1st Care Limited

Orrell Grange

Inspection report

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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?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

Orrell Grange provides accommodation and nursing care for thirty-six older people. It is situated in a residential area of Bootle with nearby facilities including shops, pubs and public transport.

This was an unannounced inspection which took place over two days on 31 July and 3 August 2015. The service was last inspected in July 2014 and was meeting standards at that time.

At the time of the inspection the previous registered manager had left the home. There was a new manager who had been in post for three weeks. They advised us they would be applying for registration. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Arrangements were in place for checking the environment to help ensure it was safe. There was a new management team in place since the last inspection of the home. The managers had carried out a review of the home's environment and identified that there were areas that required improvement.

When asked about medicines, people said they were supported well. We saw there were systems in place to monitor medication safety and that staff were trained and assessed to help ensure their competency so that people

Summary of findings

received their medicines safely. We identified some areas of medication management that needed to be improved. These included the accuracy of some records, monitoring of people on medicines that were given when necessary [PRN] or where there was choice of dosage. We also discussed the need to review and develop the medication auditing [checking] tool in use to help ensure issues were more clearly identified.

When we spoke with people living at Orrell Grange they told us they were settled and felt safe at the home. The staff we spoke with clearly described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported. All of the staff we spoke with were clear about the need to report any concerns they had.

To support the 32 people living in the home on the days of the inspection there was a minimum of two nurses, seven care staff and the manager currently working supernumerary to these numbers. The care staff were supported by ancillary staff such as a chef /cook and other kitchen staff as well as domestic staff daily. Staff reported these numbers had been consistent although there was some concern expressed that staff had left following the recent change in management. They were unsure what this meant for future staffing. We were told by managers that there was a staff analysis underway and this would be based on measuring the dependency of people living in the home and matching this to a staffing ratio. This process would continue to be developed.

We looked at how staff were recruited and the processes to ensure staff were suitable to work with vulnerable people. We saw the required checks had been made so that staff employed were 'fit' to work with vulnerable people.

We looked at whether the home was working within the legal framework of the Mental Capacity Act (2005) [MCA]. This is legislation to protect and empower people who may not be able to make their own decisions. We found examples of good practice in supporting people with decisions in their 'best interest' when they lacked capacity but this was not consistent and showed staff varied in their knowledge and understanding.

We were informed on the inspection that the home supported two people who were subject to a Deprivation of Liberty Safeguards authorisation [DoLS]. DoLS is part of the Mental Capacity Act (2005) and aims to ensure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom unless it is in their best interests. We found there was uncertainty regarding the legal status of one of the people and previous management had not reviewed this appropriately or submitted statutory notifications to inform the Care Quality Commission of the DoLS authorisations.

People told us the meals were good and well presented. We observed and spoke with people enjoying breakfast and lunch. We were told that there was choice available with meals.

We asked people if staff were polite, respectful and protected their privacy and dignity. We received positive responses. We looked at how staff supported people to use the toilet. We had received information prior to the inspection that people's privacy was compromised because the toilets near the lounge area were not suitable for people with high levels of disability. Managers told us they had identified this issue and there were plans to address this by developing the facilities.

People told us that staff generally responded to their care needs in a timely manner but we also found examples of staff not responding appropriately at times.

We received some concerning information before the inspection from relatives who were concerned that changes were being made to the home by the new managers and these were not being communicated effectively and people's opinions where not being taken into account. The relatives concerned felt unsure about the future of the home. We found there was a need to develop better systems of communication and feedback to get people's opinions about the homes development.

There was some information available in the home for people. We discussed some key information such as the complaints process and access to information regarding advocacy services. We were sent an updated copy of the homes 'Statement of Purpose' which provided accessible information; for example, regarding the complaints procedure and contact addresses for advocacy services.

We found people and their relatives were not fully involved in planning their care to help ensure it was more personalised and reflected their personal choices, preferences, likes and dislikes. We looked at the care

Summary of findings

record files for people who lived at the home. We found that care plans and records lacked recording of this information. There was minimal information about the social background, families, hobbies and interests of the people we reviewed. There was very little evidence in care plans reviewed of any communication with family. Relatives we spoke with said they had to ask for information and were not routinely involved in any care planning reviews. We saw one care record that had been recently audited to include more personalised information and reviews. We were told this standard was to be introduced with all people to help ensure a more consistent standard of personalised care.

We found the level of social activities in the home had reduced and people were not being provided with adequate planned social stimulation and activity during the day. The manager's action plan had identified this and told us some of the plans to develop this aspect of care.

