The Grange (2016) Ltd

The Grange - Benenden

Inspection report

The Green
Benenden
Cranbrook
Kent
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Tel: 01580240118

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected The Grange on 7 and 20 July 2017 and the inspection was unannounced. The Grange is a care home which provides personal care and accommodation for up to 19 adults with learning disabilities. The Grange is a large and spacious country home set in 7 acres of well-maintained gardens. Although The Grange has been established for 25 years it had been taken over by a new registered provider in 2016.

The service had a registered manager in post. 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 were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems in the service did not support this practice. For example, people assessed as not having the capacity to make a decision did not have a best interest meeting to make the decision on their behalf. You can see what action we told the provider to take at the back of the full version of the report.

Staff did not always have access to the training they needed to carry out their role. We have made a recommendation about this in our report.

The registered provider had systems in place to assess and audit the quality of the service however, audits were not fully implemented which meant that some of the shortfalls found at this inspection had not been captured in an audit. We have made a recommendation about this in our report.

People were kept safe: staff understood the importance of safeguarding people from abuse and knew how to report any concerns. Risks to people's health, safety and wellbeing had been assessed and plans were in place, which instructed staff how to minimise any identified risks to keep people safe from harm or injury.

There were suitable arrangements in place for the safe storage, receipt and management of people's medicines. Medicine profiles were in place which provided an overview of the person's prescribed medicine, the reason for administration, dosage and any side effects.

There were sufficient numbers of staff employed to meet people's needs and staff knew people well and had built up good relationships with people. The registered provider had effective and safe recruitment procedures in place.

Staff treated people as individuals and with dignity and respect. Staff were knowledgeable about people's likes, dislikes, preferences and care needs. People's privacy and dignity were respected and upheld by staff who valued peoples' unique characters. Good interactions were observed throughout our inspection, such as staff sitting and talking with people as equals. People could have visits from family and friends whenever

they wanted.

Peoples' health was monitored and referrals were made to health services in an appropriate and timely manner. Any recommendations made by health care professionals were acted upon and incorporated into peoples' care plans.

People received a person centred service that enabled them to live active and meaningful lives in the way they wanted. There were a range of varied and meaningful activities that engaged people and gave people a sense of belonging in their community.

Complaints were used as a means of improving the service and people felt confident that they could make a complaint and that any concerns would be taken seriously.

There was an open, transparent culture and people were included in the running of their home. Staff spoke highly of the registered manager and their leadership style. The management team had positive relationships with the care staff and knew people well. The registered manager took an active role within the service and led by example.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were protected from the risk of harm and abuse and staff understood their role in keeping people safe.

Risk assessments were comprehensive and reduced hazards through effective control measures.

Staffing numbers met people's needs safely.

Medicines were managed safely and stored and administered within best practice guidelines.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff did not always receive sufficient training to carry out their roles and in several courses training was out of date or people lacked the training.

The principles of the MCA were not being complied with. Where people lacked capacity best interest meetings were not being recorded and applications to deprive people of their liberty had not been submitted.

People received adequate food and drink and people to remain healthy.

People's healthcare needs were met and people had access to a wide range of healthcare professionals when they needed them.

Is the service caring?

Good

The service was caring.

Staff knew people well and used the information about people to effectively support them and build up caring relationships.

People and their families were involved in their lives and could make decisions about their care.

People were treated with dignity and respect and their independence was encouraged.

Is the service responsive?

Good

The service was responsive.

People received a person centred service and staff responded effectively to people's needs. People had access to a range of meaningful activities and were able to choose how to spend their free time.

Complaints were responded to appropriately and were used as a tool for improving services.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Quality monitoring systems had not been implemented or embedded in order to identify some shortfalls.

The culture of the service was open, person focused and inclusive.

The management team provided clear leadership to the staff team and were a visible presence in the service.

The Grange - Benenden

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 7 and 20 July 2017 and was unannounced. The inspection was carried out by one inspector.

Before the inspection we reviewed all the information we held about the service, including data about safeguarding and statutory notifications. Statutory notifications are information about important events which the provider is required to send us by law. 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.

As some people who lived at The Grange were not consistently able to tell us about their experiences, we observed the care and support being provided and talked with relatives and other people involved with people's care provision during and following the inspection. As part of the inspection we spoke with the registered manager, chief executive, deputy manager, five care staff, the gardener, craft teacher, seven people and three people's relatives. We looked at a range of records about people's care and how the service was managed. We looked at five people's care plans, medication administration records, risk assessments, accident and incident records, maintenance records, complaints records two staff files and quality audits that had been completed.

