Ashwood Court Healthcare Ltd

The Grange Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 6 and 7 March 2018 and was unannounced.

The Grange 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. The Grange Care Home accommodates up to 28 people in one adapted building.

There was no registered manager in post at the time of our inspection. The last registered manager left the service in April 2017. There has not been a registered manager at the service as required since April 2017. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Registered persons have a legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the service is run. A new manager had started work in the service on 15 January 2018 and had recently submitted a registration application to CQC.

The Grange Care Home was last inspected in July 2017. At that inspection it was rated as 'Inadequate' overall. A number of breaches of Regulation were found during that inspection and the service was placed into special measures.

At this inspection, although people and relatives gave mainly positive feedback about the service, and we found partial improvement in some areas; we continued to have significant concerns about the safety and well-being of people. Emerging risks were seen in areas where there had been no previous concerns and breaches and continued breaches of Regulation were found.

Risks including those associated with medicines, the environment, hot water temperatures, the spread of infection and fire drills had not been properly assessed or minimised in order to keep people safe. There had been partial improvements to medicines management but these were not sufficient to make medicines safe overall.

There were not enough staff to safely meet people's needs and recruitment process were not robust enough to ensure that only suitable staff were employed. Staff training was not wholly effective in some areas. There was minimal evidence that lessons had been learned and improvements made when things went wrong.

People's healthcare had not been effectively monitored and concerns escalated in a timely way. Care plans did not always reflect the current position which left people exposed to risk of receiving inappropriate care or treatment.

The principles of the Mental Capacity Act 2005 and the associated Deprivation of Liberty Safeguards had not been properly understood or applied in the service.

There was little adaptation to the premises to make them suitable for older people and those living with dementia. Not all people were consistently treated with dignity. People's involvement in care decisions and planning was not clearly evidenced.

Care plans and risk assessments were not sufficiently person-centred and in some cases did not provide step by step guidance to staff to enable them to support people in a consistent and safe way. End of life care plans required further input to make them truly person-centred. Responses to complaints were not always put into action effectively.

The service was not well-led. Issues raised at our last inspection remained unaddressed in some cases and new problems emerged in other areas. Auditing had been ineffective in identifying shortfalls. There was little evidence of people's involvement in their care or decisions about it.
Most people enjoyed a range of activities but some people being cared for in bed or living with dementia did not always receive the same level of stimulation.

Staff had received safeguarding training. They were aware of how to recognise and report safeguarding concerns. The new manager had begun to carry out staff supervisions and implement competency checks.

People had routine appointments with GPs, health and social care specialists, opticians, dentists, chiropodists and podiatrists. People enjoyed their meals and were supported to eat if necessary.

Staff were kind and caring and went out of their way to make visitors feel welcome. People were encouraged to remain as independent as possible. We received mostly positive feedback from the people, relatives and visitors who were able to speak with us.

People, relatives and staff felt the new manager was approachable and responsive. Feedback had been sought from people and their families through questionnaires and meetings.

The new manager was engaged in joint working with the registered manager of the provider's sister service and received regular input from the Clinical Commissioning Group, local authority and a range of visiting health professionals.
The service notified the Commission of incidents and events that they were legally required to and had displayed their CQC rating.

We found a number of breaches and continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Known risks to people had not been minimised. This included risks associated with medicines, the environment, fire, the spread of infection and accidents and incidents.

There were not enough staff deployed to meet people's needs.

Recruitment processes were not sufficiently robust to ensure suitable staff were employed.

There was a lack of learning from incidents.

Staff understood safeguarding processes and how to operate them.

Is the service effective?

Inadequate

The service was not effective.

People's healthcare needs had not been consistently recognised or escalated. Fluid intake and output was not always managed effectively.

Staff training was not effective in supporting them to carry out their roles.

The service was not meeting the requirements of the Deprivation of Liberty safeguards and Mental Capacity Act 2005.

Minimal adaptations had been made to the premises to make it suitable for older people/those living with dementia.

People enjoyed their meals and received support to eat them.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's dignity had not always been considered, but signage used on bedroom doors helped prevent people's privacy being

disturbed.

There was limited information in care files about people's involvement in care decisions.

Staff treated people with kindness and gentleness.

People's independence was encouraged and promoted.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care planning was not sufficiently person-centred and inaccuracies or anomalies between sources of information had not been corrected.

End of life care planning was scant and did not place emphasis on people's preferences and wishes.

Complaints were properly logged and recorded but actions arising from them were not always effective.

People enjoyed a variety of activities on some days, but there was less to do on others..

Is the service well-led?

Inadequate

The service was not well led.

Issues raised at our last inspection had not been resolved and new problems had emerged.

Progress against the provider's action plan was slow and had not prioritised the high risk areas identified at our last inspection.

Many new audits had been implemented but these were not consistently effective in highlighting shortfalls in quality and care.

There had been no registered manager in post since April 2017.

Staff said they had faith in the new manager and new governance processes had been initiated.

The provider displayed their rating and made statutory notifications to the CQC.□

The Grange Care Home

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 6 and 7 March 2018 and was unannounced. The inspection was carried out by two inspectors and an assistant inspector.

Before our inspection we reviewed the information we held about the service including previous inspection reports. A Provider Information Return (PIR) had been sent to the provider for completion but we inspected before the PIR could be returned. The PIR is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make We considered the information which had been shared with us by the local authority and other people, looked at safeguarding alerts and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

We met and spoke with ten people who lived at The Grange and observed their care, including the lunchtime meal, some medicine administration and some activities. We spoke with five people in detail and with three people's relatives or friends. We inspected the environment, including the laundry, bathrooms and some people's bedrooms. We spoke with a visiting health care professional, two senior care staff, three care assistants, kitchen staff as well as the new manager, their deputy, the registered manager from a sister service, the provider; and the provider's consultant was spoken with twice by telephone.

