The Grange Care Centre (Cheltenham) Limited

The Grange Care Centre (Cheltenham)

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected The Grange Care Centre (Cheltenham) on the 11 and 13 December 2018. The Grange Care Centre (Cheltenham) provides accommodation, nursing and personal care to 60 older people and people living with dementia. It also provides short term respite for people. At the time of our visit 59 people were using the service. The Grange is located in the Charlton Kings area of Cheltenham. This was an unannounced inspection.

We last inspected the home on 6 and 8 November 2017. At the November 2017 inspection we rated the service as "Requires Improvement". We found the provider was not meeting all of the requirements of the regulations at that time. People did not always receive care personalised care and were not always protected from the risk of infection. Care staff did not always have the training and formal support they required and the registered manager and provider did not have effective systems to monitor the quality of service they provided.

At this inspection, we found improvements had been made to the safety of the service and the provider's quality assurance systems had effectively address some shortfalls. However, sufficient progress had not been made in relation to staff training and support and people's person centred care. The provider was aware of these concerns and had a plan in place to improve the quality of care people received.

At this inspection, we found similar concerns in relation to staff training and support and in relation to people's person-centred care. The provider was aware of these concerns and had a plan in place to improve the quality of care people received.

A registered manager was not in position at the service. The deputy manager and clinical lead were providing day to day management at the home, with the support of the provider until the new manager was in post. A new manager was in the process of being recruited by the provider. 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.

People did not always receive person centred care or meaningful engagement from care and nursing staff. Some care staff did not always ensure people received care which was tailored to their individual needs and preferences. People's life histories and interests did not always inform their care plans and the activities they would enjoy.

People, their relatives and staff felt staffing had improved at the Grange Care Centre. There was a high level of agency usage which staff and people's relatives felt impacted on some person centred care. The provider was taking action to address staffing concerns by carrying out recruitment. Care and nursing staff felt they were supported by the clinical lead and deputy manager. However, care staff informed us they did not

always receive effective supervision and did not have the training they needed to meet people's needs.

People were care for in a clean, safe and well-maintained home. The provider and manager carried out effective checks to ensure the service was appropriate for people's needs. The provider had plans to refurbish the home in 2019. Nursing and care staff followed recognised infection control procedures.

People were protected from the risks associated with their care. Care and nursing staff knew how to assist people with their needs and ensure their health was maintained. People's prescribed medicines were managed well.

Staff understood their responsibilities to protect people from harm and to report any safeguarding concerns. Staff provided people with choice and worked to protect and maintain their legal rights.

People had access to a good variety of food and drink. Care and nursing staff treated people with dignity and ensured they had their nutritional support and their prescribed medicines. Catering and care staff were aware of and met people's individual dietary needs.

People's relatives felt their concerns and views were listened to and acted upon due to changes within the management team. The provider and manager were aware of this and were making opportunities to effectively engage with people's relatives.

The provider had systems in place to drive the quality of care people received. There was an action plan in place to drive these improvements. An interim management team was in place with a focus of ensuring the service was safe before a new manager started at the home in 2019. Time and consistency was required to ensure the provider's action plan was completed, improvements were effectively sustained and embedded.

We found two repeated breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have not escalated these actions as we had identified improvements at this inspection from the last full inspection in November 2017. You can see some of the action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

There were enough staff deployed to meet people's needs. People's requests for assistance were responded to quickly.

The risks associated with people's care were managed. People's prescribed medicines were managed well.

The risks associated with people's care were managed. People felt safe living at the home and staff understood their responsibilities to report abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

Care staff did not have access to all the training and support they needed to meet people's needs. Care staff did not always benefit from an effective and structured supervision and appraisal system. The service was addressing these concerns.

People were supported to make day to day decisions around their care. People received the nutritional support they needed.

People were supported with their on-going healthcare needs, including rehabilitation to return to their own homes.

Is the service caring?

Good

The service was caring.

Care staff treated people with kindness and compassion when assisting them with their personal care.

People's dignity was promoted and care staff assisted them to ensure they were kept comfortable. People's independence and individuality were respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always have access to stimulation appropriate to their needs. People did not always receive care which was personalised to their needs.

