or undertake a responsive physical intervention with a person and that this was 'against the policy of the home'.

Where decisions had been made about end of life care the GP's had completed and signed a Do Not Resuscitate yellow sticker, that was placed at the front of their care records. These forms had however been replaced with formal nationally recognised Resuscitation Council forms. These forms allowed any consultations with relatives to be recorded along with the members of nursing staff included in the decision-making process.

We looked at the food service for people. On the first day cooked breakfast food (porridge and eggs) were placed on non-heated trolleys: the food was cold. We brought this to the attention of the registered manager On the second day the cooked breakfasts were served from hot trolleys in each unit.

Breakfast consisted of a range of cereals and toast, and cooked bacon and sausages was available four days a week. Staff had established people's likes and dislikes, and told us about those who liked to have a cooked breakfast when it was available.

There were no menus or visual food information available on display in the home. The registered manager said that information was displayed on a noticeboard in one of the dining rooms but when we looked we could only see two balloons stuck on the board.

The dining tables in St George's unit were laid after people were seated at the tables and plastic beakers with squash were given out to the 16 people there. Three staff were available in the dining room and meals were served from a hot trolley. The meal was meat and vegetable stew with dumplings and boiled potatoes. There was no choice offered and people were not told what the meal was. Some people needed soft textured or pureed food - the stew and the potatoes were pureed separately. At the end of the first day we told the registered manager that people had not been told what the meal was when they were served their lunch. On the second day people were told what the meal was when it was served to them.

Staff supported and encouraged people in the dining room in a kind and sensitive manner. They told us that people would be able to have an alternative choice if they did not like the meal. One person asked "What's for pudding?" When told it was a strawberry flavoured pudding, he said he didn't like that and was offered chocolate dessert. One person didn't eat their main meal and was asked if they wanted anything else: they appeared not to want to eat. Later we saw this was recorded in the daily care notes and reported to the nurse.

We watched what happened during lunch in Adelaide unit on day two. People were sat up to the tables in the dining area and then spent time waiting for up to 10 minutes whilst nothing happened. One person got up and returned to their comfy chair in the lounge area. People were asked where they wanted to sit and whether they wanted to go into the dining room or eat in the lounge. One person was heard saying "I want to help you, is there anything I can do": he was told to sit down so he walked out of the room. A gentleman asked what was for lunch and the carer replied "shepherds pie I think".

Some people had their meals in their bedrooms. On the first day care staff carried plates that were uncovered and not on a tray to people's bedrooms. Staff took both the main meal and dessert to people's bedrooms at the same time. One hour after the start of the meal one person who was asleep in their bedroom had a bowl of chocolate dessert in front of them. Care staff checked them frequently and explained that she tended to 'graze' and often took a long time to finish her food.

People were not given a choice at mealtimes. We met with the kitchen manager on the first day of the inspection. They confirmed one main meal was offered each day and frozen

Good

Is the service effective?

vegetables were served more often than fresh vegetables. There was a three week rolling menu, which was mainly adhered to: the whole menu was usually changed three times a year. The kitchen manager felt that the kitchen staff did not have the capacity to cook two main meals each day and said the only time two main meals were offered, was when a specific fish based meal was on the menu.

In addition to the main meals the kitchen manager told us that homemade cakes and fruit were served on most days with afternoon tea. At supper time people were provided with soup and sandwiches and a hot snack meal on alternate days. Plates of sandwiches were prepared for people to snack on later in the evening or during the night if needed.

A Malnutrition Universal Screening Tool (MUST) was used to assess each person's nutritional needs and then reviewed on a monthly basis. An assessment of oral care and hygiene needs was also completed. Eating and drinking care plans stated what type of diet the person required including the consistency of the food (normal, soft mashed or pureed). Reviews of the plans were completed monthly and included weight loss or gain, a review of eating and drinking habits and GP contact.

