Oldbury Grange Nursing Home Limited

Oldbury Grange

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

We inspected Oldbury Grange Care Home on 13 January 2015. It was an unannounced inspection.

Oldbury Grange has two floors and provides personal and nursing care for up to 61 people. At the time of our inspection there were 59 people living at the home. There is a communal lounge on both floors and a communal dining room on the ground floor. There is an activities room on the ground floor and a small quiet lounge on the first floor.

A requirement of the service's registration is that they have 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 was a registered manager in post.

At our previous inspection in August 2014 we found there were four breaches in the legal requirements and Regulations associated with the Health and Social Care Act 2008. We asked the provider to make improvements in staffing, management of medication, safeguarding people from harm and care and welfare. On this

Summary of findings

inspection we checked to see whether the improvements had been made. We found the management of safeguarding issues and medicines in the home had improved since our previous inspection. Further improvements were needed in the deployment of staff within the home and ensuring care plans matched people's needs.

People told us they felt safe living at Oldbury Grange and staff we spoke with demonstrated a good understanding of their role in keeping people safe. We found the deployment of staff within the home sometimes left communal areas unattended so people were left without support if they needed it. We also found that infection control procedures required improvement so that people were protected against the risk of infection.

Medicine administration procedures were in place to assist staff in managing medicines appropriately. The provider ensured people's medicines were available as required and administered as prescribed.

People told us they thought staff had the skills to meet their needs safely and effectively. Staff received support from the management team to gain further qualifications and attend training. We observed occasions when staff did not put their training into practice, for example when supporting people with a diagnosis of dementia.

People were supported to have adequate nutrition and hydration. Where people had nutritional risks, nursing staff had sought advice and intervention from external healthcare professionals to ensure those risks were managed. People were also referred to other external healthcare professionals when a need was identified.

During our visit we found inconsistencies in the provision of care within the home. We observed some very caring interactions between staff and the people they provided support to. Staff were reassuring and engaged positively with people. We also observed times when staff failed to take opportunities to engage and speak with the people they were supporting. There were times when staff failed to explain what they were doing to people who were living with a diagnosis of dementia.

There was a lack of information in people's records about how they wanted to be cared for when they were approaching the end of their life. There was a risk that the wishes of people and those closest to them would not be respected in the lead up to and when people reached the end of their life.

Care records did not always reflect the care people required to support their personal and nursing care needs. There was also limited personal information so we could not be sure people received support that met their individual preferences.

There was a management team in place with delegated responsibilities. Staff spoke positively about the support they received from the management team who operated an on call system to enable staff to seek advice in an emergency.

The checks in place to monitor the quality of service provision had not identified some of the concerns we found during our visit.

One of the directors of the provider company was also a doctor who provided GP support to the home. They assured us there were no conflicts of interest because all service users had a choice as to which GP practice they registered with.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not always safe.

Some parts of the environment were not clean and there was a risk of the spread of infection to people who used the service. Plans for supporting people who could become agitated were not consistently completed and there was not always a staff presence in communal areas to ensure the safety of people. Medicines were managed safely and people received these as prescribed.

Requires Improvement

Is the service effective?
The service was mostly effective.

The manager supported staff to undertake training that met the needs of people who lived in the home. Assessments to identify whether people had capacity to make decisions were not always consistently completed. The manager understood their obligations under the Deprivation of Liberty Safeguards (DoLS) and had made applications when restrictions on people's liberty had been identified. People were supported to maintain adequate nutrition and hydration and referred to external healthcare professionals when a need was identified

Requires Improvement

Is the service caring?
The service was not consistently caring.

During our visit we observed some staff were kind, caring and reassuring when supporting people and providing care. However, some staff did not always take the opportunity to engage and speak with people when providing support. There were no plans in place to ensure the wishes of people and those closest to them, would be respected in the lead up to and when people reached the end of their life.

Requires Improvement

Is the service responsive?
The service was mainly responsive.

