Norton Care Limited

The Grange Nursing Home

Inspection report

Watershaugh Road
Warkworth
Morpeth
Northumberland
NE65 0TX

Tel: 01665711152

Date of inspection visit:
26 May 2016

Date of publication:
13 July 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 26 May 2016 and was unannounced. This meant that the provider and staff did not know that we would be visiting.

The Grange Nursing Home provides care to a maximum of 23 older people, some of whom have a dementia related condition. There were 21 people living at the home at the time of the inspection.

We carried out a comprehension inspection in November and December 2015 where we found multiple breaches of the regulations. We rated the Grange Nursing Home as 'Inadequate' and placed the service in 'Special measures.' Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

After the comprehensive inspection, the provider wrote to us to say what action they were taking to meet legal requirements.

We inspected the service again on 26 May 2016 to check that action had been taken. We found that significant improvements had been made in many areas of the service, although further action was required regarding the premises, documentation relating to the Mental Capacity Act 2005 and care planning. In addition, we had not been notified in a timely manner of one person's injury which had required hospital treatment.

The previous registered manager had left the service. There was a new manager in post who commenced employment in February 2016. He was not yet registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC 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 and associated Regulations about how the service is run.

People who required support with moving and handling could not currently have a bath or shower because the bathroom was being modernised and adapted. Fire instruction had not been carried out at regular intervals for night staff.

We checked medicines management. Staff were currently administering medicines from their original packaging. The manager told us that because of some minor omissions and anomalies he had requested that their pharmacy supplier provide medicines in a monitored dosage system. He explained that this would highlight any errors in a timelier manner.

There were safeguarding procedures in place. Staff knew what action to take if abuse was suspected. They were fully aware of the whistle blowing procedure. External whistle blowing training had been booked in

June 2016.

Safe recruitment procedures were followed. We found gaps in the employment history for one staff member. The manager was able to give us an explanation for the gaps and told us that this information would be added to the staff member's interview record. No concerns about staffing levels were raised by people or relatives. We observed that staff carried out their duties in a calm unhurried manner.

The manager provided us with information which showed that staff had completed training in safe working practices and to meet the specific needs of people who lived there, including dementia care and Parkinson's disease training.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. MCA is a law that protects and supports people who do not have ability to make their own decisions and to ensure decisions are made in their 'best interests' it also ensures unlawful restrictions are not placed on people in care homes and hospitals. 18 applications had been submitted to the local authority to authorise in line with legal requirements. The manager told us that these had not been authorised yet. This was confirmed by the administrator of the local authority DoLS team. Mental capacity assessments were now in place. We saw that some of these were not decision specific. The manager told us that this was being addressed.

We observed that staff supported people with their dietary requirements. An additional member of kitchen staff was on duty over the tea time period. Staff told us that this was appreciated because it gave them extra time to ensure people had a positive meal time experience, since they no longer had to prepare the meal at tea time.

Staff who worked at the home were knowledgeable about people's needs. We observed positive interactions between people and staff. People were supported with kindness and care.

Care plans were in place which gave staff information about how people's needs were to be met. Staff were in the process of changing to new documentation which they said was clearer and more person centred.

There was an activities coordinator employed to help meet the social needs of people. People told us that there was enough going on to occupy their attention. This was confirmed by our own observations. There was a complaints procedure in place. Feedback systems were in place to obtain people's views. Meetings and surveys were carried out.

The service had been through a period of change and unsettlement since our previous inspection. Staff informed us that morale had improved since the new manager had taken over.

There was currently no nominated individual overseeing the management of the service. The previous registered manager had also been the nominated individual. A nominated individual represents the provider and has responsibility for supervising the way that the regulated activity is managed. Following our inspection, we were informed that one of the directors would become the nominated individual.

A new quality assurance system was in place which effectively highlighted any areas for improvement.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to safe care and treatment. You can see what action we told the provider to take at the back of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Not all aspects of the service were safe.