Where people were at the end of their life they received support to keep them comfortable, in line with their wishes.

People and their relatives told us they felt involved and their concerns and complaints had been effectively listened to and acted upon despite changes in the management team.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The deputy manager and clinical lead were providing day to day management until a new manager started working at the home.

The service had a service development plan to address concerns they had identified. These concerns reflected those found at this inspection. Time was needed to assess the effectiveness of these actions.

The Grange Care Centre (Cheltenham)

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 was 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 11 and 13 December 2018 and it was unannounced. The inspection team consisted of three inspectors. At the time of the inspection there were 59 people living or receiving respite care at The Grange Care Centre Cheltenham.

We did not request a Provider Information Return (PIR) for the service. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information we held about the service. This included notifications about important events which the service is required to send us by law. We spoke with two healthcare professionals and one commissioner about the service. We took this into account when gathering our evidence and making our judgements.

We spoke with 10 people who were using the service and four people's relative. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We spoke with 17 staff members including eight care staff, a housekeeper, a maintenance worker, the chef, two nurses, an activity co-ordinator, the clinical lead, the deputy manager and a representative of the provider. We reviewed 10 people's care files. We also reviewed staff training and recruitment records and records relating to the general management of the service.

Good

Is the service safe?

Our findings

At our last inspection in November 2017, we found people were not always protected from the risk of infection as care and nursing staff did not follow recognised infection control processes. Additionally, people had not always received effective support with topical creams prescribed for their individual skin condition. These concerns were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to take action and they sent us an action plan which stated how they would meet the regulations in full. Following the inspection, we met with the provider and the previous registered manager to discuss the actions they were planning to take to meet the regulation. At this inspection we found the management team and provider had made improvements to ensure the requirements of the regulation were met.

People were protected from the risk of infection. Care and nursing staff followed recognised best practice to prevent the risk of infection spreading throughout the home. For example, care staff wore personal protective equipment (PPE) when they assisted people with their personal care. PPE is single use items, such as gloves and aprons, used during personal care. Care staff explained how they used the equipment to reduce the risk to people. One member of staff said, "We have enough equipment, we use it once and then it is disposed of. We all ensure we wash our hands." We observed staff wearing and removing PPE and followed recognised best practice. Housekeeping staff told us they had the equipment and resources they needed to ensure the home remained clean and free from infection.

The clinical lead discussed how they dealt with a recent outbreak of infection at The Grange Care Centre Cheltenham. The clinical lead followed a clear plan to manage the situation until they were clear the outbreak had passed. The clinical lead ensured the national public health agency was aware of the concern and followed recommended guidance on the management of an outbreak. This included restricting visitors to the home and carrying out barrier nursing to ensure the infection did not spread further.

People and their relatives felt the service was safe. Comments included: "I feel safe staying here" and "I think the home is safe, it doesn't concern me." One person when asked responded positively when asked if they felt safe. They said, "I feel safe here."

People were protected from the risk of abuse. Care and nursing staff had knowledge of types and signs of abuse, which included neglect. They understood their responsibility to report any concerns promptly. Staff told us they would document concerns and report them to their line manager or the registered manager. One staff member said, "I would go to a nurse, (the clinical lead) or (deputy manager), I know they'll sort it." Another staff member told us what they would do if they were unhappy with the manager's or provider's response. They said, "We all know we can contact safeguarding or CQC if needed." Care and nursing staff told us they had received safeguarding training.

The provider and management team responded to any safeguarding concerns in accordance with local authority's safeguarding procedures. Since our last inspection, the provider had ensured all concerns were reported to the local authority safeguarding team and CQC. The provider and management staff ensured

lessons were learnt from safeguarding incidents and used concerns to improve the service people received. For example, the management team had ensured lessons had been learnt from medicine administration issues ensuring people received their medicines as prescribed. The clinical lead and deputy manager ensured national product alerts were communicated to nursing and care staff, for example, the use of paraffin based creams following a significant concern at another care service in the country.