Care plans did not always reflect the care that people received although nurses were responsive to changes in people's health. Staff responded promptly to requests for support, however people told us they would appreciate more opportunities to engage in meaningful and fulfilling activities.

People told us they knew how to raise any complaints or concerns and there was a procedure for people to follow.

Requires Improvement

Is the service well-led?
The service was mainly well-led.

Requires Improvement

Summary of findings

There was a management structure in place with members of the management team responsible for specific tasks and quality checks. Quality checks had not picked up some of the concerns we identified during our visit. Staff spoke positively about the management team and felt supported in their roles. There was 24 hour leadership advice available to staff through a management on-call system.

Oldbury Grange

Detailed findings

Background to this inspection

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

The inspection took place on 13 January 2015. The inspection was unannounced. The inspection team consisted of five inspectors and a pharmacy inspector. Three of the inspectors worked within the adult social care directorate. The other two inspectors worked for the hospital directorate and looked specifically at the nursing care provision within the home.

We asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The provider had completed and returned the form as requested.

We also looked at the notifications sent to us by the provider. These are notifications the provider must send to us which inform of deaths in the home, and incidents that affect the health, safety and welfare of people who live at Oldbury Grange Nursing Home. We liaised with the local authority contract team, the local clinical commissioning group and the safeguarding team who provided us with information they had received about the service.

During our inspection visit we spent time observing how staff interacted with people who lived in the home. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with five people who lived at the home, five visiting friends and relatives and 15 staff. These included kitchen staff, care staff, nursing staff, matron, clinical care co-ordinator and the registered manager. We also spoke with one visiting healthcare professional and an external training assessor.

We looked at nine people's care records, medication records, records to demonstrate the registered manager monitored the quality of service provided (quality assurance checks), records relating to staff and incident, accident and safeguarding records.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they were happy with the cleanliness within the home. Comments included: "The place is spotlessly clean – they have the cleaners in every day." "It's always clean and tidy here." "There is never a smell here – only when someone has had an accident." One person told us they had some concerns as levels of cleanliness varied. Another person told us they would like a new carpet in their bedroom because "the carpet is filthy".

However, during our visit we found some parts of the environment were not clean and there were unpleasant odours in some areas of the home. There was a risk of the spread of infection to people who used the service.

We checked the bedroom of a person who had a complex medical condition which necessitated the use of some specialist nursing equipment. We observed urinary catheter bags were stored in an open cardboard box on the floor by the toilet. The person's catheter stand was stored in a plastic bowl which was also on the floor next to the toilet. This meant there was a risk of contamination. The catheter stand was soiled and dust was visible on its surface. There was a fan in the room which was used to keep the person cool. A thick layer of dust and debris was visible at the front of the fan where the air blew out. In addition, we found a nebuliser that was very dusty and had not been cleaned between uses. (A nebuliser is a machine that creates a mist of medicine which is then breathed in through a mask or mouthpiece). The bowl used to wash the person was dirty on the bottom where it had been handled. The lack of cleanliness of both the environment and equipment meant people were at risk of infection.

In another room we looked at a bed containing two mattresses; one on top of the other. Both mattresses were washable but were visibly stained. The bed had been made but the mattresses had not been wiped down.

In another room where a person was being nursed in bed we saw the bed rails were protected by bumpers. One of the bumpers had become cracked, revealing the underneath padding. This meant the bumper was no longer waterproof and would be difficult to wash down and keep clean.

In another bedroom, although the room appeared clean, when we moved the bed we found dirt behind and underneath it.

We also found levels of cleanliness in communal areas and the management of infection control were not consistently maintained. For example we found debris under the cushions on chairs in the corridors. A communal toilet on the first floor had a plastic wash bowl balanced in the bowl of the toilet. Within the dining room we sat at a table to talk to people and undertake our work. We noticed the table was very sticky and dirty. People had been sitting at the table to undertake activities and people later sat at the table to eat lunch. We did not see anyone clean the table throughout our visit. Staff were not always following basic infection control procedures to ensure the risk of the spread of infection was minimised.