People who required support with moving and handling could not currently have a bath or shower because the bathroom was being modernised and adapted. Fire instruction had not been carried out at regular intervals for night staff.

The service was changing to a monitored dosage system for the administration of medicines since the clinical lead had identified some issues and anomalies with their current system.

There were sufficient staff to meet people's needs and safe recruitment procedures were followed.

There were safeguarding procedures in place. Staff knew what action to take if abuse was suspected.

Is the service effective?

Requires Improvement

Not all aspects of the service were effective.

The environment did not fully meet the needs of people with a dementia related condition.

The manager was strengthening the service's paperwork with regards to the MCA to ensure that records clearly evidenced how staff were following the principles of the MCA.

Staff told us and records confirmed that training courses were undertaken in safe working practices and to meet the specific needs of people who lived at the home.

Kitchen and care staff were knowledgeable about people's dietary needs.

Is the service caring?

Good

The service was caring.

People and relatives told us that staff were caring. We saw positive interactions between people and staff.

People and relatives told us and our own observations confirmed that staff promoted people's privacy and dignity. We saw that staff knocked on people's doors and spoke with people in a respectful manner.

Is the service responsive?

Good

The service was responsive.

Care plans were in place which detailed the individual care and support to be provided to people. New paperwork was being put into place which staff said was more person centred.

An activities coordinator was employed to help meet people's social needs.

There was a complaints procedure in place. Feedback systems were in place to obtain people's views. Meetings were held and surveys carried out.

Is the service well-led?

Requires Improvement

Not all aspects of the service were well led.

The new manager was not currently registered with CQC and there was no elected nominated individual to oversee the management of the service. Additional work was needed with regards to records at the service and we had not been notified in a timely manner of one person's injury which required hospital treatment.

Staff informed us that morale had improved since the new manager had taken over.

A new quality assurance system was in place which effectively highlighted any areas for improvement.

The Grange Nursing Home

Detailed findings

Background to this inspection

The inspection took place on 26 May 2016 and was unannounced. This meant that the provider and staff did not know we would be visiting. The inspection was carried out by an inspector and an inspection manager.

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.

We spoke with six people, three relatives and two visitors. We conferred with a reviewing officer and a community matron for nursing homes from the local NHS Trust, a challenging behaviour lead practitioner from the local mental health trust, an administrator from the local authority DoLS team, a local authority safeguarding officer and local authority contracts officer. We also contacted a manager from another provider's nursing home.

We spoke with the provider, the manager, the clinical lead, a night nurse, a day nurse, five care workers, the head housekeeper, the cook, the kitchen assistant and maintenance man. We read two people's care plans and records relating to other people's care. We also viewed staff files, to check details of their recruitment and training. We looked at a variety of records which related to the management of the service, such as audits, minutes of meetings and surveys.

Prior to carrying out the inspection, we reviewed all the information we held about the home. We did not request a provider information return (PIR) prior to our inspection. A PIR is a form which asks the provider to give some key information about their service, how it is addressing the five questions and what improvements they plan to make.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection we identified shortfalls with the safety and suitability of the premises and equipment, safeguarding people from abuse, recruitment procedures and medicines.

At this inspection we found that action had been taken to ensure people people's safety, although some improvements were still required with regards to the premises.

People told us that they felt safe. One relative said, "It's definitely safe here." There were safeguarding policies and procedures in place. Staff had completed safeguarding training and were knowledgeable about what action they would take if abuse was suspected. They told us that they could contact the manager or provider with any concerns they had.

A new whistleblowing procedure had been written which the manager stated was, "more relevant, easy to understand and in line with contemporary legislation and protocols." External whistleblowing training had been planned for June 2016. The manager informed us, and a safeguarding officer confirmed that members of the local authority safeguarding adults team had attended a staff meeting to "explain and encourage staff to use the whistleblowing procedures." We conferred with the local authority safeguarding officer who told us that there were no ongoing organisational safeguarding concerns regarding the service.

