Prime Healthcare UK Limited

Ranelagh Grange Care Home

Inspection report

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Merseyside
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Ratings

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

Overall summary

We visited this service on the 17 December 2014. This visit was unannounced. A further announced visit was made to the service on 22 December 2014.

Ranelagh Grange Care Home is registered to provide accommodation for persons who require personal care. The home accommodates up to 35 people and bedrooms are located on the ground and first floor of the building.

The registered manager had been in post since August 2014. 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.

During our previous inspection of the home in March 2014 we found that improvements were needed in how records were managed.

At this inspection we found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

We found that the home did not always provide a safe environment for people to live. We saw that first floor windows were not fitted with appropriate restrictors and that fire doors were wedged open. We found that potential risks had not been considered or planned for in relation to equipment in use. We found that bed rails were in use but risks to the people using them had not been documented.

We found that improvements were needed in relation to planning people's care and support. Not all of the people living at the home for a short period of time had a care plan detailing how their needs and wishes were to be met.

Staff had an understanding of the Mental Capacity Act 2005. However, the provider was not always making sure people were free from restrictions. We found that the location was not meeting the requirements of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards. This meant that the rights of people who were not able to make or communicate their own decisions were not protected.

We found that records were not always in place or information was not recorded in relation to people's care needs, staff recruitment and supervision. Some records were stored in a manner that failed to protect people's personal information.

Information in the service user guide which informed people of what services they should expect whilst living at the home was out of date. This meant the people considering moving into the home and those living at the home did not have up to date information available.

We saw that there were no systems in place to obtain the views of people who use the service and their relatives. In addition we saw that the provider had insufficient systems in place to monitor and assess the quality of care and the environment in which people lived.

Sufficient staff were on duty to meet people's needs. Staff knew how to keep people safe from abuse. They demonstrated a good awareness of local safeguarding procedures and were clear on what action they would take in the event of a concern being raised.

We observed the registered manager and the staff team working well with the people they cared for. Staff were able to tell us about individuals likes and dislikes and how they supported people living with dementia.

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?
The service was not safe

We found that some areas of the home did not always promote people's safety and wellbeing. Fixtures and fittings were not in place or where not in use to protect people from harm.

People told us that they felt safe in the home. Staffing levels were sufficient to meet people's needs.

Inadequate

Is the service effective?
The service was not effective.

We found that no action had taken place to ensure that when required, people's rights in relation to decision making were maintained.

Not all of the people living at the home for a short period of time had a plan of care in place.

Records failed to demonstrate the care and support people required and the support and training staff received.

Inadequate

Is the service caring?
The service was not always caring

We observed staff treating people in a manner that respected their privacy and maintained their dignity. People told us that staff were kind and caring. Staff demonstrated a good knowledge of the people they supported and their day to day needs whilst living with dementia.

The service user guide did not contain up to date information about the service and therefore was not of benefit to the people who use the service.

Requires Improvement

Is the service responsive?
The service was not responsive.

Care planning documents were not consistently reviewed on a regular basis. This meant that changes to people's needs would not always be responded to.

People's personal records were not appropriately stored to protect their personal information.

Inadequate

Is the service well-led?
The service was not well-led.

The provider did not have effective systems in place to monitor the quality of care and service people received whilst living at the home. The views of people who used the service were not sought.

Summary of findings

The registered manager demonstrated a thorough knowledge of the people who lived at the home and the changes needed to improve the service.	

Ranelagh Grange Care 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.

This inspection took place on the 17 and 22 December 2014. The visit on the 17 December 2014 was unannounced. The second visit on the 22 December 2014 was announced.

The inspection team on the 17 December 2014 consisted of two adult social care inspectors and an expert by experience. An expert by experience is a person who has personal or professional experience of using this type of service. The expert by experience had experience in working with older people and people living with dementia.

We spent time observing the support and interactions people received whilst in communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with 15 people living at the home and eight of their visiting relatives. In addition we spoke with the registered manager, three members of staff and two visiting healthcare professionals.

We looked at areas throughout the building and the immediate outside grounds. We spent time looking at records relating to people's care needs and the records of five people in detail. We also looked at records relating to the management of the home which included duty rotas; policies and procedures in place and one recruitment file.

Before our inspection we reviewed all the information we held about the service. This included any notifications received from the registered manager, safeguarding referrals, complaints about the service and any other information from members of the public. We contacted the local authority intelligence and outcomes unit who told us that they had no immediate concerns regarding the service. We also contacted the local Healthwatch team. Healthwatch is the new independent consumer champion created to gather and represent the views of the public. They told us that they had no recent information regarding the service.