Monthly body weights were recorded for each person although this was done on a weekly basis for those at risk of poor dietary intake. A member of staff had been delegated the task of monitoring every person's nutritional status. When people chose not to be weighed, measurements of their upper arm circumference were recorded – this enabled the staff to determine the person's body mass index (BMI). When there had been a significant weight loss, a letter was sent to the GP to advise them of such. Food and fluid charts were maintained where the person's food and drink intake needed to be monitored. Those we looked at had been completed fully. Copies of each person's nutritional assessment, review forms, MUST scores and body weights were kept in the kitchen however not all of them were up to date.

The kitchen manager however was familiar with everyone's updated needs and could tell is who required fortified or 'special' diets. They had weekly meetings with the shift leaders for each unit where they discussed dietary requirements and any weight loss issues. The kitchen manager had already been told about a person being admitted and was aware of the outcome of the nutritional assessment.

Each person was registered with a local GP practice: we were told about 90% of them were registered with one practice where an NHS agreement was set up and included weekly GP visits to the home. Nurses also requested home visits whenever people were unwell. We asked two GP surgeries for their views and opinions about how their patients were looked after. They told us "Over the last few years we have had patients at this nursing home. I have been very impressed with their standards of care; the facilities are excellent and the nurses in charge are always informed and knowledgeable", "There are a number of very difficult patients with whom they deal sensitively", "Relatives are involved in decision making" and "We work collaboratively with the staff in the home to make sure that people get the best possible care. I have never had any concerns about my patients".

One GP said when relatives of people had raised concerns with them about the care of their loved one, they were aware that "everyone had done their best to resolve the issues but it was invariably due to a lack of understanding about dementia (by the relatives)". Nurses recorded all GP visits in people's care files: the same record did not record the outcome of the visit or any action to be taken.

Arrangements were in place for people to receive support from visiting opticians, dentists and chiropodists. The service worked alongside the hospital staff, community and hospital social workers, in order to make sure people were well looked after.

Good

Is the service caring?

Our findings

People told us “They are very kind to me”, “We only have to ask for help and they do so. If they are busy they explain they will come back in a minute” and “They all do their very best”. A large proportion of people were unable to tell us whether the staff were kind and caring so we spent several periods of time throughout the inspection watching the interactions between the care staff and the people they were looking after.

We observed positive exchanges between staff and people when helping them with activities such as jigsaw puzzles, art work, reading of the daily newspaper and talking about what was on the television. However we also saw some examples where things required improvement.. For example, when staff talked about people who could not eat their meals without assistance, we were told they “needed to be fed”. This terminology was demeaning and showed a lack of understanding, dignity and respect to people. Throughout the two day inspection the atmosphere was relaxed and from people’s body language and facial expressions they appeared to be comfortable with the care staff and the nurses.

Relatives were positive about the care provided. They said the care staff were “loving, caring and very patient” and “staff were very committed to their work and did a lovely job”. One relative who was a new visitor to the service said “The staff were so friendly and kind when I visited looking for a suitable home. I made my choice almost immediately”. Another said “There is a lovely homely atmosphere here and this had a great influence on my choosing The Grange”.

Two GPs told us the staff team “generally worked well with families and visitors and supported whilst they adjusted to the loss of their loved one to dementia”. They told us there had been times when relationships with families had “broken down” but “not because the staff team did not do their very best to resolve any issues”. One GP said “I have patients in other nursing homes. You cannot fault the care here and the devotion of the staff”.

During the inspection, there were two occasions when people became suddenly unwell. Both events were dealt with promptly and efficiently. Care staff ensured that each person’s dignity was maintained and that the person was comforted until they felt better.

We spoke with nurses and care staff about the people they were looking after. They were able to tell us about people’s previous life and the things they liked to do during the day to occupy their time. One nurse told us how they helped one person settle if they became agitated. Staff knew how to involve people in their care and ensured people were listened to. They told us about one person who liked to knit, one person who had their own particular chair they always wanted to sit in and another who liked to walk around freely.

