Britaniascheme Limited

The Grange Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 25 & 26 October 2016 and was unannounced. The Grange Nursing Home is registered to provide accommodation for up to 26 people with nursing care needs. There were 25 people living at the home when we visited, including some who were living with dementia. Accommodation is based on two floors with an interconnecting passenger lift. Some bedrooms have en-suite facilities. In addition, bathrooms and wet rooms were provided on both floors, together with a range of communal rooms for people's use. The third floor of the building provided administration offices and a staff training room.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

There were appropriate arrangements in place for managing medicines. The registered manager was putting new stock control measures in place to enable them to check that people had received their medicines as prescribed.

Staff sought verbal consent from people before providing care and support and knew how to keep people safe in the least restrictive way. However, decisions made on behalf of people who lacked capacity were not always recorded in accordance with legislation.

We received mixed views from people about the way staff interacted with them. Some said staff treated them with consideration, whilst others said some staff could be rough when supporting them with personal care. We have made a recommendation about this.

People were involved in the initial planning and assessing of their care needs, but said they were not routinely consulted when their care plans were reviewed each month.

People received care in a personalised way. Their individual care, support and nursing needs were met at all times. Care plans provided comprehensive information to enable staff to care for people effectively. Staff responded promptly when people's needs changed and encouraged them to make choice about every aspect of their lives.

People told us they felt safe at The Grange. Staff knew how to identify, prevent and report abuse. The registered manager conducted appropriate investigations into allegations of abuse, in liaison with other agencies.

They were enough staff deployed to meet people's needs and people told us staff usually responded promptly to calls for assistance. Safe recruitment processes were followed to help ensure only suitable staff

were employed.

Individual and environmental risks to people were managed appropriately. People were supported to take risks that helped them retain their independence and avoid unnecessary restrictions. There were plans in place to deal with foreseeable emergencies and most staff knew what action to take in the event of a fire.

People, relatives and healthcare professionals praised the quality of care delivered. Staff were skilled at meeting people's needs in a personalised way. They were suitably trained and supported in their work by the management. They responded promptly when people's needs changed.

People received a choice of meals to meet their dietary needs. They received appropriate support to eat when needed and were encouraged to drink often. People were able to access other healthcare services when needed and staff worked closely with specialists.

Staff knew people well and used their knowledge to design and deliver a wide range of activities to meet people's social needs. People were supported to follow their religious and spiritual beliefs. People's privacy was protected at all times.

The registered manager sought and acted on feedback from staff. There was an appropriate complaints policy in place and people were confident action would be taken if they raised concerns.

There was a suitable quality assurance process in place, including a range of audits and spot checks. When improvements were identified, these were actioned without delay.

There was a clear management structure in place. Staff enjoyed working at The Grange. There was an open and transparent culture where visitors were made welcome at any time. Positive links had been made with the community which benefitted people.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Medicines were managed safely overall. The registered manager was putting new measures in place to improve stock control procedures to enable them to check that people had received their medicines as prescribed.

Environmental and individual risks to people were managed effectively. There were suitable plans in place to deal with foreseeable emergencies.

People felt safe at the home and staff knew how to identify, prevent and report abuse. There were enough staff to meet people's needs and the process used to recruit staff was safe.

Is the service effective?

Requires Improvement

The service was not always effective.

People's human rights were not protected as staff did not always document the reasons for making decisions on behalf of people. However, they sought verbal consent from people before providing care and consulted with family members where necessary.

People's needs were met by staff who were suitably trained. Staff were supported appropriately in their role and were supported to gain relevant qualifications.

People's dietary needs were met and they received appropriate support to eat and drink when needed. People were supported to access other healthcare services including doctors and specialist nurses.

Is the service caring?

Requires Improvement

The service was not always caring.

Not all staff treated people with dignity, care and respect when supporting them with personal care. People were involved in initial discussions about the care and support they received, but

the provider was unable to demonstrate that people were involved in the monthly reviews of their care.