During our visit we observed inconsistent use of personal protective equipment such as plastic gloves and aprons. We observed a member of staff with the tea trolley go into one person's room and pick a dirty item of clothing off the floor. They were not wearing gloves and did not wash their hands before going back to the trolley and pouring the person a cup of tea. On another occasion we observed two members of staff did not wear protective clothing when supporting a person to reposition in their bed. The same staff then assisted other people with aspects of their care. This all posed a risk of the spread of infection.

We found this was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

When we last visited Oldbury Grange Nursing Home in August 2014 we found there was a breach in Regulation 22 of the Health and Social Care Act 2008 and associated Regulations because there were insufficient staff to meet the needs of people who lived in the home. At this visit, we found some improvements, but we still identified some concerns around the number and deployment of staff within the home.

On the day of our visit there were 59 people living in the home with 22 on the ground floor and 37 on the first floor. We arrived at the home at the end of the night shift. The night shift consisted of one nurse and two care assistants on the first floor and two care assistants on the ground floor. The day shift consisted of one nurse and four care assistants on the first floor and one nurse and three care assistants on the ground floor.

We asked people and their relatives whether they thought there were enough staff to meet the needs of everyone

Is the service safe?

living in the home. Some people thought there was enough staff. Comments included: "When you ring the bell, staff come quite quickly, there's always someone walking about." "Staff come as quickly as they can when you use the call bell, I don't have to wait that long." "The staff have time to meet [person's] needs." "[Person] is quite happy. She's told me she has no complaints and she feels there is enough staff." During our visit, we were not aware of call bells ringing for extended lengths of time.

However, three people we spoke with raised an issue about there not always being a staff presence in the lounge areas. They told us: "Sometimes I think there should be someone in the lounge all the time because there are people who need help." "Sometimes there are no staff to be seen." During our observations one person shouted for assistance with personal care. Staff responded promptly but another person told us, "[Person] keeps on until she gets what she wants, there is not always someone around."

The majority of staff we spoke with told us they felt comfortable with the staffing levels and were able to meet people's needs. One staff member expressed a concern that they felt rushed and thought extra staff were required.

Although staff told us they felt there were enough staff on duty, we found the complexity of different people's conditions and the layout of the building meant staff were not always able to meet people's needs effectively. When we arrived at 6.55am there were 14 people dressed and sitting in the first floor lounge, some of whom were at risk of falls when mobilising. Two other people were walking in the corridor. Staff were not always visible in these communal areas because they were with other people providing personal care. This meant people were left with no support for periods of time. At 8.30am we heard a person call out from the lounge. We saw another person was trying to take their walking frame away from them which put them at risk of a fall and was causing them to become agitated. Another person walked out of the lounge only wearing one slipper which put them at risk of a slip or a trip. The person was also holding a pair of spectacles which they said were not theirs. If they were the person's spectacles, not wearing them could have impacted on their vision and placed them at a higher risk of a fall. If they were another person's glasses, they would have been without them which placed them at risk. There were no care staff around to manage these situations to ensure people were safe.

We also observed there were a number of people being looked after in bed. As staff were busy, there was little evidence of stimulation for those people.

We found this was a breach of Regulation 22 of the Health and Social Social Care Act 2008 (Regulated Activities) Regulations 2010.

At our last visit we found the provider was in breach of Regulation 13 of the Health and Social Care Act 2008 and associated Regulations because medicines were not always managed safely and people did not always receive their medicines as prescribed. On this occasion we found that the management of medicines within the home had improved although further improvement needed to be made.

People told us their medicines were administered to them by staff. One person told us, "I take 10 pills, two are paracetamol for arthritis, but the rest, I have no idea. They just put them in my hand and I swallow them." We asked if they minded not knowing what their medication was for and they responded, "I just take them, they give me a glass of water or orange juice to help." Another person told us, "They don't tell you, they just give them to you so many times a day." When we asked if they took medication for pain relief, they replied, "If I have got a bad headache, they'll give them to you then."