This is the first inspection of The Grange Benenden since the change of registration.

Good

Is the service safe?

Our findings

People living at The Grange told us they felt safe. One person said, "I'm safe because it's a nice place here." Another person commented, "I know the residents and the staff and I am safe: I know I'm safe as I have a lovely bedroom." Comments from relatives included, "X has been living there for many years and has always been safe there" and "There are no problems [with safety]. I think it's a question of the length of time he's been there, the familiarity of people and if there were problems X would say."

People were protected against the risks of potential abuse. Staff members had a clear understanding of their role in safeguarding people from abuse and in the processes involved in reporting concerns. Staff received training in safeguarding vulnerable adults and were able to speak with confidence about the subject. One staff member said, "If I notice something of concern I have to report it straight away to management, using the whistleblowing procedure if necessary, and I would have to document and sign my concern." Another staff member said, "To me safeguarding means looking out for people's wellbeing and protecting them from every type of abuse." Staff members were able to describe different forms of abuse, including newer definitions such as modern slavery. There was a safeguarding file kept at the service which contained the local authority safeguarding adult's policy, protocols and guidance. This contained a flowchart staff members could follow to ensure they were reporting incidents correctly and following up concerns. The registered manager actively encouraged people to be aware of the risk of abuse and spoke about safeguarding at meetings; in addition, one of the noticeboards displayed a local authority 'abuse and what you need to do about it' poster and leaflet for people to read.

People were supported to take risks to retain their independence whilst any known hazards were minimised to prevent harm. People's care plans identified potential hazards and used effective risk assessment to mitigate any risks. Where potential hazards were identified the risk assessment tool assigned a severity and likelihood rating to calculate a risk value and then state what control measures were required to make an activity safe. For example, one person had a history of running towards the road whilst in the garden. This risk was identified in a care plan assessment and transferred to a risk assessment which outlined control measures, such as 'staff supporting the person by linking arms and guiding them to safety. Another person was identified as being at risk whilst eating and control measures had been applied such as staff sitting with the person and cutting food up. We observed two meal times where this support was delivered.

Environmental risks were being managed effectively through regular monitoring and checks conducted by the registered manager. There were up to date safety certificates for gas appliances, electrical installations, and portable appliances. The registered manager ensured that general risks such as slips and trips were regularly assessed. Regulatory risk assessments were completed to reduce hazards around manual handling, Control of Substances Hazardous to Health (COSHH) and food safety. Each risk assessment identified the risk and what actions were required of staff to reduce the hazard. Fire protection equipment was regularly checked and serviced by the provider. Staff were trained in fire awareness and staff were appointed as fire marshals with specific responsibilities. Quarterly fire drills were carried out with the people's active participation. The service held an emergency contingency plan that was comprehensive, regularly reviewed and updated.

There were enough staff employed and working each shift to keep people safe and meet their needs. The registered manager ensured that four staff were deployed in the mornings and three staff worked each afternoon. At night times there was one waking night worker and one sleep-in staff. In addition to care workers the registered provider employed a gardener to work two days a week to tend the extensive grounds; a craft teacher who worked three days a week, and a cook who worked five days a week in the kitchen. We reviewed a sample of rotas for several weeks preceding our inspection and saw that the rotas matched the assessed levels of staffing. Observations we made confirmed that staffing levels were sufficient to meet people's needs. For example, when a person required assistance with eating or attending a medical appointment there were still sufficient staff to attend to the needs of other people. One staff member told us, "There are enough staff on shift. If we cover a shift with agency staff then we always have permanent staff working with them and the agency staff are inducted fully so they understand how we work."

Thorough recruitment and disciplinary procedures were followed to check that staff were of suitable character to carry out their roles. The registered provider had recently conducted an audit of employment files and had found some historical issues, such as gaps in employment history or personal details forms that had not been updated. As a result the registered provider had sent letters to staff requesting the information and files were updated. We looked at four staff files: all had a Disclosure and Barring Service safety check, photo identification and two references. There was a full employment history and additional documents, such as copies of driving competencies where applicable.

