Goring Care Homes Limited

The Grange

Inspection report

Grange Close
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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?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

We carried out this inspection on 5 April 2016. The inspection was unannounced.

The Grange is a care home registered to provide accommodation to people requiring personal care. The service supports older people with a variety of conditions which includes people living with dementia. At the time of our visit there were 28 people living in the service.

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 enjoyed living at The Grange. People, relatives and visiting health professionals were complimentary about the registered manager and staff. Staff were kind and caring. Throughout the inspection there was a friendly atmosphere with much laughter between people, their relatives and staff.

There were group and individual activities taking place and people were free to spend their time as they chose. People had food and drink to meet their nutritional need, however some people felt the choice was limited.

There were sufficient staff on duty to meet people's needs. Staff knew people well and had sufficient training to ensure they had the skills and knowledge to support people effectively.

Care plans were personalised and identified how people's needs should be met. Risks were identified and plans were in place to manage risks. People were not always supported in line with the principles of the Mental Capacity Act 2005 (MCA).

Medicines were stored safely. Records relating to medicines were not always completed in line with the provider's medicine policy.

Quality assurance systems to monitor and improve the quality of the service were not always effective.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. 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?

Requires Improvement

The service was safe

Medicines were not always administered in line with good practice guidance and the providers medicines policy.

People felt safe and were supported by staff who had a clear understanding of their responsibility to identify and report any concerns relating to abuse of vulnerable people.

There were sufficient staff on duty to meet people's needs.

Is the service effective?

Requires Improvement

The service was not always effective.

The registered manager did not have a clear understanding of their responsibilities in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

People's specific dietary needs were met. People were not always positive about the choice of food available.

People had access to health professionals when required and were referred in a timely manner.

Is the service caring?

Good

The service was caring.

People were supported by staff who were caring and treated them with dignity and respect.

People were involved in decisions about their care and were included in the development of their care plans.

Staff showed compassion and kindness when interacting with people.

Is the service responsive?

Good

The service was responsive.

People had personalised care plans which identified how their needs should be met.

People enjoyed group and individual activities. This included visits outside the home and visiting entertainers.

People and relatives knew how to make a complaint and felt confident to do so.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Systems to monitor and improve the quality of the service were not always effective.

The registered manager promoted a person-centred approach to care and ensured people were at the centre of everything that happened in the home.

Staff were positive about working at the Grange and had regular opportunities to share ideas.

The Grange

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 5 April 2016 and was unannounced.

The inspection was carried out by two inspectors and an expert by experience (ExE). An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). 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.

Prior to the inspection we looked at notifications received from the provider. A notification is information about important events which the provider is required to tell us about by law.

During our inspection we carried out a Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also observed care practices throughout the day.

We spoke with thirteen people who used the service, four visitors and two visiting health care professionals. We looked at five people's care records, five staff files and other records showing how the home was managed. We spoke with the registered manager, the deputy manager, five care workers, a team leader and the chef.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe. Comments included; "I feel safe here as there are always others around and the call bell is usually answered quickly" and "I feel quite safe here because whenever I need help there is always someone around". Relatives felt people were safe. One relative said, "I feel [person] is quite safe here. There are always people (staff) around if they need help and the staff are very good, always making sufficient time to help residents when they need it".

Medicines were stored safely. Keys to the treatment room where the medicines trolley was stored and keys to the medicines trolley were held by the person responsible for administering medicines. Staff responsible for the administration of medicines had completed training and had their competency assessed before administering medicines unsupervised. Training was updated every three years.

During the lunchtime medicines administration the member of staff administering medicines removed people's medicines from the monitored dosage system and signed the medicine administration record (MAR) before administering the medicines. This was not in line with good practice guidance or the providers medicines policy. We spoke to the member of staff about using the incorrect procedure. The member of staff told us "I know that. In the morning it's different. It's done this way at lunchtime for quickness I suppose. It's just because I know them (people)". Another member of staff who also administered medicines said, "In the morning we sign afterwards. I know we shouldn't. You can't sign before you know what's going to happen". We spoke to the registered manager who told us they would take immediate action to ensure correct procedures were followed. We could not be sure that if people declined their medicine this would be accurately recorded when staff had signed the MAR prior to administration.