Medicines were stored securely and at the correct temperatures to ensure their effectiveness. Records showed unwanted medicines were disposed of safely.

The ordering process for obtaining medicines ensured they were available for people when they needed them. We looked in detail at 12 medicine administration records and found people were receiving their medicines as prescribed by their doctor. We looked at the records for people who were having pain relief skin patches applied to their bodies. We found these records were able to demonstrate the skin patches were being applied safely.

Information about the administration of "when required" medicines was not always clear enough to make sure people received them in a timely and consistent way. Where people had to have their medicines administered by disguising them in food or drink or administered directly into their stomach through a tube, the provider did not have all the necessary arrangements in place to ensure that these medicines were administered safely.

Requires Improvement

Is the service safe?

At our last visit we found the provider was in breach of Regulation 11 of the Health and Social Care Act 2008 and associated Regulations as safeguarding concerns were not always being managed appropriately. At this visit we found improvements had been made.

People we spoke with told us they felt they and their relatives were safe living at Oldbury Grange. Comments included: "I feel safe here" and "I feel very safe. I think you could talk to staff if you were worried about something."

We checked staff's understanding of how to safeguard people who lived in the home from abuse. We asked staff how they would respond to different scenarios to safeguard people. Staff understood what constituted abuse and their responsibility to report it to the manager. One staff member said they would not hesitate to report any concerns. They told us, "They [the people who lived in the home] are like family to me".

People and staff had access to the information they needed to help them to report safeguarding concerns. Local authority safeguarding contact telephone numbers were displayed in communal areas for people, relatives and visitors.

We looked at the safeguarding records. Where safeguarding concerns had been identified, the manager had appropriately referred them to the CQC and the local safeguarding authority. However, there was a lack of detail in some safeguarding records so it was not always clear what the advice was from the safeguarding authority and the outcome.

The recruitment procedures in place to ensure staff were suitable for the role and safe to work with people were thorough. A Disclosure and Barring Service (DBS) check and two written references were obtained before staff started work.

We saw there were assessments in place to identify risks people may have when moving, when eating and drinking, and risks of pressure sores. Where a risk had been identified the home had the equipment available to keep people safe. For example, where people were at risk of developing skin damage, staff had obtained specialist equipment to help manage the risk such as pressure cushions. However, we found the actions staff took did not always minimise the risk of people developing skin damage. For example, we observed one person had been hoisted into a wheelchair and wheeled from their bedroom without removing their sling. The sling was not made of breathable material and was not designed to be left in place. The care records for this person showed the person had been assessed to be at very high risk of pressure damage. The person's care plan stated the sling should be left in place in the chair although this would increase the risk of the person developing pressure damage. The person's care plans did not explain what staff should do to minimise this risk.

Most people who lived at Oldbury Grange had a diagnosis of dementia and could demonstrate behaviours that could be challenging to others. We found care plans were inconsistent. Some plans provided staff with information about the actions they needed to take to distract or de-escalate any behaviours. However, for one person, there was nothing in their care plan to inform staff how to manage their agitation to keep the person and others safe.

We asked if people had personal emergency evacuation plans (PEEPs) in place to provide instructions about the assistance they would need to safely evacuate the building in the event of an emergency. This is particularly important for people who are not able to mobilise independently or who may be confused as to time and place. We were told there were no PEEPs in place for anybody living in the home. This meant staff and emergency services would not have the necessary information about the assistance people required if an evacuation of the premises became necessary.

We were given a copy of the provider's business contingency plan. A contingency plan should provide information to staff about the action to take in the event of an unexpected emergency that affects the delivery of service, or that puts people at risk. For example, plans should describe how people would remain safe and protected in the event of a loss of services such as a loss of utilities or a fire. We saw the provider's contingency plan was dated August 2010 and had been reviewed in January 2014. We found the review had not identified some inaccuracies in the plan. We could not be confident the provider had a robust plan in place to ensure people were kept safe in the event of any emergency or unforeseen situation.

