Bondcare (London) Limited

The Grange Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
The Grange Care Centre is a nursing home for up to 160 adults. The home is divided into eight units. Two units specialise in the support of adults (under 65 years) with physical disabilities. The other units offered care to older people, some of whom were living with the experience of dementia. At the time of our inspection, 146 people were living at the service.

The service was operated by Bondcare (London) Limited, a private organisation. The service had previously been registered under a different provider.

People's experience of using this service and what we found
Medicines were not always managed in a safe way. Whilst we did not find people were being harmed, there was an increased risk that they would not receive their medicines as prescribed because records were not always accurately maintained.

The provider had systems for monitoring and improving the quality of the service, but these were not always operated effectively. For example, we found some planned care had not been recorded and therefore may not have happened. This included care needed to support people who were at risk of skin damage.

Following our inspection visit, the registered manager told us about improvements they had made based on our feedback.

People using the service were happy with the care they received. They told us staff were kind and met their needs. Feedback from relatives varied, with some relatives raising concerns about how people's needs were being met. However, most people using the service and their relatives indicated there had been improvements at the service since the registered manager started there.

People's care had been planned and staff knew about their needs and choices. They had assessed risks to their safety and well-being and provided support which helped to minimise these risks. People had access to healthcare services when needed. There was a range of different social activities being offered, although some people felt lonely, this was in part due to restrictions on visiting because of the COVID-19 pandemic. The building was suitably designed, decorated, cleaned and maintained. There were procedures for preventing and controlling infection, and the staff followed these.

There was enough suitable staff and they were trained and supported so they knew how to care for people. The management team regularly assessed staff competencies and skills. Staff met with their managers to discuss their work and improve their practice.

There were systems for identifying, investigating and responding to complaints, accidents, incidents and safeguarding alerts. We saw the provider learnt from these to make improvements to the service.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
This was the first inspection of the service since the current provider, Bondcare (London) Limited, took over as the registered provider on 14 January 2020. They took over the existing operating service at this time, including transferring staff over to work for them.

We had inspected the service in July 2019 when it was operating under the previous organisation. Following this inspection, we imposed conditions on the provider requesting monthly updates about the service and improvements. These conditions were also imposed on the new registration when Bondcare (London) Limited took over as registered provider. This was because we had concerns about the quality and safety of the service.

Why we inspected
This was a planned inspection based on the date of registration, concerns identified at our previous inspection of July 2019, when the service was registered under a different provider, and new recent concerns raised by visitors and staff with us.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

We have identified breaches in relation to safe care and treatment.. Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Good

The service was effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

The Grange Care Centre

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted as part of our Thematic Review of infection control and prevention in care homes.

Inspection team
The inspection was conducted by three inspectors, a member of the CQC medicines inspection team and a nurse specialist advisor. A fourth inspector made phone calls to some relatives of people using the service to ask for their feedback.

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

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We looked at all the information we held about the service. This included monthly reports they had sent us about action they had taken to monitor and improve the service, as well as notifications of significant events, safeguarding alerts and complaints from staff and members of the public. We received feedback about the service from representatives of the local authority.

During the inspection
We spoke with 15 people who used the service. We also carried out observations to see how people were being cared for and supported. Two external health care professionals visited the service on the day of our inspection, and we spoke with them. We spoke with staff on duty who included care workers, nurses, the activities coordinators, the chef, the clinical lead, the registered manager and two of the provider's area managers. We looked at the care records for 10 people. We looked at how medicines were being managed. We conducted a partial tour of the building and carried out an audit of infection control practices. We also looked at other records the provider uses for managing the service, these included audits, meeting minutes, records of complaints, safeguarding investigations and incident reports.