MAR contained details of all prescribed medicines and where people were prescribed 'as required' (PRN) medicines there were protocols in place to ensure people received the medicines as prescribed.

The provider had a safeguarding policy and procedure in place. This was displayed in the entrance to the home and included the contact details for the local authority safeguarding team and CQC.

Staff had received training in safeguarding and understood their responsibilities to identify and report any concerns relating to abuse. One member of staff said, "We do safeguarding training. It's a big thing". Staff were able to describe the different types of abuse and signs that may indicate abuse. One member of staff told us, "A person could become withdrawn or angry for no apparent reason". Staff knew where to report concerns outside of the organisation if they felt concerns had not been taken seriously by the provider.

People told us there were enough staff to meet their needs. Throughout the inspection call bells were answered promptly and any requests for assistance were responded to immediately. Staffing rotas showed that assessed staffing levels were met. The registered manager told us that agency staff were not used and there were no staffing vacancies. Care staff told us there were enough staff to meet people's needs.

One visiting health professional who visited the home several times a week told us, "There are always plenty

of staff about".

People's care records included risk assessments which identified risks associated with: falls; moving and handling; weight loss; pressure damage and self administration of medicines. Where risks were identified care plans contained guidance on how risks were be managed. For example, one person remained in bed. The care plan identified the person was at risk of malnutrition and pressure damage. The care plan stated the person should be visited hourly to check they were safe and to offer food and drink. The care plan also stated a pressure relieving mattress should be used. We visited the person and saw a pressure mattress was in place. Records showed the person was visited hourly and food and fluid intake was recorded.

Records relating to the recruitment of new staff contained relevant checks that had been completed before staff worked unsupervised in people's homes; This was to ensure staff were of good character. These included employment references and disclosure and barring checks (DBS). DBS checks enable employers to make safer recruitment decisions and prevent unsuitable people from working with vulnerable people.

Systems were in place to ensure equipment related to keeping people safe was regularly monitored and serviced. This included: Fire systems, water temperatures, window restrictors and hoists.

Requires Improvement

Is the service effective?

Our findings

The registered manager did not have a clear knowledge of their responsibilities in relation to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). 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.

The registered manager had made DoLS applications to the supervisory body. 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. However, where DoLS applications were made there was no mental capacity assessment recorded to determine if the person had capacity to consent to the restriction. For example, a DoLS application had been made for one person who was leaving the home unsupervised. The person's care plan did not identify whether the person had capacity in relation to the decision to leave the home and did not identify what restrictions were in place to keep the person safe. The care plan did not identify how staff should support the person in the least restrictive way.

People were not always supported in line with the principles of MCA. Care plans contained consent forms signed by people who did not have legal authority to do so. For example, one person's relative had signed a consent form for bed rails to be used. There was no record of the relative having legal authority to give consent. Where decisions had been made on behalf of people there was no record of mental capacity assessments being completed in relation to the decision being made and no record of a best interest process being followed.

Staff told us they had not received training in relation to MCA and had little knowledge in relation to how to support people in line with the principles of MCA. Comments included: "No, I've never heard of that"; "Capacity assessments would be mainly on a medical basis by the GP" and "Is it about the right to chose"?

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives told us staff were knowledgeable about their needs. One relative said, "The staff seem quite knowledgeable. They know about [person] whenever I ask or if they don't they will soon find out". One visiting health professional told us, "Staff know people well. Absolutely".

New staff completed an induction programme which included shadowing more experienced staff to enable new staff to get to know people. Staff told us they had competed training in subjects which included: First aid; moving and handling; safeguarding; dementia and infection control. Staff spoke positively about dementia training they had completed which included simulating the effects of living with dementia. Staff explained how this had improved their understanding of the disease and enabled them to better support people who were living with dementia.

Staff had access to development opportunities. Staff we spoke with had achieved or were working towards national qualifications in social and health care.

Staff felt supported in their role. Staff told us they had regular supervision with a member of the senior staff team. One member of staff told us they found supervision helpful to their practice. Records showed that staff had supervision in line with the supervision policy and that they were supported to identify development needs. For example, one staff supervision record showed the member of staff wanted to work towards a national qualification. The member of staff had been enrolled for the qualification.