Inadequate

Is the service safe?

Our findings

People told us that they felt safe in the home. One person told us "Safe, yes I think so" and "I'm safe and happy here." Visiting relatives told us "Mum is safer here" and "It's not like the last place, she's safe and secure here."

However, we found that areas of people's living environment needed urgent improvements to minimise risk of harm to individuals. For example, we saw that first floor windows in people's bedrooms were not appropriately restricted. This created a risk as people would have been able to open the windows and climb through them with ease. This did not conform with the guidance of the Health and Safety Executive which states; Windows that are large enough to allow people to fall out should be restrained sufficiently to prevent such falls. The opening should be restricted to 100 mm or less Staff confirmed that in the past restrictors had been fitted to all windows, however, they told us they had been removed sometime ago. We saw that a risk assessment had been developed to consider the risks to people in having unrestricted windows on the first floor of the home. The risk assessment was detailed and stated that each window would be checked twice daily by staff. The registered manager of the service told us that these checks were not recorded. Following our visit the registered manager made arrangements for restrictors to be purchased and fitted to the windows.

A handle to one person's first floor bedroom window was loose and came away from the window when it was used. Staff stated that this issue had been reported as requiring repair four weeks prior to our visit. Failure to maintain equipment appropriately may result in people being put at unnecessary risk of harm.

We saw that designated fire doors were held open by door wedges. The wedging of fire doors would make them ineffective in the event needing to automatically close should a fire break out. The registered manager told us that this had been raised by the local fire and rescue service during their most recent inspection of the home.

We found that there was an unpleasant odour on the ground floor of the building. A visiting relative also told us that they had also experienced an unpleasant odour in the same area. The registered manager told us that they would investigate the reported odour. Staff told us that refurbishment of the building was on-going.

This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. as people using the service were not protected against the risks associated with unsafe or unsuitable premises.

We found that potential risks to people were not always assessed and planned for. We saw that bed rails were in use for two people. In addition to minimise people hurting themselves if they fell out of bed a cushioned floor mat had been placed at the side of a person's bed. No risk assessment had been developed to consider any potential risks that this equipment could present to individuals.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 as people using the service were not protected against the risks of receiving care or treatment that is inappropriate or unsafe.

Two visitors commented about the cleanliness of the home. One told us, "Its not clean, there are good and bad days when it's not as clean as it could be." Another visitor commented "Its not clean, often the dining room floor has food spilt which is not cleaned up." We visited the dining room several hours after lunch. We found chips on the floor left from lunch time which was both unhygienic but also created a slip hazard for people. Facilities were available in the main dining room for staff and visitors to make hot drinks and also to store food in a fridge. We saw food stored in the fridge inappropriately. For example, we saw a packet of pasta that was past its use by date by two weeks and opened cheese that was undated. The area used for preparing hot drinks, the microwave available and fridge were not clean and contained food debris.

We saw that a copy of the local authority's safeguarding procedures was available within the home. The registered manager and a senior member of staff demonstrated a good awareness of what action they would take if they felt that a person had been abused, or were at risk from abuse. The registered manager was able to give examples of situations that they had raised with the local safeguarding team. Training records demonstrated that the majority of

Inadequate

Is the service safe?

staff delivering care and support to people had completed an on-line course titled 'abuse in the care home.' Records showed that five staff who had not completed the training were scheduled to do so in February 2015.

The registered manager demonstrated a clear understanding of what was required to ensure that new staff were recruited appropriately and safely. We requested to see the recruitment files of the three most recently recruited staff members. We had access to one staff members records only as the registered manager was unable to locate the other records. They told us that this was due to the information not being appropriately filed at the time of our inspection.

Sufficient staff were on duty at the time of our visits. We did not observe people having to wait for care. Four staff and the registered manager were on duty to meeting the care needs of people. In addition, catering and ancillary staff were on duty to meet people's other needs. The registered manager demonstrated a computerised staff calculating tool that they used to ensure that sufficient staff were on duty to meet people's needs. They demonstrated that the staffing tool considered the care and support needs of people; the physical environment of the home and occasions in which people may challenge the service. The use of a detailed staffing tool helped the manager ensure that there were sufficient staff available to give people the support they required. On person told us, "If I ring the buzzer they come straight to me."