There were safe medicines administration systems in place and people received their medicines when required. The service used a monitored dosage system where tablets arrive from the pharmacy pre-packed and in a separate compartment for each dosage time of the day. We checked the medicines administrations (MAR) charts for people and found that medicines were being signed in to the service and counted correctly, meaning that audits of medicines were being conducted accurately and regularly. MAR charts had been signed correctly to indicate that people had received their medicines. Medicines were stored safely in lockable cabinets, within a locked room. There were separate cabinets for people's topical creams and lotions and each item had a label on to indicate when it had been opened. Good administration practices were observed: staff checked the medicine, person, route and dosage before offering the tablets to people with a glass of water. One person who was due for their medicines asked if they could go and complete another task first and this was accommodated safely.

Requires Improvement

Is the service effective?

Our findings

People and their relatives spoke positively about staff and told us they were skilled to meet their needs. One person said, "We can see they [staff] have done the training: it's the way they know how to deal with problems, like if X has an [epileptic seizure] they know what to do." Another person said, "The food is good here. My favourite is fish and chips but last week I made a chicken caesar salad for the main dinner." One relative told us, "The staff definitely know how to care because X had a problem some years ago and I saw how well they cared for him." Another relative commented, "Staff certainly have the right skills: all I can say is they have the right attitude in meeting X's needs." Despite these positive comments we found some areas of practice were not always effective.

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. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). Staff members we spoke to had received training on MCA and DoLS and were able to speak confidently about mental capacity. One staff member told us, "I've had training and know that I should always assume people have capacity and that people can make unwise decisions. If a decision is made on their behalf it should go through other professionals and be on best interests." However, the registered manager had not ensured that the principles of the MCA were adhered to. The registered provider had carried out MCA assessments appropriately but had not ensured that best interest meetings followed when a person was found to be lacking capacity. For example, one person had an MCA assessment in place for medicines. The assessment was completed correctly and the person was found to lack capacity around taking their medicines. However, there was no best interest meeting to establish what action was the least restrictive and met the person's needs. There were other MCA assessments for medicines and finances where capacity had not been established and no best interest meeting followed. The Mental Capacity Act Code of Practice [a nationally recognised guide for meeting the principles of the MCA] explains that where MCA assessments establish that a person lacks capacity there should be a best interest meeting held to consult with people involved in the person's care to decide the least restrictive option. We spoke to the registered manager about the lack of best interest meetings and were told, "There are no formal best interest meetings in place other than ones when the care manager reviews. We have implemented a new MCA policy that highlighted the need for best interest meetings."

The registered manager had not made any applications for DoLS. We raised this with the chief executive who told us, "I think there are people who require a DoLS. As part of our ongoing strategy we have identified more in depth DoLS training for managers and senior staff in July 2017. Last week we completed supported decision making training for managers and senior staff. When it comes to DoLS we're looking at the 'acid test' and how to support staff." The chief executive had commissioned training from the local authority to bridge the knowledge gap for staff and enable appropriate DoLS applications to be made. However, on the day of our inspection DoLS had not been applied for appropriately.

The failure to follow the principles of the MCA 2005 is a breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff told us they had the training and skills they needed to meet people's needs. One staff member commented, "The training is good, I've recently done lots of courses. If you're interested in something you can ask for more training. I used to be X's key worker and requested extra epilepsy training and it came through really quickly." Another staff member commented, "The training has been very good. If we need it updating it's always available and the majority of training is face to face." However we found that there were some gaps in training that had not been assessed. We reviewed the training matrix found that specialist training in the administration of an epilepsy rescue medicine [a medicine that is administered after prolonged or repetitive seizures] had expired for several members of the staff team. Six staff members had training in date to administer the rescue medicine but eight staff either did not have the training or it had expired. We also noted that some staff had training had expired for the administration of medicines. We raised this issue with the registered manager and were told, "We have epilepsy and medicine training booked in August. I am writing the rota so there is always a trained person on shift [to give rescue medicines and administer regular medicines to people]. Where staff have medication training that's out of date we have completed medication competency training." The registered provider had recently implemented a new system where gaps in training had been identified and courses subsequently booked.

We recommend that the registered manager embeds in to practice the training monitoring programme to ensure that staff have the skills and training to effectively carry out their role.