People could be assured the home environment was safe and secure. Safety checks of the premises were regularly carried out. For example, fire safety checks were completed to ensure the service was safe. Fire exit routes were clear, which meant in the event of a fire people could be safely evacuated. Equipment to assist people with safe moving and handling such as hoists were serviced and maintained to ensure they were fit for purpose.

Following last inspection, the number of staff deployed had been increased by the provider and the management team to ensure people's needs were being met. People, their relatives spoke positively about this change, however discussed the high level of agency usage in the home to ensure safe staffing numbers. One relative told us, "There are more staff around, just a lot of agency, which isn't always great". One person said, "Staff come when I need them. Sometimes they seem stretched however it's not often."

Care and nursing staff told us the amount of staff deployed had increased which meant they were able to safely meet people's care needs. However, they discussed the need for more permanent staff as the high use of agency impacted on the level of person centred care people received. Comments included: "They've upped the staffing. We do have a lot of agency. Some are really good and have been here a while. It is getting better"; "We need more permanent staff, it'll help us really push the home forward" and "The problems are we have some agency who are new, it's not good for continuity. People need that." The provider informed us there was a programme of recruitment to reduce the use of agency and work was being undertaken to improve recruitment and retention.

We observed that there were enough staff deployed to assist people in a timely way. People's call bells were answered promptly. The clinical lead and deputy manager had implemented systems to ensure people who were unable to call for assistance were checked on regularly to ensure their safety and wellbeing. Due to the high level of agency and some staffing performance some people did not always benefit from meaningful engagement from staff. We have reported on the impact on people's personalised care in more detail in the "Is the service responsive" key question.

Records relating to the recruitment of staff showed relevant checks had been completed before staff worked unsupervised at the home. These included employment references and disclosure and barring checks (criminal record checks) to ensure staff were of good character. The registered manager and administrator assured where concerns had been identified during the recruitment process, that these were discussed and risk assessments implemented to ensure staff were suitable and people remained safe.

People's needs had been assessed where staff had identified risks in relation to their health and well-being. These included moving and handling, mobility, agitation, nutrition and hydration. Risk assessments gave staff guidance which enabled them to help people to stay safe. Each person's care plan contained information on the support they needed to assist them to be safe. For example, one person had clear assessments in place for staff to follow to protect them from the risk of pressure sores. There was clear guidance for staff to follow to assist the person to reposition to protect them from the risk of skin damage. Where concerns had been identified by care or nursing staff, this informed the care the person received. For example, care and nursing staff had identified one person who had a red area of skin and assisted the person with repositioning more frequently for a small period of time to maintain their skin integrity. Records

maintained by care staff showed this person was supported to reposition as stated in their care plan.

People's health and wellbeing was maintained following accidents. For example, we reviewed accident records where people had fallen or slipped. Following an accident, nursing staff ensured people were safe, comfortable and free of pain. They followed recognised post fall protocols which included frequent monitoring. Staff discussed the care and support they provided people and further actions they could take to protect people from harm. For one person the clinical lead had carried out discussions with the GP and falls team and had requested further advice on the support they could provide.

People's prescribed medicines were kept secure. The temperature of areas where people's prescribed medicines were recorded and monitored to ensure people's medicines were kept as per manufacture guidelines. Where people required controlled drugs (medicines which could be misused and required certain management and control measures) to ensure their wellbeing these were administered in accordance with the proper and safe management of medicines.

People received their medicines as prescribed. Nursing staff kept an accurate record of when they had assisted people with their prescribed medicines. For example, staff signed to say when they had administered people's prescribed medicines and kept a record of prescribed medicine stocks and when they had opened people's prescribed medicines. Nursing staff ensured a clear and constant record the support they provided people with their medicines were maintained.

We observed two nurses assisting people with their prescribed medicines. They clearly communicated what the medicines were for and asked if the person wanted to take them. They gave each person time and support to take their medicines. People were in control of the administration of their medicines throughout, offered choice by the staff member and given a drink with all their medicines.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in November 2017, we found care staff did not feel supported, and did not have access to effective supervision or training. These concerns were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to take action and they sent us an action plan which stated how they would meet the regulations in full. Following the inspection, we met with the provider and the previous registered manager to discuss the actions they were planning to take. At this inspection we found the management team and provider had made improvements to ensure staff had the skills they required. However further improvements were required to meet the regulation.