During our inspection we observed positive interactions between people and staff. Staff knew people well and used this knowledge to engage in meaningful conversations with people.

Staff protected people's privacy and supported them to follow their religious beliefs.

Is the service responsive?

Good

The service was responsive.

People received personalised care that met their individual needs. Care plans contained comprehensive information and were reviewed regularly.

People had access to a wide range of meaningful activities. People were supported and encouraged to make choices about every aspect of their lives.

The provider sought and acted on feedback from people to help improve the service. There was an appropriate complaints policy in place.

Is the service well-led?

Good

The service was well-led.

People enjoyed living at the home and felt it was well-led.

There was a suitable quality assurance process in place. Action was taken when the need for improvement was identified.

There was a clear management structure in place. Staff were positive about the management and felt supported in their work.

There was an open and transparent culture. Links with the community had been developed, which benefitted people.

The Grange Nursing 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 25 & 26 October 2016 and was unannounced. It was conducted by one inspector.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with seven people living at the home and three visiting family members. We also spoke with the director of nursing from the provider's company, the registered manager, the clinical nurse manager, a registered nurse, four care staff, two activities coordinators, a trainer/administrator, a housekeeper and two members of the catering team. We looked at care plans and associated records for six people, staff duty records, recruitment files, records of complaints, accident and incident records, and quality assurance records. Following the inspection, we received feedback from a social care practitioner from the local safeguarding team and a tissue viability nurse specialist.

We observed care and support being delivered in communal areas of the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We last inspected the service in July 2014 when we identified no concerns.

Good

Is the service safe?

Our findings

There were appropriate arrangements in place for ordering, storing and administering medicines. One person told us, "I always get my medicines and [staff] stay with me until I've swallowed them. They usually offer pain relief as well." All medicines were administered by registered nurses. The registered manager assessed the competence of staff to administer medicines before they were authorised to give them and every two years thereafter. The registered manager told us they were planning to increase the frequency of competence checks to do them annually, in line with guidance issued by the National Institute for Health and Clinical Excellence (NICE).

The registered manager was putting a new stock control process in place to help ensure that sufficient medicines were always in stock for people and repeat prescriptions were submitted before people ran out of their medicines. Medication Administration Records (MARs) were used to provide a record of which medicines were prescribed to a person and when they were given. Staff administering medicines initialled the MAR chart to confirm the person had received their medicines.

People told us they felt safe at the home. One person said, "Nothing worries me; [staff] are polite." Another person told us, "[Staff] make me feel safe as there are always two of them when they use the hoist." Staff knew how to identify and report safeguarding concerns and acted on these to keep people safe. Staff told us they wold have no hesitation raising concerns and had confidence that managers would take appropriate action. One staff member told us, "I've never raised a concern, but if I did, I know I'd get an immediate response [from management]." Another said, "I would expect to get an open and honest response from [the registered manager, if I raised concerns]. It would upset her, as I know she cares so much about people." Staff were also aware of external organisations they could contact for support, including the local safeguarding authority and CQC.

The registered manager conducted thorough investigations in response to safeguarding concerns. For example, a comprehensive enquiry was undertaken when a person was found to have an unexplained bruise. The registered manager notified the relevant authorities and CQC. They interviewed the staff concerned and took appropriate action in accordance with the provider's disciplinary procedure. Another person had been identified as potentially vulnerable and a plan had been put in place requiring certain tasks to be performed by two members of staff in order to protect the person from harm.

There were enough staff to meet people's needs. People told us staff were usually available to support them, although at busy times they said they might have to wait for assistance. They said this had rarely caused them any inconvenience or distress. One person said, "There can be very long waiting times at night, but on the whole they're OK." Another person said, "The staff do a good job; sometimes [when they are busy] they make me comfortable and then ask me to wait." A family member told us, "Sometimes [my relative] has to wait a bit, but it doesn't really cause any problems." During the inspection we saw staff were not rushed and responded promptly to people's requests for support. The registered manager told us staffing levels were based on the needs of people using the service, together with feedback from people and staff. When setting the staffing rotas, they took account of the skill mix needed to ensure there was always a trained nurse on

each shift, together with sufficient care staff throughout the day and night. The duty rotas confirmed this was always achieved. In addition, administrators, activity coordinators, maintenance staff, catering staff and housekeeping staff were also deployed each day. This allowed nursing and care staff to spend their time directly supporting people.