Requires Improvement

Is the service effective?

Our findings

People and their relatives spoke positively about the level of care provided and thought staff had the skills to support their needs. A relative told us, "I'm here every day, the care is pretty good." Another relative said, "I have absolute confidence in everything they have done, [person] always appears well cared for." One person told us, "I have to have a 24 hour service. I am very satisfied. Anything they [staff] have taken on to do, they do it and do it well."

Staff we spoke with told us they received training to support them in meeting people's care needs.

We looked at the staff training schedule which showed staff had received training in all areas considered essential to deliver safe and effective care. We saw a planned six week programme of training which included training to meet the specific needs of people who lived in the home. Records demonstrated that nearly all the care staff had completed or were completing qualifications in health and social care. This supported staff in developing their knowledge and skills.

Some of the training was distance learning which was provided by a local college. During our visit we spoke with a trainer from the college who visited the home every three weeks to provide training support. The trainer told us they had no concerns about training within the home. They said the matron and manager were supportive and uptake for training was good. They told us, "Incredibly positive in terms of training – everybody wants to do some learning here. They are very supported in terms of being given time to come and sit with me when I am here. The managers are doing the courses as well which makes a big difference. A lot of staff come in on their day off."

During our visit we observed several occasions when staff did not put their training into practice. For example, staff had received training in caring for people with dementia but sometimes failed to engage appropriately with people who had such a diagnosis. Gaps in learning had not been identified to ensure effective care was delivered consistently by staff.

The Care Quality Commission is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report on what we find.

Most records we looked at contained assessments to identify whether people had the capacity to make decisions for themselves or whether decisions needed to be made in their best interests. One person's plan of care stated they 'lacked capacity'. There were no assessments in place to show how this decision had been reached or what decision had been made in the person's best interests. Assessments had not always been completed to ensure people were protected under the Mental Capacity Act.

DoLS is a law that requires assessment and authorisation if a person lacks mental capacity and needs to have their freedom restricted to keep them safe. Staff responsible for assessing people's capacity to consent to their care demonstrated an understanding of DoLS. We were told over 20 applications had been made to the local authority where potential restrictions on people's liberty had been identified. Fifteen applications had been approved at the time of our visit.

We asked people what they thought about the food provided and whether they had a good choice. Two people told us the food was "very good". One went on to say, "There is a variety of food each day." Another person told us they had a good choice of food and it was "excellent". A visitor told us, "The food is fine, it is different every day."

We saw that at breakfast and lunch time people had a number of different meal choices and were offered a selection of hot and cold drinks. One person commented positively about the size of the portions.

People who were able to eat independently were served first. Some people had equipment such as plate guards and adapted cutlery so they could continue to eat independently. People who required support to eat were given full attention by staff and were not rushed. There was no pressure to eat quickly and the majority of meals were eaten. Staff were observant of people who needed encouragement or prompting to eat their meal.

During our visit we saw people were offered a choice of drinks and snacks mid-morning and mid-afternoon. One person told us they had enough hot drinks and said, "All of us have a cup that they come around and fill with juice." We saw drinks were available to people cared for in their bedrooms.

Nursing staff had sought advice and intervention from external healthcare professionals when they were required. For example, we saw that people requiring a modified

Is the service effective?

texture diet had been referred to and assessed by a speech and language therapist. We saw that where people had been assessed as requiring pureed food and thickened fluids, they received this in accordance with their care plan. Each food item was pureed separately so people could still benefit from individual food tastes.

People were referred to a dietician if they were at risk of malnutrition and we saw that some people required a diet fortified with extra calories. We spoke with the cook who told us the nurses kept them informed of all those people who required a special diet. The nurses also informed them of any people who were losing weight so their food could be fortified. People got their nutritional supplements as they were prescribed.

We looked at the records for a person who had swallowing difficulties and was unable to take food and fluids by mouth. They had a percutaneous endoscopic gastrostomy (PEG) in place. This is where a tube is inserted directly into a person's stomach and nutrition and fluid is passed through the tube. We saw the nutritional feed was administered as it was prescribed and at the correct rate. A fluid chart was maintained to show the person had had been administered sufficient fluids in a twenty four hour period.

