Morris Care Limited

Oldbury Grange Nursing Home

Inspection report

Oldbury Grange
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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Oldbury Grange Nursing Home is a nursing home providing personal and nursing care to up to 69 people. At the time of the inspection 56 people were using the service. The service provides support to people over 65 and younger adults including those with physical disabilities and people living with dementia.
The home is an adapted building with purpose-built extensions and accommodation is split into 4 communities over 3 floors. People have access to communal areas and large gardens.

People's experience of using this service and what we found
People could not be assured that environmental risks at the home would be consistently managed and improvements were needed to ensure that the providers governance systems identified where unsafe conditions existed.

Improvements were needed to how some medicines were stored to maintain people's safety. People received their medicines considering their preferences and national guideline by trained staff.

People were supported by staff who had been assessed as safe to work with vulnerable adults. People were kept safe from the risk of infection and COVID-19.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

The registered manager and staff were clear about their responsibilities. The service worked in partnership with a variety of community professionals to ensure people received any specialist support they needed.

Management sought people's views about the service and used that information to make improvements.

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

Rating at last inspection
The last rating for this service was good (published 8 December 2018).

Why we inspected
The inspection was prompted in part due to concerns received from a family member about the care provided to their relative. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the safe and well led sections of this full report.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified a breach in relation to the provider's governance and oversight of the service at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.
Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well led.
Details are in our well-led findings below.

Oldbury Grange Nursing Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by three inspectors.

Service and service type
Oldbury Grange Nursing Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Oldbury Grange Nursing Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.
At the time of our inspection there was a registered manager in post.

Notice of inspection
The inspection was unannounced. We visited the service on 5 October 2022.

What we did before inspection
We reviewed information we had received about the service since the provider's last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with seven people that used the service and eight family members of people who used the service. We also spoke with 12 members of staff including the nominated individual, head of quality care, registered manager, deputy manager, nurses, care assistants, activity workers and domestic staff. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We observed staff providing support to people in the communal areas of the service. We reviewed a range of records. This included eight people's care records and medicines administration records. We look at two staff members personnel files. We reviewed quality monitoring systems and a variety of records relating to the management of the service, including policies and procedures were reviewed.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

- Risks to people's health and wellbeing were not managed effectively. We found two tins of a prescribed drink thickener that was store in an unlocked cupboard in a kitchen area which was accessible to people. If ingested this could cause suffocation. We shared concerns with management at the home who took immediate action to install a lockable cupboard for it to be stored.
- We found wardrobes in some people's bedrooms had not been fixed to a wall to prevent it toppling over. This placed people at an increased risk of crush injuries. We shared concerns with management who took immediate action to secure the wardrobes.
- We found unlocked cupboards that contained products that if misused could be hazardous to people's health and should be kept behind a locked door when not in use. The registered manager took immediate action and removed items and locked doors.
- People had risks to their health and wellbeing assessed and planned for. Care plans and risk assessments were in place for people's needs such as health conditions, nutritional needs and mobility needs.
- The provider had a fire risk assessment and the people living there had personalised emergency evacuation plans written for them, identifying their needs in the event of an emergency. These plans were tested with regular fire drills.
- Checks of equipment, water hygiene and of gas, electrical and fire safety systems and equipment had been carried out by registered contractors as required by law. Regular 'in-house' checks of, for example, fire bells, fridge/freezer and hot water temperatures had taken place.

Preventing and controlling infection

- We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. During the inspection we found some wooden surfaces that were in poor condition which prevented effective cleaning.
- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was meeting shielding and social distancing rules.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was accessing testing for people using the service and staff.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● The provider's approach for visitors to the service was in line with the current government guidance.

Using medicines safely
● People said they received their medicines when they needed them. One person said, 'The nurse gives me my medicines. I have to have them at special times, and they make sure I get them on time."
● People received their medicines as prescribed and were administered by trained staff. Protocols had been drawn up considering people's preference with how and where they would like to have them administered. During the inspection we heard a nurse checking whether somebody was in pain and whether they required pain relief.
● Where people were prescribed PRN (as required) medicines, guidance was in place for staff on when and how to administer these.
● Medicines administration records (MARS) were correctly completed with no gaps. We saw evidence of regular audits of medicines records and stocks had taken place.
● Medicines were stored at the right temperature and we evidence that temperatures were checked regularly.
● During the inspection a community pharmacist was at the service who is working with the staff and people to reduce unnecessary medicines.