We saw a complaints procedure was in place and people, including relatives, we spoke with were aware of how they could complain. We saw an example of one complaint that had been received and dealt with recently. This had been responded to appropriately.

The manager was able to evidence a series of quality assurance processes and audits carried out internally. We found some of these were not currently developed to ensure the most effective monitoring. For example the way accidents and incidents were recorded and monitored was confusing resulting in the manager not being aware of incidents occurring over the last few months. Currently there was no system for auditing these to help ensure trends or lessons to be learnt were identified. We were shown a new accident audit tool which would be used for this purpose.

Other auditing tools such as the medication audit and dependency assessment tool [used to measure the nursing dependency levels of people in the home and link this to adequate staffing] and infection control audits still needed further development.

At the time of the inspection there was a new management team in place. During the inspection we discussed some of the issues arising from this change. Because of the impact of the changes at the home we were aware, prior to the inspection, of unrest amongst some staff and also relatives of people living at the home who had contacted us. Managers agreed to introduce more communication systems such as group and face to face meetings, especially with relatives and people living at the home to ensure the changes were communicated effectively.

We found that the home had not notified us of people who had been placed on Deprivation of Liberty [DOLS] authorisations.

You can see what action we told the provider to take at the back of the full version of this report.

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 always safe.

We found that people had unnecessarily been exposed to a risk because some environmental hazards and incidents had not been reported through effectively or acted on.

Medicines administered were not always monitored safely. Medication administration records [MARs] were not always completed in line with the home's policies and good practice guidance. There was a lack of clear policy and monitoring of some medicines such as those to be given when needed [PRN].

Staff understood what abuse meant and knew the correct procedure to follow if they thought someone was being abused.

There were enough staff on duty at all times to help ensure people were cared for in a safe manner. Staff had been checked when they were recruited to ensure they were suitable to work with vulnerable adults.

Is the service effective?

Requires improvement

The service was not always effective.

We found the home was not consistent in supporting people to provide effective outcomes for their health and wellbeing.

We saw that the principals of the Mental Capacity Act (2005) had not been consistently followed.

We saw people's dietary needs were managed with reference to individual preferences and choice.

Staff said they were supported through induction, appraisal and the home's training programme.

Is the service caring?

Requires improvement

The service was not always caring.

We made observations of the people living at the home and saw they were relaxed and settled. People spoken with said staff were caring when they interacted with them.

Staff treated people with privacy and dignity when they carried out care. We identified some improvements needed to facilities to ensure privacy was always maintained. We identified examples when care needs were not responded to in a timely manner by staff.

Summary of findings

People we spoke with and relatives told us the manager and staff had not always communicated with them effectively about changes to the running of the home.

Is the service responsive?

Requires improvement

The service was not always responsive.

People's care was not planned so it was personalised and reflected their individual preferences and routines.

The activity programme for people living in the home needed to be developed.

A process for managing complaints was in place and people we spoke with and relatives were confident they could approach staff and make a complaint if they needed.

Is the service well-led?

Requires improvement

The service was not always well led.

The manager to the service was newly in post and was applying for registration to the Care Quality Commission.

We found the new managers to be 'open' and keen to develop the service but there needed to be better communication, in the short term and ongoing, with staff and people living at the home to develop a more positive culture.

There were currently a lack of systems in place to get feedback from people so that the service could be developed with respect to their needs and wishes.

Some of the systems for auditing the quality of the service needed further development.

Orrell Grange

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 checked 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 was an unannounced inspection which took place on 31 July and 3 August 2015. The inspection team consisted of an adult social care inspector, a specialist advisor 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. The specialist adviser was able to review individual aspects of nursing care.

We were able to access and review the Provider Information Return (PIR) as this has been completed and returned to the Commission before the inspection. The PIR 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 also reviewed other information we held about the service.

During the visit we were able to speak with 14 of the people who were staying at the home. We spoke with three visiting family members. As part of the inspection we also spoke with, and received feedback from a visiting health care professional who worked with the home to support people.

We spoke with 12 staff members including care/support staff and the manager and the operational manager for the provider. We looked at the care records for eight of the people staying at the home and other records including medication records, two staff recruitment files and other records relevant to the quality monitoring of the service. These included safety audits and quality audits.

We undertook general observations and looked round the home, including some people's bedrooms, bathrooms and the dining/lounge areas.

Requires improvement

Is the service safe?