Records showed that the home received regular GP visits. One person told us, "The doctors do a routine round – if there's any need to see him other than that, it gets dealt with."

We spoke with a visiting doctor who was also a director of the provider company on the day of our visit. The doctor was visiting people who had been identified as being unwell or who needed a review. The doctor told us that during their visits to the home they had not had any concerns about the care people received. They told us that nurses were responsive to the health needs of people using the service and that they always referred people to their GP in a timely manner.

Requires Improvement

Is the service caring?

Our findings

People told us that staff were caring and treated them kindly. Comments included: "Staff are always welcoming, they've helped me a lot." "The staff are kind to people, I haven't found any fault there at all." "I find it nice, everyone is very nice, they are all very friendly to you." One person told us, "When I first came it was older women [care workers] they used to ask you about you and your family, but I get the impression now it is just a job. They're good but the older ones used to make you feel they cared, but they're all very pleasant." A relative told us their family member could be verbally abusive and said, "The girls take it good". Another relative said, "Staff are caring. If people are upset they always sit with them."

One visiting relative told us, "Most of the carers are really good, but they can only do so much. I've not had a problem with any of the staff, I feel [the person] is treated with respect. It is just the little things that are ruining what could be a good job. The trouble is all these little things are important."

During our visit we saw some good demonstrations of kind caring support. Our use of the Short Observational Framework for Inspection (SOFI) tool found care staff appeared to genuinely care about people although there sometimes appeared to be a priority of completing tasks over individualised care. Staff did not always take the time to engage and communicate with people when they had the opportunity. For example, some people were given their meals or asked if they wanted a drink without description or any conversation. In contrast we saw another member of staff was jolly and pleasant to all the people they were offering drinks to. One person told us, "There's always a nice cup of tea in the day and I always get a smile."

The level of care provided to people, especially those living with a diagnosis of dementia did not always support people to feel settled. Staff were not consistent in explaining what care they were about to deliver to people who used the service. We observed people being transferred from chairs to wheelchairs using a hoist. Staff spoke with people and reassured them whilst they were undertaking the manoeuvre. However, we saw a member of staff move a person in a wheelchair. The staff member did not explain to the person why they were going to move them and where they were taking them.

We observed a person to be distressed and shouting out in their room. The person had a diagnosis of dementia and was being assisted with their personal hygiene by two members of staff. We observed the staff did not speak with warmth and made no attempt to reassure the person or explain what was happening. We reviewed the care records for this person to determine the level of support they required. The care plan stated the person was resistant to personal care but did not offer any guidance about how staff should support the person when delivering personal care to minimise their distress and offer consistency in their care.

During the day we observed some good examples of people being offered the opportunity to make every day choices about their care and support. Kitchen staff informed people individually of the lunch time menu and the choices available to them. The activities co-ordinator offered people the choice of participating in activities.

We found staff were not always consistent when respecting people's dignity. One person was wearing a skirt. We saw staff put a blanket over the person to protect their dignity when they were hoisted. However, on another occasion we observed a female being hoisted into a chair without respect for dignity. Their undergarments were clearly visible in a mixed gender lounge. The registered manager was also present and immediately reminded staff of the need to use a blanket to maintain the person's dignity.

Visitors to the home could visit any anytime and people told us they had no problems seeing their families. One relative told us, "I can come any time." Another visitor told us they were made welcome and offered hot drinks by staff.

Records showed that where a need had been identified, people were referred to independent advocates such as an IMCA advocate. This indicated the manager knew the correct procedures to follow to ensure people were given a voice and their rights protected.

We saw people had a Do Not Attempt Cardio Pulmonary resuscitation (DNACPR) order in place. However, the wishes of the person and those closest to them had not been sought in respect of end of life care. None of the care records we looked at contained information for staff on how to care for individuals when they were approaching the end of their life. There was a risk the wishes of people and those closest to them would not be respected in the lead up to and when people reached the end of their life.

