The Grange (Chertsey) 2002 Ltd

The Grange Retirement Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
The Grange Retirement Home is a care home providing accommodation, personal and nursing care to up to 62 people in one building. People were living with a range of complex health care needs. This included people living with dementia, diabetes or Parkinson's disease. At the time of our inspection, 54 people were living at the service.

People's experience of using this service and what we found
Following our focused inspection in September 2021, we found the registered provider had taken some action to address the concerns we had identified. This included making the accident and incident and safeguarding processes and systems more robust. This helped keep people safe from harm at The Grange.

However, there was an inconsistent approach at the service which meant at times, and for some people, their safety and wellbeing was at risk. Restraint was being used for one person without clear guidance in place and staff did not always ensure they were with people who were at risk of choking when they were eating their meals.

Staff working at the service did not always follow good infection control practices as we saw staff not wearing their masks correctly. In addition, some people's rooms had strong odours and although management were aware of the issue, particularly in relation to one person, they had not taken action to address this.

Although we found sufficient number of staff within the service for the number and dependency of the people living there, deployment was such that some people had to wait for care. This was particularly evident during lunchtime and in regard to one to one engagement for those people who remained in their room to help prevent social isolation.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Staff had received additional training since our last inspection and planned supervision had been arranged so they could meet individually with their line manager. However, we observed a lack of care and respect shown towards people by some staff and a lack of interest to enable people to make their own choices. People said staff did not always take time just to talk to them and those people who spent a lot of time in their rooms felt isolated.

People lived in an environment that had not taken people's needs into account as there was a lack of evidence of its suitability for people living with dementia. However, management told us an improvement plan was in place and we will check on this at future inspections.

Despite audits taking place within the service, we identified shortfalls which had not been identified by those audits. This included a lack of detail in people's care plans and a lack of management oversight of the practices of staff, particularly agency staff.

Governance processes were not effective as they did not help to hold staff to account, keep people safe, protect people's rights and provide good quality care and support. The registered provider had failed to meet the deadline set by them since our last inspection for making improvements and embedding them into practice as we found continued concerns at the service.

Management followed national guidance in relation to testing, visiting and admitting people safely to the service. People received their medicines in line with their prescription as staff followed good medicine management practices.

People received support and input from healthcare professionals when required and they told us they were provided with sufficient food and drink. People said some staff were very caring and we found individual staff knew people well.

People and their relatives were involved in the running of the service and invited to give their views and feedback. Management worked with external agencies 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 (and update)
We carried out a focused inspection at this service in September 2021 when we inspected on the key questions of Safe, Effective and Well-Led. Prior to that we completed a fully comprehensive inspection in August 2019 covering all key questions. The overall rating for the service following our focused inspection was Requires Improvement and we found breaches of Regulation. We also took enforcement action against the registered provider for a failure to have good governance processes and systems in place, which meant people did not receive a good quality of care. The registered provider completed an action plan after that inspection to show what they would do and by when to improve. We used this action plan at this inspection to see if the registered provider had completed actions in line with the timescales they told us they would.

At this inspection we found that not all breaches of Regulation had been met. We also identified a new breach related to respect and dignity. As we identified shortfalls at the service on the day of inspection, we decided to open out this inspection to a fully comprehensive visit, covering all key questions.

Why we inspected
This inspection was carried out to check on actions taken by the registered provider since our last inspection and to see if they had met the breaches of regulation as well as the enforcement action we took. The overall rating for the service has remained as Requires Improvement. This is based on the findings at this inspection.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least Good. We will work with the local authority to monitor progress.

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 effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

The Grange Retirement 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 Care Act 2014.

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
The inspection was carried out by three inspectors.

Service and service type
The Grange Retirement Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

A new manager was at the service, however they had yet to register with the Care Quality Commission. As the service is without a registered manager the registered provider is legally responsible for the service.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a Provider Information Return in advance of this inspection. This is

information providers are required to send us with key information about the service, what it does well and improvements they plan to make.

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service.

During the inspection
We spoke with 12 people who used the service about their experience of the care provided. We spoke with 15 members of staff including the operations manager, manager, deputy manager and an external consultant employed by the registered provider.

We reviewed a range of records. This included 11 people's care records, three recruitment files and medication records. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training and supervision records, policies relating to the service, people's care plans and daily notes, staff, residents and relatives meeting minutes. We spoke with six relatives of people who lived at The Grange for their views and feedback.

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 the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. 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

At our focused inspection in September 2021, we found that people may not always be safe because staff did not take enough action to respond to potential risks and information for staff was inconsistent. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found some improvement at this inspection however this was not across the board and we observed poor infection control practices which meant there was still a breach of Regulation 12.

