Bradbury House Limited

The Grange

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
The Grange accommodates up to 25 people with a learning disability and/or autistic people. People living at the service may also have mental health conditions. People lived across four schemes. These schemes are The Grange, The Courtyard, Priddy Farmhouse and Meadowlands. People have their own apartments with en-suite facilities. Within the services there are some communal areas and The Grange has a separate group kitchen. All of the services are on a working farm site and there are day centre opportunities for people to participate in farm activities. At the time of the inspection there were 25 people living at the service.

People's experience of using this service and what we found
We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.
Based on our review of the key questions safe, effective, responsive and well-led, the service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture.

Right Support
The service did not always give people care and support in a safe, clean and well-maintained environment.
People were not always able to pursue their chosen interests and achieve their aspirations and goals because of staffing shortages at the service. The home was reliant on agency staff that did not always know people well.
Staff had not always communicated with people in a way that met their needs. Staff had not always supported people in the least restrictive way possible. This had been addressed by the provider. People were supported to have some choice and control of their lives. The policies and systems in the service supported this practice.
People had a choice about their living environment and were able to personalise their rooms.
Staff did everything they could to avoid restraining people. The service recorded when staff restrained people, and staff learned from those incidents and how they might be avoided or reduced. The provider's behaviour specialist reviewed all incidents to ensure appropriate support was being delivered.

Right Care
Some aspects of people's medicines were not managed safely.
The service did not always have enough appropriately skilled staff to meet people's needs and keep them safe.
Health and social care professionals were involved in the care and support of the people living in the home.
Referrals had been made to the local community learning disability team.
People received care from staff that had been through a recruitment process. Staff were caring in their

approach towards people.
Staff understood how to protect people from poor care and abuse. The service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Right Culture
Staff turnover was high. Staffing was not always planned in respect of people's individual needs which meant they were not always receiving their one to one support. Permanent and regular agency staff knew and understood people well and were responsive to their needs.
There had been a lack of leadership in the home. There had been no registered manager at the service since April 2021.
The provider and the manager had failed to implement a robust system to monitor the quality of the service. Improvement in areas of risk management had not been fully implemented in respect of the property, fire and cleanliness.
The geographic location of the service was isolated. There were limited public buses available to transport people to the local towns and community facilities if they wished. The service had vehicles available at each scheme, however there were not always drivers available.

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

Rating at last inspection
The last rating for this service was good (05 November 2018).

Why we inspected
The inspection was prompted in part due to concerns we received about potential abuse and unsafe staffing levels. A decision was made for us to inspect and examine those risks.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

We have found evidence that the provider needs to make improvements. Please see the safe, effective, responsive and well-led sections of this full report.

The overall rating for the service has changed from good to inadequate based on the findings of this inspection. You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Grange on our website at www.cqc.org.uk.

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

We have identified breaches in relation to safe care and treatment, safe staffing and good governance at this

inspection.

We issued a letter of intent and the provider responded with an action plan to address our most serious concerns.

We made recommendations that the provider reviews their processes to ensure people receive person-centred care and reviews people's capacity assessments in line with the principles of the Mental Capacity Act 2005.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions, it will no longer be in special measures.

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 safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

The Grange

Detailed findings

Background to this inspection

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

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
Five Inspectors and an Expert by Experience carried out the inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
The Grange is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. The Grange is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. There was a manager in post who was in the process of starting their application to become the registered manager.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We used the

information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We received feedback from the local authority. We used all this information to plan our inspection.

During the inspection
We spoke with nine people who used the service and seven relatives about their experience of the care provided.

We spoke with 17 members of staff including the locality manager and the quality assurance lead for the service.

We reviewed a range of records. This included nine people's care records and multiple medication records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We requested feedback from eight professionals involved with the service.

Inadequate

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- The provider failed to protect people from the risk of avoidable harm. The provider had not protected people from harm in the event of a fire, and act to reduce the risk of a fire occurring. The provider had commissioned an externally qualified contractor to undertake a fire risk assessment that identified various shortfalls, including high and medium risk items. The provider failed to rectify all of these shortfalls, within the required timeframes. This increased the risk a fire would occur, and that people would not be evacuated safely.
- The provider failed to act and undertake maintenance works to improve environmental safety. There were numerous examples of this, such as some of the emergency lighting in one service had been defective since October 2021 which posed an evacuation risk. The staff had repeatedly reported this risk. However, at the time of our inspection the emergency lighting had not been repaired.
- The provider placed service users at increased risk of avoidable burns from hot surfaces. We identified radiators in communal hallways that the provider had failed to risk assess, or introduce measures to mitigate the risk, such as radiator covers.
- Risks to people were not always assessed and fully mitigated. One person's care plan stated they were at risk of choking. Whilst there was some information describing the control measures to reduce the risk recorded in the person's care plan. Staff described additional information of how they supported the person, however this was not recorded. This meant information would not be available in the event of an unfamiliar staff member supporting the person, placing them at risk.
- Another person's care plan contained conflicting information relating to their eating and drinking requirements and an assessment that had been completed by a speech and language therapist. This meant staff may not follow the current assessment.