We 'pathway tracked' six of the people living at the service. This is when we looked at people's care documentation in depth, obtained their views on how they found living at the home where possible and made observations of the support they were given. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care. We also looked at care records for four other people.

During the inspection we reviewed other records. These included staff training and supervision records, staff

recruitment records, medicines records, risk assessments, accidents and incident records, quality audits and policies and procedures.

We displayed a poster in the communal area of the service inviting feedback from people and relatives. Following this inspection visit, we did not receive any additional feedback.

Inadequate

Is the service safe?

Our findings

People we spoke with told us they felt safe living at The Grange. One person told us their bedroom windows only opened a small amount and said, "So I feel quite safe. Nobody could get in from the outside". Another person said "I have no qualms or fears about anything here". A relative commented "I am so very grateful that they (staff at The Grange) look after mum" and "They know what to do, they are all trained" and "Mum is safe here."

Despite receiving mostly positive feedback from people, relatives and visitors we had significant concerns about the safety of the service in a number of areas.

Our last inspection found medicines had not always been safely managed. At this inspection there had been some improvements, but more work was needed to make medicines management consistently safe for all people.

There were no photos on medicines administration records (MAR) and many of the MAR were loose in a folder. This created a risk of confusion between people and their correct medicines. On the second day of our inspection this situation had been resolved after inspectors highlighted the risks to managers.

Some medicines shown on MAR as prescribed for regular use had been offered to people on an 'as needed' or PRN basis by staff. The impact of this was seen in the case of a person with severe pressure wounds who should have been receiving pain relief four times daily, but instead had only had one single dose in the two weeks leading up to the sores developing. This person lived with dementia and there was no pain scale or information in place to show how they expressed pain. Records made by staff documented that the person's 'Legs are very painful, shouting in pain every time staff try to hoist or even just lift them' and that 'legs are quite stiff so when [person's name] moves them [person's name] hollers' Despite this, no pain relief had been given. A healthcare professional confirmed that in their opinion this person was experiencing pain. A visitor to the service told us that their loved one had needed pain relief in the form of paracetamol on one occasion but their prescription had not arrived so the visitor gave the person two of their own paracetamol tablets. The visitor did add that staff had then gone to collect the prescribed paracetamol but it was concerning that the service did not have supplies of people's pain medicines readily available. A manager confirmed to us that they had paracetamol in stock for the person with pressure wounds.

The morning medicines round started at 08.00am and took until 10:30am to complete on the first day of our inspection. This meant that people did not all receive their morning medicines within one hour of the time printed on the MAR. Staff confirmed that the round always took this long and sometimes until 10:45 am; although the managers denied this consistently happened. Best practice guidance had not been followed because medicines should be given within an hour of the times pre-printed on MAR; in this case 08.00am. Staff administering medicines told us that they were frequently interrupted or obliged to carry out other tasks as care staff were "Very busy". The actual times of administration were not recorded on the MAR. One person had a pain relieving gel at 10:20am approximately and was due another dose at 12pm; which staff said was given around 1pm the same day. This was unsafe practice because the information provided with

this medicine stated that there should be four-hour gaps between doses. Another person who received medicines at lunchtime had their first dose at around 9:30am and there was no system in operation to record the times of these doses to ensure proper gaps. The manager told us that the round would be divided in two going forward to cut down on the total time it took to complete. We will follow this up at the next inspection.

Records about prescribed creams had not been completed in the two weeks leading up to our inspection. These had been removed from people's rooms for updating to a new improved format by managers. In the meantime no records were kept of prescribed barrier and moisturising cream applications, other than occasional reference to 'creams applied' in staff daily notes; which did not identify which creams and to which areas. This was concerning in the case of people identified as at risk of skin breakdown within care plans and for whom regular cream applications were recorded as necessary. There was no recent evidence of cream applications for a person who had developed ungradable pressure wounds.

The failure to manage medicines safely is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were stored safely and at appropriate temperatures. Temperatures of medicines rooms, the trolley and the medicines fridge were being routinely documented. Handwritten MAR entries had been signed off by two staff to confirm they were complete and accurate. Recording sheets for adhesive patches were in use but not being completed in the way they were designed to be. Staff were not indicating the site of the medicines patch by the use of a cross on a body map. This is important so that the application site is alternated because the adhesive patches can sometimes cause skin irritation. PRN protocols were in production stages but were not yet in use operationally. Liquid medicines had been dated on opening and had been disposed of in a timely way. Returns to the pharmacy had been properly bagged, labelled and documented. Medicines about which there are special legal requirements were correctly stored and recorded.

At our last inspection people were at risk of unsafe care and treatment because staff did not always follow procedures set out in risk assessments and some risk assessments were not updated to always reflect people's changing needs. At this inspection the issue continued and known risks had not been properly reduced in a number of areas.

One person was known to make attempts to leave the service unattended; their care plan recorded that this risk should be minimised by staff knowing the person's whereabouts at all times. However, twice during the inspection the person was seen trying the front door with no staff in the vicinity to see what they were doing for up to eight minutes. The front door was not locked or alarmed and could be opened fairly easily. On the second day of our inspection a pre-planned locking device was fitted which prevented the door being opened without a code being entered.

