Grange Residential Homes Limited

# The Grange Residential Home

## Inspection report

The Grange
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Tel: 01284769887

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12 July 2016

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## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

| | |
|---|---|
| Is the service safe? | Requires Improvement |
| Is the service effective? | Requires Improvement |
| Is the service caring? | Requires Improvement |
| Is the service responsive? | Good |
| Is the service well-led? | Requires Improvement |

# Summary of findings

## Overall summary

The inspection took place on 12 July 2016 and was unannounced.

The service is registered to provide care and support for up to nine people with learning disabilities. At the time of our inspection eight people were using the service.

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. 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.
Staff were trained in safeguarding people from the risk of abuse and systems were in place to protect people from all forms of abuse including financial. Staff understood their responsibilities to report any safeguarding concerns they may have, although they did not know how to report concerns externally.

Risks had been assessed but actions had not always been taken to reduce these risks and some actions were not robust. Risk assessments were in place but some had not been appropriately reviewed. A new records system was being implemented and assessments were being updated as part of this project.

Staffing levels matched the assessed safe levels. Recruitment procedures, designed to ensure that staff were suitable for this type of work, were robust.

Medicines were administered safely and records related to medicines management were accurately completed. A concern was identified with regard to the management of medicines for people when they were away from the service.

Staff training was provided and regularly updated. Some relevant training had not been provided to all staff.

Staff had not received training in the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) at the time of our inspection but this has been provided since. The MCA and DoLS ensure that, where people lack capacity to make decisions for themselves, decisions are made in their best interests according to a structured process. Where people's liberty needs to be restricted for their own safety, this must done in accordance with legal requirements. An appropriate application had been made for one person but had not yet been authorised.

People were supported with their eating and drinking needs and staff helped people to maintain good health by supporting them with their day to day healthcare needs.

Staff were very caring and treated people with kindness making sure their dignity was maintained. Staff were positive about the job they did and enjoyed the relationships they had built with the people they were supporting and caring for. However, some decisions were made without due regard for the people who used

the service.

People, and their relatives, were involved in planning and reviewing their care and were encouraged to provide feedback on the service. Care plans were in the process of being reviewed in order to reflect people's current needs.

There was a complaints procedure but no formal complaints had been made. Informal concerns had been managed well.

Staff understood their roles and felt well supported by the management of the service, although structured supervision was not regular.

Quality assurance systems were in place and action had been taken to address any concerns. Record keeping was good and there was clear management oversight of the day to day running of the service. The manager had not submitted all the required notifications regarding health and safety matters to CQC.

We found a breach of regulations during this inspection. You can see what action we have told the provider to take at the back of this report.

## 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.

There were enough staff and recruitment systems were robust.

Systems were in place and staff were trained to safeguard people from abuse.

Risks were assessed but sometimes action was not taken to minimise risk or action was not robust.

Staff were trained to administer medicines and mostly managed well.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

Staff did not all receive the training they needed to carry out their roles and formal supervision of staff was not in place.

The service had followed legal requirements relating to the deprivation of people's liberty but knowledge of the MCA was not good and the service had not always operated in accordance with the legal framework of the MCA.

People were well supported with their dietary and healthcare needs.

### Is the service caring?

**Requires Improvement**

The service was caring but did not always uphold people's rights.

Staff were patient, compassionate and kind and relationships between staff and the people they were supporting were good.

It was not clear how people had been involved in all decisions about their care.

People were mostly treated with respect but some interactions and some written records were not respectful.

## Is the service responsive?

Good

The service was responsive.

People, and their relatives, were involved in assessing and planning care.

People's choices and preferences were recorded in their care plans and people were able to follow their own interests and hobbies.

There was a complaints procedure but there had been no formal complaints.

## Is the service well-led?

Requires Improvement

The service was not well led in all aspects

The familial culture of the service was welcomed by many but blurred professional boundaries.

The manager had not submitted the required notifications to CQC regarding serious health and safety matters.

Record keeping was good and there was good management oversight of the day to day running of the service.

# The Grange Residential Home

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 took place on 12 July 2016 and was unannounced.