Most people enjoyed the food offered. However some people felt the choice was limited and did not meet their likes and dislikes. Comments included: "The food could be better. There is too much cream and too much veg"; "A relative brings fresh fruit in for me as they (provider) only ever seem to have bananas here. We never seem to have salad and I'm used to quite a lot of both salad and fruit. I love them both" and "We do have fish occasionally but it always seems to be in batter. We should be eating oily fish like sardines and mackerel".

People had a choice of two meals at lunchtime. However, portions of one option ran out and people were not able to have their choice. People were offered an omelette as an alternative.

People were offered drinks and snacks throughout the day. People who chose to remain in their rooms had jugs of water and drinks to hand. This ensured they had regular access to food and drink to meet their nutritional needs.

People who required support to eat and drink received one to one support from care staff. Staff sat with people and supported them at the person's own pace. People were prompted and encouraged to eat and drink sufficiently to meet their nutritional needs. People's specific dietary requirements were met. For example, one person required a soft, fortified diet which they received.

Where people were at risk of weight loss, weight was monitored monthly and action taken where weight loss was noted. For example, one person had lost weight over a three month period. The person had been referred to the care home support service and for an assessment by the Speech and Language Therapist.

People had access to health professionals where their condition indicated this was required. Records showed people had access to GP, district nurses, chiropodist and memory clinic. Visiting health professionals told us people were referred to their services appropriately and in a timely manner.

Good

Is the service caring?

Our findings

People were complimentary about the caring approach of staff. Comments included: "It's a good home. I can't grumble at any of them. They're all very good"; "The place is very good. The care is good"; "Staff like this young lady (the person pointed to a member of staff) are very helpful and kind". Relatives and visitors were positive about the caring atmosphere in the home. One visitor told us, "It feels like a big happy family with everyone smiling". A relative said, "Staff are very willing. A lot of the time they treat them as if they were their own family. It's lovely to see".

Visiting health professionals were extremely positive about the staff working in the home. One health professional told us, "Staff are really lovely, genuinely caring and very warm. They (staff) look after them very well".

Staff spoke with and about people in a caring and respectful way. Staff clearly enjoyed their work and were positive about the caring attitude of the staff team. One member of staff told us, "We're really lucky here. All our carers (care staff) are really good".

Throughout the inspection we saw many kind and compassionate interactions. Staff took time with people, explaining and reassuring when people were anxious. For example, one person became anxious because they could not see. A care worker sat with the person explaining to them that they had a condition affecting their sight and reassuring them they had a hospital appointment to have treatment for the condition.

Staff stopped to talk with people as they passed. There were many interactions where staff and people laughed and clearly enjoyed each others company. Staff knew people well and chatted about families and events that had happened.

People were treated with dignity and respect. One relative told us, "Carers always knock before they come into the room and they always treat residents, whether it is (person) or anyone else with care, respect and dignity".

Staff were discreet when supporting people with aspects of their personal care. For example, one member of staff sat closely to a person and held their hand. The member of staff asked the person quietly if they would like to go to the bathroom. The person smiled and nodded. The care worker then supported the person to stand, explaining what was happening at every stage.

Staff showed empathy and compassion when supporting a person who had recently suffered a bereavement. Staff spoke to each other about the person's mood and showed genuine concern about how they could support the person through their bereavement.

People were involved in developing their care plan. One relative told us, "The deputy manager went through all the care plan with me". Another relative said, "The family have been fully involved both in the care plan on admission and in review since".

Staff ensured people were involved in decisions about their care and respected people's choices. For example, people who chose to remain in their rooms were supported to do so.

Good

Is the service responsive?

Our findings

People told us staff were responsive to their changing needs. One person said, "The home has adapted to the changes as my needs have changed. I can't criticise the care I get at all".

People were encouraged to maintain their independence. Comments included, "Staff encourage me to be independent" and "The staff give me as much independence as I can manage but are always happy to help whenever I ask for it. Nothing is too much trouble". One relative said, "Staff allow more independence but as dependency has changed they have been ready to assist".

People were assessed prior to moving onto the home and assessments were used to develop individualised care plans. Care plans identified how people needs were met in relation to areas including: personal care; communication; mobility; nutrition and hydration and social activities. Care plans were reviewed and updated monthly.