- There was an inconsistent approach at the service, which meant some people may not live safely and free from unwarranted restrictions because the staff did not always assess, monitor or manage safety well.
- One person was recorded as being at risk of choking and their care plan stated they should be 'sat up during meals'. However, we observed them half lying down eating their lunch. We were told this person had capacity and chose to eat their lunch this way. We checked their records but there was no assessment to demonstrate they understood the risk of eating their meals without sitting upright.
- Another person was observed eating lunch in a reclined position. The registered provider informed us following the inspection that this person did not like to sit fully upright. However, we noted they were eating their lunch without staff supervision, which was not in line with their nutritional care plan guidance and potentially left them at risk of choking.
- Unauthorised restraint was being used on one person without the knowledge of management and without staff being trained or understanding the need for recording when it was used. There was no guidance in this person's care plan in relation to the restraint being required or how this should be provided. We raised this with the operations manager and manager who both said this was, "Unacceptable." Immediately following our inspection, we were informed, training had been delivered on restraint and positive behaviour support.
- One person was at risk of falls. Their mobility care plan stated a (chair) sensor mat should be in place due to this risk. This was also mentioned in the person's deprivation of liberty application, however there was no sensor mat on the person's chair and staff told us they did not remember there being one.
- We did note other people's risk assessments were comprehensive and covered all key areas however, such as risk of falls, pressure damage or malnutrition. One person was at risk of choking and they had been referred to an appropriate professional to assess this. A second person was at risk of pressure damage and a skin integrity care plan had been put in place. A third person required their bed to be at the lowest level and needed a Zimmer frame for walking. We saw they had both of these.
- We also heard from relatives who told us they felt their family member was kept free from harm. One relative said, "Lots of things are put in place for her safety. She's safer here than she was at home because

she kept falling." A second relative told us, "The staff completely understand the risks relating to my relative."

● Action had been taken to help reduce the risk of people developing pressure damage to their skin following concerns at our last inspection. The operations manager told us, "We are gradually replacing people's pressure mattresses to automatic ones. Six or seven have been replaced already and we have another 12 to go. We start off with these ones for new residents now."

● People may be at risk in the event of an emergency. Details of people residing at the service were held in the fire folder in the entrance to the building, to be used by the fire service. However, when we reviewed the list in the fire folder it was not accurate. We noted five people were still named on the list who no longer lived at The Grange and four people had recently moved in and were not included in the list. This meant the fire service would not be given the most up to date information about people living at the service.

The on-going potential risk to people was a continued breach of Regulation 12(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● We were not assured that the provider was preventing visitors from catching and spreading infections. Two people's rooms had a very strong odour. We spoke with management about one person's room in particular. They told us, "It's in the carpet and the chair. He needs a chair and flooring that can be washed. It's in the underlay of the carpet." A second person's bed bumper was cracked and there was an additional bumper on the top of their wardrobe which was split down the side and black with dirt. A staff member told us this was their old bumper and should have been removed. We noted later in the day it had been taken from the person's room.

● We were not assured that the provider was using personal protective equipment (PPE) effectively and safely. We observed staff not wearing their masks correctly during the day as we saw two staff members enter a lounge area, on separate occasions, to speak with the nurse without their mask on. Additionally, when we knocked on one person's door and the staff member opened it, they had their mask under their chin. As we left our inspection, four staff entered for their night duty shift and none of them had their masks on.

The lack of robust infection control processes was a breach of Regulation 12(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● 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 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.

● The service and staff were facilitating visits for people living in the home in accordance with the current guidance. Visits took place in the conservatory area on the ground floor and relatives had to book a visit prior to arriving at the service. Evidence of a negative lateral flow test was required and visitors were given appropriate PPE to wear.

Staffing and recruitment

At our focused inspection in September 2021 we issued a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 due to a lack of staff on the floor to assist people in a timely manner. We found some improvement at this inspection and the provider was no longer in breach of Regulation 18.

