M S Frois

Grange Cottage

Inspection report

Albert Road
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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 25 March 2015 at which breaches of legal requirements were found. This was because the registered provider had not followed robust recruitment processes to check new staff were suitable to work in the home, staff had not received training to carry out their duties safely and people had not given formal consent for the support they received.

After the comprehensive inspection, the registered provider wrote to us to say what they would do to meet legal requirements in relation to the breaches.

We undertook this unannounced focused inspection on 26 November 2015 to check that the registered provider had followed their plan and to confirm if they now met legal requirements.

During our focused inspection we also identified new areas of concern around fire safety, safe handling of medicines and the competence of people working in the home. This report only covers our findings in relation to these topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Grange Cottage on our website at www.cqc.org.uk.

We found that improvements had been made to the processes used when new staff were employed, however some of the information required by law had not been obtained for one new member of staff. We also found that, although care staff had received training to meet people's needs, the registered provider and a person who supported the night care staff had not completed any training. This meant the registered provider continued to be in breach of the regulations relating to training and to staff recruitment.

People had given formal consent to the care they received and we saw that the care staff respected the choices people made about their support. The registered provider had taken action to meet legal requirements regarding obtaining consent from people.

Grange Cottage provides care and accommodation for up to nine people who need personal care. The home is situated in the small town of Grange Over Sands on the coast of Morecambe Bay. The property is a large six bedroom cottage, five with ensuite facilities. There are three one bedroom ensuite rooms in a bungalow in the adjoining garden. The property has been adapted and extended for its current use as a care home.

There was a registered manager employed in the home. 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 and associated Regulations about how the service is run.

People told us that they felt safe living in this home. They said they usually received support from care staff

who knew the care they required and how they wanted this to be provided.

People followed a range of activities in the local community that they enjoyed.

People were placed at risk because medicines were not always handled safely. People had not always received their medicines as their doctor had prescribed.

People were not protected against the risk of fire. Fire hazards had not been identified and fire safety procedures were not always followed.

People who lived in the home could not be confident that they would receive the support they needed or their care safely when the registered provider worked as the night staff member.

We discussed the issues we found with the registered manager of the home. They took immediate action to safeguard people from further risk including ensuring people were protected from the risk of fire and by removing untrained individuals from delivering care.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to safe handling of medicines, protecting people from the risk of fire, ensuring people delivering care were trained and competent and in staff recruitment. You can see what action we told the provider to take at the back of the full version of the 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?

Inadequate

The service was not safe.

People were not protected from the risk of fire.

Medicines were not always handled safely and people had not received their medicines as their doctor had prescribed.

There were times when people were not supported by competent and skilled individuals.

Although improvements had been made to the processes used when new staff were employed, the information required by law had not been collected for a new member of staff.

Is the service effective?

Requires Improvement

The service was not always effective.

People were not always supported by individuals who were appropriately trained.

People were asked for their consent to the care and support they received.

Grange Cottage

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.

This inspection took place on 26 November 2015 and was unannounced. This was a focused inspection to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection in March 2015 had been made. We inspected the service against two of the five questions we ask about services: is the service safe and is the service effective. This is because the service was not meeting legal requirements in relation to those questions at our comprehensive inspection.

The inspection was carried out by one adult social care inspector.

Before our inspection we reviewed the information we held about the home, this included the provider's action plan, which set out the action they would take to meet legal requirements.

At the visit to the home we spoke with five people who lived there, the registered manager, and two care staff. We also spoke with a local GP who was visiting the home. We looked at minutes of residents' meetings and of staff meetings, three people's care records, staff training records, staff recruitment records and records relating to how the home was managed.

Inadequate

Is the service safe?

Our findings

People who could speak with us told us that they felt safe in the home. However two people told us that the registered provider, who worked in the home, did not always speak to them in a respectful way. We saw that people were relaxed and comfortable with the staff who were working in the home during our inspection.

At our comprehensive inspection of this home in March 2015 we found that people were not protected because robust procedures were not used when new staff were employed. We found that two staff had been employed without the provider obtaining their own Disclosure and Barring Service check. This meant people could not be confident that the staff were suitable to work in the home.

This was breach of Regulation 19: Fit and proper persons employed, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our focused inspection we looked at the records around recruitment for the one new staff member who had been employed. We found that the registered manager had obtained a Disclosure and Barring Service check for the member of staff, had discussed their previous experience with them at interview and had taken up references to check that they were of good character. However we found that some of the checks required by law had not been completed. The registered manager had not verified the reason why the person had left one previous position working with vulnerable adults, had not obtained evidence of a qualification relevant to the individual's employment in the home and there was no written explanation for one gap in their employment history.

Although we saw that improvements had been made to the recruitment process, we found it was still not meeting legal requirements.

This showed a continuing breach of Regulation 19: Fit and proper persons employed, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider had not ensured they had obtained all the information required before employing a new member of staff.

At our focused inspection we found that people were not protected against the risk from a fire. We saw a fire door, which should have been kept closed, was held open by a fire extinguisher. This meant a fire could spread through the building. The fire extinguisher could also have been damaged, meaning staff could not rely on it to work effectively if they had to use it. We also found flammable material stored in the same room as the heating boiler. This could cause a fire to spread and placed people at risk.

We looked at people's personal emergency evacuation plans, (PEEPs). These told staff the support people would need to move away from a fire. We saw that the five PEEPs we looked at should have been reviewed in 2014 but had not been. One held inaccurate information, as the person's mobility had decreased and the support they would need in the event of a fire had changed.

This was a breach of Regulation 15: Premises and equipment, of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014 because the provider had not ensured risks from fire were properly controlled.