Staff treated people with respect by talking to them in a kind and considerate way. They offered people choices, engaged with them in a friendly manner, shared humour at times and reassured those who were anxious or distressed. Staff were observed communicating with people appropriately and respectfully and used other methods of communication where needed. Staff said “We can find out in their care plan any issues with communication” and “family sometimes help us understand”.

Good

Is the service responsive?

Our findings

Relatives and friends were not aware of any relatives meetings and said that meetings would be useful. Comments included, "I would like those, so I could be involved more in my relatives care " and "It would be good as my friend will be here a long time and it is his home now". We spoke with one of the management team about these comments and were told that relative meetings had been tried before and been poorly attended, therefore they had an "open door policy" and relatives were always welcomed to raise any issues individually. Most relatives told us they would talk to nursing staff initially if they needed to, but wouldn't hesitate in accessing the home manager if an issue wasn't resolved. However there was confusion about who the home manager was.

Care files we looked at included information about the person's life, information about their dementia and other health needs and an assessment of their daily living needs. Each person was fully assessed before admission to ensure that the service was able to meet their needs. The assessments covered all aspects of the person's daily life, specifics about how their dementia presented and any nursing care needs. Individual personalised care plans were devised and detailed how personal care, mobility, eating and drinking needs, and continence needs were managed. Where people presented specific behaviours, plans were in place identifying any known triggers and what worked best to manage those behaviours. Following our previous inspection service significant improvements had been made with care plans. We found the care plans were well written, concise and direct and provided information about how planned care was to be provided. All care plans had been meaningfully reviewed and amendments made where a person's needs had changed.

Each care file contained a day profile and a night profile. These set out the routines that worked and did not distress the person. Care staff told us they were able to input into these profiles if they found that changes were needed and something else worked better. Care plans were reviewed on a monthly basis and any changes were recorded.

Some relatives were not aware of "about me" or life history records , but thought that this information may had been gathered previously on admission. They did say they had been asked to tell the staff about the person's past life, important dates and important life events.

All staff received a handover report from the nurse in charge of the previous shift and were told about significant happenings and any changes in people's health or welfare. We sat in on the handover report between the night staff and the day staff on day two: there was good exchange of information between the nurses and the care staff.

A programme of activities for people to participate in was led by an experienced activity organiser. The Activity organiser was outstanding and had through her own passion for learning, researched and implemented engaging and person centred activities. The programme consisted of different group activities and those undertaken with just one person. The activity organiser told us they planned activities based on people's life history and preferences. A group of people were supported to choose what afternoon film they were going to watch. One person was helped to do a jigsaw and another was having a dance with the staff member. We overheard a staff member having a conversation about a news topic with a person living with dementia who was confined to bed: even though the person was confused at times, the interaction had a positive effect and we heard laughter.

Requires Improvement

Is the service well-led?

Our findings

People were not able to tell us whether they thought the home was well-led or not. Relatives felt the service was "well run and managed well" however this comments were attributed to one of the senior members of staff and not the registered manager. Relatives were unaware of the responsibilities of the registered manager. One relative said "I thought (named person) was the manager" and another said "I have never seen the registered manager, I am not sure who you are referring to". It was evident from our conversations with not only relatives but also healthcare professionals who were in the home during the inspection that the care management role sat clearly with a senior manager and not the registered manager.

The registered manager told us they "walked the floor every day" but did not make notes of what they saw or any actions they may need to take. Whilst the registered manager showed us around the service at the beginning of the inspection we noticed areas where improvements were required. We saw care staff who were not wearing their uniforms appropriately but this went unchallenged. Later we looked at the services uniform policy: this stated the uniform was necessary to convey a professional and efficient image and failure to adhere to the policy would result in disciplinary discussions.