The provider failed to manage and assess potential risks to people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- After the inspection, we contacted the local fire service and local safeguarding team and informed them about our concerns in relation to fire safety.
- In response to the fire safety risks we identified, we wrote to the provider and requested an action plan to determine what would be done, and by when, to improve safety for people living at the service. The provider responded with an action plan to reduce these risks.
- People had individual risk assessments in their care plan. Areas covered included, activities, leaving the service, traveling in vehicles and the environment. The assessments included indicators of the risks and plans in place to mitigate them.
- Some people could become anxious, leading to incidents where they harmed other people, staff or the

environment. There were plans in place about how staff should support people at these times. Staff told us restraint was only ever used as a last resort to keep people safe.

● One person commented on when they had been restrained by staff, "It was professional, staff tried to talk me out of it first but couldn't. Staff are trained so it's all above board."

● One person had an agreed plan for seclusion in their apartment when they were anxious and presenting harm to others. The provider had recently implemented a system for recording this after receiving advice from the local safeguarding team.

● Restraint was only ever used as a last resort and where necessary, for the minimum time. Records demonstrated there was minimal restraint used. Staff told us incidents of restraint had reduced for one person due to a change in their approach. Where restraint was used this was recorded on an incident form and reviewed by the provider's behavioural specialist. One staff member told us, "We don't have to restrain anyone, we prefer to talk to people and try to avoid incidents. We know people's triggers and know what to avoid."

● The training staff received on restraint was certified as complying with the Restraint Reduction Network Training standards.

Preventing and controlling infection

● The provider had failed to ensure that measures to protect people from COVID-19 were being adhered to. On the first day of the inspection on entering one of the schemes, staff were unmasked despite the providers COVID-19 policy requiring the wearing of masks. On the second day of the inspection no checks were made for COVID-19 test results for two of the inspectors.

● We saw that some people's apartments were unclean and an infection control risk. We were told that people were assisted to be independent in cleaning their own accommodation. The provider had not however ensured that where people neglected to keep their accommodation and bedding clean that there was a proportionate response to mitigate the risk of people self-neglecting. In one of the services there was not an effective system for cleaning mop heads, the manager wasn't aware of how these should be cleaned and stored.

● Cleaning schedules did not specify which person's apartment they referred to. This meant it would be difficult for the provider to assess where, if any improvements were needed.

● There was no evidence of a full Infection control audit being carried out. We saw infection control checklists, but these were limited and did not cover all areas required. Areas not covered included, checking the cleanliness of people's apartments and communal areas and ensuring appropriate systems were in place for cleaning and storage of mop heads.

The provider had failed to ensure systems were in place to protect people from the risk of infection. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Communal areas in the service were generally clean. We observed staff cleaning communal areas during the inspection.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service. There had not been any new admissions to the service.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes

● The provider had safe systems in place to ensure visits were managed in line with the government

guidance.

Using medicines safely

● The provider had failed to ensure that medicines were consistently safely managed across the service.

● Some people had been prescribed PRN medicines for use on an "as required" basis. Although protocols were in place the level of detail included was inconsistent across The Grange. Some protocols lacked detail particularly for the use of anti-anxiety medicines. The protocols did not explain the signs people might display if they were becoming agitated or the steps staff should take before resorting to the use of medicines. In addition, staff had not recorded the outcome of using the PRN medicines. There was no record to enable the assessment and effectiveness of the PRN medicine.

● Medicines that required additional security were checked weekly. However, the record keeping in relation to checking in one of the services was incorrect because of how staff documented the stock checks.

● The temperature of medicine cupboards was checked and recorded. However, across the schemes, this was inconsistent. In one scheme there were seven days when the temperature had not been recorded. Additionally, the medicines storage cupboard temperature had been running high. There was nothing documented to show that staff had recognised this or that they had escalated their concerns.

● In one service the keys to the medicine's cupboard were not held by staff who were responsible for administering them. This contradicted the provider's policy which stated, "Medication must be stored in a secure, locked cabinet and the keys to the cabinet must be kept by the staff member responsible for administering."