Our findings

Arrangements were in place for checking the environment to ensure it was safe. For example, some recent health and safety audits were completed with respect to the nursing equipment in the home including specialised mattresses and mobility aids for people such as wheelchairs. We discussed maintenance with the maintenance person employed in the home. We were told there had been a lot of changes recently and the role of the maintenance person had been more clearly defined and designated. We were shown a range of daily and weekly checks being carried out including, safety checks for windows, hot water and fire safety checks. At the time of the inspection there was testing being carried out on the call bell system in the home. There was a system for staff to report general repairs.

Personal emergency evacuation plans [PEEP's] were available for the people resident in the home.

We spot checked other safety certificates for electrical safety, gas safety, mobility equipment and kitchen hygiene and these were up to date.

We were concerned that, despite these measures, that some aspects of health and safety and adaptation of the environment still needed attention. For example, regarding health and safety checks, there had been hot water checks made to ensure water was at a safe temperature for people to use but these had not included testing bath or shower temperatures where the risk of the effect of a scald was increased. We saw there were gates in place at the bottom of stairs. Staff told us these were for 'safety reasons'. These were not specified however and we did not see an assessment of why these were in place. We found they were constantly left open. We reported this to the manager. We looked in the laundry and saw this was very small for the size of the home. This had been discussed with the provider on previous inspections. Managers told us there were plans to develop the home's environment but the laundry was not considered an immediate priority. We did observe a lot of staff throughput however to access the back of the home. This presents as a risk to maintaining effective infection control. We discussed the need to review this issue in the shorter term.

These findings are a breach of Regulation 12(2)(d) & (h) HSCA 2008 (Regulated Activities) Regulations 2014.

When asked about medicines, people said they felt they were supported well. All the residents we spoke with said they received their medication on time. One person said, "I always check the time and the tablets to make sure they're the right ones, I've never been given the wrong ones." All the relatives told us as far as they knew people were getting their medication on time; there were no concerns raised about medicines.

Both nurses on shift were normally engaged in giving out medicines. The medicine round was split into two so that people could receive medications at a reasonable time. We saw the medications being given out on day one of the inspection and these were completed by 10.30am [morning round]. This was carried out safely so people got their medicines and they were recorded as per the home's policy; following each individual administration the records were completed by the staff. We were concerned with the observation on the second day of the inspection of an agency nurse taking medication to a person's room without the medication record or evidence of the person's identity. This could increase the risk of the person receiving the wrong medicines.

Although there were no people in the home who were having medicines given covertly [without their knowledge but in their best interest] we were able to see that nursing staff understood the principals involved in how this would be managed. The home had a medication policy which we saw. We saw the policy was due for review in April 2015 and the current policy does not contain any guidance with respect to the administration of medicines covertly. The manager said this would be addressed.

We looked at the medication administration records [MAR's] for six people. We found some anomalies with each of these. For example:

- Some people were prescribed creams for various skin conditions. We found the records relating to the administration of these were not accurate. We spoke to one care staff who said they had applied a person's cream that morning but had not recorded this. We found three records for people on creams – two had not been filled in for the previous three days and one had not been signed for the day previous. It was not possible to tell from the records whether people had had their creams applied. The manager said they had recently introduced the cream charts and staff needed reminding to complete these.

Requires improvement

Is the service safe?

- We found most of the records we saw did not have a date on them when medicines had been received. We had to refer to other records such as the controlled drug register [for one medicine] to get an accurate count of the number of tablets in stock. We also saw on occasions the amount of medicines in stock had not been 'carried over' to the new medication record when starting a new cycle. This was, again, confusing when trying to carry out a stock audit.
- We looked at records for people who were prescribed medicines to be taken 'PRN' [when required] including medicines prescribed for when people may be in pain. We found that some information was unavailable to guide staff how to administer medicines prescribed in this way. The importance of PRN care plan to support administration is that staff have a consistent understanding of why and in what circumstances the medication is given and administration can be consistent and can also be regularly reviewed.
- We found a similar situation with respect to people who were on a 'variable' dose of a medication. When people were prescribed medicines which had a choice of dose [for example one person on paracetamol which needs monitoring accurately to ensure dosage is not exceeded over 24 hours] we found there was no information recorded to guide staff when selecting the appropriate dose of medication for each person. It is important that this information is recorded to ensure people were given their medicines safely and consistently.
- One person had medication for pain control via a seven day slow release analgesic patch applied to their skin. This had been prescribed and marked clearly on the MAR when it was due for replacement. However there was no indication where the patch had been applied or a daily signature identifying staff had observed the patch remained in place and medication continued to be administered. It was not clear from the records whether the patch was still in place and the medication was being administered.

The medication administration records did not always support a safe practice.