After the inspection
We spoke with the relatives of seven people who used the service. We reviewed additional information the registered manager sent us.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

- Medicines were not always being managed safely at the home.
- Some people were prescribed medicines such as inhalers to be taken as required (PRN). Guidance in the form of care plans were not always in place or person centred to help staff give these medicines consistently.
- Some people were prescribed medicines to be given via percutaneous endoscopic gastronomy tube (PEG). However, these were not always recorded on the medicines administration records (MAR) to be given via PEG. This meant there was a risk these could be given orally in error by the staff. PEG allows nutrition, fluids and/or medicines to be put directly into the stomach, bypassing the mouth.
- Incorrect dosage of prescribed insulin was recorded for one person in their care plan, diabetes care plan and their insulin administration chart. This meant there was a risk the wrong dose of insulin could be administered.
- For another person who was prescribed insulin, the nurse on duty had not signed the MAR to record administration of the morning dose of insulin on the day of the inspection. The nurse informed us they had administered the medicine, however forgot to sign the MAR. Also, the staff had not been recording the daily check of blood glucose levels and insulin administration on the designated form for past three months. This is poor record keeping, and also puts the person at risk of harm as it could not be verified if the insulin had been administered as prescribed.

We found no evidence people were being harmed. However, failure to manage medicines in a safe way was a breach of Regulation 12 (Safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- There was a medicines policy in place. The management team received and acted upon medicines alerts. There was a process in place to report and investigate medicines incidents.
- There was adequate stock of prescribed medicines.
- Medicines Administration Records (MAR) were in place for prescribed medicines. Some MARs were handwritten and these were appropriately checked and signed by two members of staff.
- Medicines including controlled drugs (CDs) were stored securely and at appropriate temperatures. Some people self-administered their medicines and stored them in their own room. Appropriate risk assessments were carried out regularly to ensure these were stored securely.

Systems and processes to safeguard people from the risk of abuse

● There were systems and processes designed to protect people from the risk of abuse. People using the service and their relatives told us they felt safe.
● The provider had safeguarding and whistle blowing procedures and the staff received training in these. They were able to explain what they would do if they suspected someone was being abused. Individual and group meetings with staff included discussions about safeguarding procedures.
● The provider had responded appropriately to safeguarding alerts. They had worked with the local authority, and other external organisations, to investigate these and help protect people from further abuse. We saw records of recent alerts included detailed investigations into the background of the situation, what went wrong and what lessons could be learnt.
● The registered manager kept a log of all safeguarding alerts and used this to help identify any trends or themes where improvements were needed.

Assessing risk, safety monitoring and management
● The risks to people's safety and well-being had been assessed, monitored and managed. The staff carried out assessments of risks relating to people's care, including their physical and mental health, skin integrity, use of equipment, risk of falls and nutritional risks. These assessments were regularly reviewed and updated. They included plans to reduce the risk of harm and to support people to be independent where they could be.
● The staff received training so they could assist people to move safely. This included training and competency assessments in the use of different types of equipment. They were also trained and assessed to make sure they could support people with different aspects of care and to eat and drink safely. Where people had been assessed as at risk of choking, there were suitable plans in place, including modifying the textures of food and drink. We saw the staff followed these plans and supported people in a safe way to reduce risks.
● The staff had completed COVID-19 risk assessments, which identified when people were at greater risk of serious illness from the disease and ways to help prevent infection.
● The provider carried out checks on the environment to help make sure it was safe. These included checks on electrical, gas and water safety as well as a fire risk assessment and checks on fire safety. There were individual evacuation plans so the staff knew how to support people in the event of a fire or another emergency.

Staffing and recruitment
● There were enough staff deployed to meet people's needs and keep them safe. Some people living at the service, relatives and staff said they would like higher staffing levels, but records indicated people's needs were being met in a timely way and they did not have to wait for care. People confirmed this, telling us the staff supported them if they used the call bells or needed assistance.
● The provider used a dependency rating assessment to calculate staffing levels. They were continuously recruiting new staff in order to help make sure staff absences and vacancies were covered. The provider had reduced reliance on temporary (agency) staff, and except for some incidents of sickness cover, care was provided by their own permanently employed staff. This meant people using the service were supported by familiar staff who had a consistent approach.
● People using the service and their relatives generally felt staff were skilled and suitable to care for them. The provider had systems to recruit staff who were suitable. These included inviting potential staff for interviews and carrying out checks on their identity, references and any criminal records. Following successful recruitment, all new staff undertook an induction which included training, assessments and supervision. This helped the provider to make sure staff had the skills and competencies needed to care for people safely and well.