The registered manager told us that they were in the process of revising and updating the policy and procedures in relation to the management of people's medicines. We saw that detailed procedures were in use, however, these procedures failed to consider the most recent up to date guidance. For example, the policy and procedures failed to refer to National Institute of Clinical Excellence (NICE) guidance in relation to managing medicines in care homes. The NICE guidance dated 2014 provides recommendations for good practice on the systems and processes for managing medicines in care homes. We saw a senior member of staff supporting people to have their medicines on two occasions. We saw that people received their medicines in a safe, calm and unrushed manner. The member of staff confirmed that they had received training in the administration of medicines with the local authority and that they felt they had the knowledge to support people with their medicines safely.

We saw that medicines were stored safely in locked cabinets. Medication Administration Records (MAR) were completed by the staff once a person had taken their medicines to record what had been administered. We saw that the MAR had been completed at the time and date required.

Inadequate

Is the service effective?

Our findings

People told us positive things about the staff who supported them, five people described the staff as "Kind and caring" and one person told us, "The staff are very good and experienced."

People views on the meals served included; "Food is nicely cooked and served", "This reminds me of school dinners" and "The foods ok." One person told us, "You probably can have an alternative, but never thought to ask, just eat what I get or leave if I don't like it." People told us that they had a choice of what time they had breakfast. We observed two people enter the dining room after 11:00am. They each had cereal, toast, tea or coffee. One person told us, "I like to get up late."

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The registered manager demonstrated a good awareness of identifying the appropriate times in which to and how to apply for a DoLS on behalf of individuals. They had access to the local authority's policy and procedure on DoLS. The care records did not demonstrate that the principles of the Mental Capacity Act 2005 had been used when assessing an individual's ability to make a particular decision. For example Information made available to us regarding one person who consistently tried to leave the building demonstrated that DoLS applications should have been made in line with current guidance. At the time of this inspection no DoLS had been applied for that person or on behalf of any person who used the service The registered manager confirmed that there were no policies or procedures in place to inform or support best interests decisions made on behalf of people..

The lack of DoLS applications failed to ensure that the rights of people, who were not able to make or communicate their own decisions, were protected. **This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.**

Care planning documents showed that people's fluid intake had been monitored. Staff explained that this monitoring was to ensure that people received sufficient hydration for their needs. The fluid charts had pre-printed information to inform staff of the correct minimum recommended fluid intake for people of a specific weight. We saw that these records for a number of people had not been completed since October 2014. In addition we saw that information on the fluid intake charts failed to demonstrate that people had received their minimum recommended intake. There was no evidence that care planning records or monitoring charts had been reviewed. This demonstrated that people may be at risk from not receiving appropriate care and support as accurate records were not maintained. Staff told us they had received supervision with their manager every two to three months, had an annual appraisal and attended regular staff meetings. We asked to see evidence of staff supervision and the minutes to recent staff meetings. The registered manager told us that records were not maintained of staff supervision and that the minutes to the meetings had not been written. They told us that they recorded team meetings to capture the discussion and that staff had agreed to these recordings.

Training records failed to demonstrate that staff had undertaken all of the training required for their role. **This is a breach of Regulation 20 of the Health and Social Care Act 2008 (regulated Activities) regulation 2010.**

We visited the main kitchen and saw that three meals of spaghetti, egg and chips had been placed under an unlit grill. Staff told us that the meals belonged to people who had chosen not to eat the food at lunchtime. The meals had been uncovered for more than three hours. A member of staff disposed of the food immediately. Failure to store food appropriately could have an impact on people health and safety.

The majority of people were seen to take their meals into the communal dining room. Other people ate their meals in the lounge area. The menu was displayed in the dining room. We saw that a list of people's dietary needs and wishes was available in the kitchen. The list highlighted if an individual required a soft, diabetic, high fibre or a high calorie diet. Staff on duty demonstrated a good awareness of people's individual food likes and dislikes. They told us that people's preferences in relation to food and drinks were always sought prior to them moving into the home.

We sat in the dining room whilst lunch was served. Staff demonstrated that they knew people's likes and dislikes and were friendly and cheerful serving the food. Staff told

Inadequate

Is the service effective?

us that if a person didn't want the planned meal an alternative would be offered. We saw that there was no information available around the dining room to inform people of what alternative meals were available to them.

We observed people freely moving around the inside and outside of the building. Four people told us that they had a choice of what time they wished to get up in a morning and what time they went to bed.