Systems and processes to safeguard people from the risk of abuse
● People and their relatives told us they felt the service was safe. One person commented, "The home is very good I feel very safe." A relative said, "I do feel they are safe there because [person] is happy."
● The provider had systems in place to protect people from harm or abuse. Staff had completed regular safeguarding training and had reminders displayed in the home about what process to follow.
● Staff were able to tell us about different types of abuse and what action they would take if they suspected abuse was occurring at the home.
● Safeguarding concerns were reported to the local authority safeguarding team and the registered manager worked with them to ensure any issues were appropriately addressed.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

Staffing and recruitment
● Staff were recruited safely. Records showed references and Disclosure and Barring Service (DBS) had been obtained before staff commenced their employment. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers

make safer recruitment decisions.
● When agency staff are used at the home, the provider tried to ensure the same staff were used. This ensured that people at the home knew who supported them.
● Throughout our visit we saw staff responding to the needs of the people living there in a timely manner.
● A staff member told us, "Even when its busy I always get time to sit and chat with the people I support".
● A family member spoke about observing carers providing support to their relative and told us, "I came away after 40 mins with a renewed confidence in the homely and caring ethos of the home".

Learning lessons when things go wrong
● Accidents and incident were fully documented and investigated to identify ways of preventing them from happening again.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The provider had developed systems to provide oversight of the service through electronic monitoring and through the use of provider visits to carry out audits with additional support from external consultants. However, improvements were needed to ensure unsafe conditions at the home were always identified and rectified.
- Despite audits being carried on the environment at the home they had failed to identify risks people were exposed to.
- Audits had failed to identify that drinks thickeners were being stored unsafely in open cupboards in an accessible kitchen area. When made aware the provider took immediate action to ensure they could be safely stored by installing a lockable cupboard.
- Audits had failed to identify some wardrobes in people's rooms were not secured to walls. After the inspection the provider investigated how this had occurred and told that a member of staff responsible for room audits had failed to identify that after decoration they had not been secured again and would be taking action to prevent this from happening again.
- Audits had failed to identify that products that could be harmful were not kept behind locked doors when not in use.

The providers governance systems failed to identify and manage unsafe conditions. This placed people at risk of harm. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager had notified CQC of events which had occurred in accordance with their legal responsibilities.
- The registered manager ensured that the ratings of their previous inspection were displayed prominently in accordance with their legal responsibilities.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- There was a positive culture at the service. Staff provided personalised care, which was kind, sensitive and caring. People were able to make choices about their care and support. There were regular reviews of their care to make sure this remained person-centred.
- All staff we spoke with said they felt supported by the registered manager. A staff member said, "during the recent heatwave, the registered manager helped by serving drinks to people and helping so staff could have

extra breaks".
● A family member told us, "I consider myself very lucky to have the reassurance that (my relative) is happy, well cared for and has made so many friends amongst the fellow residents and staff".
● Another family member told us, "After being told about the end of life decision in April, I happened to see the manager in the corridor and asked them exactly what that meant. They took us to their office and gave us over half an hour of their time to discuss this".

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The provider asked people using the service, staff and other stakeholders to complete satisfaction surveys about their experiences. The provider used the information to plan improvements for example people had asked for more flowers around the home and the provider was in the process of developing a "flower club" where people helped make displays of flowers to be used around the home.
● Meetings were held with people, friends and relatives and staff to discuss the service and how care should be provided.
● Staff told us they have the opportunity to discuss any concerns at staff meetings and performance reviews, but they could approach the registered manager at any time.
● The provider published a monthly newsletter that provided people and their friends and relatives information about what was happening at the home.
● Information about people's equality characteristics and life histories were sought to help plan personalised care for them and this included talking to friends and relatives when the person was not able to provide this information themselves.

Continuous learning and improving care
● The provider had developed a plan for ongoing improvements at the service.
● The registered manager and management team invested in the service to embrace change and deliver improvements.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The registered manager understood duty of candour and the need to be open and transparent when things go wrong.
● A family member told us "I have no reservations about the management's willingness to take on board any matters of concern that may arise".

Working in partnership with others
● The staff worked in partnership with others to help meet people's needs. They regularly consulted with healthcare professionals to assess, monitor and meet people's needs

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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems at the home were not effective at identifying where unsafe conditions existed in the environment at the home.