Thermostatic valves had not been fitted to taps despite this being raised at our last inspection. The most recent temperature recordings for hot water had been carried out on 25 January 2018 and in some bedrooms had reached well in excess of 50 degrees. No temperature records were in place for February 2018 and inspectors physically checked the water in the hand basin of one bedroom and found the water to be too hot to keep their hands beneath. The provider was made aware of the seriousness of the risks to people of scalds and said plumbers were arranged to fit special valves on Friday 9 March 2018. The provider said they had been "let down" by another plumber as the valves were supposed to have been fitted much sooner. Signage was in place above sinks to warn of the hot water but some people were living with dementia and may not realise the dangers. We contacted the provider on 9 March 2018 to ask them to

confirm the thermostatic valves had been installed and were informed they had not, but that plumbers had assessed the job. We told the provider that urgent action was needed to ensure water temperatures were within safe limits for people. They confirmed that they had turned the boiler down and sent us records of the reduced temperatures in each bedroom.

Other risks to people from the environment were found. There was a broken radiator cover in the room of a person living with dementia. There was a possibility of them touching the hot radiator but also of snagging their skin on the jagged edges of the wooden fretwork cover. A boiler cupboard containing hot pipes was unlocked and accessible, as were several unoccupied rooms which contained stacked up furniture which could be a hazard to people. We observed one person living with dementia walking around upstairs on their own and with no staff in the vicinity. We were assured by the managers that locks would be placed on these doors.

Linen was stacked on the floor in open linen cupboards which could create a fire risk. This was removed during the inspection once we highlighted the risk to managers. No fire drills had been carried out since our last inspection in July 2017; despite this featuring in our last report. Fire alarm tests were documented as happening weekly, but there had been no testing of the evacuation process to ensure this could happen safely and effectively. Personal emergency evacuation plans had not been updated to show deterioration and changes in some people's mobility. The manager said these would be updated promptly.

The risk from the spread of infection had not been safely managed. There was an unpleasant odour resembling stale urine in the main lounge, some corridors and several bedrooms. In one bedroom the smell was exceptionally bad. The carpet in this room was dirty and stained and there were splashes of liquid which looked like drinks up the walls. Skirting boards were grimy and latex gloves were seen down the toilet. Inspectors discovered that an armchair cushion in the room was drenched with urine on its underside. A towel sticking out of a drawer was stained with faeces. The person using this room lived with dementia. The provider said there were plans in place to replace carpets.

The sluice was sited in a cupboard with an inaccessible hand wash sink which was piled with stained plastic urinals. There was no soap, antibacterial hand rub or paper towels available in the sluice. The sluice sink was stained and dirty and had more stained urinals in it. The floor was piled high with commode pans, bowls and other items. The sluice was cleaned during the first day of our inspection when inspectors drew it to the attention of managers. They said that staff did not always use the sluice but sometimes tipped urine away in the bathrooms; which in itself created a risk of infection being spread. Two toilets upstairs had no hand wash basins in them. There was a sign on the inside of one door which asked people to use the wipes and antibacterial gel available but there were no wipes in the toilet; although the gel was available.

Two kitchen fridges had temperatures of 11 degrees when thermometers were checked by inspectors. The Food Standards Agency recommends that fridge temperatures should be less than 5 degrees. No temperature recordings had been made on the day before our inspection. A manager told us that new fridges would be ordered to replace these. Homemade egg mayonnaise in another fridge had been labelled as 'Made on 6/3; use by 16/3'. Similar labels were in place for jelly and decanted tinned fruit. The cook said they knew this was wrong and remedied the labelling but there was a risk that the egg at least might have been served beyond a reasonable date had it not been for us querying a ten day retention date on a high risk food item.

Incident forms were completed by staff to show details of when people had falls. There was also a new falls audit which recorded the time and place falls happened and immediate actions taken. However, the information about falls had not been updated into people's care plans and falls risk assessments. For

example; a person had been assessed as able to use the stairs unsupervised. Previous falls records showed they occasionally fell when dizzy. They had two further falls in February 2018; one which recorded they had become unsteady on their feet. Neither of these falls had been used to update the falls risk assessment or consider whether the person was still safe on the stairs.

Another person had fallen from their wheelchair while unattended and actions were recorded as 'Staff informed not to leave [Person's name] unattended in wheelchair'. However during our inspection we observed that this person was left alone in the dining area for around 20 minutes without staff being in the dining area with them. Their care plan information about falls had not been updated to include guidance to staff about supervising this person while in their wheelchair; which meant they remained at risk. Although improved auditing systems had been put in place to log falls and any trends associated with them, there was a lack of learning from incidents and accidents because actions to prevent future occurrences had not been taken.

The failure to mitigate known risks to people and protect them from avoidable harm is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection, people had been supported to move with a hoist by one staff when they had been assessed as needing two staff to keep them safe during manoeuvres. At this inspection two staff were observed supporting people where necessary.

Equipment and utilities including hoists, the passenger lift, fire extinguishers and lighting, gas and electricity had all been safety-tested and maintained where necessary. Legionella testing had now taken place and a certificate of conformity issued. Gloves and aprons were available around the home and staff were observed using these. Antibacterial gel was also available throughout the service.

At our last inspection there were not enough staff deployed to meet people's needs. At this inspection there had been no improvement. On the first day of our inspection managers said there should be four care assistants and one senior care staff in the mornings, three care staff and a senior in the afternoons and one care staff and one senior overnight. There were 21 people using the service with needs such as care given in bed, insulin-controlled diabetes, immobility requiring hoisting, catheter care and a range of other conditions including dementia.

There was only one senior care staff and three care staff on duty on the first morning of our unannounced inspection, one of whom was in their induction period. This did not match what the managers has said was the required staffing levels. Call bells were sounding almost continuously and we heard two people calling "Help, help" from their bedrooms. The deputy manager had to intervene to provide care and support while showing us around the service. We received mixed feedback from people, relatives and visitors about staffing. One person told us "They are short staffed occasionally but the staff help one another." Another person and their relative said "There is enough staff"; while a further person added "Sometimes there could be more. At one time there were tons of them but it seems to have dwindled down a bit." One further comment we received from a person was "Sometimes staff just don't have the time to make as much fuss over us as they would like, -it is usually better in the afternoons."