Staff absence was normally covered by existing staff working additional hours. However, the registered manager and the clinical nurse manager were trained nurses and were able to cover nursing shifts when needed. The provider also used two regular staff members from a care agency to cover care shifts on occasions. Arrangements were in place to help ensure agency staff were suitable to support people living at the home. They received appropriate induction and usually worked alongside regular members of staff who understood people's needs.

Robust recruitment processes were in place to check the suitability of staff before they were employed by the service. Staff records included an application form, full employment history, written references and checks with the disclosure and barring service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care services. Once employed, staff DBS checks were renewed every three years, so the provider could identify any changes. The registered manager also followed a clear process to check that staff employed were entitled to work in the UK. Staff confirmed these procedures were followed before they started working at the home.

People were supported to take risks that helped them retain their independence and avoid unnecessary restrictions. For example, staff encouraged people to mobilise using their walking frames; they remained close by, in case the person required additional support, but allowed them to travel at their own pace. One person had been issued with a walking frame, but had chosen to use a walking stick instead as they found this more convenient. The person was aware of the added risks, but had chosen to accept them in order to maintain their independence. Another person liked to propel themselves in a wheelchair, which presented certain risks. Again, they were aware of the risks and had chosen to take them; in order to minimise the likelihood of harm staff made sure the person's room and corridors were kept clear of clutter.

Where people had fallen, their risk assessments were reviewed and staff considered additional measures they could take to protect the person. These included reviewing the layout of their rooms to remove hazards, lowering people's beds, using equipment to monitor people's movements and referring them to fall prevention specialists. Senior staff also completed 'multi-factorial risk assessments' where people had experienced multiple falls; these looked at a wide range of factors that could contribute to the person falling. The assessment for one person showed that the environment at The Grange did not suit their needs, so they were supported to find an alternative home that was more appropriate for them.

Staff were able to explain the risks relating to people and the action they would take to help mitigate them. For example, they demonstrated an understanding of pressure area care and used a nationally recognised tool to assess individual risks to people from skin breakdown. Repositioning charts and preventive equipment, such as pressure relieving cushions and special mattresses were in use. A clear process was in place to make sure the mattresses were adjusted, and remained, at the correct setting for each person. Some people were supported to transfer between their bed and chairs using a hoist. People had individual slings for the hoist that were fitted to them and if their weight changed a new sling was provided of the correct size.

Risks posed by the environment had been assessed and were managed appropriately. Equipment, such as hoists and lifts, were serviced and checked regularly. Upstairs windows had restrictors in place to prevent falls. In addition, the temperature of hot water outlets was controlled through special valves and monitored

regularly, which helped protect people from the risk of scalding. Accidents and incidents were analysed to identify any patterns or common causes. None had been found, but the registered manager was clear about the action they would take if any themes became apparent.

There were plans in place to deal with foreseeable emergencies. A 'fire rucksack' was readily available and contained essential equipment, such as torches, two-way radios, foil blankets and contact details for staff. Staff had been trained to administer first aid and there was a comprehensive programme of fire safety training and fire drills in place. Two staff members were not clear about the fire assembly point. We raised this with the registered manager who agreed to reinforce the fire safety procedures to staff. Fire safety equipment was maintained and tested regularly. Evacuation equipment were kept in the rooms of people who were being nursed in bed and a staff member was developing personal evacuation plans to help identify the support people would need if they had to be evacuated in an emergency.

Requires Improvement

Is the service effective?