We looked at how medicines were audited. We were shown the current auditing tool used. Continued audit checks helped ensure safe practice as they would identify issues that could be fed back to staff to help improve safe administration. The audit tool was brief and lacked detail. We discussed how the audit could be improved to include some areas that we found to be less consistent. Some of the issues we identified such as the lack of PRN care plans and inconsistent records for the application of creams were on the audit tool but had not been identified on recent audits carried out.

These findings are a breach of Regulation 12(f) & (g) of the HSCA 2008 (Regulated Activities) Regulations 2014.

The Provider Information Return [PIR]sent by the provider before the inspection told us that all nursing staff are being enrolled on medication updates / training with the local pharmacist and will also complete medication competency assessments.

We asked the people living at Orrell Grange and their relatives if they felt safe and were ever concerned about anything. People were generally positive in their response. One person said, "I can't say why, but I feel safe". Another person said, "It's well established, there's plenty of people looking out for you." Other comments were; "There are so many people around", "The security generally is good, I've never been frightened, the staff are approachable".

A relative said "The staff are good, the medical side is good." Another relative commented, "They make sure [person] doesn't fall". One relative commented on the recent changes in the home which has seen new management and staffing. They were concerned that staffing may be affected as some staff had already left; ''I'm concerned that if they're changing the contracts and cutting the hours down. We've been told this by staff this can't be good for the residents.''

We checked the staffing in the home. People we spoke with varied in their responses when we asked them specifically about staffing levels and whether they thought there was enough staff on duty day and night to meet their needs. Comments made included; "At the moment everything is fine", "Not really (enough staff), they're always rushing round, I feel sorry for them", "Sometimes I wait a bit longer than I'd like, it depends on what they're doing.'' A relative said, "Sometimes [person] can wait for 25 -30 minutes to be repositioned." Another relative reported, "Sometimes no [not enough staff], especially when they're needing the toilet, but I don't think it's a regular thing."

Requires improvement

Is the service safe?

We spent time in the lounge and dining area. We saw staff present to support people. We saw people receiving support to mobilise [for example] and staff were not hurried and took their time to ensure people's safety and wellbeing. We did test out the ability of staff to respond in good time to call bells and found this was compromised when staff were busy doing other duties.

To support the 32 people living in the home on the days of the inspection there was a minimum of two nurses', seven care staff and the manager currently working supernumerary to these numbers. The care staff were supported by ancillary staff such as a chef /cook and other kitchen staff as well as domestic staff daily. Staff reported these numbers had been consistent although there was some concern expressed that staff had left following the recent change in management. They were unsure what this meant for future staffing.

We discussed these concerns with the manager and Operations Director for the provider. We were told that there was a staff analysis underway. This followed a report by the Operations Director into the current working of the home. We were told this would be based on measuring the dependency of people living in the home and matching this to a staffing ratio. We were shown the company's preferred dependency rating tool. We discussed the fact that the tool did not rate anybody in the home as 'high dependency' despite there being an apparent high level of nursing and personal care needs. The manager showed us another tool which they preferred and agreed a review of the dependency tool was important for future staff planning. We were advised following the inspection that the dependency tool had been revised and was in use.

We looked at how staff were recruited and the processes to ensure staff were suitable to work with vulnerable people. We looked at two staff files for staff recently recruited and asked the manager for copies of appropriate applications, references and necessary checks that had been carried out. We saw these checks had been made so that staff employed were 'fit' to work with vulnerable people.

The staff we spoke with clearly described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported. We spoke with staff who told us they had undergone specific training in safeguarding and how to report abuse although they said this had been a 'while ago'. The new manager had started to complete a training analysis and there was a planned session regarding safeguarding as we were inspecting. All of the staff we spoke with were clear about the need to report through any concerns they had.

There had been three safeguarding incidents that had occurred at Orrell Grange since April 2015. None of these were reported by the home but by visiting health care professionals or relatives who had raised concerns. The concerns were around the nursing and personal care of the three people highlighted in the allegations. The safeguarding investigations highlighted concerns with a person receiving end of life care, pain management and the quality of the information contained in people's care files including the care planning.

The home demonstrated they were keen to liaise and work with the local authority safeguarding team and agreed protocols had been followed in terms of receiving feedback regarding these issues. This approach helped ensure people were kept safe and their rights upheld. We saw that the local contact numbers for the Local Authority safeguarding team were available and a policy was available for staff to follow.