We checked the management of medicines and found that action had been taken to address all of the concerns we found at the previous inspection. There was a safe system in place for the management of Warfarin. Warfarin is a medicine which helps prevent blood clots. We checked 10 people's medicines administration records and noted there were no gaps in the administration of medicines. The service had changed pharmacy supplier due to problems with their previous pharmacy. The GP told us, "The change in pharmacy has been good."

Staff currently administered medicines from their original packaging. The manager told us however, and records confirmed that there had been several errors identified during their medicines audits. The clinical lead had noticed that eight people's medicines did not tally up with the amount staff had stated had been administered with the number of medicines in stock. As a result of these findings, the manager told us that they had asked the pharmacy to provide people's medicines in a monitored dosage system (MDS). MDS provide oral medicines in time-specific blister packs to ensure that the correct medicine is taken at the correct time.

Staff had redesigned the homely medicines procedure with support from the community matron for nursing homes. We noted that homely medicines were now managed safely. Homely medicines are those medicines which can be bought over the counter such pain relief and cough medicines. The community matron informed us that the management of homely medicines had improved.

Care plans and protocols were in place for "as required" medicines. "As required" medicines are those given only when needed, such as for pain relief. This meant that information was available for staff to ensure there

was a consistent approach for the administration of these medicines. In addition, we noted that an emergency dose of Aspirin had been prescribed for people in the event of a heart attack.

Controlled drugs were managed safely. These are medicines which require stricter controls because they are liable to misuse. There was a safe system in place for the disposal of medicines.

We checked staffing levels and looked at the last four weeks of staff rotas. New rotas had been formulated. These included a "twilight shift" where an additional care worker was on duty from 8pm until 11pm. A member of night staff said, "This helps ensure that the residents receive timely care and support." In addition, a kitchen assistant was now on duty from 12.30pm until 6.30pm to help prepare tea and assist over the tea time period. A care worker said, "It's so much better now – so much better, it means we can concentrate on helping the residents and not have to be going in and out of the kitchen."

People, relatives and staff did not raise any concerns about the number of staff on duty to support people. We observed that staff carried out their duties in a calm unhurried manner and a member of staff was present in the lounge area throughout the day, to ensure people's safety. We saw that staff monitored people discreetly. They sat and talked with people individually and joined in with communal conversations.

Staff told us, and records confirmed that correct recruitment procedures were carried out before they started work. One new member of staff said, "They were very efficient with all my checks." We saw that Disclosure and Barring Service (DBS) checks had been obtained. A DBS check is a report which details any offences which may prevent the person from working with vulnerable people. They help providers make safer recruitment decisions. Two written references had also been received. We noted that there were gaps in one person's employment history. The manager was able to explain these gaps and told us that he would update the staff member's recruitment records with this information.

We spent time looking around the premises. We saw that the home was clean and there were no offensive odours in any of the bedrooms or communal areas we checked. A new sluice room had been built and a sluice machine had been installed for the cleaning and disinfection of continence equipment, such as commode pots. This room also housed the boiler; the manager told us that they were getting a new boiler and new flooring would be laid as soon as the new boiler had been installed.

New equipment had been purchased following our previous inspection. This included new shower chairs, commodes and hoist slings. Regular checks were carried out on this equipment to ensure its safety and suitability. Risk assessments were also in place to ensure staff were aware of any potential hazards and what action to take to minimise these risks. Bed rails had been appropriately assessed and bed rail covers were now in place to reduce the risk of any injuries caused by possible entrapment in the equipment. An occupational therapist and community matron had been involved in advising about the safe use of bedrails and other equipment at the home. The provider's action plan stated, "The home is investing large sums of money to ensure that the environment and equipment used for our residents and staff is of high quality, safe, fit for purpose and reliable."

An open staircase was located near to the main entrance of the home. A risk assessment had been put in place to inform staff what actions they should take to promote people's safety around the staircase. A new keypad had been installed at the top of the stairs to reduce the risk of people accessing the stairs from the first floor. This was linked to the fire alarm system. The manager told us that they were going to install a sensor at the bottom of the staircase which would be linked to the nurse call system. This would alert staff if anyone accessed the stairs.