People and their relatives felt the permanent care and nursing staff employed by the provider knew how to meet their or their relative's basic needs. Comments included: "I really can't fault the staff"; "The staff are really good with us" and "The staff do seem to know what they're doing."

Care staff told us they had most of the skills to meet people's needs. Comments included: "I think I have the training I need" and "I have the skills I need to meet people's needs." Three members of staff told us they would benefit from additional training and support. This concern was echoed by the home's clinical lead and deputy manager. Comments included: "I think we could do with more training, particularly in relation to end of life care and dementia care"; "I would like more support and training around end of life care, I find it can be difficult, particularly talking to families"; "I think we all need more face to face training, particularly around dementia, engaging with people and end of life care" and "I think we need more training." The deputy manager and clinical lead were discussing staff training needs with the provider prior to the new manager starting in post in 2019.

Staff did not always have access to an effective supervision (one to one meeting with their line manager) and appraisal system which enabled them to develop their skills. The clinical lead and deputy manager were aware of this and had started a supervision programme to provide staff with the formal support they required. Comments included: "I haven't had one for a long time, it would be useful" and "We need supervision. I haven't had one for over six months."

Staff did not always receive effective support when they started work at The Grange Care Centre Cheltenham. One member of staff told us that they had not received any formal support whilst working at the home, despite this being their first job in a care setting. They told us, "Since I started, no one has asked me how I am getting on. I don't know if I'm on probation, or if I'm doing a good job. Communication is not always good." We discussed this concern and staff supervision with the clinical lead. They reassured us this member of staff would be supported and they would ensure all staff had effective supervision.

Care and nursing staff did not always have access to the training and support they needed to meet people's needs. While improvements had been made and staff felt supported, further improvements were required. These concerns were a repeated breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care and nursing staff had a good understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) and knew to promote choice when supporting people. The 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 Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lacked mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Care and nursing staff understood and respected people's rights to make decisions about their care and support. Staff explained how they embedded the principles of the MCA into their practice. We observed care and nursing staff assisting people to make choices, such as what they would like to eat at lunch and providing choices of drinks and snacks. For example, one person was given a choice of their dinner. They chose to eat half of their dinner; however, told staff they had had enough. Their choice was respected, they were supported to move to a comfortable seat of their choice and enjoy a bowl of ice cream. Care and nursing staff told us how they supported people living with dementia to make choices regarding their care. Comments included: "We give people choice. Get people to help in their own time" and "One person can make simple choices, sometimes they need support to make a choice."

People's mental capacity assessments to make significant decisions regarding their care at The Grange Care Centre been clearly documented. For example, a best decision was made for one person to have their medicines administered to them covertly as they did not have the mental capacity to understand the risks to their wellbeing if they refused their prescribed medicines. Assessments had been carried out to see if this people could make a decision. The service worked with each person's family members, lasting power of attorneys and relevant healthcare professionals, including GPs to discuss the support they could provide in the person's best interests. The GP had identified the medicines which were to be administered covertly and how they should be administered. Nursing staff were aware of this information and it was clearly documented in the person's care records.

At the time of this inspection a number of people were being deprived of their liberty within the home. 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 MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager was aware of their responsibilities to ensure where people were being deprived of their liberties that an application would be made to the supervisory body. Where people were living under DoLS this was reflected in their care plans. Care plans also documented how staff should support people in the least restrictive manner. Where people were under constant supervision or equipment was in place to monitor people's safety and movements, such as sensor mats, this was included in DoLS assessments and relevant mental capacity assessments had been completed.

Care plans provided a clear record of the support people needed with all aspects of their individual needs. This included support around moving and handling, medicines, dementia care, anxiety, behaviours that challenge, pressure area care, diabetes and nutrition. For example, one person's care plan provided clear details on how care and nursing staff should assist them with their emotional wellbeing and anxieties. There was a clear plan in place of how to support the person, and indicators of when the person was becoming agitated. Their plans linked to support staff should provide, including the use of prescribed medicines if required. Care and nursing staff discussed how they assisted this person. One member of staff told us, "We spend time reassuring and redirecting them. They like to be outside, which isn't always possible with this weather."