People told us they liked the food and were able to make choices about what they had to eat and be actively involved in the preparation of meals. One person commented, "I like being in the kitchen helping to prepare the food. We have a menu meeting and we decide what we want." Another person told us, "We choose the menu. Today is eggy bread for lunch and we choose what we want to eat: we're trying to be healthy. One relative told us, "I've tried the food there and it's good. There's always fruit and vegetables and they eat quite healthy." We spoke to the cook who had received training in food safety and hygiene in addition to other courses. The cook was aware that one person followed a gluten free diet, another person was on a low fat diet and one person was on a soft diet with food cut up in to small pieces. The cook knew that there were three foods this person should avoid and was also able to correctly list the preferences of other people, such as one person not liking fish. The cook received feedback about the food verbally and told us about the last complaint they received, when someone wanted gravy with a Shepard's pie: which was accommodated. There was a kitchen assistant rota on display in the kitchen with a different person working in the kitchen each day. One person told us, "The cook was on holiday last week so we did 'come dine with me' and residents cooked. We did healthy meals and it went down really well." Another person told us, "Everyone who applied to work in the kitchen as an assistant was interviewed for the job and I think that was important."

On the second day of our inspection there was a special celebration and a person had requested a barbecue. They told us that they had asked for burgers, sausages, two types of chicken, salad and potato salad. At lunch time we saw that this meal had been prepared by the cook with the help of one person in the kitchen and one person cooking on the barbecue. Everyone really enjoyed the meal and it was a social event with one person playing music, another person serving drinks and the person whose event it was inviting other staff members and the craft teacher and gardener to share a meal and a drink. People asked for beer and wine and were offered a selection of alcoholic and soft drinks. One person commented, "This is a feast" and everyone gave the person who cooked the food a round of applause.

People had access to health and social care professionals. Records confirmed people had access to a GP,

dentist and an optician and could attend appointments when required. People had a health action plan which described the support they needed to stay healthy. One staff member told us, "We have strong ties with the doctor's surgery in Cranbrook and have lots of appointments in Maidstone and Pembury hospitals. We have physiotherapists and chiropodists visiting people and residents know they can tell us if they feel ill and we monitor those who can't speak." People with medical conditions received effective treatment. We reviewed the care plan for one person with epilepsy and the person saw a neurologist every six months and an epilepsy nurse every three months to monitor their condition. There was an epilepsy care plan in the file which was written in detail and contained effective information on the person's history, type of seizure and treatment. Seizures were being monitored and recorded and showed that staff members were following the guidelines on administering rescue medicines. People had accessed a range of medical appointments supported by staff members from the service. One person had five medical appointments in 2017 with services ranging from GP, chiropodist, optician and nursing. Where people had been sent for tests, such as routine blood tests, these had been followed up, recorded and actioned by staff members.

Good

Is the service caring?

Our findings

People were treated with kindness and compassion in their day-to-day care. One person told us, "The staff are caring. I've got a lovely key worker; she looks after me. For my birthday last year I got a tablet and she helps me with my emails: I email my mum, brother and friends." Another person commented, "The staff are special people in my life." A third person told us, "The staff are lovely; they help me to clean my shower." One relative told us, "I think the staff are very caring. X gets on with all the staff and loves them to pieces. When they [staff] go on holiday they see something and say, 'X would like this' and bring it back home for him, so yes, they care."

Staff members had got to know people well and built up meaningful relationships that were based on trust and respect. One staff member commented, "X likes to refuse things, e.g. shopping trips, but when you know her better, she's more likely to go out. She used to have mobility issues so will say she cannot go, but when you know her you know how to praise her and encourage her and then she will go out and do things." On the day of our inspection we observed very open, familiar relationships between people and their staff and these were apparent throughout the inspection.

People and their staff team interacted as equals and staff knew how to interact with each person. Some people were looking at a video on a tablet with a staff member when one person pointed to another person and said to the staff 'he's struggling'. The staff member smiled and gently said, 'He's a Liverpool fan, he's used to struggling.' Both people and the staff member laughed together and enjoyed the joke: as the staff member assisted the person to see the video better they had a relaxed conversation about football transfers, Liverpool FC and the Wimbledon tennis tournament. The person clearly enjoyed this typically 'male' interaction of gentle joking and talking about sport and there were signs of affection between this person and the staff, such as touching the shoulder when speaking or the person laying their hand on the staff members arm. This was typical of the interactions between staff and people. People enjoyed using humour to speak to their peers. For example, one person came to the lounge from the kitchen and waved a cucumber at another person as they didn't like cucumbers: the person laughed and said, "I'll threaten you with a cheese sandwich", which caused lots of laughter. During a reminiscence session people were looking through their old photo albums. People spoke fondly about their memories and events that were important in their lives. One staff member commented, "I've learned so much about our residents from sitting, talking and listening when we've looked through photos." When people wanted to know who was in a photo staff members had the information to hand and showed they knew people and their histories well.