The inspection team consisted of one inspector and one 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. Our expert had experience of services for people with learning disabilities and mental health needs.

Before we carried out our inspection we reviewed the information we held on the service. This included statutory notifications that had been sent to us in the last year. A notification is information about important events which the service is required to send us. We also reviewed the Provider Information Return (PIR). 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 six people who used the service, four relatives, four care staff and the registered manager. We also gathered feedback from Suffolk County Council provider support team who have particular responsibility for quality improvement in services and staff from the local adult social care team.

We reviewed three care plans, four medication records, two staff recruitment and induction files and four weeks of staffing rotas. We also reviewed quality and safety monitoring records and records relating to the maintenance of the service and equipment.

Requires Improvement

# Is the service safe?

## Our findings

People who used the service told us they felt safe. One person said, "I do feel safe. I know that there are good staff looking after me." Another said that if they were concerned about their safety, "I'd go to [member of staff]." We found that staff knew how to spot the signs of abuse and take appropriate action. Staff had received training in safeguarding people from abuse and were able to tell us what they would do if they suspected or witnessed abuse. They knew how to report issues within the service although they were not aware that concerns could also be reported directly to external agencies including the local authority and CQC, although this information was displayed at the service.

Safeguarding concerns at the service had been referred to the local authority but CQC had not been notified of a recent concern. We discussed this with the manager who was not aware that this was expected of them. They assured us they would learn from this.

We noted that one person had a history of walking into other people's bedrooms. The service had taken steps to protect people by giving each person a lock on their door and providing an alarm on the person's bedroom door so that staff would be alerted if the person had left their bedroom. Some people chose not to lock their door which meant that staff were required to remain vigilant in order to manage this potential risk.

We saw that risks associated with people's day to day activities such as, eating and drinking, bathing and taking medicines had been assessed. Actions had been put in place to reduce risks as much as possible. We found that staff were able to tell us, in detail, about people's assessed risks. Risk assessments, and all care records, were being transferred to an electronic system. Some assessments we saw had not been reviewed for some years but these were gradually being updated as they were uploaded onto the new system.

People's risk of falling had been assessed and one person had recently moved bedrooms so that they no longer had to negotiate the stairs. We noted however, that one person's room had been used by some visiting school children to change in. They had left their bags all over the floor which presented a clear trip hazard for this person, who was visually impaired.

People received care and support from staff who knew them very well. One relative told us, "They could do with more staff but they are first class in every way." Staff told us they felt there were enough staff on shift to meet people's needs and keep them safe. Many staff had been at the service for several years. Agency staff were used but there was always a permanent member of staff on shift. We looked at four weeks of rotas and saw that staffing levels matched the service's assessed safe levels. There was no on call system in place but staff told us that the manager lived close by and they were clear they would call her in any emergency.

We reviewed staff files and found that the service had recruited people safely and carried out all appropriate checks, including one with the Disclosure and Barring Service (DBS), to ensure that staff were suitable to work in this setting. Volunteers had also been recruited safely and had DBS checks in place.

There were systems in place for the safe ordering, storage, stocktaking, administration and disposal of medicines. Medicines were stored in suitably locked cabinets and clearly organised. Staff administered medicines in pairs, with one staff member checking the other's practice and staff confirmed to us that this always happened. Staff had received training in administering medicines. When a recent error with medicines administration had taken place the manager had retrained the member of staff and introduced a new system designed to ensure that the error was not repeated. People received medication reviews appropriately and medication procedures were audited by the manager.

Medication administration record (MAR) charts had been fully completed and there were protocols in place for prescribed medicines which people took only occasionally (PRN). Each person's consent to take their medicines had been sought and was documented, alongside their particular preferences as to how they liked to take their medicines. One person who used the service told us, "They give me 10 tablets a day. I have it at 8 o'clock, another at 3, another at 5 and another at 10. The staff do it for me."

We noted that there was some confusion with regard to one person's paracetamol. Records relating to the dose and frequency did not all match and it was not entirely clear how much should be given. The manager assured us they would clarify this. We also found that whilst most stocktaking measures were good, the stock of one medicine for epilepsy did not match records which meant that the person may have been administered one dose too few.