● Although the service had enough staff, including for one-to-one support for people who required it, our observations on the day were mixed. At times we saw a sufficient number of staff and at other times, it was difficult to find a staff member, in particular at lunchtime. People's meals were left to get cold because staff were not deployed suitably to ensure they were available to assist people with their meal.
● People gave mixed views on staffing levels and there was a risk that people could become socially isolated. Some told us, "We have got bells in our rooms. If we cannot walk, we can push our bells and they come to us" and, "There is always someone around if you need something." However, others said, "I called out for staff as I wanted to go to the toilet. I waited so long, I had to walk myself" and, "I have nothing to do. They don't have enough staff. When they do, I can play dominoes with them."
● Staff also gave mixed feedback on staffing, with one staff member telling us, "There are enough staff available on a shift to meet people's needs and keep them safe. Even when residents go to hospital for appointments, staff accompany them." And another saying, "Usually we have three on the floor and that is enough staff." However, other staff said, "There are times when we really struggle. Like last week when two people cried off their shifts. It was hard, hard work."
● We received similar feedback from relatives we spoke with. Some relatives commented. "I think that has been the key issue – the adequacy of staff numbers. There have been a lot of staff changes over the past few months. I understand they are trying to recruit more staff" and, "No there are not enough staff. It's a continued source of annoyance to me." However, others told us, "There never seems to be a problem if she needs assistance," "He's not left on his own so there are enough staff" and, "They have always been well staffed in the past."
● The operations manager described the dependency tool used to calculate the number of staff required on each shift. They demonstrated they were working with more staff than the tool had determined.
● People's dependency was automatically reviewed every 28 days, and updated whenever there was an admission or discharge, so senior management could check staffing levels were appropriate. We noted staffing levels had been increased since our last inspection. The operations manager told us, "[Manager] and [outgoing manager] are supernumery so they can go on the floor if we dip below our required staffing level. We have made the nurses more responsible for their units and introduced walkie talkies so we can contact the nurse on the floor, for example, if we hear a call bell ringing for a long time."
● Much of the rota was currently being filled by agency staff. This helped the registered provider meet the required staffing levels.
● The registered provider told us they had identified the need for better skill mix on each floor and as such had an on-going recruitment drive to employ more senior care staff and nursing staff. This would enable them to ensure there was continuous oversight and support for staff as well as monitor the timeliness of people's care.

We recommend the registered provider continues to regularly review the deployment and skill mix of staff on each floor, so that people can receive time and attention promptly when they require it.

● Staff were recruited through a robust process. Prospective staff completed an application form, gave evidence of right to work in the UK and provided identification. Staff also underwent a Disclosure & Barring Service check (DBS) which helped establish if staff were suitable to work in this type of setting.

Learning lessons when things go wrong

At our focused inspection in September 2021, we found a failure to record accidents and incidents robustly. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Although the provider were still in breach of Regulation 12, we found processes around incident and accident recording had been improved and we no longer had concerns in relation this part of the regulation.

● Staff raised concerns and recorded incidents and near misses and this helped keep people safe. Accidents and incidents were recorded and lessons learnt as a result. For example, one person had not received one of their medicines for three consecutive days. A staff member told us, "I went through the criteria (for notifying CQC) as this could have been neglect." They went on to say the GP was consulted at the time for advice and the nurse concerned asked to complete reflective practice.
● We read details on accident and incident reports were more robust and all incidents were reviewed and logged by the manager. Each month an analysis was carried out to review trends or themes. This was broken down to individual people so action could be taken. For example, one person was referred to the falls team as a result of several falls.
● A daily 'flash' meeting was held and this forum was used to share information about incidents relating to people and appropriate actions were discussed. Learning was taken from incidents, such as reflective practice or further training.

Systems and processes to safeguard people from the risk of abuse

At our focused inspection in September 2021, we found a failure to report safeguarding incidents where appropriate to safeguard people from the risk of abuse. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found processes had been improved at this inspection and the registered provider was no longer in breach of this regulation.

● Since our last inspection reporting processes for potential safeguarding concerns had been strengthened and staff knew how and when to raise a safeguarding concern. The operations manager told us, "We have been doing a lot of reporting to safeguarding. Particularly if we cannot identify why the incident happened. We have [social care professional] coming over next week to talk through the criteria for what meets a safeguarding concern."
● Additional safeguarding training had been delivered to all staff since our last inspection and the training was adapted to meet individual roles. For example, clinical staff were provided with more detail around signs to look out for.
● Staff were aware of the different types of potential abuse. A staff member told us, "I would go straight to the manager and if they did nothing I would go higher and then to CQC if they still didn't listen."
● Relatives told us they felt their family member was safe. One relative told us, "I've never been concerned about her safety. That's always been a critical point for me because she can't talk. I've never had any safeguarding concerns." A second said, "He's absolutely safe. It's the best place for him."

Using medicines safely
● People were supported by staff who followed systems and processes to administer, record and store medicines safely. Relatives told us, "This is one point that they have always been strong on" and, "Her medication has always been done correctly."
● People's medicines were stored in lockable medicines trollies to be taken on the floor when administering. The trollies were kept in a locked clinical room which staff ensured was at the optimum temperature for storing medicines.
● Clinical staff were responsible for medicines ordering and they had a good relationship with the

pharmacist, telling us, "If we have any problems, we can call him and he will sort it out."