People's care plans reflected their diversity and protected characteristics under the Equality Act. People's

sensory needs had been identified and staff were prompted to make sure people had access to equipment to assist them with their independence. For example, staff checked people's hearing aids were in working order and their glasses were accessible.

People had access to health and social care professionals. Records confirmed people had been referred to a GP, continuing healthcare professionals, occupational therapists and physiotherapists. People's care records showed relevant health and social care professionals were involved with people's care. For example, one person had been admitted to the home following a stay in hospital. The person had been admitted with an underlying infection. Nurses liaised with professionals to ensure the person benefitted from effective treatment and to reduce the spread of infection.

Where people were at risk of choking or malnutrition, they had been provided with a diet which protected them from these risks such as soft meals and high calorie diets. Care and nursing staff knew which people needed this support. For example, one person was assessed as being at risk of choking. There was clear guidance in place for staff to support this person regarding their meals ensuring they received a pureed diet which was fortified to meet their nutritional needs. Care staff confidently discussed how they assisted this person to support them to reduce the risk of choking. One member of care staff told us, "We ensure they have the support they needed. We make sure they're sat upright. Sometimes with a bit of support and prompting they will help themselves."

People and their relatives mainly spoke positively about the food and drink they or their relatives received in the home. Comments included: "It's lovely" and "I do like the food I'm given, I enjoy most of it." However, some staff raised concerns with us regarding the variety and quality of the meals people received in the afternoon. Comments from staff included: "There is not always lots of variety. It's always sandwiches and the residents just aren't eating them" and "There needs to be more variety and quality. Like omelettes. Something a bit different for the residents to enjoy." We discussed these concerns with the clinical lead who informed us they would review the mealtime options.

Care staff supported people to have access to food and drinks throughout the day. Drinks were in communal areas and people's rooms and were refreshed daily or more often if required. Since our last inspection the clinical lead and deputy manager had implemented a mealtime routine for care staff to follow to ensure people who required support to enjoy their meal received this at the same time as their meal. This ensured people were supported to eat a hot and freshly cooked meal. Staff explained this system worked well and they were always looking for opportunities to improve mealtimes.

People were comfortable in their environment and did not appear agitated when walking around the home. Since our last inspection the two units upstairs had been opened out to give people more freedom. Staff spoke positively about this change had impacted on people such as one person who liked to walk around the unit. The provider had appointed a new maintenance man and they had plans to develop and improve the environment, including making a large communal space on the first floor of the home. The provider had plans to refurbish and redecorate the home in 2019, including making the home friendly for people living with dementia. Additionally, plans were already in place to replace the flooring in people's rooms when needed. The maintenance man told us of the plans they had to renovate the home's garden, including an allotment area with raised beds and a children's play area.

Good

Is the service caring?

Our findings

At our last inspection in November 2017, we found people's needs were not always effectively acknowledged or met. These concerns were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to take action and they sent us an action plan which stated how they would meet the regulations in full. Following the inspection, we met with the provider and the previous registered manager to discuss the actions they were planning to take. At this inspection we found the management team and provider had made improvements to ensure people's needs were being acted upon and that staff assisted people in a kind and compassionate manner.

People and their relatives spoke positively about the caring nature of staff employed at The Grange Care Centre. Comments included: "The staff are definitely caring"; "They're very good to us, I like them" and "They make sure I am looked after."

Care staff spoke positively about people and told us how they worked with nurses and the management to respond to people's changing needs. For example, staff told us about one person who had a history of falling or placing themselves on the floor. They talked about how they had increased their supervision of the person and worked with the management to discuss changes in the person's wellbeing with family. We observed staff were mindful of the person and their wish to move around the home. They supported the person patiently and warmly.