A member of domestic staff was placed in the kitchen during our inspection to do the cooking because the cook was on leave, leaving the cleaning staff short. They told us they had received food safety training but had not received any training at all about nutrition for older people and could not say if anyone had pureed or soft diets. There was a whiteboard however in the kitchen which listed people having special diets.

Senior staff said that while carrying out the medicines rounds they frequently had to assist with taking people to the toilet or even getting people dressed because there were not enough staff to call upon. These interruptions extended the length of the medicines round until 10:30-10:45am most days according to this staff member; which created risks to people of receiving their doses too close together. Care staff were seen running in and out of the laundry with washing and told inspectors that they had to do the laundry while on shift as there was no designated laundry staff .They also said that breakfasts were prepared by care staff and not kitchen staff. These extra domestic duties took time away from supporting people and meeting their care needs.

Another staff member said they had worked a recent shift when there was only themselves, one other carer and the new manager on duty. They told us that people sometimes were not supported to get up until 11am in the mornings because of the lack of staffing. A healthcare professional told us there never felt as though there were enough staff about when they visited. Staff told us "Every shift I have been on has been short [staffed]." We reviewed rotas which showed that a number of days in the past month had not been staffed according to the numbers we had been told were necessary to meet people's needs.

Two formal complaints regarding staffing had been made to the provider since our last inspection. One complaint detailed the staff being 'exhausted' with their 'workload too great' and that 'there are never enough on duty and they appear stretched to their very limits'. Another complaint made in December 2017 raised concerns about their loved one being cared for when staff were 'at their wits end.' In both cases the provider had responded to complaints assuring relatives staffing levels were being addressed. The provider told us that staffing levels had been increased in response to the complaints but they had sometimes fallen again since that time.

We sought and received an undertaking from the provider that staffing levels would be immediately increased. On the second day of our inspection this had happened with the addition of two agency staff on duty. One of these staff was seen trying to lift a person under their arms; but was prevented from doing so by the permanent staff working with them. The other agency staff was observed offering biscuits to a person with diabetes, who said "Take those away I'm diabetic" so there was a risk that people less able to communicate could receive inappropriate care. Agency staff told us that they had not had the opportunity to review people's care files. One agency staff told us they supported a permanent staff member, changing beds and giving personal care to people, following instructions from permanent staff. Neither staff had a good understanding of the people they were supporting but told us they felt supported.

The provider's action plan stated that an increase in night staffing 'Requires urgent action'. This was due to be completed by 1 February 2018 and was based on the outcome of analysis of when most falls in the service had happened. The provider told us that three night staff were planned but this had not happened at the time of our inspection. The provider told us that they were proactively recruiting staff but were waiting for references to be received before allowing new staff to work in the service.

The failure to ensure enough staff were deployed to meet people's needs was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Recruitment processes were not sufficiently robust to ensure suitable staff were employed to work with people. Disclosure and Barring Service (DBS) and identity checks had been made and documented. DBS helps employers make safer recruitment decisions. Some application forms completed by staff had unexplained gaps in their employment histories and references had not always been sought from the most recent employer or an appropriate referee. At our last inspection there were no issues around recruitment but a warning notice was served in respect of fit and proper persons employed following our inspection of

July 2016. There was evidence therefore that improvements in this area had not been sustained.

The failure to operate a robust recruitment process is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff knew how to identify possible abuse and how to report it. There was a safeguarding policy in place and staff had received up to date training about this subject. Safeguarding referrals had been made appropriately by the service including one for a person who had ungradable pressure wounds during the inspection.

Inadequate

Is the service effective?

Our findings

People, relatives and visitors all felt the service operated effectively. One person told us "The staff are all very good-they know what they're doing". Another person said "I think the staff are very efficient," and "Sometimes they are presented with difficult situations and they seem to take it in their stride." A visitor said "Staff are very receptive. I would happily live here".

Although people and their relatives felt the service and staff were effective, our findings showed that this was not always the case.

People were not consistently protected from avoidable deterioration in their health conditions.
One person was found to have severe pressure wounds the day before our inspection. Staff had not noticed the deterioration in this person's skin quickly enough to prevent the wounds developing. Although staff and the manager had picked up on changes to the skin on the Saturday, the district nurse was not made aware of them until the following Monday ; by which time the wounds had degenerated further and now required intensive treatment. Staff and the manager did not recognise that the changes they had seen in the skin indicated pressure wounds. A referral about this was made to the local safeguarding authority by the service and the district nursing team.

This person had been assessed as at very high risk of developing pressure wounds from July to December 2017 but no recorded assessment had been made or updated since that time. At the time the person developed the pressure wounds they were not sleeping on a special pressure-relieving mattress; even though they had been identified as being at very high risk. Care plan instructions were for staff to monitor and cream this person's skin daily, but there were scant records of cream applications since 19 February 2018. The deputy manager told us that creams charts had been removed from people's rooms so the format could be improved, but this meant there was no consistent or reliable record that this person had creams applied twice daily to help protect it from breakdowns; and they had gone on to develop severe pressure wounds.

Another person had a urinary catheter in place. Care plan directions said that staff should record urine output daily but we found this had not happened since 19 February 2018.Records of output made prior to this date often showed low levels such as 500mls and documented that urine was 'dark'. This might indicate a urine infection but managers were unable to tell us what had happened to follow up on the dark urine or low output noted. A manager told us that although not documented, this person had a good fluid output on the second day of our inspection and was well in themselves.