● Medicines training had been provided to staff by the pharmacist and only trained and competency assessed clinical staff administered medicines to people.

● People's medicine administration record (MAR) showed people received the medicines they required in line with their prescription. MARs were up to date and had no gaps or errors.

● Where people required, 'as and when' medicines, these were accompanied by protocols to guide staff on how a person may indicate they required this medicine.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance

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 Act 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 MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

At our focused inspection in September 2021 we found a lack of compliance with the principles of the Mental Capacity Act 2005 and issued a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found little improvement at this inspection and the provider remained in breach of Regulation 11.

- Staff did not demonstrate best practice around assessing mental capacity, supporting decision-making and best interests decision-making.
- Some people had mental capacity assessments in place to demonstrate their capacity had been assessed in relation to any potential restrictive practices. For example, one person was determined to have capacity to understand the need for bedrails and that they lived in a service which had locked doors.
- However, whilst one person's capacity assessment and best interests decision referred to them having one to one support, there was no clear capacity assessment in place regarding this, how it should be provided or consideration as to how this could be provided in the least restrictive way. There was also no capacity assessment or best interests decision in relation to the restraint used when supporting this person with their personal care. The use of restraint or one to one support was not referred to within their DoLS application.
- A second person had no capacity assessment in place in relation to them receiving one to one support.
- Other people's capacity assessments also lacked detail or evidence that an agreement had been reached

in the person's best interests. For example, the use of CCTV in the service. There was no description on why this was needed or how it would be used.

The continued failure to follow the principles of the Mental Capacity Act 2005, was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience

At our focused inspection in September 2021, we found a failure to ensure staff received appropriate training and supervision. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found some improvement and plans to continue this at this inspection and the provider was no longer in breach of Regulation 18.

● We reviewed the training matrix to see if staff had been provided with more recent training in areas where there were shortfalls at our last inspection. We found access to additional and specific training had improved and staff had been provided with training to enable them to carry out their role.
● Staff confirmed they had attended training and said they had induction when starting at the service where they were given the opportunity to read people's care plans.
● The operations manager told us "We have completed training on oral care, mental capacity, safeguarding and DoLS, together with an understanding of assessments and how to complete them appropriately. We have focused on the completion of work and worked alongside staff who continue to need support."
● They added, "We have changed the training so it is now all face to face. Compliance with training is currently 66% on mandatory training, but we've added loads of additional topics which staff are having to undertake. For example, not everyone had dementia awareness or dignity in action training, but we've now rolled it out across the board. Staff have until the end of February (2022) to complete all the additional courses."
● We reviewed the supervision matrix and saw not all staff had received regular supervision. For example, seven staff had only had group supervision since they commenced at the service and a further six had their appraisal in July 2021, but no individual supervision since. However, we were also provided with the current years' planned supervision matrix which showed us management had allocated regular supervision sessions for staff.
● Although staff attended group supervisions and staff meetings, it is important that staff have the opportunity to meet with their line manager on a one to one basis to discuss their role, progression, concerns or training requirements.
● In addition, the service was running shifts on a high percentage of agency staff who told us they learnt from each other (agency staff) how to support people and the routines of the home. They said they did not meet with the manager to discuss the service or their performance. This meant there was a potential risk of poor practice going unnoticed. We saw this during our inspection, when staff failed to demonstrate a respectful approach to people by communicating with them. We have covered this more in the Well-led key question.

Adapting service, design, decoration to meet people's needs

At our focused inspection in September 2021, we issued a recommendation to the registered provider in relation to the premises in which people lived. We found little improvement at this inspection, however there was a service improvement plan in place.

● There was little in the way of stimulation for people living with dementia. The lounge on the first floor was

decorated nicely and one puzzle and dominoes available. With this exception, people did not have access to any sensory items in their room. There was nothing that would have demonstrated the service supported people living with dementia such as bold signage or items of interest.
● People had en-suite bathrooms, but items such as toilet seats were all white. The crockery used for drinks and plates were all white/beige. Coloured plates and toilet seats can sometimes help with people who are living with dementia's perception, this had not been considered for anyone.
● One person's hot water tap was broken and the water was running constantly. We tested the water and found it was cold. Another person told us, "I tell them the water is cold and they say no, it's not." Following our inspection, the operations manager told us the broken hot water tap had been repaired.
Relatives told us, "It's old (the building) but comfortable, there is a nice garden which is well used in the summer months" and, "It has narrow corridors and high ceilings and is quite dark. It is in the process of being done up; it does need refurbishing."
● Although we found little change at this inspection, we were told by the operations manager there was a service improvement plan in place with regard to the interior of the service. We also read from meeting minutes redecoration would be completed by March 2022. We have reported on this more in our Well-led key question. After the inspection the registered provider told us a refurbishment plan was in place but did not supply to this to us.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care; Assessing people's needs and choices; delivering care in line with standards, guidance and the law