The registered manager told us that all staff had or were planned to participate in an induction provided by the local authority. Staff training information demonstrated that the majority of staff had completed training in relation to the role of a care worker; abuse in the care home; infection control; moving and handling and managing challenging behaviour. The registered manager told us that the majority of training was delivered by DVD and that they were in the process of sourcing more local face to face training for the staff team. We spoke with a senior member of staff who told us that they thought they received sufficient training for their role.

A Church of England service takes place on a monthly basis within the home and one person received communion every week. The registered manager told us that both the monthly service and weekly communion were accessible to everyone. One person told us that the registered manager had arranged to take them and another two people to the local church on Christmas Eve to attend Mass. This helped ensure that people were supported to practice their faith whilst living in the home

Requires Improvement

Is the service caring?

Our findings

Five people described the staff as, “Kind and caring.” One person told us “I’m well looked after here and I’m very happy.” Another person told us, “The staff treat me well, they’re all very nice.” Other comments we received included; “Could have nothing better”, “I like it here”, “Staff know me well and treat me good” and “The staff are very good, polite and respectful.”

Visiting relatives told us, “The staff are caring and kind, but they all seem stressed out, they’re so busy” and “Staff are smashing.” Another relative told us, “Staff are very good, kind and caring. She [their relative] has a beautiful clean room and she’s very happy. Also they make us so welcome.”

We saw staff supporting people in a caring manner. For example, we saw people being supported to mobilise around the building in an unrushed manner and staff gave assurances when people needed it. Staff were able to tell us about how they cared for people and they demonstrated a good awareness of people’s likes and dislikes. For example, staff were able to describe people’s choices, likes and dislikes in relation to the times they got up in a morning and went to bed; how and where they liked to eat their meals and personal care preferences.

We saw staff reassuring people throughout our visit. For example, one person was concerned about the length of time they would have to wait until they could return to their home address. Staff discussed the person’s concerns and offered their reassurances. Another person told us of their concerns regarding their medication. Once this was brought to the registered manager’s attention we saw that the registered manager discussed the concern and that they reassured the person.

Throughout the majority of our visit we saw staff treating people with dignity and respect. For example, we saw staff spoke with people in a respectful manner and it was evident that positive relationships between people and the staff supporting them had been made. However, on one occasion we observed a practice that failed to protect a person’s privacy and dignity. We observed two members of staff talking by an open toilet door in which a person was in a state of undress. This practice demonstrated that staff failed to protect the person’s privacy and dignity.

Information was available to people in the form of a service user guide. The purpose of the service user guide was to provide information about the service provided to people living at the home and to people considering moving into the home. The information contained policies and procedures, and what services people could expect whilst residing at the home. We looked at the document and saw that the information had not been updated since 2007. For example, information relating to the registered manager was out of date, the document referred to the Care Home Regulations and the Commission for Social Care Inspection (CSCI), both these regulations and CSCI had not been in operation for several years. Failure to provide people with up to date information about the home may result in people making decisions that are not in their best interests.

Inadequate

Is the service responsive?

Our findings

People told us that the only thing they did was watch television. One person told us "We don't do much really" and another person told us "I'd like to do some line dancing or we could do some exercises in a chair." A visiting relative told us that there used to be an activities person but they had left and had not been replaced.

During the visit we found there was a lack of activities and stimulation for people. We observed people mainly sat in the communal lounges watching television. This demonstrated that a mentally and physically stimulating environment was not planned for people.

We also found concerns around care plans which could lead to a risk of people not receiving the care they required.

A number of people were living at the home for a short period of time. We saw that their needs had been assessed prior to them moving in. However, whilst we found that care plans were in place for people staying long term at the home, we found that care plans had not been developed for people living at the home for short periods of time. For example, one person's needs assessment stated that they had started to have increased low moods, agitation and memory difficulties. We saw, and staff confirmed that there was no plan of care as to how staff were to support the person with these needs. The person also had been prescribed medication to be taken when required. Care planning documents were not available to inform staff as to when this medication should be offered to the person. Individual staff were able to tell us in detail how they supported the person but failure to record information as to how people's needs were to be met meant there was a risk that people would not receive the care and support they required. None of the people spoken with were aware of the contents of their care plan.

The registered manager and staff told us that they had previously developed care plans for all people who stayed at the home for a short period, however, due to time constraints they had not been completed for some time.