Fire safety checks had been carried out. We noted however, that there was no evidence that night staff had received regular fire instruction to ensure that they were aware of the correct procedures in the event of a fire. The manager told us that this would be addressed. He also told us that a fire officer was visiting the following week to check fire safety at the service.

We noted that certain checks had been carried out on the premises and equipment to ensure they were safe. Gas, fire safety, electrical tests and 'Lifting Operations and Lifting Equipment Regulations' (LOLER) checks on moving and handling equipment had been undertaken. The manager told us that they were arranging for an asbestos survey to be carried out in line with legal requirements since asbestos containing materials, if found can pose a health risk.

We checked the communal bathroom and shower room and noted that new non slip flooring had been laid in the shower room. The manager told us that due to the small size of the shower room, people who required moving and handling could not use this room safely. The main bathroom therefore was going to be converted into a bath and shower room with a designated changing area. A new shower chair had been purchased. This was due to be delivered when the modernisation of the bathroom was completed. This meant at the time of the inspection five people, who required assistance with moving and handling were not able to have a bath or shower.

This was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Safe care and treatment.

Staff told us that people who were currently unable to have a bath or shower were supported to have a full body wash at least twice a day. The manager told us that the modernisation of the bathroom was due to be completed imminently.

Individual assessments were in place where people had been identified as being at risk. They described the actions staff were to take to reduce the possibility of harm. Areas of risk included falls, moving and handling, malnutrition and pressure ulcers. We noted that these were accurate and had been reviewed and evaluated regularly.

We noted that accidents and incidents were recorded and analysed. This procedure helped to ascertain if there were any trends or themes, so that action could be taken to help prevent or reduce the likelihood of any further incidents. Action was taken if concerns were raised around frequent falls. Sensor mats had been purchased for those at risk of falls.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection we identified shortfalls in the support and supervision of staff, access to health and social care professionals and concerns relating to the MCA. In addition, the environment did not meet the needs of people with a dementia related condition.

At this inspection we found that improvements had been made, although further improvements were still required regarding the environment and evidencing the MCA.

People and relatives told us that they considered that the service effectively met people's needs. One person said, "Oh yes, they know what they are doing." Another person told us that they felt that the more mature care workers met their needs more effectively than the "younger ones." A relative said, "The dementia care is very good. They have a very good understanding of dementia care."

We spoke with a challenging behaviour clinician who told us that she had organised challenging behaviour training for staff at the home. She said, "It helps them gain a greater understanding. The staff are very enthusiastic." The community matron for nursing homes told us, "They have engaged in all the training and they did that quickly. They have all completed CHANT [Care Homes and Nutritional Training] and have done falls awareness. They are also going to engage with [name of speech and language therapist] to do training in that area."

Staff told us that there was sufficient training available. We spoke with the activities coordinator who told us, "I do all the same training as the care staff. I have done Parkinson's [disease] training, safeguarding, just like everyone else." Information about training was displayed on a notice board. Falls prevention, challenging behaviour and nutrition training was advertised and we noted that staff had signed up for various training courses.

The manager provided us with information which demonstrated that staff had carried out training in safe working practices and to meet the specific needs of people who lived there, such as training around dementia care. The manager stated, "Training is a priority at the Grange and staff have enrolled and completed modules through [name of local NHS Trust's training department], online training, face to face and in house training programmes." This was confirmed by an administrator from the local NHS Trust's training department. The manager also stated that he and the administrator had enrolled on a Level 5 National Diploma in Leadership and Management in Health and Social Care, "in order to learn contemporary ways of leading people."

Staff told us, and records confirmed that they undertook induction training when they first started working at the home. This meant that staff felt prepared when they started working independently at the home and supported the effective delivery of care.