Preventing and controlling infection

● The provider's systems and processes helped to prevent and control infection. They had appropriate procedures, which had been reviewed and updated to include the risks associated with COVID-19.

● People using the service, visitors and staff confirmed the staff wore masks, gloves, aprons and other personal protective equipment (PPE). There was enough PPE, and this was distributed to each unit and easily accessible for staff, so they could change this when needed. There was information and posters were displayed to remind people, staff and visitors about hand hygiene, PPE and social distancing.

● The service was clean and there were robust schedules to make sure it stayed clean. These included regular checks and audits of the environment and equipment being used, systems for disposing of waste and for managing laundry.

● People using the service, staff and visitors were regularly tested for COVID-19 and there were appropriate systems for responding to any positive test results and managing outbreaks at the service. People using the service and staff had also been offered vaccinations against COVID-19 and flu.

Learning lessons when things go wrong

● The provider had processes for learning when things went wrong. They investigated all accidents, incidents, safeguarding alerts, complaints and other adverse events. They also carried out reflective practice to identify any trends and discuss action needed to improve the service.

● There were records to show the registered manager had a good overview of adverse events and discussed these with other staff. They also liaised with external organisations, such as the local authority, and other care home managers for shared learning about concerns.

● The provider had responded appropriately to COVID-19 outbreaks, managing these and learning from the experience to reduce the risk of further outbreaks.

Good

Is the service effective?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated good. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Supporting people to eat and drink enough to maintain a balanced diet

● People were supported to have enough to eat and drink to maintain a balanced diet. However, we spoke with 11 people about food and 10 of these gave negative feedback about the quality of the food with comments which included, ''The food is low grade'', ''The food is unpalatable'' and ''I don't like the food it is not good quality.'' One person told us they had raised this issue, but nothing had been done about it. Some relatives also commented on this telling us people did not like the food. One relative told us the person was left with food which they regularly did not eat. We noted the provider's own surveys about food indicated several people were not happy with this.

● We discussed this feedback with the registered manager and senior managers. One of the senior managers explained there was a good range of choices, but it was hard to accommodate the tastes of such a large and diverse group. We saw that the provider had carried out a food survey in order to ascertain people's views about their meals so they could make improvements to the provision of meals to people.

● Staff assessed people's nutritional needs and created care plans regarding these. They monitored change in people's weight or appetite. When people were at nutritional risk, the staff had made appropriate referrals for additional healthcare interventions from external professionals. We found people were receiving the support they needed with nutritional risks.

● There was a varied menu which offered a wide range of choices including for different cultural needs, health and lifestyle choices. The chef had information about people's dietary needs. They told us they asked for feedback from people using the service.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● People's needs had been assessed before they moved to the service. However, the COVID-19 pandemic had impacted on this process and some relatives expressed frustration about this. For example, three relatives told us they had not been consulted during the assessment processes and discussions around people's needs. They felt they had not been given this opportunity. The registered manager explained that assessments had been carried out over the phone because of restrictions with visiting. This meant it was not always possible to gather all the information needed to create a person-centred plan at this stage. However, they felt the staff continued the assessment process after people moved to the home in order to get to know people better.

● Assessments included information about people's health and personal care needs as well as assessing the risks relating to these needs. Care plans and assessments were regularly reviewed and updated to make sure changes in people's needs were identified and planned for.

Staff support: induction, training, skills and experience

● People were cared for by staff who had the training and support they needed. New staff completed inductions which included a range of training, observations and assessments of their competencies and knowledge. There was a programme of regular training for all staff to make sure their knowledge and skills were kept updated.

● The registered manager and other senior staff were qualified trainers. The staff also accessed online learning and training courses organised by the provider. The staff confirmed they undertook a range of training and this was helpful.

● Staff participated in regular team and individual meetings with their manager to discuss their work and the service. They told us they felt supported and felt they could approach the registered manager if they had any concerns. They also explained how supervision meetings had helped them learn and improve their practice.

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

● The service was a suitable design and suitably decorated to meet people's needs. The service was divided into eight separate units with lounges and dining areas. All bedrooms had en-suite facilities. Since the COVID-19 outbreak, people mostly stayed within their own units. However, there were also communal facilities such as a coffee bar, garden and sensory room which people could also use.