Monthly reviews of care plans for those people with care plans in place were not consistently carried out. For example, one person's care plan for nutrition had not been reviewed since September 2014. For another person whose nutritional risk assessment stated that their needs had changed there was no reference to these changes in the person's care plan.

Failure to record people's up to date care needs may result in them not receiving the care and support they require **This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.**

We saw one notice that gave people information about how to raise a complaint about the service. This notice was situated behind a door that was permanently wedged open. This meant that the complaints procedure would be difficult for people to locate. The service user guide also contained the complaints procedure, however, this information out of date information in relation to the Care Quality Commission. A visiting relative told us "I never knew how to complain but after there was an issue social services were involved so I know now I can complain to [the registered manager] or social services if necessary." Two relatives told us that although there were some issues they were reluctant to complain in case it had an impact on their relatives care.

Inadequate

Is the service well-led?

Our findings

There was a registered manager in post who registered with the Care Quality Commission in August 2014. People told us positive things about the registered manager, for example, one person told us "The boss [the registered manager] is ok, I can talk to him." A visiting relative told us that the registered manager makes himself available and he listens. Two senior care staff supported the manager in the running of the service and to ensure that a senior member of staff was available at all times during the day and night. In order to provide this cover the registered manager was working split shifts throughout the day in order to support the staff team.

Relatives gave us mixed feedback as to how the staff communicated with them. One relative told us, "Communication with us is very good" but other relatives told us, "They call me sometimes but not always, it seems to be when they want me to take mum to hospital" and "They only let me know if they want me to take mum [to appointments] and sometimes I am not given much notice." Another relative told us about the introduction of the 24hr emergency phone number for the home. They told us that they had been given a card with the number on and if they had any concerns she could call.

People told us that the registered manager spoke with them often and that they were always around. However, none of the people spoken with or their relatives remembered being asked for feedback on the service either verbally or via a questionnaire. The registered manager told us that there was currently no system in place to formally gather the views of people who used the service and their relatives about how the service met their needs. They told us that they were planning to develop and 'on-line' survey for people to complete and that a paper version of the survey would also be available. A lack of opportunity for people to give their views on the service they received may result in people not having the opportunity to be express their thoughts and opinions. In addition, it fails to give the provider the opportunity to learn from people who live in the home and to plan and develop the service.

We saw that there were no effective systems in place for the monitoring of the service that people received. For example, we saw that people's care planning documents had not been reviewed on a regular basis. identified risks for individuals had not been assessed and planned for and the lack of review of records failed to identify when information was missing or required updating.

Identified environmental risks had not been addressed which could put people at risk from unnecessary harm. In addition, we saw that records were not completed appropriately for their purpose and other records required were not available. For example, records relating to staff supervision and training, staff meetings and recruitment and policies and procedures were not available. The registered manager told us that there was insufficient time to manage administration work as the priority was ensuring the comfort and welfare of people who used the service.

The home manager completed a weekly audit that was then sent to the provider. We saw that the audit requested information that included the cleanliness and security of the home; the funding of people; food choices; medicines storage and resident's choices. We had no access to any of the previously completed weekly audits as the registered manager told us that they were archived away inappropriately. A representative of the provider visited the home occasionally and they were available to contact by telephone at any time. No records of the provider visits were maintained.

This further demonstrated that there were insufficient monitoring systems in place to assess the quality of the service that people received. **This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.**

We saw that personal information relating to people who use the service and staff was not always protected. For example, we saw a downstairs vacant bedroom was being used to store records relating to people who use the service and staff. The room was unlocked which enabled anyone to have access to the information.

This demonstrated that information was not being managed in a manner that protected individual's personal and private information and **is a breach of Regulation 20 of the Health and Social Care Act 2008 (regulated Activities) regulation 2010.**

The registered manager demonstrated that they had clear ideas to improve the service in the future for the service which included the involvement of people who used the

Inadequate

Is the service well-led?

service and the promotion of people's, respect, independence and equality. However, there was no formal action plan in place to further develop the service. The registered manager demonstrated a clear understanding of the key challenges and improvements needed to be carried out around the home. The registered manager told us that the provider managed the budgets for the service.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance. Regulation 15 (1) (c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services People who use services were not protected from inappropriate or unsafe care as people's needs were not planned for to ensure their. welfare and safety. Regulation 9(1)(b)(i)(ii)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment People who use services were not protected from inappropriate care as no suitable arrangements were in place for obtaining, and acting in accordance with, the consent of service users in relation to the care provided to them.