Requires Improvement

Is the service caring?

We saw no evidence that an end of life care pathway was being used within the home. For example, the Gold Standards Framework (GSF). The GSF is a national framework of tools and tasks that aims to deliver a 'gold standard of care' for all people nearing the end of their lives. The management team and the provider were not familiar with this framework to help ensure people received the level of care and support they may need when they were at end of life.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection in August 2014 we found there was a breach of Regulation 9 of the Health and Social Care Act 2004. We asked the provider to make improvements in the provision of care and welfare within the home. At this inspection we found some improvements had been made but further improvements were needed.

People told us staff were responsive if they needed assistance. One person told us, "They're very good. If you're struggling which I sometimes do because of my eyes, they will immediately come and help." Another person told us, "If you want something they'll come and get it for you." Relatives we spoke with told us staff were responsive when asked for information about their family member's care. One relative told us, "Anything I want, advice or whatever, they are so helpful."

We looked at nine sets of care records. We found care records did not always reflect the care that people received. For example, one person's care plan stated they should be checked every hour. When we looked at the documentation relating to the checks at 12.45pm, we found nothing had been documented to suggest checks had taken place since 9.30am. We asked a member of staff how often the person should be checked. They told us that checks should take place every two hours. We could not be sure from checking the records and speaking to staff whether the person was receiving care that met their healthcare needs.

We looked at the records for a person who had a PEG tube in place. The entry site to the PEG was crusty. It was difficult to establish when the area around the PEG tube had last been cleaned or rotated as there was no documentation to indicate this. It is important that people who receive their nutrition via a PEG receive regular oral care. There were no records to confirm if this person was receiving regular oral care to prevent their mouth becoming dry, sore or infected. We could see the person's mouth was dry. We immediately informed the matron of our concerns and asked what was being used for mouth care. The matron informed us that warm water would be used. We asked the deputy matron how often this person should receive mouth care. They told us that every six hours should be enough. Following a discussion, the deputy matron obtained some glycerine swabs to undertake mouth care for the person.

We saw nurses were responsive to changes in people's health. On the day of our visit one person was displaying the signs of a urine infection. Once confirmed, the doctor was contacted and antibiotics were prescribed. A relative told us that their family member had been very ill at one time but their health had now improved. They went on to say, "Staff spotted the signs really quickly and got her to hospital. The care here is exceptionally good."

We attended two handovers between shifts. One from the night to the morning shift and one from the morning shift to the afternoon shift. One of the nurses on the morning shift did not attend the handover from the night nurse. We were assured they had been given a separate handover. We found the information that was handed over was minimal and basic.

Care plans we looked at contained some information about people's preferences, but this was brief. We saw that one person liked to read magazines and watch the television. We observed that when this person was taken from their bedroom to the lounge, they were placed in a position where they could not interact with other people. Staff did not offer magazines or ask if the person would like to watch television as set out in their care plan.

When we visited Oldbury Grange in August 2014 activities were only available for a short period each week day afternoon. At this visit we found improvements had been made in the support provided to people to follow their hobbies and interests and participate in activities. An activities co-ordinator provided group activities such as singing, music sessions and bingo. They also undertook individual activities such as playing games with people and reading to them and one to one chats. We saw people engaged in a painting activity. The activities co-ordinator praised people's efforts and people responded positively.

People we spoke with indicated that further improvements needed to be made to provide people with meaningful and fulfilling activities that would contribute to their wellbeing. We asked one person what they did during the day. Their response was, "I lead a very exciting life. I sit in the chair all day and watch rotten television." They told us they needed support with one of their interests and said, "There are so many people that they get round to you about once every six weeks. You accept things without really thinking about it." Another person told us, "Nothing much you can do, just watch the TV."

Requires Improvement

Is the service responsive?