We discussed some of the limitations of the current environment of the home. The home had been purpose built a number of years ago but the care needs of the people admitted had changed in recent years and people's care needs were now more acute. This meant an increased use of nursing equipment. There were obvious storage issues that the provider was trying to address as well as some needed adaptations to the home. More space had been created with the addition of a conservatory since the last inspection. We were told of some work in progress however including the creation of a disabled toilet near the day room and new office accommodation being developed. We received an update for the Operations Director following the inspection which gave further detail and clarification to this.

Requires improvement

Is the service effective?

Our findings

Prior to our inspection we received the outcome of two safeguarding investigations carried out by Sefton safeguarding team in July 2015. These raised concerns regarding the nursing care of the two people concerned.

In the first instance there were concerns around the findings for a person receiving palliative care who was also at risk of acquiring a pressure ulcer. The safeguarding team found that care planning lacked necessary detail so that the person's health care needs could be carried out safely. For example the person's urinary catheter was not changed within the prescribed time frame; significant needs such as the monitoring of pain lacked adequate care planning to support staff in their care; a lack of detail regarding wound care so it was difficult to trace the wound care history; lack of assessments regarding equipment used to carry out care and lack of assessment regarding a history of falls.

The second safeguarding feedback also raised concerns around the monitoring of peoples health care needs. This was with respect to accuracy of past medical history; detail of records such as body maps and accident records; review of health care needs [care planning]; monitoring of skin condition; and nursing staff adhering to standards of record keeping.

During our inspection we reviewed the nursing and health care for four of the people living at Orrell Grange. One of the people we reviewed was able to communicate fully and said they had experienced good care and support. They had been in the home for a number of years and knew the staff well. The person had care needs around a pressure ulcer and they told us this was improving. We found the wound was well documented and monitored by the nursing staff and where there had been a need for referral for extra health care support this had been made. Records and care planning gave a clear history and we were able to follow the care given.

We found, however, this was not consistent and we identified issues with each of the other three people reviewed which reflected the findings of the safeguarding team. For example, one person had specific care needs around the management of pain. We were informed the person screamed out with pain when being moved sometimes. There was no pain management chart either in the person's room or care records. The nurse was aware the person was on pain relief medication but there was no review of its effectivness. There was no clear moving and handling chart visible in the person's room or care record that identified the appropriate technique for moving the person to minimise pain. The 'positional' chart we saw in the bedroom did not contain information of when the person was last moved.

The person had a specific medical condition that required monitoring and specific first aid intervention if the condition displayed itself. There was no care plan regarding this condition or risk assessment and plan of action if they needed emergency intervention. There was a lack of detail regarding the medical history. The feed regime in the care plan did not appear easy to follow and was unclear regards the person's ability to tolerate oral fluids and diet. We saw the person's finger nails were getting long and beginning to 'cut' into the palm. There appeared to be no evidence in daily records or care plans when nails needed cutting.

In another example we saw a person's eating and drinking care plan identified they had 'a good appetite and eats a soft diet but may need assistance due to her dementia'. The person was totally dependent on carers to administer food and fluids. There was no support plan or reference to thickened fluids, yet thickened fluids were administered along with a pureed diet.

This was also unclear with another person. It was unclear from the care plan if they could tolerate a pureed diet. The care worker providing support was unaware and informed us the person's feeding was the responsibility of nursing staff only. However when we spoke to relatives we were informed the relative gave thickened fluids occasionally and showed us a can of 'thick and easy' in the person's room.

It is important that clear information is available in care records regarding the consistency of thickened fluids as there is a risk of choking if not monitored effectively.

The action plan for the home devised by the new management team highlights the management of some of these issues, in particular the management of pain, as an issue that needs improving.

These findings are a breach of Regulation 9(3)(b)(h) of the HSCA 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service effective?

We looked to see if the service was working within the legal framework of the Mental Capacity Act (2005) [MCA]. This is legislation to protect and empower people who may not be able to make their own decisions. Many people being supported at the home had the capacity to make decisions regarding their care. We saw examples where people had been supported and included to make key decisions regarding their care. For example we looked at three people who had had DNACPR [do not attempt cardio pulmonary resuscitate] decisions agreed and made. This showed people had been consulted and consent given and followed good practice guidance in line with the MCA. Where there needed to be a test of the person's mental capacity to be involved in the decision, this had been referenced.

In another example we saw a 'best interest' decision had been made with respect to the use of a lap belt on a chair and bedrails as measures to reduce the risk of the person falling / injuring themselves. We saw this decision had included input from health and social care professionals involved with the person's care.