People's independence was encouraged and their involvement in the day to day running of their service was apparent. During one of the 'manager's drop in clinics' a person had requested to manage their own medicines. The registered manager and the deputy manager drew up a strategy to enable the person to safely and gradually take control of their own medicine. As a result the person had started to administer their own medicines with staff supervision. Care plans detailed how staff were to encourage people to be more independent. For example one care plan stated, 'X has little self-care skills as he has always had heavy support but we are working towards independence with him.' The plan went on to state how praise and encouragement were to be used to enable the person to complete part of their personal care routine. The

first day of our inspection was a very hot day and the registered manager asked a staff member to ensure that people had cold drinks. Rather than just fetch cold drinks the staff member automatically asked if a person wanted to do it. One person volunteered and was given appropriate support to fill jugs of different flavoured cooled drinks and serve drinks to people. The staff member stood back when safe and allowed the person to complete the task: other staff members and people thanked and praised the person, which was well received. On another occasion a food delivery was made and people were supported to take the lead and put their food away. One person told us, "I like to be independent and staff help me with that. They help me to clean my bedroom as I struggle with that."

People were supported to express their views and be actively involved in making decisions about their care, treatment and support. We saw that during annual reviews and care plan reviews people were consulted and their opinion was listened to. One staff member told us, "We have a checklist that is completed to show what people have done in the day and one person asked to write their own which was great. Another resident writes up a feelings chart at nights and only asks for help with spellings. That way people can feel in control of their lives." The registered provider had ensured that people were involved in their care planning and daily lives and had produced a policy titled, 'Involving Supported Individuals' that set out what all employees had to do to include people in decisions. The policy listed actions expected of all staff as a condition of their employment. Actions included: ask for views on the services received; involve people in the recruitment of new staff; involve supported individuals in the induction of new staff; get feedback from supported individuals to support induction reviews and appraisals; ensure that opportunities available are accessible to all individuals; support individuals to make decisions about their day to day activities; involve supported individuals in quality assurance by observation and discussion about their support, and involve individuals in the decision making within their service. This ethos of consulting people and listening to their views was carried out through the delivery of service at The Grange.

People's privacy and dignity was respected by staff. We observed that staff members routinely knocked on people's doors before entering and that people were confident to tell staff members they didn't want to see them, and staff respected this. One person was going on holiday and had packed their suitcase. A staff member asked if they could check the contents of the case and the person said 'no'. This decision was respected and instead a different staff member spoke with the person to remind them of the different items they will need for the holiday, to ensure the person had all the items they needed without opening up their suitcase against their wishes. One relative told us, "Staff respect X's privacy; he has his own room and he can be on his own if he wants to and has the opportunity to socialise, but he has the opportunity to do his own thing and not be disturbed."

Good

Is the service responsive?

Our findings

People were receiving a person centred service. One person told us, "I do lots of activities. I like bowling and the cinema and we saw 'Beauty and The Beast' not long ago.' Another person commented, "I've cleaned my room today, been to the bank to get money and watched the tennis with my friends.' A third person told us, "I get to do cooking, swimming, pub trips, bowling, craft and gardening. We go to the seaside when we can. On birthdays you can choose what you want to do. We go for walks and we go on holiday. I've been abroad to Tenerife and Mallorca." A relative told us, "They definitely personalise care. X tells us 'so and so' has taken him to the pub: he enjoys having a drink and tonight he's off to Hastings to see a status quo revival band and he's status quo mad so it's perfect for him." Another relative commented, "Every resident is different and they are treated as so. It depends on people's needs and personalities but they're treated as individuals."