People told us they would feel confident to raise any concerns with staff or the manager. “If I have any concerns I just have a word in the office and it is usually put right.” A relative told us, “I would feel able to talk to staff if I had any concerns but I can’t think of anything I’ve had to raise with them.” Another relative told us that if they had any concerns they would talk to the staff and they were confident staff would listen. They went on to say, “Everything is fine with [person], I have no reason to grumble about the home at all.” People told us they had nothing to complain about.

The complaints procedure was available in the service user guide that was kept in each person’s bedroom. We were told there had been no formal complaints received by the service since our last visit. We were aware from our own notifications that some people had raised concerns about the service on an informal basis. As there was no process in place to capture informal concerns and any action taken to resolve them, we could not be sure they had been dealt with to the satisfaction of those concerned.

Requires Improvement

Is the service well-led?

Our findings

The registered manager was supported by a matron and a care co-ordinator. Each member of the management team took responsibility for specific tasks such as staff training, infection control audits and medication. However, we found the overall governance process was disjointed with no one person having a complete overview of the service.

Surveys to assess the quality of the service had been sent to people, their relatives, staff and visiting professionals to the home in February 2014. We saw the results of these surveys had been analysed but not always effectively actioned. For example, 50% of relatives had indicated they were not always satisfied with the temperature in the home. The manager told us relatives had been informed that rooms had individual room or radiator thermostats to control the temperature. However, this did not address the concern for people who had a diagnosis of dementia who would not have the capacity to adjust the thermostats. No action had been taken to investigate the issue further. There was no record of temperature checks in people's bedrooms or communal areas. On the day of our visit, all the members of the inspection team found some areas of the home were cold. We saw two comments in the suggestions/comments book in the foyer. On 14 December 2014 a person had written 'Room downstairs was freezing'. This comment was repeated on 1 January 2015 but the manager was not aware of these comments as the book had not been checked. This indicated that once an issue had been raised, insufficient action had been taken to respond to it. The organisation had failed to make appropriate improvements based on people's feedback.

Quality assurance and audit processes were in place but had not identified the problems we found during the inspection. For example, infection control audits were undertaken and we found concerns in infection control. This showed us that quality assurance systems at the home were not sufficient in identifying risks so they could be promptly acted upon. An effective quality assurance system is essential for management to receive assurance regarding the performance of different areas of the home.

There was building work taking place at the time of our visit. We did not see any staff checking that workmen were working in a manner that did not impact on the people who lived in the home. At 7.45am workmen were working with the radio on next to bedrooms. They were disturbing people who were still in bed and trying to sleep.

The registered manager had sent notifications to us appropriately about important events and incidents that occurred at the home. The registered manager should also inform us of any DoLS applications that are approved by the local authority. We had not been informed of the 15 DoLS applications that had been approved.

Staff spoke positively about the support they received from the management team. The registered manager had recently worked some shifts as a nurse which meant they had an understanding of the challenges faced by staff. Staff told us they received regular supervision on a one to one basis and through observation. Staff told us they felt well supported by the nurses. The nurses told us that if they had any concerns they would raise them with the matron. Staff told us there were staff meetings where they were able to share their opinions.

We found the management operated an on call system to enable staff to seek advice in an emergency. This showed there was leadership advice 24 hours a day to manage and address any concerns raised.

One of the directors of the provider company was also a doctor who provided GP support to the home. We spoke with them about conflicts of interest as the owner of the home and also a GP for the home. The provider assured us there were no conflicts of interest because all service users had a choice as to which GP practice they registered with. The provider also told us there were four GPs at the practice, all of whom were on call different days of the week. If people were registered with the practice, they would only see the provider as their GP if the provider was on call. The service user guide available to all people who lived in the home was clear about the provider also offering a GP service to the home.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **People were not always protected against the risks of acquiring an infection because appropriate standards of cleanliness and hygiene were not maintained.**

Regulated activity	Regulation
Accommodation and nursing or personal care in the further education sector Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **People's safety and welfare was not always ensured because there was not sufficient staff available at all times to meet their needs.**