Our findings

We observed that staff sought verbal consent from people before providing them with care or support. However, during the care planning process, senior staff did not always document decisions, which they had made on behalf of people, in accordance with the Mental Capacity Act 2015 (MCA). The 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 decisions made on their behalf must be in their best interests and as least restrictive as possible.

Prior to making some decisions on behalf of people, managers completed assessments of people's mental capacity using the recommended two-stage test. However, assessments had not been completed for all relevant decisions and were limited to decisions about the person's ability to leave the home without staff support. MCA assessments had not been completed for other decisions, such as the provision of nursing care, the administration of people's medicines and the use of bedrails. Staff told us they had consulted with family members about these decisions, but had not recorded their views or recorded the reasons why the decisions taken were in the person's best interests.

Some family members had a power of attorney (POA) in place to enable them to act on behalf of their relatives. However, senior staff were not clear about the legal power that the POA provided. For example, we found senior staff had invited family members to give consent to decisions relating to the health and welfare of their relatives, when the POA was limited to financial decisions. We discussed the above issues with the registered manager, who took immediate action to review the way decisions were made and recorded for people. By the end of the inspection, they had identified suitable forms for this purpose and had started completing them for the relevant people.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). 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 were being met. We found the provider was following the necessary requirements. DoLS authorisation had been approved for five people. They told us they had completed assessments for three other people, but concluded that DoLS were not needed as the people were assessed to have capacity. The registered manager constantly reviewed DoLS authorisations to check they were still needed and was aware of the process for renewing authorisations. Staff understood their responsibilities and knew how to keep people safe in the least restrictive way.

People's needs were met by staff who were skilled and suitably trained. One person told us, "I'm happy with the care here and with the people who look after me; they're good." Another person said, "The care is excellent, you can't beat it." A further person described the quality of care as "first class".

Staff were positive about the training they received and said they could ask for any additional training they

felt would benefit people. For example, a staff member told us they requested additional training in supporting people to move safely. They said, "I needed more training and now feel more confident." Staff demonstrated an understanding of the training they had received and how to apply it. An activity coordinator told us they were undertaking an extended dementia course. They showed insight into the needs of people living with dementia, were skilled at communicating with people and had clearly built positive relationships with them. Another staff member showed similar insight when they said, "If people become agitated or aggressive, you have to ask yourself 'Why are they behaving like that?'. Often it's because they can't express themselves. You have to explore the reasons and support them accordingly."

All staff completed the provider's 'mandatory' training which included safeguarding, moving and handling, infection control and fire safety. Further training, specific to their role, was also available to each staff member. In addition, staff were supported to obtain relevant vocational qualifications; most had obtained level two or level three qualifications, whilst senior staff had obtained management diplomas.

Trained nurses told us they were supported to complete training and personal development to meet the requirements of their registration. One said, "I'm preparing for my re-validation [as a registered nurse] which is due soon. In preparation, I did a palliative care course at the hospice and updated my catheterisation training. Before that, I did my syringe driver training." These were skills nurses used to support people on a daily basis. Staff from the home had also taken part in the 'Six Steps to Success Programme'. This is an end of life care quality improvement programme for care homes, funded by the Clinical Commissioning Group (CCG). The programme aims to improve the quality of end of life care delivered to people.

New staff completed a comprehensive induction programme before they were permitted to work unsupervised. This included a period of time working alongside a more experienced member of staff. A new staff member told us, "The induction was quite in-depth; every little thing was signed off [by a senior staff member]. It was good." Arrangements were also in place for staff who had not worked in care before to undertake training that met the standards of the Care Certificate. This is awarded to staff who complete a learning programme designed to enable them to provide safe and compassionate care to people.