People enjoyed positive relationships with care, nursing and other staff. Throughout the inspection the atmosphere on all units was friendly, inviting and lively in the communal areas with staff engaging with people in a respectful manner. We observed when care staff assisted people with their needs they did so in a kind and compassionate manner. Staff promoted people's choices and respecting people's wishes. For example, one person enjoyed a pleasant conversation with a member of staff as they sat together and talked about their dinner.

People were supported to maintain their personal relationships. For example, People and their relatives told us that visitors could visit at any time and there were no restrictions in the visiting times. One person told us, "My husband visits me everyday, that isn't a problem." Another relative said, "I can visit whenever I want. I think that is good."

People's dignity was respected by care staff. For example, when people were assisted with their personal care staff ensured this was carried out in private. People living at The Grange Care Centre were treated with dignity and respect and their wishes were respected. For example, staff ensured doors were shut when personal care was being provided. They ensured that when entering a person's room they knocked on the door and clearly acknowledged the person, so the person was clearly aware of their presence. Where someone had had an accident, staff supported them with patience and respect and ensured they received support to maintain their comfort. Care and nursing staff told us how they ensured people's dignity was respected. All staff members told us they would always ensure people received personal care in private and would ensure they were never exposed.

People were able to personalise their bedrooms. For example, people had decorations or items in their bedroom which were important to them or showed their interests. For example, one person's room contained photos of their family and people who were important to them. One person told us how they had access to the home's wifi which enabled them to maintain contact with their loved ones whilst residing in the home. They felt this was important to them and was planning for their eventual return home, and to their family at Christmas.

People where possible were supported to make decisions around their care and treatment. For example, one person's care plan clearly documented their views and also their wants and wishes regarding their end of life care. This person alongside their family had also made a decision to refuse resuscitation in the event of cardiac arrest. This decision was clearly recorded in the person's care plans. Other people had completed advanced care plans which documented how they wished to spend their final days and what things were important for them to have at the end of their life, such as family and specific music. Additionally, one person had clearly documented who they wished to be involved in their care and how information should be provided to them; this provided the person with comfort knowing that their information would not be shared without their permission.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in November 2017, we found people did not always receive person centred care or have access to activities which reflected their needs and preferences. These concerns were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to take action and they sent us an action plan which stated how they would meet the regulations in full.

Following the inspection, we met with the provider and the previous registered manager to discuss the actions they were planning to take. At this inspection we found the management team and provider had made improvements to ensure people had access to a structured activity programme. However not all care staff (including agency staff) ensured people had access to person centred care and stimulation as staff did not always have the guidance and information they required. People's care records were not always person centred. However further improvements were required to meet the regulation.

People did not always benefit from effective stimulation and social interaction which was personalised to their individual needs and preferences. People's care plans contained life histories, including people's hobbies, work history and interests. However, whilst this information had been sought and recorded it had not informed their activity or engagement care plans. People's care plans did not provide guidance for staff to support people in the activities that they enjoyed or were appropriate to their needs and abilities. We observed that some staff (both permanent and agency) did not always engage with people or provide them with stimulation. For example, we observed that staff did not engage or interaction with people when they provided them with food or drinks, during breakfast and lunch providing limited engagement. We also saw staff entering lounges, however not take an opportunity to speak or acknowledge people.

We observed that people often went periods of time up to half an hour without engagement from staff. Often people were withdrawn or asleep as there was a limited amount of interaction from care staff. This meant sometimes people went without the support they needed and their choices were not always acted on. For example, one person was assisted to get ready for their lunch time meal, they were becoming anxious as they waited for their meal. When staff provided the meal, the person required prompting and encouragement to enjoy their meal. However, care staff were busy assisting other people, which meant the person was left waiting for assistance.

Care staff, the clinical lead and deputy manager had recognised that people did not always benefit from effective person centred care. For example, one member of care staff explained how they had made changes to people's care following a change in unit. They told us, "Upstairs residents weren't always encouraged to get up, they stayed in bed, for no reason, as staff didn't encourage them. We're trying to promote change and make life more engaging and meaningful. Staff need support and training." Another member of staff said, "There is a task orientated culture which is deeply engrained. We're trying to engage staff in engaging the residents more." One person told us, "Some staff are nice, however some of them don't say much."