We also saw that, even though there were clear processes in place for administering people's medicines when they were on social leave, these involved removing tablets from the dosette box and putting them in clearly labelled bottles. Although this is a practical solution, this is classed as double dispensing and is not an acceptable practice with regard to safe medicines management.

Requires Improvement

# Is the service effective?

## Our findings

We saw that staff met people's needs in a skilled and competent manner which demonstrated that they knew the people well. We observed close relationships between the staff and the people they were supporting and caring for. One relative told us, "It is an amazing place. [My relative's] meds are done. They take [them] to the GP."

When staff first started working at the service they received a comprehensive induction and good support from the manager. New staff spent time shadowing permanent staff and then began to work as a full member of the team. We saw that where staff required additional support in their first few months, in order to complete their induction, the manager was happy to do this.

Although staff told us that they felt well supported we found that supervision was provided on an informal basis and that formal supervision sessions for permanent staff were not held regularly. Each person had an annual appraisal and was encouraged to develop their skills and take nationally recognised qualifications.

Training records showed that staff received training to help them carry out their roles. Although a variety of training was provided we saw that some training, including epilepsy and Makaton (a sign language used by some people with a learning disability) had not been provided for all staff, even though this was relevant to some people who used the service. One member of staff told us the staff team had asked for Makaton training on a number of occasions.

We noted that people's consent was not always established before care and treatment was provided. The manager and care staff had not received training in the Mental Capacity Act (MCA) 2005 at the time of our inspection but this has since been provided to all staff, except the most recently employed. Staff were clear about people having the right to make their own decisions on day to day matters such as how to spend their money but demonstrated that some more significant decisions were taken on people's behalf, either by staff or by relatives. This was not done in accordance with the MCA.

We saw that people who used the service had received treatment, such as an influenza vaccination, without their capacity to consent to this being assessed. There had been no Best Interests decision for those people who would not be able to give informed consent to this. In addition we saw that on one person's file there was a note stating that the person's relative did not want them to have a particular medical procedure. There was no assessment of this person's capacity to consent to this decision and no Best Interests meeting had been held. We spoke with a member of staff about this and the information they gave us indicated that the medical procedure would be an appropriate one for this person. However the member of staff showed no understanding of the principles of the MCA and stated, "[The relative] thought it too invasive. We've always gone along with that obviously."

Where a person's liberty and freedom to leave the service needed to be restricted for their own safety, an application has to be made to the local authority to comply with the Deprivation of Liberty Safeguards (DoLS). We saw that one application had been made to the local authority but this was awaiting

consideration by them. The person had bedrails fitted but there was no assessment of their capacity to consent to this on their file. We received conflicting information about this person's capacity from staff and the manager.

This was a breach of the Health and Social Care Act 2008 Regulated Activities Regulations (2014) – Regulation 11.

People who used the service were supported to eat a healthy and varied diet. They told us they enjoyed the food, with one person saying, "Very nice food here. I like salad with jacket potatoes. Another said, "My favourite food is salad. I do like chips." The cook demonstrated a detailed knowledge of people's likes and dislikes and devised the weekly menus in accordance with this. If people did not like the cooked option an alternative was offered. We noted one person being given a sandwich as they did not appear to like their meal. On the day of our inspection a party of local school children were visiting and we observed that the children were served first at lunchtime which meant some people were waiting a long time for their food which caused them to become distressed.

We saw that food and fluid charts were completed appropriately and people were encouraged to drink, although no choice of drink was offered. We observed one person had an adapted cup to help them drink independently and a person with a visual impairment had their food cut up to assist them to eat. There was a display relating to healthy foods in the kitchen and the people who used the service had taken part in a project to promote health through good food and increased activity. Although the display was rather more appropriate to a setting for children, it clearly demonstrated a commitment to health promotion on the part of the service.

People were supported with their healthcare needs and staff worked in partnership with a variety of healthcare professionals, including neurologists, psychiatrists and district nurses to meet people's needs. Records confirmed that people attended dentist and optician appointments regularly with the support of the staff.