People were cared for by staff who were appropriately supported in their role. Individual meetings were held between staff and their line managers on a quarterly basis. These meetings were used to discuss progress in their work, training and development opportunities, and other matters relating to the provision of care to people. During these meetings guidance was provided by the line manager in regard to work practices and opportunity was given to discuss any difficulties or concerns the staff member had. Staff told us that these meetings were useful and supportive. Annual appraisals were carried out to award performance ratings to staff, based on their year's work, and to consider further personal or professional development. We were told, and observed, that the registered manager had an open door policy. Staff spoke highly of the registered manager and the clinical nurse manager, together with the ethos in the home. They described a supportive atmosphere where members of the management team could always be approached for advice and guidance. A staff member said, "It's amazing here. I really feel supported; I can't fault [the management]; they've been so understanding."

People were satisfied with the overall quality of the food. Their dietary needs, likes and dislikes were recorded in their care plans, known to staff and followed. People were offered a choice of meals, based on a four weekly rolling menu plan which was reviewed every six months. If people did not want any of the menu options, they could ask for alternatives. For example, at lunchtime, one person requested, and were given, a salad.

Staff were attentive to people and encouraged them to eat and drink well. People on special diets received

these as needed. Some people needed their meals pureed and we saw these were presented in an appetising way that allowed people to distinguish the individual food items. Other people needed full support to eat and we saw this was given on a one-to-one basis in a dignified way by staff who engaged patiently with them. Other people just needed occasional prompting to eat and this was done in a supportive way.

Staff assessed the risk of people becoming malnourished using a recognised tool and took appropriate action to reduce the risk. For example, they recording how much people were eating and drinking, where necessary, fortified people's meals and provided high calorie drinks. They also monitored people's weights on a monthly basis, or more often if needed, and took action when people experienced unplanned weight loss. For example, one person told us they were receiving an oat-based cereal with cream twice a day, together with high calorie smoothies. These had helped stabilise their weight. Another person told us, "I lost weight in hospital, but I'm now eating better and recovering." A variety of drinks was available throughout the day; staff checked they were within people's reach and encouraged them to drink often. A person told us, "[Staff] make sure I always have a drink handy."

People were supported to access other healthcare services when needed. Records showed people were seen regularly by doctors and specialist. Staff had positive working relationships with specialist nurses, including a tissue viability nurse who was providing advice in relation to two people with long-standing pressure ulcers. Written feedback from the nurse included: "[Staff] are always responsive to advice and maintain contact re progress after the visits. They refer to myself in an appropriate way and the documentation in the home is good."

Requires Improvement

Is the service caring?

Our findings

We received mixed views from people about the way staff supported them. Some people described staff as "kind", "polite" and "courteous". They said staff treated them with consideration and compassion. One person told us, "[Staff] help me to wash and are very considerate; they don't make you feel self-conscious about it, which is good." A family member said, "[Staff] seem very kind and have [my relative's] best interests at heart."

Other people, however, told us some staff did not always behave in this way. They said staff sometimes handled them roughly when supporting them to wash and dress. One person told us, "Some [staff] are very good, but some are not so good. They grab hold of my [injured foot] when getting me out of bed, and sometimes they catch my foot on the body of the [hoist]. One [staff member] has a very brusque manner; I think [they] mean well, it's just their manner." Another person said, "Sometimes the handling [by staff] is a little rough and I have to call out and say 'Oow! That's my bad shoulder'." A third person said of the staff, "[On one shift] they're very kind and helpful, but on [the other shift] staff are different altogether; they just stand there and don't help. Everything is too much trouble for them." A further person told us, "Most [staff] are quite gentle, but some are a bit matter-of-fact and aren't very gentle with me. You say, 'This hurts or that hurts' and they think you're just saying it; but you're not. I often say to them, 'You don't know how painful [my back] is'. There's one [staff member] that doesn't seem to like me. [They] rush things and don't seem to have a lot of patience with people." We discussed these concerns with the registered manager who reminded staff of the importance of treating people with care.

We recommend the provider reviews their staff training and monitoring arrangements to ensure that staff treat people with dignity and respect, in a compassionate and caring way according to their individual needs.