People were supported by staff who did not always know their needs or preferences. For example, due to

the use of agency staff at the service, there were sometimes staff on duty who did not know people's preferences. People's care plans did not always provide staff with the information they needed to support people. As they had not always been updated to reflect people's personal choices, including information regarding their life history or interests. For example, staff discussed one person with us who walked with purpose around the home, had a low weight however had a big appetite. This was not reflected in their individual care plans.

We discussed these concerns with the manager and the operations director, who were aware of some concerns regarding activities and engagement from care staff. A new activity co-ordinator team had recently been recruited and actions in relation to activities had been identified as part of the services management and leadership plan.

People did not always benefit from person centred support from care staff. We have not escalated this action, as improvements have been made ensuring people have access to a wide range of activities tailored to their needs and preferences. These concerns were a repeated breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A new activity team had been recruited and had started to implement a number of changes to the home, including new activities and external entertainers for people with dementia, supporting people to access the local community and supporting the local community to access the home (such as church groups, local schools and toddler and baby groups). The activity co-ordinator told us, "We're a prime location in the community. We've connected with a church three miles away and one over road, we have a mother and toddler group in. We're doing a lot of work inviting local schools, and linking with Middleton House (sheltered housing scheme) next door. We went over to the fayre." They also told us how they were supporting people out into the community on day trips. They said, "We get the residents our as much as possible. We've had a trip to Weston Super Mare and a city farm. We're fundraising for a minibus to enable us to get more people out into the community."

The activity co-ordinator also discussed new ways of engaging people's relatives and visitors in the home and activities. They spoke positively about generating a "whole home" approach to activities and engagement. They had started a monthly newsletter providing information to people and their relatives in relation to activities, upcoming events, social media and changes in the home such as the development or an in-house shop.

Staff and relatives spoke positively about the activity co-ordinator and the impact they had already had on people living at The Grange Care Centre. Comments included: "(Activity co-ordinator) is doing a fantastic job, really enthusiastic and getting the residents out and about"; "The activities have really improved" and "(Activity coordinator) is getting us all involved. We had a Christmas decoration competition. It was good fun we (staff and people) enjoyed it."

We observed a music session for people on the first day of our inspection. One member of the activity team was encouraging people to get involved in the singing, by playing instruments and singing alongside them. People were also involved in arts and crafts sessions focused on making Christmas decorations.

People's relatives were informed of and involved in any changes in their relative's needs. For example, one person was being supported to stay at their families' home over Christmas. Nursing staff were ensuring the family had all the information they needed, including medicine records to ensure they could maintain the person's needs. Care records showed that where people's needs changed, the service informed their relatives and involved them in their care. For example, one person sadly passed away during our inspection,

the clinical lead told us how the person's family were informed and involved in decisions at the end of the person's life.

People were supported at the end of their life and to maintain their comfort. The clinical lead explained the support they provided people and their relatives at the end of life. They discussed a recent situation where the person's family and GP were involved in an important decision at the end of the person's life. The clinical lead discussed improvements they planned to make to people's end of life care, this included ensuring staff had effective training and support. They were also looking at ways to capture people's wishes and preferences regarding end of life care when they moved to the home.

People and their relatives knew how to make a complaint if they were unhappy with the service being provided or if they had any concerns. For example, one person's relative took time to raise concerns about a situation they had observed over the weekend prior to our inspection. They had arranged a meeting with the clinical lead and deputy manager to discuss these concerns.

The deputy manager and clinical lead kept a record of complaints and compliments they had received about the service. They had clearly investigated these complaints and discussed the outcomes with people and their relatives. For example, one person complained about the conduct of staff during a night shift. The deputy manager and clinical lead listened to these concerns and took effective action and engaged with all staff regarding the right way to approach people.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in November 2017, we found the provider and the registered manager did not always operate effective systems to monitor and improve the quality of care people received. These concerns were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to take action and they sent us an action plan which stated how they would meet the regulations in full. Following the inspection, we met with the provider and the previous registered manager to discuss the actions they were planning to take. We found improvements had been made to ensure the service met the relevant regulation, however further work, time and consistency was required to ensure improvements were effectively sustained and embedded.