The manager told us they had recently been waiting over six months for specific health input from two local healthcare teams. They had attempted to chase this up by phone but had not managed to escalate this successfully. In the intervening period staff were attempting to meet this person's healthcare needs without the input from these relevant healthcare professionals.

Requires Improvement

# Is the service caring?

## Our findings

There was a slightly mixed picture with regard to how people's independence was promoted and how they were treated with dignity and respect.

We observed that people appeared happy with the way staff provided care and support. Staff demonstrated that they knew people very well and the atmosphere was caring and supportive. One staff member described how they, and their colleagues, were skilled in calming a particular person when they became distressed. They told us, "We take [them] to a quiet spot. It could be anything that upsets [them] and [they] can't express what [they] want. ...All the staff know how to help calm [them]." Another staff member said, "We treat people with respect and honesty."

Staff supported people in a relaxed way and were compassionate and kind. Most people who used the service were very positive about the way staff treated them. One of the people who used the service said, "They are kind, alright. I get hugs." Another said, "I get woken up at 7 o'clock in the morning – have my cup of tea in bed!" A relative told us, "I have nothing but high praise for the staff." They also praised the homely environment saying, "It's as near to a home environment as you can get. [My relative] needs a small environment. People are patient and there is tie to chat." We observed this during our inspection and noted that staff spent time chatting to people a great deal.

We also received some comments which were less positive, such as, "[The manager] told her off." We observed one person being asked if they wanted a hot or a cold drink. They replied they wanted both and the manager said, "You can't have both." On another occasion a member of staff asked a person if they had finished their drink. When they answered that they had not they said, "Can you finish it then please." There appeared to be a lack of understanding on the part of some staff that people could make their own choices, small and large, and that these needed to be respected.

A relative told us that they were not happy with the way their relative was treated and said that, "Basic care is lacking. I just want her to be pleasantly treated." This opinion was very much in the minority, but their feelings were strong.

We saw that a large party of school children were visiting the service and had changed their clothes, leaving their bags in one person's bedroom. Although the manager told us they had asked the person concerned if they were happy with this we found this showed a lack of respect for the person's privacy. It was not entirely clear why the schoolchildren had been invited and for whose benefit. Although we saw people playing a board game with the children after lunch and some lovely interactions, mostly people who used the service and school children were fairly separate.

Written language used in care plans and daily notes was mostly very respectful. However we did also find entries such as, 'Can tell fibs, especially if [they] have done something wrong' and 'tells tales, can cry, will try and get others in trouble.' This language is not particularly respectful or professional.

People were involved in decisions about their care and support and had been involved in developing their care plans. People's personal information and care plans were kept private. One person told us, "[Staff member] is my keyworker. We talk about care plans – all about me." Information was mostly shared with people in a format that they understood. One person used a picture book to help them. However one person's care plan stated that they used Makaton to assist their communication we did not see staff using this and staff had not received training. Another person had an activity planner on their wall which was very out of date. When we asked them about it they said, "I can't read it because I can't read can I?"

Another person told us about how they spend their one to one time and stressed how much they enjoyed their keyworker's company. We observed one person had built a clear bond with a member of staff who supported them to do woodwork. Regular access to this hobby was found to be very beneficial to this person's wellbeing.

The manager told us that people were less independent than they had been in the past and nobody went out alone anymore. This was related to people's increasing age and also to their health conditions. Within the service people were encouraged to be independent, although some tasks, such as cooking, were done by staff. One person told us, "[Staff member] is my keyworker. He does the laundry and I do the hoovering and dusting." Another told us, "I do the ironing."

The service did not use an independent advocacy service but did communicate with relatives and involve them in decisions about people's care. One relative said, "They keep in touch. I am very pleased. I can assure you that [my relative] is well looked after." Relatives were free to visit the service whenever they wished and we noted people popping in during our inspection visit.

Good

# Is the service responsive?

## Our findings

A relative explained to us how happy they were with the way service had supported their relative to have a fulfilling life. They said, "[My relative] comes here but they always have their bag packed and ready to go back on a Sunday. Even I could not care for [my relative] as well as they do."