● The building was appropriately decorated with matching furniture. Some interactive features, such as those helpful for people experiencing dementia, had been removed during the COVID-19 pandemic to reduce communally touched surfaces. The registered manager acknowledged this was not ideal and hoped there could be a return to a more interactive environment in the future.

● There was enough suitable equipment to meet people's needs, including specialist beds, specialist mattresses and sensor mats, hoists and entertainment systems. The provider arranged for all equipment to be regularly checked to make sure it was safe.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

● People were supported to access external healthcare services. Nurses worked on each unit monitoring people's health and well-being. They closely monitored changes in health and made referrals for specialist healthcare support when needed. The GP conducted rounds twice a week as well as seeing people who needed more urgent attention. These rounds had been 'virtual' using video calling since the outbreak of the COVID-19 pandemic, but the registered manager said these worked well and doctors visited if needed.

● There was a clinical lead who oversaw how healthcare needs were being met. They regularly discussed any changes in people's conditions with staff and the registered manager in order to make sure people received the care they needed.

● The staff had created care plans relating to different healthcare conditions. These plans included guidance to explain how the condition was managed and how to identify any concerns relating to these conditions. The plans were regularly reviewed.

● We spoke with two visiting healthcare professionals who told us they worked closely with the staff who provided good support for people.

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

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

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

- The provider made sure people, or their representatives, consented to their care and treatment. The staff carried out assessments of people's mental capacity. Where people were identified as lacking capacity, they had consulted with their representatives to make sure decisions were made in people's best interests.
- The provider had applied for DoLS authorisations when needed and kept a record to state when conditions were imposed, how these were monitored and when authorisations needed to be reviewed.
- People using the service told us the staff asked for their consent before providing care.

Requires Improvement

Is the service caring?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- People were generally well treated and supported. During the inspection we witnessed one interaction which was not respectful or kind. We told the registered manager about this and they addressed the issue by speaking with the staff member concerned.
- One relative raised a concern with us that staff did not respect the intelligence of the person and spoke with them in a patronising way. Two other relatives explained they felt people did not get the attention they needed, and staff did not know about their individual personalities and needs. We discussed some of this feedback with the registered manager who acknowledged the concerns family members had, and how hard it had been for them when they could not visit people regularly.
- Other people using the service and relatives spoke positively about their experiences. Their comments included, ''There is one particular staff member who is excellent'', ''One lovely carer really helps me'' and ''I think they are quite friendly and caring.''
- Except for one incident, we saw staff were kind, caring and considerate towards people. They offered people choices, spoke politely and allowed people to take their time. We saw one person became distressed and a staff member went over to them and put their arm around them to offer comfort.
- The provider carried out audits to make sure people were being treated with dignity and respect. They also arranged supervision and reflective practice for staff where they felt improvements were needed. The registered manager observed staff carrying out various tasks and asked people using the service for their feedback about dignity and respect.
- People were supported to be independent where they were able. Care plans recorded people's skills and the things they could do for themselves. They confirmed staff encouraged them to be independent when they wanted to be.

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

- We saw the views and wishes of people using the service were recorded in care plans where these were known. When they had expressed specific decisions or needs based on their culture, religion and lifestyle, these were recorded.
- People told us they were given choices about how they spent their time and about their care. They explained staff respected their decisions and listened to them.

Requires Improvement

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people's needs were not always met.

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

● People received personalised care, however, we found that some care records indicated care plans had not always been followed. For example, for one person who had a pressure sore, a visiting tissue viability nurse had recommended the person was re-positioned every two to three hours to reduce the risk of further skin damage. The person required staff support with this. Records of care for this person were incomplete to confirm the person was being repositioned regularly to prevent complications associated with pressure area care. For example, during a three-day period before our inspection, the care records showed the person had been re-positioned only three times in 24 hours for two days and only twice in another 24-hour period. We discussed this with the registered manager who told us the lack of recording, in this instance, was due to Wi-Fi connection problems meaning the staff could not record these interventions. However, in the absence of the electronic records there was no other record to indicate whether the person had been repositioned or not. Therefore, it was not clear whether the person was being cared for according to their plan of care.