● Not all handwritten entries on medicine administration records (MAR) had been signed and counter signed in line with NICE guidance to minimise the risk of recording errors.

● Not all staff had their competency assessed to ensure they were competent to administer medicine's.

The provider had failed to ensure medicines were consistently managed safely. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some people self-administered their medicines. Staff supported people to become competent to do this. When people did self-administer, staff completed stock checks of medicines twice a week. Some people had been prescribed topical medicines such as creams and lotions. People were supported to apply these independently where possible.

Staffing and recruitment

● People had one to one hours commissioned to meet their individual needs. These hours were not always being met by the service.

● The staff in each service confirmed the minimum safe staffing levels. We reviewed the staffing rotas and observed times when staffing had dropped below these minimum levels.

● People told us they didn't always get their one to one hours, which meant they couldn't always do what they wanted to do. Comments from people included; "They try their best, but it seems they are constantly short staffed", and "Staff are kind, caring and thoughtful, they try to get us out, but they are up against it." Relatives also raised concerns over staffing and the high turnover of staff.

● Staff told us at times there were not enough staff. Comments from staff included; "Staffing is abysmal, it does have an impact on staff and service users. They are not able to do the activities they want if there are not enough staff. They do always get to their appointments, they are prioritised", "There's not enough permanent staff" and "Staffing is not great, people don't always get out, in comparison to the other houses we are not too bad, but we are not fully staffed."

The provider had failed to ensure sufficient numbers of suitably qualified staff were deployed across the service. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider completed checks on the suitability of potential staff and agency staff. This included obtaining references and checks with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and help prevent unsuitable people from working in care services. We found there were gaps in the employment records in three of the staff files we viewed. There were also no interview records held on their files. We discussed this with the provider who told us they would review staff files.

Systems and processes to safeguard people from the risk of abuse

● People told us they felt safe living at The Grange. Comments from people included, "I always feel safe here, I'm relaxed, and the staff are kind" and "They [staff] have been good to me."

● Staff knew how to recognise and report abuse. Staff said they would report any concerns to the managers. Staff were confident the managers would take action to ensure people were safe. Staff were aware who they could report concerns to outside of the organisation if they felt they were not listened to.

● There was safeguarding information in the schemes directing staff on actions they should take if they had any concerns.

● The inspection was triggered by concerns relating to allegations of abuse. There were processes in place to ensure concerns were reported to the local safeguarding team and appropriate referrals had been made.

Learning lessons when things go wrong

● There were systems in place to report incidents and accidents. These were recorded and reviewed by the manager, behaviour specialist and the providers senior management team. The behaviour specialist analysed incidents for themes and trends and where things could have been approached differently.

● In one of the services there was a delay in recording an incident, the manager confirmed this had been discussed with the provider's behaviour specialist who had reviewed the person's care plan.

● Staff told us incidents were manageable and not a regular occurrence. Comments from staff included, "It feels better than it did a few years ago, there are not so many incidents and it seems calmer" and "We give them [people] time to calm down, knowing the guys really helps, we know their triggers."

Requires Improvement

Is the service effective?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- The provider failed to ensure staff received training relevant to their roles. We reviewed the current staff training matrix. Staff received the induction program when they joined the service, however annual refresher training was frequently out of date. We found there were some gaps in staff records of their induction.
- We found staff had not always undertaken the provider's mandatory training. For example, some staff had not completed safeguarding, Deprivation of Liberty Safeguard training and Mental Capacity Act training but had been working with people for some time.
- Staff were not always supported to access training that was specific to peoples' support and health care needs. For example, some people using the service were living with epilepsy and diabetes however relevant training was not always undertaken by staff. Not all staff had received training in autism and learning disabilities. This meant they may not have the skills and knowledge to support people appropriately.
- Staff were trained in the use of restraint; however, some staff training had expired.
- There was also a high use of agency staff who did not always have the level of training required to meet people's needs. Not all of the agency staff working in the service had received training in restraint.

The provider failed to ensure sufficient numbers of suitably qualified staff were deployed across the service. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff received one to one supervision with their line manager. This provided them with an opportunity to receive feedback and discuss any concerns. There had been some gaps in the frequency of staff supervision, and we saw there had been improvements in this area.

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

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

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

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

● Where people were able to consent to their care and support, this was evidenced in their care plans.

● When people were thought to lack the capacity to make specific decisions capacity assessments had been completed with input from the person and other relevant people, such as relatives and social workers. We found however not all the capacity assessments remained relevant or had been recently reviewed.