At our focused inspection in September 2021 we found a failure to support people with their health care needs. This was a failure to meet Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Although the provider was still in breach of Regulation 9, as reflected in our key questions of caring and responsive, we found improvements had been made at this inspection in relation to how people were supported to manage their health needs

● People were referred to healthcare professionals when appropriate. There was evidence of people being seen by the GP, occupational therapist, nurse practitioner and the speech and language therapy team (SaLT).
● Even when people did not have any health conditions that required regular contact with a healthcare professional, there was still evidence they had been supported to see the GP or practice nurse when they were unwell.
● Following on from the 'flash' meeting actions, the nurses, in conjunction with the GP, were reviewing fluid charts for people as some people had them but no longer needed them.
● Staff completed an assessment of each person's physical and mental health either on admission or soon after. Staff used nationally recognised tools to help determine a person's needs. This included malnutrition tools and pressure damage assessments.
● Staff carried out handover each day at the beginning of their shift to share information about people. A staff member said, "The nurses who worked the previous night will tell you all about the residents."

Supporting people to eat and drink enough to maintain a balanced diet
● People were provided with sufficient food and drink and told us they enjoyed their meals. One person said, "Very nice. We have breakfast, lunch and dinner and plenty of cups of tea." A second person told us the food was, "Pretty good." We spoke with one person following their lunch and asked them if they had enjoyed it. They told us, "Oh yes. I enjoy all my meals." Relatives commented, "She's definitely not undernourished" and, "From what I see, it's (the food) very nice."

● Where people were on modified diets, these were prepared for them. The chef told us care staff provided a list of people's dietary needs and preferences and this was displayed in the kitchen. The preparation of texture-modified diets was carried out by the chef and individual meals for those who had allergies or required a diabetic diet were provided.
● Where people were at risk of choking, advice had been sought from SaLT and an appropriate diet recommended. For example, a puree diet.
● People's weights were checked each month and an audit carried out to look for people at risk of malnutrition or those requiring further health professional input.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last fully comprehensive inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. Some individual staff were caring. However, people were not always cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- People did not always receive attentive or respectful engagement from staff.
- We observed three people sitting in the lounge area during the morning. Other than a cleaner commenting to one person, "You've got a lovely smile on your face today, that's good," staff in the lounge did not make any effort to engage with people. Another staff member was later seen sitting with people for a period of time, but all they did was watch television. During the afternoon we observed a similar situation with a staff member not engaging with people in a lounge. Instead, they sat, either watching the television or entering information onto their hand held (care plan) device.
- We observed people's plates were taken away from them without staff asking if the person had finished and we observed everyone's (hot) pudding being given out whilst people were still eating their main course. This meant it would have been cold by the time they came to eat it.
- Staff did not show warmth or respect for people, and people had a poor lunch time experience. We observed a staff member take a person's meal to their room and leave it on the bedside table. The staff member did not knock or speak to the person. Five minutes later, a second staff member, who again did not knock or speak to the person, brought the person's cutlery to their room. A further five minutes later, the first staff member went back into the person's room to assist them to eat. The staff member did not communicate with the person whilst supporting them to eat and rather than sitting beside the person, they stood up at the side of their bed to support them with their lunch.
- A second person was calling out and we went to speak with them. We found they had been left their meal on their bedside table. We asked the person if they required assistance to eat, which they told us they did, and yet there were no staff to assist this person. A further person, who also required assistance, had their meal untouched by their bed, with no staff assisting them. Both people's meals would have been cold at this stage. We alerted staff to these people and asked that they were brought fresh meals and supported.
- We observed a further staff member taking someone their lunch into their room. They did not tell the person what the lunch was but instead just said, "Eat your lunch now."
- Some people told us they were not happy with the care they received. One person said (about the staff), "A lot of them are very nice, but some of them are not. It's the way they talk to me. It's 'what do you want now? Stand up, stand up!' But I can't and when they do come to pull me up, they are rough." A second person told us they became agitated and upset at times because they wanted to be at home. We asked if staff comforted and reassured them when they felt this way and they told us, "No, not always."

The lack of respect and dignity shown towards people was a breach of Regulation 10(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Respecting and promoting people's privacy, dignity and independence

● Staff did not respect people's privacy or encourage their independence and although a staff member told us, "They all have different choices – knock on the door and introduce yourself and ask how they are" we did not see this happen in practice.