There were inconsistencies however which showed that staff needed to develop a fuller understanding of best practice with respect to consent. For example we saw two examples of mental capacity assessments made for care interventions when the people involved clearly had capacity to consent. One was a person who had full mental capacity had a best interest decision assessment in their care plan with reference to staff administering their medication; the other was for consent around the use of bedrails for a person.

We also found many 'generic' assessments being made to cover consent around general care issues which were not specific. The home's action plan identified this and states, 'all mental capacity assessments undertaken must be issue specific'. This is the underlying principle of the MCA. On occasions we found that when best interest decisions were made there was a lack of evidence to show the input of relatives in terms of speaking as advocates for people who lacked capacity and whether they had been consulted as part of the decision making process.

The managers had highlighted further training was required for staff regarding the MCA.

We were informed on the inspection that the home supported two people with a Deprivation of Liberty Safeguards authorisation [DoLS]. DoLS is part of the Mental Capacity Act (2005) and aims to ensure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom unless it is in their best interests. When we reviewed these people we found one had clear documentation in place [a 'standard authorisation'] showing an assessment and authorisation had been issued by the Local Authority for the restriction in place which was seen to deprive the person of their liberty in their best interest to ensure their safety. The second person's records did not support they were on a DoLS order. The authorisation in place was from a previous care home but had not been reviewed. This has been reviewed since the inspection and an application submitted to the Local Authority for an assessment and authorisation.

These findings are a breach of Regulation 11 of the HSCA 2008 (Regulated Activities) Regulations 2014.

People living at Orrell Grange told us they felt staff were competent and able to carry out care. We looked at the training and support in place for staff. The training matrix for staff was updated by the Home manager. We could see areas of training updates for staff that needed attention; for example training around the Mental Capacity Act 2005, Deprivation of Liberty Safeguards and infection control. Managers explained that a training audit had been conducted and there was a full training programme in place to address the shortfalls. This was highlighted on the management action plan being worked towards. At the time of the inspection we saw training sessions being carried out for staff covering safeguarding of vulnerable adults, first aid, infection control, health and safety, dignity and respect and food awareness. All staff had recently received training in COSHH [Control of Substances Hazardous to Health].

When we spoke with staff they told us they had received training in the past but this had been sporadic at times. The staff we spoke with had qualifications at NVQ / diploma in care level. We were informed that at least 80% of the care staff had such a qualification.

Nursing staff varied in their experience and clinical updates. We spoke with one nurse who had good background and experience in palliative care and leadership; other nurses had less experience or evidence of current update. The managers explained that the training and support programme included nursing staff. This would start with supporting nurses to attended medication awareness

Requires improvement

Is the service effective?

updates. The manager informed us that all of the nursing staff had been in receipt of a personal supervision session over the last three weeks to get a baseline for support needed.

We asked about the food in the home. We had a variety of responses but most were favorable and the overall consensus was that the food was good. Comments included: "It's very good really, all my food is pureed, it's tasty", "It's passable. I don't know if I get a choice, but I get enough. I always wait until the drinks come round, but there's enough staff to get you one if you want one", "The food's good, I've just got no appetite at the moment" and "It's quite alright, I'm on a certain diet and the kitchen sticks to it, they're very good.''

Relatives we spoke with felt similar but they did comment that there should be a menu to choose from. During our visit we witnessed drinks and biscuits being served in the morning and afternoon periods. Those residents who preferred to stay in their rooms were provided with jugs of water or juice.

We observed [and joined in with] the lunchtime meal. For those people who didn't want the main meal, they were offered soup and sandwiches. The sandwiches were served on a variety of bread and barm-cakes both white and brown. Pudding was cake and custard or yoghurt.

Requires improvement

Is the service caring?

Our findings

We asked people if staff were polite, respectful and protected their privacy and dignity. We received mainly positive responses. Comments included: ''The staff are all nice", "They are very good, there's no faults there", "They're lovely'', ''They are very short staffed sometimes, the toilets are a problem, and I have to wait ages to get off the toilet" and "Everyone is so good, they all treat me right, they go out of their way to help you''.

We looked in more detail how staff supported people to use the toilet. We had received information prior to the inspection that people's privacy was compromised. This was because the toilets near the lounge area were not suitable for people with high levels of disability. For example many people at Orrell Grange now need to be moved using a hoist. Because the door to the toilet had to be left open to accommodate the hoist people had been exposed to view. We saw that the problem had been addressed by the use of a curtain placed on the corridor to protect people from view when using the toilet. Managers told us they had identified the issue and there were plans to address this by developing the facilities. We received confirmation following the inspection that the necessary work would be completed in the near future.