This person was known to be at risk of urine infections and had another condition which required them to drink regularly. Care plans about their health stated that a minimum of 1500mls should be encouraged daily. However fluid charts showed that they had drunk as little as 250mls on one day in the week before we inspected. Other days showed totals of 320mls, 680 mls and 750mls. On one day however, fluid charts recorded that this person had drunk 1730mls. A manager told us that one of this person's conditions actually meant that their intake should be limited to no more than 1500mls daily. This was confirmed by the

provider's consultant who told us that a health professional had given this instruction. However this had not been transposed into care plans or staff handovers and meant this person was at risk from receiving too little or too much fluid.

Daily notes made by staff in the week leading up to our inspection documented that this person had reported feeling unwell; with a headache, discomfort in their stomach, feeling tired or being unsettled at various points. Despite this and given the person's known medical conditions, managers could not say how fluid input and output had been monitored or why the GP had not been asked to assess the person. One manager told us that they knew the person well and that they had had a cold so a GP was not needed. There remained a risk that this person's health could deteriorate because their input and output had not been properly monitored in line with care plan directions.

Some people lived with diabetes and required their blood sugar levels to be monitored. One person had been experiencing unstable blood sugar levels which were being monitored by staff and with blood tests. However, there was no information in this person's care plan about safe upper limits for these levels and senior staff were unable to tell us what these were. During the inspection period this person's blood sugar levels dropped to 2.6mmols. Staff gave the person orange juice, jelly babies and a jam sandwich and blood sugar levels rose to 11.5 mmols. The record of staff actions taken did not match the instructions in this person's care plan. This created a risk that staff might not address low blood sugar appropriately or recognise when upper levels required further intervention. When informed about the fluctuation in blood sugar levels the GP provided a changed insulin prescription for this person.

In December 2017 a safeguarding investigation found that one person had been given insulin by staff on four occasions when their blood sugar levels had indicated this would not be safe for them. The staff member responsible for those errors no longer administered insulin and staff had received further training about diabetes.

Managers told us that a person living with dementia had had regular input and assessment from community mental health teams about their aggression and confusion. However when we checked records about this we saw that contact made with the team on 5 February 2018 was due to be followed up with a treatment plan on 6 February 2018 but this had not happened. The new manager confirmed to us that this should have been followed up. Following our inspection the provider sent us information to show that this person had a medication review on 6 February 2018 but this had not been documented at the time it happened and only in retrospect.
A healthcare professional said that assessment of health conditions by staff was sometimes lacking in the service, stating that the service needed to "React to the changes in people" and "Get better at assessment." However they also added that they knew people were happy living there.

The failure to assess, monitor and mitigate risks to people's health is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who were able to speak for themselves said that staff would call a GP in if they asked for this or would facilitate the person making the call themselves. One person told us" I go to the doctor but sometimes doctor comes here." They added "I have my own dentist and I go there. Sometimes I get a taxi but I can get the bus." This person was more independent than most of the people living at The Grange. Another person said "You just ask if you want to see a doctor and the doctor will be in after lunch on the same day." They added "Staff ring the GP to get advice any time they want, the chiropodist comes every six weeks and the dentist comes in once or twice a year."

The service was supported by various community health professionals in providing care and treatment to people. These included the GP, district nurses, occupational therapists, opticians, chiropodists, dieticians and speech and language therapists.

At our last inspection we found a lack of understanding around the requirements of the Mental Capacity Act (2005) and 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 make 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). Restrictions could include, for example, bed rails, lap belts, stair gates, restrictions about leaving the service and supervision inside and outside of the service.

At this inspection attempts had been made to improve assessments and records, but managers confirmed that there were some people who lacked capacity to make their own decisions about remaining at the service. They told us that these people would be prevented for their own personal safety from leaving The Grange if they tried. In these situations MCA assessments and DoLS applications should have been considered but had been delayed because there had been no keypad lock on the front door of the service until 7 March 2018. The keypad lock to the front door should not have been the deciding factor in whether to apply for a DoLS, but rather whether people would be prevented from leaving and/or constantly supervised.

MCA assessments had been made for other specific decisions but associated best interest decisions had not always been made in consultation with professionals or documented the least-restrictive practice considered.

The failure to operate within the principles of the MCA is a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we raised concerns about staff training. At this inspection we continued to find that training had not properly equipped staff to carry out their roles effectively. At this inspection we continued to find that training had not properly equipped staff to carry out their roles effectively. Staff had received a range of mandatory training in subjects such as moving and handling, safeguarding and health and safety. However some staff had not completed training in dementia awareness and end of life care. For other staff training had not been effective in practice. Senior staff and managers were recording clinical observations to help in making decisions about people's health and any treatment needed. Managers confirmed to us that they had not yet received any training about how to conduct clinical observations but a senior staff member said they had been taught what to do during medicines training.

One person with a pre-existing heart condition had complained to staff of a 'Racing heart' during the night shift. The staff had recorded clinical observations twice; which showed oxygen saturation levels dropping to 87% on the second measurement. Staff documented that they had not called 111 because the person did not want them to and the person had then gone to sleep. A different senior staff member told us that their training told them that oxygen levels below 90% were an emergency and that they would have "Called 999" without asking the person, if they had been on duty that night. This lack of consistency between staff training and understanding placed people at potential risk of not receiving appropriate treatment. Staff told us that this person had been "Fine and well" the morning after they had reported their heart racing and the GP had not been involved.

Staff and managers had not recognised signs of deterioration in a person's skin as indicative of pressure wounds and had delayed informing the district nurse because of this. By the time the district nurse examined the person just two days later, ungradable pressure wounds had developed, which were preventable with the right care and treatment.

Staff and managers had not fully understood the importance of providing sufficient fluid intake and monitoring the quantity and condition of urine output for a person with a catheter and associated health conditions. This exposed the person to risk which had not been properly reduced by adequate training and knowledge. The manager told us that a number of training sessions were booked including clinical observations.