Staff informed us they felt supported by the new manager. One staff member said, "It's a lot better now, there's someone to talk to." Regular supervision sessions were carried out and staff had an annual appraisal.

New supervision forms were in place which the manager stated "addresses relevant staff issues in a more conscious and strategic way." This was confirmed by the records we viewed. Supervision and appraisals are used to review staff performance and identify any training or support requirements. The manager stated, "Staff have the right to refuse supervisions with any supervisor and can choose and change their supervisor without giving reasons. This empowers staff and encouraged better outcomes from supervisions." This was confirmed by staff. One staff member said, "[Name of manager] has told us that if anyone doesn't feel comfortable with their supervisor, then we can ask for someone else." The provider carried out the manager's supervision. We read the manager's last supervision which stated, "Working very hard in implementing significant changes to the way the home is working."

The manager had encouraged staff to volunteer to be "champions" of various disciplines such as moving and handling, dementia, palliative care, skin integrity, infection control, dignity and nutrition. The manager stated in their action plan, "These champions will receive extra training in their disciplines, teach their colleagues and ensure all relevant paperwork and audits are in place…Introducing champions makes staff feel valued, get involved and ensure that all targets of care are addressed in a holistic fashion." Staff told us, and records confirmed that this system had been implemented. One staff member said, "I feel so empowered, [name of manager] is so good, he lets us blossom and focus on our strengths and interests." Another told us, "It's fab to be able to get your teeth into something – the 'champions' thing is great. I've set up a file [of information] and I'm going to a [infection control] conference."

Many staff had worked at the home for a long period of time. This experience helped them carry out their duties in an effective way. This was confirmed by the GP who said, "Many of the staff on the floor have been here a long time. You see the same staff and they know the patients."

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Records showed that assessments had been undertaken to check whether people's plan of care would amount to a deprivation of liberty and whether written applications needed to be submitted to the local authority. 18 applications had been sent to the local authority to authorise. We spoke with an administrator from the local authority DoLS team who told us that these had not yet been authorised.

We noticed that mental capacity assessments had been carried out. We saw that some of these assessments were not always decision specific. The manager was knowledgeable about the principles behind the MCA and best interests decisions. He told us that he was strengthening the service's paperwork with regards to MCA to ensure that records clearly evidenced how staff followed the principles of the MCA.

People told us that staff asked for their consent before carrying out any care or treatment. This was confirmed by our own observations. We saw staff asked people for their consent before delivering any care. We talked with staff, who demonstrated they were aware of the importance of involving people in decisions and listening to their views about what they wanted. One staff member said, "I always ask – it's down to them." At our previous inspection, we found inconsistencies and irregularities with consent forms. We

discussed this with the manager who told us that he would discuss these forms with people and relatives to ensure their authenticity and accuracy.

People were complimentary about the meals. Comments included, "The food is lovely," "The food is very good indeed" and "It's very nice." One person told us however, that they did not like many of the meals. We passed this feedback to the manager for his information. Relatives were also complimentary about the meals and the meal time experience. One relative said, "The menus have changed, they now go through for tea at tea time and there's a choice of meals like poached egg or sandwiches." Another relative told us that their family member had been reluctant to eat. She told us, "They [staff] went out of their way to encourage her to eat. She likes jam and bread and ice cream and they would cut up tiny little pieces of bread. They put themselves out to coax her."

We spoke with the cook and kitchen assistant, who were both knowledgeable about people's nutritional requirements and preferences. Kitchen staff had attended the local NHS Trust's 'Care Home and Nutrition Training' [CHANT] which was organised by the dietetics department. The kitchen assistant said, "It's a good course. It's told us about how to measure BMI's [body mass index] and food records and risk assessments." She explained about food fortification and the recipes she now used after attending this course, "There's the Greek cooler I make which has Greek yoghurt, fruit puree, I might add honey or chocolate, but it adds loads of calories." The cook told us, "We use full fat milk and we use cream – plenty of cream and we always have fruit – look there's strawberries. We know what they like and what they need. [Name of person] can eat stewed meat but not roast meat it's too dry and for residents with diabetes we use sugar substitutes when we are making things like custard, porridge, jelly and rice pudding."