At other times people told us staff closed their bedroom doors during personal care and that staff knocked before entering.

We asked whether people felt listened to and whether their views and opinions were sought and acted on. We received some concerning information before the inspection from relatives who were concerned that changes were being made to the home by the new managers and these were not being communicated effectively and people's opinions where not being taken into account. The relatives concerned felt unsure about the future of the home.

People told us during the inspection they had not been involved in meetings with managers or staff and had not fed back via any other means such as surveys. One person said they had attended meetings in the past and completed a survey but this had been a while ago 'and nothing changed'.

We asked the new manager whether there had been any meetings with people living at the home and their relatives regarding the new changes being implemented over the past five / six months. We were told there had been no formal meetings or any other communications to survey opinion. Following discussion the Operations Director and the home manager advised us they would organise a meeting the following week. We saw this being advertised before we completed the inspection. We were also shown the draft of a letter outlining some of the changes which we were told would be sent to the people living at the home and their relatives. We received information following the inspection from the Operations Director that the meeting had been well attended and had helped to allay people's anxieties.

Staff told us that they did spend time 'talking' with people although time for this was limited due to the amount of physical care work needed on a daily basis. We made observations at times throughout the inspection. The interactive skills displayed by the staff when engaged with people were seen to enhance people's sense of wellbeing and were positive. We saw, however, staff did not always respond in a timely and flexible way so people did not have to wait if they needed support. For example we spent time with one person in their bedroom. They indicated they needed a drink but there was no glass available. We pressed the call bell [this was out of reach for the person concerned] and staff did not respond. We waited ten minutes before going to find a staff member.

There was some information available in the home for people which were displayed in the entrance foyer. We discussed some key information such as the complaints process and access to information regarding advocacy services. The Operations Director sent us an updated copy of the homes 'Statement of Purpose' which provided accessible information regarding the complaints procedure and contact addresses for advocacy services.

We asked about people receiving care at the end of their life and whether they had been consulted about any wishes or plans. We were told there were no people currently receiving end of life care. We reviewed one person who was frail and looked at whether any consideration had been given to advanced planning around end of life wishes if there was a sudden deterioration in the person's health. We were told by staff advance care planning was only undertaken when it was appropriate to discuss 'Do not attempt cardio pulmonary resuscitation' (DNACPR). The person concerned did have a DNACPR in place with a print out of the 'six steps to success' framework around end of

Requires improvement

Is the service caring?

life care. However there was no documentation identifying the person's choices about end of life care or what support their family would require when they were closer to dying. We saw the care plan which stated 'end of life was not discussed with [person] as it would worry [them]'. This identified the person may have capacity to make their own decisions if given the right information in a compassionate and empathic way. There was no follow through documented on how this 'worry' would affect the person as they became less well or how staff planned to minimise the concern.

Requires improvement

Is the service responsive?

Our findings

We asked people and their relatives how staff involved them in planning their care to help ensure it was more personalised and reflected their personal choices, preferences, likes and dislikes. People were not clear about this. One person said, "I don't think they're into that really, but they know this is my chair.'' Another person said "It's a hard one to answer, I wouldn't like to say."

This extended to the way personal care was delivered. For example nobody had been formally asked or given a choice about who provided personal care. One woman said "No you can't choose, I have male carers and I'm happy to have him bath and dress me." Another women replied similarly; they 'didn't mind' but had not been asked or given a choice.

We looked at the care record files for people who lived at the home. We found that care plans and records lacked recording of this information. For example some care records highlighted the person's religion on admission but there was no follow up regarding whether this was practiced.

There was minimal information about the social background, families, hobbies and interests of the people we reviewed. There was very little evidence in care plans reviewed of any communication with family. Relatives we spoke with said they had to ask for information and were not routinely involved in any care planning reviews. One relative said, ''They don't involve us.'' Another said, '' I'm not sure about a care plan, it's probably planned around routine.''

We discussed this with the manager who showed us a care record that had been recently audited to include more personalised information and reviews. We were told this standard was to be introduced with all people to help ensure a more consistent standard of personalised care. The manager's action plan shared with us identifies this issue and states, 'care records must show evidence of collaborative and consultative partnership working with people using the service'.

These findings are a breach of Regulation 9 of the HSCA 2008 (Regulated Activities) Regulations 2014.

Prior to the inspection we received some concerns that the level of social activities in the home had reduced and people were not being provided with adequate social stimulation and activity during the day. We were told some planned activities had been cancelled and the provider had stopped the use of the homes mini bus which had previously been used to take people out locally.