● Whilst we were in one person's room talking to them, a staff member came in without knocking or speaking. The person asked the staff member what they wanted and they said, "I just came to check on you." The person told us when they left that this staff member was, "One of the good ones" and yet, the staff member had not demonstrated a respectful approach by just walking into the person's room.

● Whilst chatting with a second person in their room, the housekeeper came in with a carpet cleaner. They did not knock on the door but apologised to us when they saw us in the room with the person. Despite the apology they carried on sweeping the carpet around the person's bed.

● One person told us, "I don't want to be here. It's not right. This is not the right place for me. I can still do things for myself, and I want to be independent. I want to be able to go and just make a coffee on my own, but I can't, and I have to ask if I want one."

● We saw people were all given plastic cups for their hot drinks. However, we did not see any risk assessments in people's care plans to demonstrate the registered provider had considered whether these were necessary, or if the person would be safe using crockery.

The lack of respect and dignity shown towards people was a breach of Regulation 10(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to express their views and be involved in making decisions about their care

● Some people were not always enabled to make choices for themselves as some people were given meals by staff without them checking that these were the meals people wanted. We asked people if they were able to choose what they had for their lunch. They told us, "We don't really. We have what we're given." One person told us after their lunch that if they had been given the choice, they would have preferred the other meal option from the menu.

● A staff member told us, when we asked if people were able to choose their lunch meal, "They (kitchen staff) come around, but if they're asleep, they just chose for them."

The lack of a dignity and respect shown to people was a breach of Regulation 10(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Despite our observations and the negative feedback we received from some people, others told us they liked the staff. One person said, "They have been excellent. They look after us very well." A second person told us, "We are well looked after. They are very nice here. The ones that do my care are very nice." Other comments included, "Most of them are (caring) and some are, brilliant" and, "They treat me all right. If they didn't, I would tell them off."

● Relatives gave positive feedback about staff. One relative told us, "She definitely has a rapport with staff." Others commented, "The permanent staff are very kind," "The staff are ever so kind and caring; I really do believe that," "I do think that the staff are kind and caring" and, "They are nice friendly people. They have always been polite to me."

● We also saw a staff member assist a person with their teeth so they could eat their lunch and the exchange between the person and the staff member was pleasant whilst they were being supported.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last fully comprehensive inspection, this key question was rated as Good. At this inspection this key question has deteriorated to Requires Improvement. This meant people's needs may not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- The service may not always meet the needs of people using the service. This was because there was a lack of information or guidance in place for staff. One person was recorded as having suicidal tendencies but there was no care plan in place or signs to look out for which may alert staff.
- One person's care plan detailed that the person may have behaviours that challenged themselves or others. However, there was no direct guidance for staff on what they should do if there was an incident of aggression. There was no reference to potential triggers for behaviours or any proactive steps staff could take to create a more relaxed environment for the person.
- A second person's care plan stated they refused to eat and drink. Whilst this had been identified, there was no guidance for staff on how to encourage them in their nutrition and hydration intake.
- People may not receive support with oral health care. One person was recorded as needing their teeth brushed twice daily. However, we found their toothbrush on the top of their bathroom cabinet caked in dried toothpaste. A relative told us, "I do feel oral care has been overlooked. It needs to be part of the daily routine and it isn't. Her teeth aren't brushed in the morning. Her toothbrush is dry and sometimes hasn't been moved since my last visit."
- Where people had one to one support there was a lack of guidance for staff on how this should be provided, how the person was able to have any privacy or what level of interaction would be of benefit to the person. We were told by staff that the information would be in the person's 'behaviour' section of their care plan, but there was nothing written in there.
- There was little information in the, 'Who I am' section in some people's care plans and we did not see any past history recorded which would help staff get to know people and which could be used as a basis for conversation. Management told us they were aware of this and the activities staff were completing this section with people.
- We reviewed the care plan for one person. This noted that staff should find out this person's interests to establish the right approach to social engagement, but this had not happened. Their care plan lacked details regarding their daily life and interests and some sections of the care plan were blank.
- Despite these shortfalls, we found some regular staff knew people's needs and relatives confirmed this. One relative told us, "They treat my wife as an individual. I think the staff know my wife" and another said, "Yes, they do know Mum. Mum brightens up when she sees them." One person received one to one support from staff and the staff member was able to explain to us this was because they were at high risk of falls and would, "Try to walk around" if they did not have staff with them.
- The operations manager told us they were reviewing each person's care plan to ensure it contained the most up to date, relevant information and they kept a log where they had identified gaps. However, they had not picked up on the gaps we found.