Information in people's care records showed they (and their families where appropriate) had clearly been involved in assessing and planning the care and support they received. Senior staff conducted monthly reviews of people's care plans and said they involved people in the reviews. However, when we spoke with people about this, none knew that they had a care plan, could not recall ever having seen one, and said they were not regularly consulted about the care and treatment they received. The review forms used by staff included a section to allow staff to record the views and comments made by people and their family members during the reviews, but these had all been left blank. We discussed this with the registered manager, who agreed that the recording of people's involvement in care plan reviews was an area for improvement.

During the inspection we observed positive interactions between people and staff. Staff used people's preferred names and approached them in a friendly and relaxed manner. When medicines were being given, staff checked people were happy to receive them and explained what they were for. When supporting people to move, they were patient and encouraged people not to rush. One person did not appear comfortable on a dining chair and a staff member fetched them a cushion, which helped them to visibly relax during their lunch.

Staff spoke about people warmly and demonstrated a detailed knowledge of them as individuals. A staff member told us, "This is like my second home. I love looking after [the people here]." Another staff member said, "We have to make sure we listen to our patients and go through their care plans for information to help us understand them." A third staff member told us, "This is often [people's] last home, so we have to make sure they are comfortable." Staff used their knowledge of people to strike up meaningful conversations with them. We heard staff talking with people about their former jobs, hobbies, interests and families. At lunchtime, when a person was given their dessert, the attending staff member asked, "Would you like some cream on it, I know you love it?" After some good-natured banter, the staff member brought the cream and the person enjoyed their dessert.

Staff protected people's privacy at all times. They took care to make sure toilet and bathroom doors were closed when they were in use and described practical steps they took to protect people's privacy when delivering personal care. These included keeping the person covered as much as possible, explaining what they were about to do and checking people were ready and willing to receive the proposed care and support. People told us they could choose the gender of the care staff member, or request a particular staff member, to support them with personal care. This information was included in care plans, known to staff and followed. Staff knocked and sought permission before entering people's rooms. In addition, confidential care records were kept securely and only accessed by staff authorised to view them.

People were supported to follow their religious beliefs. Representatives from a local faith group attended each month to hold a service. Staff had also made arrangements for a minister of religion to visit one person on a weekly basis. People's care plans included information about the person's spiritual needs and how they should be supported. The registered manager told us a staff member had built a very close relationship to a person and their family by praying with them in their final days. Although their religious beliefs were not the same, the staff member recognised, understood and supported the person's own spiritual needs. The registered manager said the family had made of point of acknowledging this at the person's funeral and said the staff member had brought them "great comfort" by praying with them and supporting them during the person's death.

The registered manager told us staff came from a diverse range of cultures and backgrounds. They said this benefitted people as it emphasised the need to recognise everyone's individual needs, value systems and culture. A staff member told us, "Everyone is different and you have to know how to approach them and respect them as individuals."

Good

Is the service responsive?

Our findings

With the exception of one person, who felt their needs were not met consistently at night, all other people told us they received personalised care and support that met their needs at all times.
In particular, people spoke enthusiastically about the high level of activity provision they could access. One person said, "The entertainment is really good. We do quizzes, quoits and darts, which is a bit competitive. [The service has] also got a van and [staff] take us out for coffee." Another person told us, "The arts and crafts is brilliant."

The service employed two activity coordinators to run activities for six days of each week. These provided people with appropriate mental and physical stimulation. Activities were advertised on the home's notice board for the coming week and included trips to local attractions, exercises, quizzes, board games, baking, arts and crafts. External entertainers also visited to perform to people. Some people were being nursed in their bedrooms and the activity coordinators told us they made a point of inviting the entertainers to visit them so they did not miss out on the activity. In addition, the activity coordinators spent time on a one-to-one basis with people in their rooms, doing individual activities, such as supporting the person to reminisce. One of the activity coordinators told us, "Some people are not too keen on the chair exercises, but our board games involve leaning forward and back, so act as a form of exercise to keep them moving."