We spoke with people on the inspection and found they had mixed feelings and opinions regarding activities in the home. Comments included: "I just sit, there's nothing going on", "not much to do; I watch TV in the evening, I just sit here and watch what's going on. I don't go out in the garden much", ''I watch telly", "I watch the television, and we have a quiz, do jigsaw puzzles, I like those, I never get bored", "I read magazines, I love the telly, and at night I listen to music.'' A relative said, "There's nothing going on downstairs, I think it's terrible they've taken the bus.'' Other relative's commented, "[Relative] just sits in a chair, [relative] loves entertainment but there hasn't been any up to now" and "They had a hobbies person and mum loved it. They have no stimulation whatsoever, I worry about that, she used to make things and talk about the past."

We spoke with the manager who discussed the reasons for some of the changes and showed us early plans to develop a positive range of activities for people. The action plan we saw said, 'dedicated activity co-ordination staff must be recruited into post for social' recreational and occupational engagement purposes'. This was to be actioned by 30 September 2015.

We saw a complaints procedure was in place and people, including relatives, we spoke with were aware of how they could complain. The new manager had identified the complaints procedure was out of date and in need of review. This was carried out during and after the inspection and included in a revised 'Statement of Purpose' for the home. We saw an example of one complaint that had been received and dealt with recently. This had been responded to appropriately by the Operations Director.

Requires improvement

Is the service well-led?

Our findings

We reviewed some of the current quality assurance systems in place to monitor performance and to drive continuous improvement. The manager was able to evidence a series of quality assurance processes and audits carried out internally. We found some of these were not currently developed to ensure the most effective monitoring. For example we looked at how accidents and incidents were recorded and monitored. We found the current system of recording confusing with three separate accident records in operation with no reporting through to a named person for monitoring purposes. The manager was therefore unaware of some recent accidents that had occurred in the home. Currently there was no system for auditing these to help ensure trends or lessons to be learnt were identified. We were shown a new accident audit tool which would be used for this purpose.

It was not clear when the last full audit covering infection control had been carried out in the home. The last audit recorded was in October 2013. An audit of mattresses had been carried out in April 2014 and the manager showed us a very recent audit of mattresses in the home which she had just completed.

Other auditing tools such as the medication audit and dependency assessment tool [used to measure the nursing dependency levels of people in the home and link this to adequate staffing] still needed further development.

These findings are a breach of Regulation 17 of the HSCA 2008 (Regulated Activities) Regulations 2014.

Due to concerns identified by the provider, the new manager had replaced the previous manager. The new manager of the home had been in post three weeks. We were told the new manager would be applying for registration with us [the Care Quality Commission [CQC]. The home's manager was supported by the Operations Director who was also present for the inspection.

The new management team were replacing a previous management team of long standing. During the inspection we discussed some of the issues arising from this change. The operations manager had carried out an in depth analysis of the home in May 2015 which had detailed many areas for improvement. There had been a resultant action plan formed listing nearly 40 action points that needed to be achieved. Both of these reports were shared with CQC.

We were able to discuss current progress. Because of the impact of the changes at the home we were aware prior to the inspection of unrest amongst some staff and also relatives of people living at the home who had contacted us with concerns about the impact of the changes. We discussed possible reasons for this. Managers agreed to introduce more communication systems such as group and face to face meetings, especially with relatives and people living at the home to ensure the changes were communicated effectively.

Following the inspection we were sent an update detailing plans for immediate upgrading of some areas of the home and new staff to be employed. The update told us a meeting had been organised with people living at Orrell Grange and their relatives which had been well attended.

We found that the Care Quality Commission had not been notified of people who were placed on DoLS authorisations. This is a requirement under the Health and Social Care Act 2008 Registration) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Some environmental hazards and incidents had not been reported through effectively or acted on.** **Regulation 12(2)(d) & (h)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Medication administration records [MARs] were not always completed in line with the home's policies and good practice guidance. There was a lack of clear policy and monitoring of some medicines such as those to be given when needed [PRN].** **Regulation 12(f) & (g)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **We found the home was not consistent in supporting people to provide effective outcomes for their health and wellbeing. Regulation 9(3)(b)(h)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **People's care was not planned so it was personalised and reflected their individual preferences and routines.** **Regulation 9(1)(c) (3)(a)**

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The principles of the Mental Capacity Act (2005) were not followed consistently.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **There were currently a lack of systems in place to get feedback from people so that the service could be developed with respect to their needs and wishes.** **Some of the systems for auditing the quality of the service needed further development.** Regulation 17(1)(2)(a)(b) (e)