● We identified care plans were not always in place for people who suffered from seizures. For example, we assessed the care planning for three people who were prescribed anti-seizure medicines and found there were no care plans relating to these medicines or how the person experienced seizures. This meant there was a risk staff may not be able to monitor or manage their care appropriately. We discussed this with the registered manager who provided evidence to show that care plans were in place for some other people with known seizures. However, care plans should be in place for all relevant people in order to help staff understand their individual needs.

● Some relatives told us they did not think people's needs were always met. One relative told us, ''[Staff] do not understand the pain [person] might be in and how to deal with stiffness and they leave [person] in one position for too long.'' Another relative told us, ''[Person's] nails are sometimes dirty and too long and they do not always brush [person's teeth].'' Other relatives told us they felt people's needs were being met, including feedback from one relative that the person always looked well when they spoke with them on video calls. People living at the service told us they were happy with the care they received. Most care records we viewed showed regular care was given in line with care plans. People who we met and those we saw during our observations were clean, well dressed and looked comfortable.

● The staff recorded people's needs in care plans which were regularly reviewed and updated. The staff were aware of these plans and were able to describe about how they cared for different people as individuals. The staff were allocated to specific units, so they got to know people well.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● The provider employed a team of activity coordinators and trained care staff to help engage with people

and provide a range of social and leisure activities. However, the COVID-19 pandemic had meant some activities had stopped or been reduced. There had been a reduction in visits and group activities, and this had an impact. Some people expressed this with one person telling us, ''It is lonely here,'' and a relative commenting, ''My impression is that [person] feels very lonely.''

● Other people we spoke with told us they did not mind a lack of group activities as they managed their own leisure time with puzzles, craft activities, books and using phones, electronic tablets, television and laptops. People also told us they liked using the sensory room for relaxation. Some people told us they played games with staff and enjoyed talking with them.

● The activities coordinators had developed a plan of different activities, which included quizzes, arts and crafts, religious worship and reading. They visited people in each unit and their rooms to offer individual support and talk with them. During the day of our visit, activity coordinators were offering glasses of sherry, juice, snacks, talking with people and reading newspapers with them. They told us they had adapted the activity programme but still made sure people had things to do and time to interact with them.

● The activities coordinators also tried to make sure religious ceremonies and special days were celebrated. They had a range of equipment which they could use to provide sensory, music and craft activities, as well as making use of the garden in better weather.

● People were supported to stay in touch with families and friends using video calls. The provider was updating the visiting arrangements in line with changes in government guidance. People using the service, families and staff were looking forward to increasing the number of visits and hoped this would enhance people's well-being and reduce social isolation.

Meeting people's communication needs

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

● People's communication needs were being met. The staff spoke a range of languages and were able to communicate with most people in their first language. The staff also told us they used flash cards, text and mobile devices to communicate with some people who had limited speech. We saw these methods of communication were part of their planned care.

● The staff had created communication care plans for each person. These included information about any barriers with communication and how to support people to communicate their needs and to understand others.

● The provider was able to produce key documents and information in a range of formats and languages when this was required.

End of life care and support

● People received the support they needed at the end of their lives. The staff were trained to care for people who were very unwell and dying. They demonstrated a good understanding of the support they needed to give to make sure people were pain free and comfortable. The nurses were trained to administer end of life medicines and worked closely with doctors and palliative care teams to help make sure people were assessed regularly and had the support, care and medicines they needed.

● The staff had created end of life care plans, which included information about any preferences, religious needs and who to contact at different stages of a person's illness and in death.

● There were no visiting restrictions when people were dying, and family members could stay with the person in their room as long as they wanted and needed.

Improving care quality in response to complaints or concerns

● Improvements were made following complaints and concerns. The registered manager and/or senior managers investigated all complaints and completed detailed reports of their findings. They gave feedback to the complainant explaining what they had done, apologising and checking the complainant was satisfied with the outcome.