● We found some care plans that had been reviewed were relevant and contained good information. For example, where people were diabetic there was information to assist staff on what to do should the person's blood sugars become too high or drop too low. Relatives told us they had been involved in their family member's care plan. Relative's said, "I am involved. I received a copy of the care plan. It was comprehensive," "They've always insisted that they speak to me about her care" and, "I have been in on the meetings and I gave my opinions."
● Other people's care plans contained a range of information to assist staff with providing person-centred care. There was information relating to people's communication, continence, mobility, oral hygiene, nutrition, sleep and wound care. One person's physical health resulted in them developing a sore on their hands. This was recorded in their care plan and an area that staff needed to keep an eye on.

The lack of person-centred care planning was a breach of Regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
● There was a risk of people being socially isolated as there was insufficient staffing hours to allow staff to spend meaningful time with people on an individual basis. People told us activities took place at the service, but these were limited and those people who spent a long time in their rooms felt isolated. One person said, "We have two ladies employed to entertain us and they are excellent at it. They try to see everybody in the building. But they have been asked to do other jobs, so they have less time to do the activities."
● This was confirmed by the activities staff who told us, "We make sure we see everyone every morning, just to see how they are." They told us they recorded this engagement and reported any concerns they noted about people. However, they added that in recent months, the time they had available to engage people in activities had been reduced due to staff shortages. One told us, "Sometimes we are short of staff, so we help the care staff. We keep an eye on people in the lounge or help out at lunchtime." They also said they had to oversee relatives visiting the service.
● Some people told us they felt isolated. One person said, "I shout out for staff to attract their attention because I am so lonely." A second person said, "I am safe, but not happy." They told us staff did not have time to spend with them socially.
● We asked one person how they found things living at The Grange and they told us, "Boring. I can't get out of bed and I just have to lay here looking." We asked if staff came to chat with them and they told us, "Apart from bringing in drinks and things like that you're the only person I've seen all day." A second person told us they were pleased we had gone to speak to them as they were, "Bored and lonely" and a third said, "I'm unhappy because I am bored."

The lack of stimulation for people was a breach of Regulation 9(3)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Group activities were arranged in communal areas where people could join in. Relatives told us, "There is a calendar of activities. They do sing songs on Monday. They sing the same songs each week", "They have lots of little games and he goes for walks", "They have two staff who are activity coordinators. They are always looking for new things to do" and, "They really do their best to include everybody."
● We also had positive feedback from some people. One person told us they were happy with everything. They spoke to us about going out for walks, "Sometimes to the town centre and sometimes through the woods." The staff member accompanying the person was able to tell us about this person's interests and hobbies.
● A second person said, "There were activities going on before the COVID outbreak" and a further person

had received a hand massage and told us they enjoyed this, "Very much."

End of life care and support
● Although there was no one currently living at the service who was receiving end of life care we saw that some people had advanced care plans in place. These recorded people's preferences around their end of life care, including whether or not they were for active treatment.
● One person's end of life care plan asked that a particular family member was contacted and involved at this stage of their life.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● Information around people's individual communication needs was recorded in their care plans. One person was recorded as sometimes slurring when speaking and staff were advised to ask them to slow down and reassure them which would help them with their speech and understanding. We heard a staff member with this person repeating information to be able to communicate with them.
● A person told us staff were good with people unable to communicate. They said, "When I watch staff work with those who can't communicate so easily, I get a lot of pleasure in watching the reaction of those people. They're really good with them."

Improving care quality in response to complaints or concerns
● There was a complaints procedure in place and information on how to make a complaint was made readily available. Where complaints had been made, we could see these had been responded to promptly and to people's satisfaction.
● Relative's told us they knew how to make a complaint. One relative said, "Yes, I know how to make a complaint. Since the new management has come in, they have been approachable."
● We read senior staff had met with family members to resolve any complaints and in the event it was related to a maintenance issue this was resolved within a day.
● We also read compliments received by the service. These included, 'It's a relief to know that [person's name] referrals are now firmly in place' and, 'I have always had confidence that all staff members will try to do the best for [person] and other residents and would never allow them to be unavoidably harmed or neglected. It was the staff who kept our faith with The Grange'.

Inadequate

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 the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate due to a number of continued breaches and lack of significant improvement in the service. This meant there were considerable shortfalls in service leadership which did not assure the delivery of high-quality care.

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

At our focused inspection in September 2021 we found a lack of good governance and robust management oversight within the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found little overall improvement at this inspection, a number of continued shortfalls, therefore the provider remained in breach.