● For example, one person had a capacity assessment stating staff held their tobacco, staff told us this was not relevant as the person held their own tobacco. Another person's capacity assessment had not been reviewed since February 2020. This stated the person's door to their apartment would be locked at specific times for their safety when they were anxious. This was not the current practice and the person's door was not locked. This meant the person may be disproportionately restricted by staff who were not aware of the person's current needs.

● We discussed this with the providers senior manager who told us they were aware some of the capacity assessments needed updating. They confirmed there was a plan in place to address this.

● People were able to make most day to day decisions about their care and support as long as they were given the right information in the right way, at the right time. People told us they could choose what they did, however staffing levels sometimes impacted on this.

We recommend the provider reviews people's capacity assessments in line with the principles of the MCA to ensure they remain relevant.

● Where people required DoLS applications, these were completed and submitted to the local authority. Where DoLS applications were pending approval from the local authority, we saw evidence of the managers following this up by email. Where there were conditions on people's DoLS we saw these were being met.

● One person's DoLS stated their apartment door could be locked at times when they were anxious and in potential danger. Staff told us this had been overused in the past and that this had recently improved. Records of when this was occurring had not been kept. The provider confirmed they had put systems in place to ensure if this occurred staff kept detailed records, they also told us they had started completing spot checks on the service to check the restriction.

● Staff told us they supported people in the least restrictive way. One staff member commented, "I think people are safe in an unrestricted way, we have got people here on DoLS but they manage it in the less restrictive way."

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

● People's needs were assessed prior to them living at The Grange. There was a system in place to support the transition of people prior to moving into The Grange and during their first six months. The assessment covered communication support and consideration to environmental needs.

● People's care plans were based on people's assessed needs and preferences, however the quality of the care plans across the service was mixed. People's records were not always up to date, lacked detail and some of them had conflicting information.

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

● People's care plans detailed the support they required regarding their eating and drinking requirements and how staff would encourage them to eat a balanced diet. Some people were able to cook their own meals, whilst others required support from staff.

● We saw referrals were made to a dietician where required.

● One person told us they would like more support with cooking healthy meals and that staffing had

impacted on this.

Adapting service, design, decoration to meet people's needs
● All of the people living at The Grange had individual apartments. We found the quality and decoration in the apartments were mixed. Some were well maintained, whilst others required maintenance work.
● The manager of one of the services told us people could choose the colour of the main feature wall in each room and the provider's policy was for the other walls to be white. We discussed this with one of the provider's senior managers who confirmed people were able to choose the colour of their apartments.
● We saw evidence that some people's apartments had been specifically adapted to meet their individual needs. For example, one person who liked the sensory experience of water had their apartment fully refurbished to ensure they were able to enjoy this without causing damage to the environment.

Supporting people to live healthier lives, access healthcare services and support
● People's care plans included details of their health needs and how staff supported them with appointments. Where people found it difficult to access community services with staff, alternative plans were in place such as family members supporting them.
● People attended health appointments as required. These included appointments with the GP, psychiatrist, chiropodist and opticians. One person told us, "They call 111 if you are ill." A relative commented, "[Name of person] has a medical condition which is managed well, and hospital updates are forwarded to me."
● People also received annual health checks with their GP. The service worked alongside health professionals such as dieticians and occupational therapists.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Meeting people's communication needs; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

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

- People's needs were not always fully planned and met, which meant they did not always receive person-centred care.
- People's communication needs were not always being fully met. For example, in one service a person's care plan referred to them using specific communication tools at specific times. A staff member and the manager of the scheme confirmed this was not currently being used. The manager told us there were plans to introduce this.
- People told us they could do activities of their choosing however staffing had impacted on this. This meant people did not always have the freedom to do what they wanted.
- People had individual care plans; we found the quality of the care plans was mixed.
- Care plans did not always include detailed and accurate information relating to people's needs. For example, one person's care plan stated they required a 'strict routine' to reduce their anxiety, there was no detail of what the person's routine was. The care plan also referred to them being 'over stimulated' but did not detail what would attribute to this. This put their wellbeing at risk. The community access section of the care plan did not include details of where the person liked to go in the community.
- One person's care plan contained contradicting information to an assessment that had been completed by a health professional.
- Whilst we saw some evidence of people's involvement in their care, for example them signing care plans to demonstrate their agreement and having recorded conversations with staff. Not everyone felt involved in this. One person told us, "I haven't seen it [care plan] recently. I used to be involved but it doesn't happen now."

We recommend the provider reviews their processes to ensure people receive person-centred care and their care planning is accurate.