Staff and managers had received training about MCA and DoLS but a continued lack of understanding was evidenced at this inspection and had been highlighted at our two previous inspections.
There was an induction process in place, which managers told us was completed in the first 12 weeks of employment. During induction, managers told us staff completed a weeks' worth of shadow shifts prior to working without supervision, allowing staff the time to get to know people. However, we observed this did not happen. We observed one staff member working without supervision during their first week. There was an induction checklist within staff recruitment files, which had been completed to varying levels, and not completed for the newest recruit. Staff told us the induction process could improve, and needed to be more comprehensive, showing staff around the home, explaining the complex home layout and with an improvement in training delivered. Managers told us training was discussed with staff during interview, and any gaps in training provided where required. Interview records did not support this. Staff told us they had been observed by another carer prior to working without supervision, however there was no documentation to confirm this had taken place, or to confirm the new staff member was competent.

The failure to ensure staff are trained and competent is a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The new manager had begun to complete staff observations, and showed us examples of three observations completed on staff. The new manager said these were still a work in progress.

Staff verbally sought people's consent when delivering care and support. Daily notes recorded when staff had checked that people gave their permission for staff to carry out personal care for example.

People's needs had been individually assessed before they were admitted to the service. However, information we reviewed was limited in detail and did not record much about people's preferences. For example, there was no information about people's religious or spiritual needs and how these might be met, or records of whether people preferred male or female care staff to support them with personal care. Staff had received training about equality and diversity but this had not been reflected in people's care planning to show how people were supported to live their lives in the way they wished. Managers told us that care plans were in the process of being re-written and updated to include a far greater picture of people's choices. More detail was documented about people's food and drink likes and dislikes but overall this is an area requiring improvement.

There was little adaptation to the premises to make it suitable for older people or those living with dementia. No picture signage had been used to identify communal rooms or toilet facilities or help people to orientate themselves in the service. Most bedroom doors had people's names on them, but many of these were in small writing. There was a blackboard showing the menu for the day but no photos had been used to make this information more accessible for people. This is an area for improvement. The provider had

however purchased some new furniture such as low tables which had rounded edges to prevent people hurting themselves on sharp corners.

People told us they enjoyed the meals on offer and had a choice of two different meals at lunch and supper. The meals looked plentiful and appetising. Some people needed support to eat and staff generally offered this, although we observed that one person was only prompted by staff to eat initially and waited 20 minutes before receiving full support with their meal. One person told us "The food is good, not exceptional. At least it's decent." Another person said "It's pretty good. The meat is tender and tasty and I've put on weight." A further person commented "You can ask for more if you want." People's weights were monitored and dieticians involved where people were losing weight.

Drinks were available throughout the day on tea trolleys and in jugs of water and squash in people's bedrooms. One person told us "There's always plenty of tea and water" and another person added "We can ask for a drink, hot or cold, at any time throughout the day and night.

People were complimentary about the care staff gave them. One person told us they had recently fallen out of bed twice and that "Staff looked after me as if I was at death's door." They added "I had a carpet graze and the staff said not to get it wet. The staff kept the graze covered and dry and it healed very well." A visitor said that their loved one was "Less agitated, much calmer since moving into the home."

Requires Improvement

Is the service caring?

Our findings

People, relatives and visitors told us that staff were caring and compassionate. One person said "The Grange is good. And staff are always happy." Another person told us "People here are nice, which makes a difference, they talk to you." A further person commented "[Staff name] is lovely, I don't know why I pick her out specially, nothing is too much for her."

At our last inspection people's dignity had not always been protected because toilet doors were sometimes open while people used them. At this inspection the situation had been resolved by the fitting of automatic door closers. We continued to have some concerns however because a number of people were sitting in nightclothes or had no covering at all on their bottom halves and could be seen in their bedrooms from corridors, by anyone walking around the service.

One person's bedroom had an extremely strong smell of urine with a stained carpet, broken radiator cover and dirty walls and skirting. The underside of their armchair cushion was soaked with foul-smelling urine, was heavily stained and their towel was marked with faeces. The walls were bare except for a wall clock which had stopped working. Managers told us that the service could no longer meet this person's needs because they showed aggression and challenging behaviour; and an alternative home was being sought for them. This person was living with dementia and it was undignified for them to be spending time in these conditions in the meantime.

The failure to consistently ensure people's dignity was respected is a continued breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Since our last inspection new signs were in use by staff to show when doors should not be opened because personal care was being given. These reduced the risk that other staff or visitors would enter bedrooms while people were receiving intimate support from staff. A person told us "If I go into the bathroom, staff tell people 'just a minute, [Person's name] is in there' for example."

There was limited evidence within care plans to show that people were involved with decisions about their care. People we spoke with were either unsure or said they had not been involved with their care planning. Most people said that while they enjoyed a choice of meals, they were not routinely involved in decisions about menus; and this is an area requiring improvement. One person said "I would like more fish and more vegetables". We asked people about how much choice they felt they had over their lives in The Grange and received varying responses. One person said that they sometimes felt as though decisions were made for them but "Most of what they suggest is fine, so I don't really mind." Another person said that had a routine but felt they could probably change this if they wished.

We observed kind and gentle interactions between staff and people throughout the inspection. Staff spoke with people respectfully and with affection, sometimes complimenting them on their hair or clothing which clearly pleased people. The manager was observed holding a person's hand while they spoke with them. When the manager left, the person told us "It is very comforting and staff put their arms around you."

Another person commented "They all look after me". One relative told us that the manager took people to short appointments at the hospital to save them having to wait for hospital transport.

Staff were considerate of people and were seen asking them where they would prefer to sit and checking they were comfortable before they left them. Despite being very busy, one staff went to collect a person's book from their bedroom because they had forgotten to bring it to the lounge. They did so with good grace and the person was very appreciative of the gesture. Relatives and visitors were greeted warmly by staff and there was a friendly atmosphere. One person had a birthday during the inspection and the cook had made a beautiful pink-iced cake to celebrate.