Over the two days of our inspection, we observed a wide range of activities in progress. These included a lively discussion about the Royal Family, board games and sessions of reminiscence. Each person had a 'social care plan' containing information about their background, hobbies and interests. These had been used to design meaningful activities, tailored to people's individual needs. For example, one person used to be keen on reading, so the service had purchased some talking books and large print books for their use. Another person was registered blind and was given a selection of fabrics to touch and feel; the activity coordinator supported the person to identify the fabrics and talk about their uses, which the person clearly enjoyed.

Care plans had also been developed to advise and guide staff about people's care, support and nursing needs. They were centred on the needs of each person and their medical history, their preferred daily routine and how people wished to receive care and treatment. The care plans included information about people's medicines; continence; skin integrity; nutrition; and mobility. When we spoke with staff, they demonstrated a good understanding of people's needs and preferences. They knew how each person liked to receive care and support. For example, which people needed help to re-position regularly, which people needed to be encouraged to eat; whether people preferred a bath or a shower; and how people preferred to spend their day. Records of daily care confirmed that people received care in a personalised way according to their individual needs. For example, one person needed regular exercise to maintain their core strength and staff were supporting them to do this daily.

Staff responded promptly when people's needs changed. For example, a person with diabetes had their blood-sugar levels checked several times a day. When their readings were outside the normal level, staff responded by offering the person something to eat; they then re-checked the person's blood-sugar level

afterwards to make sure they had returned to normal. Another person had a catheter; this is a device used to drain a person's bladder through a flexible tube linked to an external bag. The person told us their catheter often blocked, so staff monitored this and acted quickly to unblock it when this occurred. When people became unwell, staff sometimes needed to take samples for analysis. They did this in a timely way and followed up on people's test results. A urine sample had been sent for analysis during the week preceding our inspection, but no result had been provided by the GP. It transpired that the sample had been lost in transit, so staff had obtained a further sample which they sent again for analysis.

Advanced care plans were also in place for most people. These helped ensure people's end of life choices and preferences were known and documented. They detailed all aspects of care that people said were important to them and included the person's preferred place of death.

The nurses conducted reviews of people's care plans each month. Any identified changes were updated in the person's care plan, and communicated to other staff, to help ensure people's current needs were known and met. A staff member told us, "We've just started [a new system] for care plan reviews and it's going very smoothly."

People were supported and encouraged to make choices about every aspect of their lives, including when they got up and went to bed, where they took their meals and how and where they spent their day. For example, a staff member described how they supported people living with dementia to choose their clothes each day. They said, "[Some people] struggle with choice and change their minds often; so we limit the choice. We show them two items of clothing and describing the colour and what they are like; they usually pick or show a preference for one."

The registered manager sought feedback from people and their families in a variety of ways. These included questionnaire surveys and three-monthly 'residents forums' which were well-attended by people and their families. Feedback from people was analysed and posted on a notice board at the entrance to the home for the information of people and visitors. Survey results showed people were satisfied with the overall quality of service they received. The registered manager told us any individual issues raised during the feedback were addressed directly. For example, one person had commented that they would prefer a different supper; this had been discussed with them and a suitable alternative that would meet their dietary needs had been agreed.

People knew how to complain about the service and the complaints procedure was prominently displayed on the home's notice board. People and family members felt senior staff were approachable and that any concerns or complaints would be listened to and addressed effectively. One person told us, "I've never noticed anything wrong, but if I did I could talk to any staff member. For example, I just asked to see the administrator about something and she appeared straight away." One complaint had been received in the past year and we saw it had been investigated appropriately, and dealt with promptly, in accordance with the provider's policy.

Good

Is the service well-led?

Our findings

People liked living at The Grange and told us the service was well-led. One person said of the service, "There's nothing they could do better; I would recommend it." Another person told us, "[The home] is well run and the manager knows what she is doing." A family member said staff were "organised" and "seem to work well together".