People were able to choose what activities they took part in and suggest other activities they would like to complete. Activities were discussed each morning in a residents meeting and the daily boards were updated to show people what they had chosen to do. There were four time slots for activities, morning, midday, afternoon and night. On the second day of our inspection we checked the board and it accurately reflected what people had chosen to do. One person was helping in the kitchen, four people were doing craft activities, two people were helping in the garden, and five people were helping to set up, prepare the room for a celebration and cook for the barbecue, one person was at the dentist and two people had gone out for lunch. Other activities for the day included pamper sessions, men's groups, walks, college and planting flowers. One person had a' now and next' board with the current and subsequent activity to enable them to sequence and transition more effectively. One person told us, "For craft we make pin bags, memo boards, paintings, door stoppers, draft excluders and make our own cards. X made me a special card for my birthday."

We observed different activities over the two days of our inspection. In the craft room one person was sat threading beads on to a necklace. There was furniture that was in the process of being painted and repaired. The craft teacher explained that the men like to 'upcycle' furniture and then sell it during open days. A small bookcase was in the process of being restored by people. Another person was sewing decorations on to aprons. The craft teacher had made the aprons and the person chose which colour thread they would like to use. The person told us, "I like using red, yellow and purple thread." One person had been seated in the dining room earlier in the day and needed prompting several times by staff to participate in a conversation. However, when they were in the craft room they were initiating conversations asking the teacher and their peers about plans for the evening, talking about dogs, and holiday destinations. The person was visibly relaxed engaging with their craft work and conversation flowed easily in the group. Another person joined the group and decided to thread beads. The person told us, "I like drawing. I like craft and helping out." The craft teacher explained that the person came every morning to the craft room to do different activities and the person showed us a selection of the artwork they had produced, some of which was on display. Two people were tending to the chicken sheds and discussing how to clean the sheds and what to do next. They told us they liked working outside and keeping the chickens clean and the foxes away. One person commented, "We get three or four eggs from them [the chickens] every morning."

Care plans were personalised and each file contained information about the person's likes, dislikes and people important to them. There was a section at the beginning of each care plan explaining the person's family history, such as where each person had been born and lived, what parents did for employment, and which family members were active in the person's life. Details unique to each person were included in plans, such as one person who prefers to sleep with the bedroom door open and another person who will say, 'bye-bye' if they are becoming upset and want to be left alone. Preferences around personal care were clearly recorded with directions for staff to prompt where possible and guidance on how to actively support people who required that level of support.

People were actively supported to maintain relationships that were important to them. One person's care plan described how staff should support the person to purchase, write and send cards and presents to their relatives. One person struggled with knowing when visits to parents were and could experience anxiety around this. Their care plan managed this by directing staff to support the person by staff phoning the family and facilitating a convenient time and day for the visit to the family home. The person's parents would then call them on the day of the visit to tell them. This resulted in the person maintaining better relationships with their family. One relative told us, "When we go there staff are always working but we're always made to feel very welcome."

Some people at The Grange had behaviours that may challenge. Where this was the case people had individualised care plans to help staff manage their feelings and any behaviours that may arise from their anxieties. Positive behaviour support plans (PBSP) were kept with daily notes so that staff had ready access to the plans. We reviewed one plan that had been written in the past 12 months by a clinical psychologist. The plan was written using clinical language but was easy to follow and staff spoke confidently about how to implement the plan. There were sections of the PBSP that described to staff how best to support the person to manage the anxiety that was the driver for any behaviours that may challenge. Staff were directed to use 'labelled praise' i.e. to say the person's name and then directly use praise, and were encouraged to use 'active listening' to have regular check-ins with the person. The PBSP described clearly what the early warning signs of behaviours that may challenge were and what staff needed to do to support the person at each stage. The plan described how repetitive speech was used to seek reassurance from staff and how staff members could respond quickly to reduce anxiety then offer the person lots of praise after every task. There were other examples of detailed positive behaviour support planning which enabled people to maintain low levels of anxiety and engage in daily tasks.

Complaints and concerns were taken seriously and used as an opportunity to improve the service. The complaints procedure clearly set out the different stages, and people who are responsible for responding, at different stages of a complaint. The registered manager had started a log of all complaints received since July 2016 with any action taken to resolve the complaints clearly recorded. There had been four complaints recorded and a resolution reached in all cases. As the result of one complaint a staff member had been supervised and retrained. Another complaint led to the registered provider making an apology to the complainant and a third complaint had led to prescription toothpaste being included in a later medicine administration round.

Requires Improvement

Is the service well-led?