People were encouraged to be independent as far as possible. Care plans generally included information about tasks people were able to manage for themselves and those with which they needed more support. Where people needed walking frames or walking sticks, staff ensured these were close by them so that they had their mobility equipment to hand. Special cutlery was provided for some people so that they could continue to feed themselves.

One person was observed helping out with the tea round and laying tables for lunch. Managers explained that this person enjoyed keeping busy and that the activity helped them to maintain their independence and feel useful.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection care plans were in the process of being updated. At this inspection managers continued to tell us that care plans were "A work in progress". The provider's action plan stated that the care plan format was being changed and would be finalised by June 2018. In the meantime, however, we identified a number of cases where the lack of detailed or consistent information or updates created the risk that people would not receive appropriate care and treatment. For example; guidance for staff about diabetes management differed in care plans from staff practice because staff told us they had received updated training which superseded care plan instructions. There had been no revisions or additions to the care plans and risk assessments of people who had a number of falls, so that their needs could be reconsidered and adapted as necessary. Directions from a healthcare professional about a person's fluid intake had not been transposed to their care plan about hydration. Changes in some people's mobility had not been updated to reflect the current position. Some care plans were scant, with incomplete assessments or minimal information for staff to follow. In care plans we reviewed, there was a lack of step-by-step guidance about how people's care should be delivered and their preferences in relation to this and how they could be supported to live their lives as individuals.

There was nobody receiving end of life care at the time of our inspection, but managers told us about a person who had previously been thought to be approaching their last days. There was minimal information in people's care plans about how their end of life care would be managed. End of life care plans were not completed in people's files, to take into account people's comfort, any pain assessment needed, choices and final wishes. Although the provider's action plan documented planned improvements to end of life care planning and collaborative work with the local hospice and district nursing team this had yet to happen, despite some actions having been due by 1 February 2018.

The failure to ensure people's needs and preferences are reflected in care planning is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives told us that staff responded well to their needs. One person told us "I know staff do their best for me and will try to come to me when I use my bell". A relative said that The Grange held a file of information about their loved one's history. They said they felt this "Ensures continuity of care for Mum".

At our last inspection there had not been an effective complaints system in operation. At this inspection the recording of complaints had improved but actions in response to them had not been consistently taken. There were three complaints documented since our last inspection. One of these had been about the loss of personal possessions from a person's bedroom. Minutes of a staff meeting in February 2018 referred to the complaint and staff were reminded that all bedroom doors must be closed when people were not in them to limit the possibility of further incidence. However, during the inspection we observed that not all doors were closed when bedrooms were unoccupied to prevent others from accessing them. An inventory of belongings had not been taken prior to this person moving into the home, managers told us this was still not in place, but due to be implemented. This is therefore an area requiring further improvement.

Complaints had been logged and records of their progress maintained. Information about investigations into complaints had been documented and copies of responses to complainants retained in the complaints file. People who were able to speak with us said they would speak to the staff of manager with any concerns and a relative said the new manager was "Very approachable, very easy to deal with, very accommodating". Relatives and visitors said they felt welcomed at any time in the service. One visitor said "From when the door opened today you got the sense that it is really lovely." They said they found staff "Very welcoming." A person living at The Grange commented "Visitors can just arrive; it's very free and easy."

Most people told us they enjoyed the activities on offer in the service and said these were discussed at resident meetings. On the first day of our inspection, there were no organised activities for people and they mainly sat in the lounge either sleeping or watching TV. Other people stayed in their bedrooms and there was no stimulation for them other than staff visiting them with meals, drinks or to deliver care. However, on the second day of our inspection people enjoyed a visit from a guitarist, the hairdresser and many look part in a lively reminiscence session in the afternoon. One person told us "I get involved in the things I can. Somebody comes, she has lots of bits and she does exercises with us. We like that, she's very good. We get a not bad assortment of activities. Every now and again you think you might like to do something else. People come in with lots of things to do and if you don't want to do them you don't. Most people do join in. We have greyhound racing too. We give them all names. We like that."

Another person said "There's bingo and we're getting music. Every other Wednesday we have reminiscing activity, that's good. We used to have more activities, one or two more, some have dropped off. They are going to employ somebody to run activities here so there is obviously an awareness that they need to step up on that." There was no designated activities staff at the time of our inspection, although domestic staff had recently accepted a change into this role and would be taking this up in the near future. A notice board gave details of planned activities and any entertainers due to visit.

Inadequate

Is the service well-led?

Our findings

At our last inspection the service had not been well-led. At this inspection there had been a lack of noticeable improvement in some areas, despite increased input from the provider and a full management team.

Since our last inspection the provider had appointed a new manager who had been working at the service since 15 January 2018. In addition there was a deputy manager and the registered manager from the provider's second service who was providing additional part-time support. The provider had also appointed a consultant from 15 December 2017, who was spending two days per fortnight at the service to help implement improvement actions. There was no registered manager; there had been no registered manager since April 2017. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Registered persons have a legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the service is run.

An action plan had been produced by the consultant following our last inspection and contained 141 items to be addressed. The plan did not specifically prioritise based on risk or highlight the issues that were raised at our last inspection; and as a result, most of these had not been adequately resolved at the time of this inspection. Some improvements had been made around medicines management and the provider told us that focus had been placed on this area in the first instance. Some of the completion dates for actions had not been achieved and there remained a large number of items requiring resolution at the time of this inspection.