There was a suitable quality assurance process in place. It included audits of infection control, the management of medicines and care planning. Following the audits, improvement actions were identified and implemented where needed. For example, aspects of people's care plans were highlighted as needing amendment and this was done.

The registered manager also completed an audit of all deaths at the home to check the right processes were followed, such as regular visits by the person's GP to avoid the need for a post mortem and discussions with the person and their family members to determine whether resuscitation should be attempted. In addition, the registered manager undertook unannounced spot checks during the night to assess whether staff were working effectively. Staff told us these included speaking with staff, looking at people's care plans and checking records were up to date. One check had identified that staff were not meeting the provider's expectations in relation to the delivery of care to people and appropriate action was taken in line with the provider's disciplinary policy.

The Director of Nursing, from the provider's company, visited the home at least once a month to conduct a monitoring visit. As part of this, they checked the environment, talked to people and staff, observed care being delivered, dip-sampled a selection of care plans and conducted a range of audits. They told us they focused their visits on particular themes each month and aimed to cover all key aspects of care provision over the course of a year. Areas for improvement were addressed and action taken. For example, one visit had identified the need for new photos to be taken of people to help ensure medicines were given to the right person and we saw this had been done.

There was a clear management structure in place. This comprised of the Director of Nursing (from the provider's company), the registered manager, the clinical nurse manager, senior care staff and an ancillary staff supervisor. The clinical nurse manager stepped up to manage the home when the registered manager was not available; they also took part in an on-call rota to be available to provide advice and support to staff out of hours.

The registered manager is a registered nurse and kept up to date with the latest clinical advice and guidance in order to maintain her registration. They were members of the local Registered Managers' Network and the Nursing Homes Association, and had taken part an end of life steering group. These contacts provided them with a useful network for advice, guidance and support which they used to help ensure the service followed the latest best practice guidance.

Staff enjoyed working at the home and spoke positively about the management, who they described as

"approachable". Staff turnover was relatively low and some staff had worked at the home for many years. This helped ensure the continuity of care for people. Staff said teamwork was "really good" and made the following comments: "Everything is well organised. We feel respected and valued for our knowledge"; "[The Director of Nursing] is amazing; so kind and considerate. I can't fault her"; "[The registered manager works really hard and is good with everyone. She deals with any problems straight away"; "[The managers] do listen to us. Whatever I tell them, they act on it"; and "[The registered manager] is easy to talk to; she's honest and open and staff meetings are interactive". One staff member needed to pray at certain times of the day to meet their religious needs and told us the registered manager allowed them to use their office for this, which they appreciated.

Staff meetings were held regularly and provided an opportunity for staff to express their views and make suggestions for improvements. A staff member told us, "We have meetings and [the management] do listen to us. You can always talk to [the registered manager]." Another staff member told us the way care plans were reviewed was changed following a suggestion from a staff member. This demonstrated that staff were willing to express their views and make suggestions for improvements.

There were effective methods of communication in place to help ensure that information about people's health and care needs were understood by all care staff. These included meetings at the end of each shift to verbally pass on information to the next shift; handover notes to document important information about people; and daily reports to the duty manager so they were aware of changes in people's needs and could arrange any additional resources needed.

There was an open and transparent culture at the home. A monthly newsletter was produced to keep people and their families up to date with events that had taken place or were planned. It highlighted people's birthdays and forthcoming activities, together with changes to the staff team or initiatives the home were taking part in. Visitors were welcomed at any time and could stay as long as they wished. There were good working relationships with external professionals and notifications about significant events were reported to CQC as required.

Positive links had been developed with the community to the benefit of people. These included links with faith groups and with a local school. We were told that children from the school visited during the year and sung carols at Christmas. In addition, people from The Grange sometimes attended assemblies at the school, which we were told they enjoyed.

The registered manager had also developed a 'quality board'. This was a notice board used to display the result of quality surveys and the outcomes of audits. It helped inform people, staff and visitors about the quality and safety of the service being provided at The Grange.