At this focused inspection we found that people had not always received their medicines safely or as their doctor had prescribed. We found that one person had been given two doses of their medicine at the same time and another person had twice been given one medicine at the wrong time. We also found a person had not been given a night time medicine, but their medication administration records had been signed to state they had received the medicine. Another person had been given a medicine but this had not been recorded. These errors placed people at risk. We saw that these errors had all been made by the registered provider when they had worked as the night staff member.

This was a breach of Regulation 12: Safe care and treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the registered provider had not ensured that medicines were managed safely.

We also found that there were times when there were not sufficient staff with the appropriate skills and competence to meet people's needs and to ensure their safety. During the day there enough staff on duty to support people. During the night there was one staff member on duty and another person, who lived on the premises, who could be called on as required if people needed two people to provide their care.

People who lived in the home told us that most of the staff were nice and knew the support they needed. However two people told us that, although the registered provider was kind to them at some times, there were also times when the registered provider did not speak to them in a pleasant or respectful way.

We looked at the records held in the home. These showed that while the registered provider had worked as the night staff member they had made five errors with handling of people's medicines over a five week period. We also saw that they had not completed records relating to the support provided to one person. The records we looked at also showed that the registered provider had not recorded checks on the premises which were required to ensure people were provided with a safe place to live.

We also found that the care staff employed in the home were not confident the registered provider knew and would provide the care people required. We saw records of communications between the care staff and the registered provider where the care staff had specifically reminded the provider to carry out essential tasks that were required to keep people safe and to ensure their health. The care staff we spoke with confirmed that they sometimes had to remind the registered provider about the care people required in order to try to ensure people received the support they needed.

People who lived in the home could not be confident that they would receive the support they needed or their care safely when the registered provider worked as the night staff member.

This was a breach of Regulation 12: Safe care and treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people were not always cared for by individuals who were skilled and competent to provide their support.

At our focused inspection we shared the concerns we had found with the registered manager of the home. They took immediate action to ensure the safety of people who lived at Grange Cottage. They removed the flammable material from the boiler room and ensured the fire door was closed. They also ensured that all the care staff on duty were aware of how to support people in the event of a fire and arranged for a fire safety consultant to check the fire extinguisher was safe to be used.

The registered manager also provided us with written confirmation that the registered provider had been removed from providing care and that their duties had been taken over by trained staff.

After our inspection we shared the concerns we had found regarding fire safety with the local fire and rescue service and passed our findings to the local authority, responsible for safeguarding people.

Requires Improvement

Is the service effective?

Our findings

People who could speak with us told us that most of the staff who worked in the home knew the support they needed and how they wanted this to be provided. They told us that they followed a range of activities in the local community, either on their own or supported by a staff member if they required.

At our comprehensive inspection in March 2015 we found that staff who worked in the home had not received training to ensure they had the skills and knowledge to deliver care safely and competently.

This was a breach of Regulation 18: Staffing, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our focused inspection the care staff working in the home told us that they had completed a range of training including in safeguarding people from abuse, emergency first aid and safe moving and handling. The care staff also told us that they were supported to obtain appropriate qualifications in health and social care relevant to their roles. This was confirmed in the training records we looked at.

We saw that the registered manager had developed good systems to identify when care staff had completed training and when this needed to be renewed to ensure the care staff maintained their skills and knowledge.

However we found there were occasions where there were no staff on duty at night who had completed training to meet people's needs and ensure their safety. This placed people at risk. Night time care was provided by one member of staff with another person, who lived on the premises, available to assist if required. The registered manager could not provide any evidence to show that this person had completed training to be able to provide people's support or to ensure their safety.

The registered provider worked some nights providing care in the home. There were no records of training the registered provider had completed to ensure they had the skills and knowledge to provide people's care. Records we looked at showed that the registered provider had been responsible for five errors in managing medicines during a five week period. The registered manager told us that they had requested that the registered provider attend training in handling medicines but said they were unsure if the registered provider had done so. The registered manager contacted the registered provider during our inspection. The registered provider told the registered manager that they had not completed medication training, despite having made errors in handling medicines and being requested to do so.

This was a continuing breach of Regulation 18: Staffing, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people could not be confident their care would be provided by individuals who had completed appropriate training.

After our inspection the registered manager removed the untrained individuals from providing care and provided us with written confirmation of the actions they had taken to ensure people received care from staff who had completed appropriate training.

At our inspection in March 2015 we also found that there was no evidence in people's care records to show that they had given consent to the care they received. This was a breach of Regulation 11: Need for consent, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our focused inspection on 26 November 2015 we found that the provider had followed the action plan they had written to meet the shortfalls in relation to the requirements of Regulation 11 described above.

People told us that they had agreed to the care they received. They also said that they could refuse any aspect of their planned care, as they wished. Throughout our focused inspection we saw that people were given choices about their lives and the support they received. We saw that the staff on duty respected the choices that people made about their care.

We looked at the care records for three people. We saw that people's care had been discussed with them and people who could do so had signed their care records to show that they consented to their care being provided. The records also showed that where people had refused an aspect of their care their wishes had been respected. The registered provider had taken action to meet legal requirements regarding obtaining consent from people.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment How the regulation was not being met: The registered provider had not ensured that medicines were managed safely. Regulation 12 (1) and (2)(g) People were not always cared for by individuals who were skilled and competent to provide their support. Regulation 12 (1) and (2)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had not ensured risks from fire were properly controlled. Regulation 15 (1)(d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered provider had not ensured they had obtained all the information required by law before employing a new member of staff. Regulation 19 (3)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider had not ensured that all

persons working in the home had completed appropriate training.
Regulation 18 (2)(a)