Our findings

The registered manager provided effective leadership to the service and people spoke in positive terms about the management of the service. One person told us, "The Manager is lovely; I've known her a long time." Another person commented, "[Manager] is lovely and really looks after us lot here. Tonight she's taking X to see a concert." One relative told us, "[Manager] is wonderful we've seen [manager] develop over the years and over the years given more responsibility. Recently she was assistant manager and was given a deserved promotion and we personally are delighted that she got the job. She has the experience and the personal hands on know-how. She shows no favour but just gets on and does the job." Another relative stated, "I know [Manager] and she is nice and she's been there for years and knows the people very well." However, despite these positive comments there were some areas of practice that required improvement.

Quality assurance systems were not fully implemented or embedded to monitor the quality of service being delivered and the running of the home. The registered provider had conducted a service wide audit upon taking over the service in 2016 and had produced an action plan to implement the changes they had identified as being required. However, the action plan was still being implemented during our inspection. Although some audits had been designed and discussed they had not been fully implemented and embedded in to practice. For example, there had not been a full audit of staff training. The registered manager told us, "We hadn't formally picked up the gaps in an audit but we had reviewed the training matrix and booked training." The chief executive was working on a full provider audit that would cover training and we saw a copy of this new auditing tool. However, it had not been completed yet. The registered manager commented, "We're setting up new systems and there is some trial and error. Previously, there was a sporadic meds audit, training was managed reactively and the health and safety checks were tokenistic." From the action plan we could see that the registered manager was implementing changes to the service and making regular checks. For example, the infection control policy was updated and an infection control risk assessment had been written in line with new national guidance.

We recommend that the registered provider implements a robust auditing system to monitor the quality of service delivered.

Some day to day checks and audits were in place and were effective in highlighting areas for improvement. There were first aid box checks where the contents were checked regularly to ensure people could be kept safe in an emergency. There had been a new medicines audits implemented that looked at security, conditions of storage, any signature gaps on charts and if medicines were out of date. The audit had picked up on medicines errors and gaps in signing for medicines. The registered provider had audited the staff files and found some historical information was missing from people's files. As a result staff members with incomplete recruitment files received letters requesting the information be provided and we saw that this had happened. A local authority commissioner had visited The Grange to conduct a quality audit in June 2017. An action plan had been produced and the registered manager had completed all the action points.

The service promoted a positive culture that is person-centred, open, inclusive and empowering. One

relative told us, "It's a wonderful atmosphere and very homely. We saw many different places before we settled on The Grange: you can feel it." Another relative commented, "I think it's become even more professional. It was a family oriented business before the present owner took over. They have a proper management structure and appropriate qualifications are observed and training is being encouraged. Many of the new people are on a learning curve but are motivated. All the changes that have happened haven't impacted on the residents." The registered manager spoke about implementing a culture change where staff were more empowered to take decisions and ownership of their role. One staff member told us, "There's been a major difference: positivity and more structure. I've been encouraged to take responsibility to change the common room to a games room. There's more structure for staff so we have a better understanding of how The Grange works."

People were encouraged to take an active role and be included in the running of their home. There were regular residents meetings, menu planning meetings and activities meetings. There was an open culture where people could speak about anything to a manager and be listened to. There was a regular 'managers drop in' session where one person had requested to control their own money and a plan was put in place to support them to do this, and another person requested a seaside trip and this was recorded as completed. The registered manager sought the opinions of people and their relatives in regular surveys. A service user questionnaire had been sent out and completed by 17 people in 2017 and answers to questions were nearly all positive. Questions such as, 'are staff nice', 'do you get to go out' and 'can you do what you like' all scored 100 per cent positive responses. Comments included, "I feel happy", "I like this place and the staff" and "I have happy friends here". Relatives completed a survey and all were returned with positive comments such as, "The Grange is unique on every level: delivers high standards of care, welfare and social activities. It feels like a happy family home and all the residents are happy, friendly and welcoming." We saw one survey where a person had requested more visits to their family and this had been facilitated.

The registered manager was aware of their responsibility to comply with the CQC registration requirements. They had notified us of events that had occurred within the home so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken. They were aware of the statutory Duty of Candour which aimed to ensure that providers are open, honest and transparent with people and others in relation to care and support. The Duty of Candour is to be open and honest when untoward events occurred. The locality manager confirmed that no incidents had met the threshold for Duty of Candour.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered provider had failed to act in accordance with the MCA 2005.