In addition to issues from the last inspection remaining unaddressed, new concerns had emerged in areas where we previously had none. This was a worrying situation and we made the provider aware of our significant and continuing concerns. During the inspection, some of the problems we identified were immediately put right by the provider or managers; such as the lack of enough staff on shift, the unclean and cluttered sluice, the fire risk from linen being stored on the floor, foodstuffs being relabelled in the kitchen, MAR being re-affixed in the folder and photos of people being taken to assist in safe administration practice. However, these issues had not been remedied by the provider or managers until they were highlighted by inspectors. The response to concerns was reactive rather than proactive; despite the very large action plan that had been produced.

Following our last inspection, many more audits had been introduced and implemented by managers. However, this increased checking had failed to recognise many of the shortfalls in the safety and quality of the service that we found. In some instances, auditing had identified problems, which had then failed to be addressed or had been inaccurately recorded as completed. For example, an infection control audit carried out at the end of January 2018 picked up on the issues with the sluice cupboard, but these remained unresolved nearly six weeks later when we inspected. A fire audit completed just days before our inspection reported that PEEPs had been updated when we found that they had not in some cases. A health and safety audit did not prompt managers to check that boiler cupboards and unused bedrooms were kept locked, and these were found open and accessible to people living with dementia. Medicines audits had been

undertaken but had not included checks that staff were administering all medicines in line with MAR directions or monitoring of the time taken to complete medicines rounds.

Risks to people had not been adequately assessed, monitored and minimised in the service. This had been contributed to by the lack of focused auditing, action planning and insufficient management checks. Some risks that were highlighted in our last inspection report were still unmitigated at the time of this inspection. This included; hot water temperatures, lack of staffing, proper risk assessment and care plan preparation, fire drills, staff training and operation of the MCA. Emerging risks were also found in the environment, control of the spread of infection, medicines, recruitment processes, healthcare and hydration.

The failure to assess, monitor and mitigate risks to the quality and safety of the service and to individual people using the service is a continued breach of Regulation 17 of the Health & Social care Act 2008 (Regulated Activities) Regulations 2014.

The provider told us about how they were improving governance of the service through regular meetings with the management team and consultant. These were designed to increase and maintain oversight of the quality and safety of the service. The first governance meeting had been held at the beginning of February 2018 and reviewed items from the action plan which had been completed and those which still required attention. Items which had been improved included the completion of a Legionella risk assessment, a new safeguarding policy, new laundry equipment purchased and a number of new audits commenced; amongst many others. However, the minutes of the governance meeting also noted that 'Staff observation of health indicators has led to improved proactive referrals to multi-disciplinary team for intervention and assistance.' This did not reflect our findings during the inspection and therefore provided undue assurance about this issue. The meeting also highlighted the very many actions which were on-going or still required completion.

The provider, management team and the provider's consultant all told us that they had been working very hard to implement improvements in the service. However they said that they needed more time for this to be effective and for changes to be embedded and sustained. Although our last inspection took place in July 2017, they felt that the intervening seven months had not been sufficient time to make the significant number of changes needed. The provider told us "I still believe this is a good home, I'm not going anywhere, I'm here for the long-term and we will be successful".

The provider explained that the new manager had started working at The Grange on 15 January 2018 and that actions to make the service better had only started in earnest from that point. The provider said they had interviewed many candidates for the role of manager but had been determined to recruit the right person for the job; which had caused a delay in the manager's appointment. It is a legal requirement of the provider's registration to have a registered manager in post, but the service had been without one since April 2017. The new manager had only just begun the application process to become registered with the CQC at the time of our inspection. In the period where the service had been without a registered manager, standards of care and safety had noticeably deteriorated.

The failure to comply with conditions of registration is a breach of Regulation 33 of the Health and Social Care Act 2008.

There was friendly and cooperative culture amongst staff and managers during the inspection. Staff told us that they had faith in the new manager to move the service forward in a positive and effective way. People and relatives were impressed with the new manager and her attitude. One person told us "We've got a new manager and she is good. It is better now" and another said "The manager is very approachable, is visible

and accessible." Staff told us of the new manager "Is very good. They could do very well here. They are hands on and will muck in and help."

The new manager said they were determined to make things better at The Grange. However, we found that the involvement of three managers and the consultant meant that we were frequently receiving a different response to our questions from each of them, which did not always give us confidence that what we were being told was correct. On a number of occasions managers said the consultant had given them particular instructions when the consultant said they had not. We were referred to the consultant for information about how dependency scoring translated to staffing numbers but then informed that the management team and provider all had access to this information. Staff told us there were "Too many people giving direction" and that it could be confusing.

The manager said that they were kept abreast of developments in social care through joint working with the registered manager of the provider's sister service and regular input from the Clinical Commissioning Group, local authority and a range of visiting health professionals. The manager felt they were beginning to foster beneficial working relationships with these groups for the benefit of the people using the service.

Feedback had been sought from some people and relatives by way of a questionnaire which sampled eight people living at the Grange and asked their views about a number of areas including safety and food offering. The majority of people questioned were wholly satisfied with the service. It was unclear why only eight people had been selected to respond to the questionnaire as it may have proven useful to the provider to have a more complete overview of people's experiences of the service. This is an area for we have identified for improvement.

Resident meetings were held as another method for gathering people's views and input about the service. We were provided with handwritten copies of minutes from the last resident meeting in December 2017. These noted items to be discussed such as whether staff would be receiving training about dementia and if the issues raised at the last CQC inspection were going to be addressed. However, the minutes included no reference to discussions about either point during the meeting and did not record what people had been told about these matters. Meeting minutes should accurately reflect what was discussed and agreed at meetings and this is therefore an area for improvement.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had conspicuously displayed their rating in the reception area and on their website.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. This enables us to check that appropriate action had been taken. The manager was aware that they had to inform CQC of significant events in a timely way and notifications had been received appropriately since our last inspection.