The programme of audits had been delegated to other key people in the staff team by the registered manager but the manager did not maintain an oversight to ensure that the audits and quality assurance checks had been completed. Medicine audits had been completed regularly by the clinical lead nurse and the head housekeeper checked each bedroom was maintained to an acceptable standard on a weekly basis. Care plans and risk assessments were regularly checked and we saw where amendments had been made to plans and assessments. The maintenance team had a programme of weekly, monthly and quarterly checks of equipment, fire safety equipment and water temperatures to complete. Although the provider had a programme of audits in place to monitor the quality and safety of the service, the registered manager relied upon other members of the team to complete these and did not have a system in place to ensure the checks had been completed.

The providers visited the service on at least a monthly basis. We were told they "walked around the building", spoke to staff and to people living there. No records of these visits were kept so there was no evidence that the registered provider was kept informed of any significant events or shortfalls within the service. This could affect their ability to fulfil the obligations of a registered provider.

Any falls, accidents or incidents that occurred resulted in a paper record being kept. We looked at the records for the last six months. The falls record log listed the number of falls each person had in a month. For one person there had been three falls in October 2014, three in November 2014 and one in December 2014. There was no analysis of the fall, what time of day it had happened and what actions had been taken. There was no identification of triggers or trends and this meant that preventative actions were not considered.

Staff were confident in the management of the home and felt that the managers were knowledgeable and effective leaders. However like the comments from the relatives, the senior manager rather than the registered manager was seen as the main point of reference in the majority of cases. Staff made the following comments: "I chose to work here after qualifying as a nurse as I did some student nurse placement work here and enjoyed it very much", "This is a good place to work", "Managers are supportive of nurses and their continuous professional development" and "Working here has built my confidence".

It was evident there were good working relationships between the staff team. In December 2014 anonymous comments were posted on the CQC website. We were told there were poor relationships between staff with a culture of bullying and harassment. We explored these issues indirectly with staff on duty during the inspection, however we did not receive any evidence to support those claims.

Staff said they generally worked in one particular unit and therefore got to know each person well. Care staff were employed as dedicated staff for one of the units but the nurses did rotate between the units so they knew everyone individually. The staffing structure within the service was as follows: the registered manager, the clinical lead nurse, nurses, senior care staff and shift leaders and care staff. The care team were supported by catering staff, housekeeping staff and an administrator in order to meet people's daily living needs. The clinical lead was working closely with the night staff team at the time of our inspection, in order to embed improvements with staff attitudes and culture that had been identified.

Requires Improvement

Is the service well-led?

Staff meetings were held regularly and records were kept of all meetings. There were regular night staff meetings, meetings with shift leaders and senior staff meetings with the nurses, the clinical lead nurse and the registered manager. Staff confirmed that there were regular meetings and if they were unable to attend a copy of the meeting notes were posted in the staff room.

The registered manager was aware when notifications of events had to be submitted to CQC and delegated this task to a senior manager. A notification is information about important events that have happened in the home and which the service is required by law to tell us about. The registered manager and senior manager however were unaware that notifications about deprivation of liberty applications had to be submitted after the outcome of that application was known.

A copy of the complaints procedure was displayed at each of the two entrances and also included in the service user guide, information about The Grange Care Centre. Relatives were given a copy of the guide so they would know what to do if they wanted to raise a concern or complaint. The procedure stated all complaints would be investigated and responded to in writing. The service had received five formal complaints in the last year and CQC had also been contacted about the issues the families raised. The records we looked at evidenced the actions taken by the management team and the providers but there had been no analysis of what went wrong and why the relationships had broken down with the families.

The Grange Care Centre considered itself to be a specialist service, did not demonstrate that best dementia care practice was embedded in the environment of the service. The opportunities to embrace environmental enhancements for people living with dementia were not present and there was little visual and cognitive additions to enhance their well being.

We recommend that guidance be sought from Dementia specialist organisations regarding environmental enhancements to benefit people living with dementia.