● We saw there had been learning from complaints, and changes made to the service, along with staff meetings, reflective practice and improved communication as a result of complaints and feedback from people, their relatives and staff.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Continuous learning and improving care

- There were systems for monitoring and improving quality. However, these had not always identified where improvements were needed, for example medicines audits and care audits had not picked up some of the concerns identified during our inspection visit. People using the service did not always receive a high-quality service. Some records of care were incomplete.
- The registered manager was responsive to the feedback we gave at the inspection, looking into areas of concern we identified, starting to address these and giving us feedback after the visit. They spoke with staff involved, reviewed records and contacted the regional director about issues where they needed support to make the required improvements.
- There was a range of comprehensive audits which were used to continuously monitor the service, these included regular visits from senior managers.
- Since Bondcare (London) Limited had taken over provision of the service there had been improvements in all areas. The registered manager had also introduced changes which had benefited people using the service and staff. They supported the staff to take part in reflective practice to learn from things that went wrong. There were weekly clinical meetings and daily meetings with heads of each unit to discuss the service, identify any problems and plan for these.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People using the service felt there was a positive and open culture and they were able to speak up and discuss how they felt. One person said, ''The home is brilliant and staff are friendly.'' Another person told us, ''Overall, they treat me well.'' Some relatives felt further improvements were needed. Their comments included, ''The staff do not always hand over information to each other'', ''The staff tell us they are overworked and that makes you wonder what is going on'', ''They do not consult me apart from asking about the COVID-19 vaccine'' and ''I try and find out what is going on with [person's] care but the staff do not ring me back.'' Some of these anxieties reflected how relatives had felt removed and isolated from the home during the COVID-19 pandemic and restrictions. The registered manager understood these concerns and had tried to improve communication with relatives. We saw relatives who had regular contact appreciated this and felt better supported.
- The staff we spoke with were positive about their experiences working at the home, and mostly felt supported. However, there had been several concerns raised by staff over the past year. The provider had responded to these individually and the registered manager told us they recognised some staff had felt

negatively about changes at the service. We saw the registered manager had tried to address these concerns by involving staff in decision making, improving training and support, spending time working alongside staff on the units and having an 'open door policy' inviting feedback and discussions.

● Several of the relatives we spoke with told us they were happy with the service. Some told us they had access to care notes and records through the electronic care planning system so they could monitor people's care. Comments included, ''Things have improved a lot'' and ''I think The Grange is very good, I recommend it, they are kind and I am grateful [person] is looked after.''

● The provider asked people using the service to complete information about their experience of specific areas of care, such as dining experience, activities and staff.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The provider had a range of policies and procedures including dealing with complaints, safeguarding alerts and incidents. The registered manager understood their responsibilities to be open and transparent. We saw they had contacted and written to complainants apologising and informing them about what they were doing to put things right.

● The provider had sent notifications to CQC as required about adverse events. They had also liaised with commissioners and the safeguarding authority to investigate and respond to allegations of abuse.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● The registered manager was a nurse and experienced care home manager. They started working at the service in 2020. They had introduced changes which had improved the service and they understood about their regulatory responsibilities. The registered manager responded to feedback we gave, taking appropriate action to address areas of concern. They had a good understanding of their regulatory responsibilities.

● The provider is required to send CQC information about the service each month because of conditions on their registration. They consistently complied with this, providing a good level of detail about the service.

● People using the service, family members and staff gave positive feedback about the registered manager. Their comments included, ''[Registered manager] is very kind, approachable and lovely'', ''I feel very supported by the manager'' and ''[Registered manager] has a hands-on approach and asks staff for their ideas.'' The registered manager had introduced a new system to record feedback from people following formal and informal discussions. They used these records to monitor where improvements were needed and how concerns were addressed.

● The registered manager was supported by a team of senior staff who knew the service well. The registered manager, clinical lead and deputy managers had a good knowledge of people's individual needs. They had regular discussions to help make sure the staff were providing appropriate care to meet people's needs.

Working in partnership with others

● The registered manager and staff worked with external agencies, such as the local authority, healthcare professionals and other providers. They attended forums and webinars with other care providers. These forums helped to share information and helped managers learn together.

● The healthcare professionals we spoke with explained the staff made timely referrals and followed their recommendations and guidance to help meet people's needs.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not always ensure safe care and treatment of service users. Regulation 12