- Other care plans we reviewed were detailed, person-centred and accurate. The provider was in the

process of updating all of the care plans.

● In other services we observed staff using people's preferred communication methods such as signing and the use of communication boards. People's care plans included details of their communication needs.

● Records demonstrated people were attending some chosen activities on the providers farm, in house and in the community. Activities included; playing cards, cooking, swimming, horse riding, attending local car boot sales and cafes.

● During the inspection we observed people being supported to attend the local community, the providers farm and staff supporting people with chosen activities such as football.

Improving care quality in response to complaints or concerns

● There had been no recent formal complaints and staff confirmed informal complaints were often quickly resolved with people. Where people raised concerns, service user discussion forms were completed. However, there was no provider oversight of these complaints and how they had been resolved. This meant the provider could not be assured they were aware of the issues affecting people and act on these complaints to improve the service.

● People told us they would speak to the manager or staff if they were unhappy and issues were usually resolved. Relatives felt able to contact the service to raise any concerns. One relative commented, "I would call the main office and they are generally quite good."

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- The provider had failed to implement systems and use them effectively, to monitor and improve the quality and safety of care provision in the service.
- The provider had failed to ensure that high risk fire hazards were rectified within required timeframes. This placed the safety of people at risk.
- The provider had not ensured that staff who were assigned to service level checks had sufficient skills to undertake them. For example; service level fire risk assessments were not robust; the staff undertaking them had not identified the shortfalls which had already been identified by an externally qualified contractor.
- Service level health and safety checks were not robust or accurate.
- The provider failed to ensure maintenance, was completed in a timely way. Maintenance lists for every service identified repeated requests by staff for essential repairs over months and some dating back to January 2021. For example, one person's front door frame had been noted as needing repair in February 2022 and had not been fixed at the time of the inspection.
- The provider had failed to ensure service level checks were undertaken effectively to identify shortfalls, errors and omissions. For example, medicine audits when undertaken did not identify issues such as a lack of detail in PRN protocols or failures to ensure controlled medicines stock records were accurately recorded. There was also a failure to ensure identified actions were completed.
- There were no recent provider level checks of the quality of care provision in the service and a lack of infection control audits.
- The provider had failed to ensure people's one to one hours were being consistently met.
- Registered managers are appointed by the provider and registered with the Care Quality Commission (CQC). They should be in day-to-day charge of services providing regulated activities such as personal care. The provider had failed to ensure the service had a registered manager to oversee and manage the service. At the time of our inspection, the service had been without a registered manager for over a year.
- There was limited provision for people to meaningfully engage about their needs, goals and aspirations. There had been no recent surveys for people and regular resident meetings had not been taking place consistently across The Grange. One person commented, "Meetings haven't happened for a while."

This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- There was a manager in post who was responsible for the day to day running of The Grange. The manager

had started the process to apply for the registered manager position. Each service also had an allocated manager, senior team and staff team.
● Statutory notifications were submitted as required. Statutory notifications are important because they inform us about notifiable events and help us to monitor the services we regulate.

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

● There were mixed levels of engagement with people and staff across the schemes. Staff meetings were not taking place consistently. The provider could not be assured staff feedback was acted upon, where there was an action plan this was not always followed up.
● Staff commented positively about working at The Grange and the people they supported. Staff were clear about the aims of the service.
● People told us they were happy living at The Grange. Comments included; "I have more freedom here and the staff are friendly", "I like it here" and "It's good living here."
● Staff told us they felt able to approach the manager with any concerns.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider was aware of their responsibility to act openly and honestly when things went wrong.
● The managers were aware where concerns had been identified, appropriate notifications should be sent to the CQC as required by law, and to the local authority.
● Staff knew they had to report concerns to the managers and were confident that these would be acted upon.

Continuous learning and improving care; Working in partnership with others
● As stated elsewhere in this report training records identified that training and staff engagement were not being undertaken as frequently as required. Therefore, we cannot be assured that continuous learning to improve care was taking place.
● The service worked in partnership with services, such as a range of multi-disciplinary health professionals.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to establish and operate governance systems to identify shortfalls in the quality of care provision and safety. Regulation 17(1)(2)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure sufficient numbers of suitably qualified staff were deployed across the service. Regulation 18 (1)(2)(a)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people were not always assessed and mitigated. The provider did not do all that was reasonably practicable to reduce risks. The provider had not ensured the premises were safe. Medicines were not always managed safely. People were not fully protected from infection control risks. Regulation 12 (1)(2)(a)(b)(d)(g)(h)

The enforcement action we took:

We served a warning notice, the provider must be complaint by 21 June 2022.