Each person had a care plan which was person centred and contained information staff needed to help guide them to offer the right support and care. Some information was not current but this was being updated as plans were moved to a much more person centred electronic system. This made reviewing plans difficult. Relatives had been invited to contribute to the new person centred plans. Basic information was available on each person and new and agency staff could refer to this, as well as asking more experienced colleagues.

People received care that responded to their individual needs and were positive about the way the service supported them. One person said, "I have a room alone which I am pleased about." Another described their various activities saying, "I get up first and have my bath and get dressed myself. I go to [day centre] on a Tuesday, it's not far. I do line dancing and card making. Monday I am here and I go to [day centre] on a Wednesday."

The service responded well to people's changing needs as they became older. Many people had been at the service a long time and we saw that actions, such as moving someone to a downstairs bedroom, had been put in place to accommodate people's declining mobility. A member of staff explained to us, "As residents are getting older we need to find things to keep their attention span. We need to keep people stimulated."

People spent their days in different ways and were supported to follow their own interests and hobbies. Several people were very involved with the local church and attended regularly. One person told us, "I go to prayer meetings on a Wednesday and church on a Sunday." Another person said, "I do like church. I like going to God's house." Other people pursued hobbies such as woodwork, zumba and gardening. We saw one person being supported to decorate their bedroom. A wall planner documented the various activities people had been involved with each week.

Consideration had been given to the deployment of staff. We saw that one member of staff had been found to get on particularly well with one person who used the service and we saw that this person was often supported by this member of staff.

Care review meetings were held to discuss people's care and to receive feedback. Formal reviews had not taken place with adult social care staff from the local authority but the manager was in the process of arranging this. In addition surveys were sent out annually to gather feedback from relatives and people connected with the service and feedback was broadly positive.

The service had a complaints policy in place. No formal complaints had been logged. Informal issues were dealt with well according to people we spoke with. One relative said, "All problems are sorted out really

quickly."

Requires Improvement

# Is the service well-led?

## Our findings

People were involved in the day to day running of the service and were consulted about the development of the service and all knew who the manager was. The manager and staff showed us little evidence of exactly how this consultation was achieved and the impression was that the manager made the decisions. For example, although inviting school children to spend the day at the service and inviting local scouts to come and do their badges at the service demonstrated a link to the local community, it wasn't clear who had issued the invitations and for whose benefit. Sometimes it was not clear whose home this was.

The service operated on a family model and this had many benefits and suited most of the people who used the service well. However, the service is not a family and we found that sometimes boundaries were blurred and the manager took on a parental role which was not always appropriate, although clearly well meaning. This service model provided further complications when concerns were raised, as they were with one set of relatives. The manager had employed several members of their immediate family to work in care roles at the service. The relatives who spoke with us had found this presented a barrier which the manager had not fully appreciated.

Staff were positive about the manager and the way the service was run. Staff who were not members of the manager's immediate family told us that they felt supported and never found that having so many family members working together presented any concerns to them. One staff member told us, "We have regular staff meetings. The manager tells us what she wants changed and then anyone can say anything."

The service was underpinned by Christian values, which all the people we spoke with shared. Bible quotes were displayed throughout the service and a prayer board had been put up at the request of the people who used the service.

The manager had not always kept CQC informed of significant matters relating to the health and welfare of people who used the service. We had not been informed of an accident which resulted in a serious injury for one person or of a recent safeguarding matter. It is a requirement to inform CQC of these matters.

We found that staff records were well organised and comprehensive. The new recording system for information related to the people who used the service was good and staff were confident in its use. Over time this will be a great asset to the service.

An audit system was in place to monitor the quality and safety of the service. Staff carried out daily checks, such as water and fridge temperatures and these were reviewed by the manager. A medicines audit was carried out and the manager had clear oversight of medicines issues and had responded promptly and effectively following an incident where there was an error related to medicines management.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>The provider had failed to ensure that care and treatment of people who used the service must only be provided with the consent of the relevant person. Regulation 11 (1) (2) (3). |