● We asked management to tell us what changes had been made since our last inspection. The operations manager said, "I think you will find the home is in much more of a positive position. We've still got things to do, we're not 100%, but much further down the road than previously." They added, "We've got good oversight now and some good audits which are picking up issues. The audits have shown us we need to review staff skills, we need more equipment and further training for staff is required." However, despite being told this, we identified shortfalls and poor practice within the first three hours of our inspection. This demonstrated to us management did not have a system in place to robustly monitor the quality of care people received and in particular staff practice.
● The registered provider was not alert to the culture within the service and management had failed to ensure staff displayed the right values and behaviours towards people. During the day, the whole staff team on the first floor were agency staff. These staff displayed poor practices as they did not take time to make basic conversation with people when carrying out tasks or give people the respect, privacy and dignity they deserved. Management had not noticed this, and they were only made aware when we brought it to their attention.
● On leaving our inspection, four staff members came in for their night shift without wearing masks. This was picked up by the operations manager.
● No changes had been made to the environment since our last inspection, despite our recommendation. People still lived in an environment where management had not taken time to check whether sensory items or areas of interest would improve people's experience of care. Despite management knowing that one person carpets and furnishings needed changing, they had not acted on this.
● Management had not recognised that some people felt socially isolated. This was not just in relation to COVID-19 and the current outbreak, but in general as they told us staff did not take time to just come and talk with them.
● Although management were working through the care plans, there continued to be a lack of

contemporaneous records in place for people. Risks had not been identified and guidance wasn't in place for staff to help them manage those risks.
● There was a genuine sense, however, that senior management cared for people and wished them to have a good life at The Grange. But, despite this, the registered providers had failed to make the required improvements identified at our last inspection.

The on-going lack of good governance and management oversight at the service was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered provider and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; 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
● Services registered with the Care Quality Commission are required to notify us of significant incidents or accidents affecting people using the service. We checked and found that we had received notifications from The Grange in line with requirements.
● We saw the ratings from our previous inspection displayed within the service and the registered provider had included the ratings on their website.
● Some staff felt there had been some positive changes since our last inspection. One staff member said, "The management are more proactive." They told us senior staff and managers were, "Supportive." The new manager told us, "I feel very supported. Even the home managers of the sister homes and the director are amazing. We've had some very good training here, which I've never had before."
● There was a new chef at the service and they and management had agreed a plan of action to improve the dining experience for people. They told us, "I have been asked to involve residents more in planning the menu and to meet residents to hear their feedback. I am going to introduce 'show plates' so residents can see and smell the food when making a choice about what to eat."
● We reviewed the medicines audits and saw these sampled 10 people's medicines and their medicine administration record each month. These had not identified any major issues, but a couple of areas for improvement and both were being addressed.
● Where people experienced accidents or incidents, or complaints were made to the service, an apology was given.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Resident's meetings were held in which we read that activities and mealtimes were discussed. Actions were identified to be taken forward, such as specific activities for people.
● Relatives were also encouraged to be involved. Senior management told us, "[Manager] has met with a lot of relatives. We are also emailing relatives globally as well as individually. They have fed back that they feel their relative is safer and they now know who to contact. [Manager] plans to get residents involved in interviewing prospective staff." They sent us evidence of communication with relatives, together with minutes from remote relative's meetings following our inspection.
● Relatives had confidence in the new management team. One relative told us, "The operations manager is very reassuring." Another said, "They've just changed the management. They are trying to listen to the residents. They have introduced Zoom meetings and a newsletter. One concern was that it took a long time to answer the front door. Now there's a lady near the door to let us in. This is a very positive development." All relatives felt listened to and their views taken seriously.
● Management engaged with people. We saw a manager come in and speak with three people. They chatted for around five minutes. We asked people if they saw much of the manager's and one person told us, "Oh yes, they come and check that everything is all right." Although we did observe this, management

were not aware of the poor culture being displayed by staff within the service.
● Regular staff meetings were held. Individual meetings were held for clinical staff, support staff and kitchen staff which meant topics addressed areas relating to the specific job role.

Continuous learning and improving care; Working in partnership with others
● The operations manager told us of new processes being introduced to the service to help pick up on shortfalls and monitor people's care. These included a monthly manager's audit which would cover every aspect of the service. They said, "We've introduced a monthly manager audit which gives a snapshot of every area of the home, this is alongside our medicines audits, wound, weight, dining, infection control, DoLS and care plan audits."
● The operations manager told us there was a service improvement plan relating to the internal decoration of the premises which was due to be completed by the end of March 2022. We will check at our next inspection that this has happened.
● The service worked closely with their GP and nurse practitioner. Weekly visits were made to the service and staff could contact them for advice at any time.
● Following our focused inspection in September 2021, management had worked with the local authority to address shortfalls, receiving support and advice from the quality assurance and safeguarding teams.