At this inspection we found an interim management team were in place. This team were working to an action plan to maintain people's safety and drive improvements across the home. The provider was in the process of recruiting a new manager. 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. We have rated the service as "requires improvement" due to there being no registered manager.

The interim management team consisted of the deputy manager and clinical lead. They explained they were focused on maintaining a safe service, providing stability and making necessary improvements until a new manager started. They discussed some of the changes they had made, which included increased monitoring of people living at the home in the short term to ensure their needs were being met, particularly due to the use of agency staff working at the service. They discussed that they did not wish to carry out major changes due to the upcoming management change as they did not wish to unduly unsettle staff.

The management team were working to an action plan following audits carried out by representatives of the provider. Where audits had been completed actions had been added to the home's action plan. Each action had been assigned to set staff to follow. These actions focused on people's care records, staff induction, training and support and DoLS applications. The management team were taking action with the support of the provider and a registered manager from one of the providers other services. The provider informed us they were planning to implement an electronic care planning system once recruitment had been carried out and improvements had been embedded and sustained regarding people's ongoing care records.

The action plan produced by representatives of the provider had identified the concerns and shortfalls we had identified at this inspection, however due to the number of actions, not all of these had been acted upon, partly due to time constraints. The deputy manager and clinical lead had been focused on ensuring the service was including maintain safe staffing levels and ensuring that people received safe care and treatment as well as their prescribed medicines. The clinical lead told us they carried out the majority of assessments for people before coming to the service, so was able to ensure the service only accommodated people whose needs they could effectively meet. The clinical lead and deputy manager ensured staff received day to day support and communication and carried out routine assessments as required by the

provider.

These audits included health and safety audits, care plan audits, infection control audits and management of medicine audits. These audits demonstrated the service were making continuous improvements. Where shortfalls had been identified these actions had been added to the services overarching action plan.

The service had sought the views of staff, people's relatives and healthcare professionals. The results of these surveys were analysed and feedback was provided. Where individual concerns had been raised, the relative was invited to discuss the concern so effective action could be taken. For example, one relative raised a slight concern regarding their relative's fluid intake records. This had been reviewed and effective action taken.

The clinical lead and deputy manager reviewed incidents and accidents which occurred at the home on a monthly basis. This formed part of their key performance reports to the provider. The clinical lead provided us with their recent report for November 2018. These reports enabled the clinical lead to identify any possible trends in incidents, such as what time of day incidents are occurring and where they are occurring. The report also monitored pressure area care concerns, medicine errors, safeguarding concerns and complaints. Recent reports evidence the home was responding to concerns and taking opportunities to develop.

Staff spoke positively about the clinical lead and deputy manager and felt they received the support they needed. While staff felt the management was supportive they were still looking forward to the continuity and stability they hoped a new manager would provide. Comments included: "(Clinical lead) is amazing. So approachable and will always help"; "(Clinical Lead) is good for any concern about care, they get it sorted. I think both (clinical lead) and (deputy manager) are incredibly supportive of us"; "they've made some really good changes, which are helping" and "(Deputy manager) is really good, she makes us really understand the changes. We are moving in the right direction."

The management team and provider ensured staff received information through meetings and day to day communication, such as a daily flash meeting. They had identified that communication for staff was an issue which needed to be addressed to ensure staff had the information they required. Team meeting minutes discussed staffing in the home, with the recent meeting discussing staff coverage during the Christmas holidays. The management communicated their expectations of staff in relation to care planning, cleaning and interaction with people. Staff were also able to communicate their views and ideas. Daily flash meetings between staff provided an overview of people in the home and any concerns. These meetings had been implemented to improve communication throughout the home.

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 9 HSCA RA Regulations 2014 Person-centred care People did not always receive care which was personalised to their needs and wellbeing. People did not receive effective stimulation and engagement from staff. Regulation 9 (1)(a)(b)(c) 3(a)(b)(c)(d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Care staff did not always receive the training and support they required to meet people's needs. Regulation 18 (1)(2)(a)(b).