Care plans included details of what people could do for themselves. Where necessary risk assessments identified the support needed to manage the risks associated with maintaining independence. For example, one person had declined the use of a hoist when transferring. Support had been sought from health professionals and equipment had been supplied to enable the person to continue to transfer safely without a hoist.

Care plans identified people's histories, likes and dislikes. For example, one person had enjoyed knitting, sewing and reading. Another person's care plan stated they enjoyed reading the newspaper. The person told us the registered manager brought their newspaper to them each day. We saw them enjoying the paper during the day.

The home did not employ an activity coordinator, however the registered manager told us a member of the care team was allocated each day to organise social activities. On the day of our inspection people enjoyed a bingo session organised by care staff. People enjoyed individual activities through the day. For example, one person was completing a crossword. Staff stopped each time they passed to help the person and prompt them by reading out crossword clues. Staff involved other people in the activity. Another person was in a quiet area of the home with a volunteer reading poetry to them. A visiting health professional told us, "There are always activities going on. They make a real effort".

We saw photographs displayed of outings people had enjoyed and of entertainment that had been organised within the home.

People had built meaningful relationships with each other. Staff supported people to spend time together. For example, one person came into a communal area of the home. The person wanted to sit with someone they knew. Staff suggested where they could sit to spend time together and supported them to move. Both people were clearly pleased to be able to sit together.

People and relatives knew how to make complaints and felt confident to do so. One relative told us they had raised a concern. The relative said, "Everything was sorted". The provider had a complaints policy and procedure in place. Records showed that complaints had been responded to in line with the policy and to the satisfaction of the complainant.

Requires Improvement

Is the service well-led?

Our findings

Systems to monitor and improve the quality of the service were not always effective. The providers Quality Assurance Policy was out of date and contained incorrect information in relation to regulation. The policy stated an internal audit would take place quarterly. There was no record of regular quarterly audits being completed. Records showed that some audits had been carried out, however where issues were identified actions had not always been completed. For example, a medicines audit carried out by an external agency on 20 January 2016 identified that the provider did not have a policy relating to the procedures for ordering medicines. The action plan stated this would be completed by 31 January 2016. The policy had not been written at the time of our inspection. The same audit also identified that staff were not always following guidance in relation to signing medicine administration records (MAR) after a person had taken their medicines. We found this issue had not been addressed.

The Quality Assurance Policy stated that meetings would be held monthly for people using the service. There were no meetings held for people or their relatives to enable them to give feedback on the service.

A quality questionnaire had been sent out in January 2016. The results of the survey had not been used to inform an action plan to improve the service. For example, questionnaire responses included feedback about activities, a request for regular meetings for people and the quality of food provided for supper. No action had been taken as result of the questionnaires.

This was breach of Regulation 17 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014

People were complimentary about the registered manager. One person told us, "The manager usually brings the papers and post round and has a chat at the same time. She will take a tray out if it needs doing and is very hands on. She is not afraid to get involved".

Staff told us the registered manager was supportive and enjoyed working at the Grange. One member of staff said, "[Registered manager] is very good, very approachable". Another told us, "I enjoy my job".

Visiting health professionals were positive about the manager and the senior care staff. Comments included, "[Registered manager] is excellent" and "There is brilliant communication. They [senior staff or manager] always contact me if they have a concern or are unsure. I have really good relationships with the manager and staff".

The registered manager promoted a caring, person-centred culture in the home by ensuring people were at the centre of the service. People enjoyed living at The Grange and described it as 'homely'.

Staff were positive about the communication between staff and the registered manager and had regular opportunities to share ideas and raise issues. For example records of regular staff meetings showed staff took the opportunity to find solutions to issues and share learning as result of incidents that had occurred.

Accidents and incidents were recorded and any actions needed as a result of the accident identified. Actions took account of positive risk taking. For example, one person had fallen when attending an activity outside of the home. A discussion with the person and relatives identified the benefit of continuing to attend the activity outweighed the risk of a fall and the person was supported to continue the activity. Although the registered manager had a good knowledge of the accidents and incidents that had occurred in the home there was no formal method for monitoring trends and patterns.

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 11 HSCA RA Regulations 2014 Need for consent The provider did not ensure care and treatment was provided with the consent of the relevant person.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not ensure effective systems and processes were in place to assess, monitor and improve the quality and safety of the service for people.