People's nutritional needs and preferences were recorded in their care plans. We spoke with the cook who told us that they had received written information about people's likes and dislikes and any special diets people required. This meant there was good communication between care and catering staff to support people's nutritional well-being.

One person had a Percutaneous Endoscopic Gastrostomy (PEG). This is a form of specialist feeding where a tube is placed directly into the stomach and by which people receive nutrition, fluids and medicines. We spoke with the clinical lead who was knowledgeable about this person's nutritional needs and was able to explain their feeding regime which was reflected in their care file. We spoke with this person who confirmed that staff were proficient with this task and that staff never forgot to support them with their nutritional needs. The person's relative said, "They are very good and they involve [name of person]."

We noted that people were supported to access healthcare services. We read that people attended appointments with their GP, consultants, dietitian, speech and language therapist, dentists, opticians and podiatrists. We spoke with a GP who told us that he visited the home at least weekly to carry out reviews of people's care and treatment. We also conferred with the community matron who told us that she visited regularly.

Staff spoke enthusiastically about their plans to make the environment more "dementia friendly." This included themed corridors, a café area and Italian styled dining room. The manager stated in their action plan, "We have engaged the consultancy of Stirling University who are renowned for their research and implementation of dementia friendly environments. A dementia team led by the dementia champion within the home are using an auditing tool bought from Stirling University to identify environmental needs and implement necessary decorations."

At our previous inspection we found that some of the furnishings appeared to confuse certain people. The

lounge carpet was highly patterned and we saw one person bending down to pick what they thought were flowers from the carpet. At this inspection, new non slip laminate flooring had been laid in the two lounge areas and main corridor. We spoke with one relative who said, "Isn't it great, it's finally been done."

The manager was aware that further work was still required to ensure that the environment fully met the needs of those who had a dementia related condition.

Good

Is the service caring?

Our findings

At our previous inspection we raised concerns that some people were being transferred to the shower room on a shower chair whilst being wrapped in towels. This did not promote people's privacy and dignity.

At this inspection staff told us that they no longer did this. One staff member said, "I can't believe we did this, but we now know and we definitely don't do that anymore."

People and relatives were complimentary about the caring nature of staff. Comments included, "They are all lovely" and "She is very happy with the care here."

We observed that people appeared happy and looked well presented. We saw staff chatting with individuals on a one to one basis and they responded to any questions with understanding and compassion. One person, who had a dementia related condition, was reluctant to go to the dining room for lunch. Staff had previously informed us that this person used to be a plumber. We heard a staff member say, "Oh [name of person] we need the radiators checked in the dining room would you mind coming to the dining room." The person went to the dining room to check the radiators and while he was there we observed that he enjoyed his lunch. A member of staff said, "It's not about deception, it's about entering their world so you can communicate with them. If someone is saying that they want their mother, you don't say, 'Your mother is no longer alive' they are indicating that they want comfort and maybe want a hug."

At tea time one person got upset. We saw that staff had placed a photograph of the person's wedding day on the table beside her so she could look at her husband's face. A staff member said, "It helps for her to see him there." Staff were knowledgeable about people's likes, dislikes and interests. One staff member said, "I was just speaking to [name of person] about the caravan. She used to come up here for holidays" and "We have one lady here who likes a cuddle. We sit and talk to them, it's important."

Staff spoke enthusiastically about ensuring that people's needs were at the forefront of everything that they did. One staff member said, "Everything is about the residents. That's what we are here for." Another staff member said, "We care for them as though they were our parents, it's what you would want. They are almost more of your family than your own family – you see them more." A third said, "This is the residents' home and we are coming into their home."

We found that staff were respectful in their approach. They treated people with dignity and courtesy. Staff spoke with people in a professional and friendly manner, calling people by their preferred names. We found that people's privacy was promoted by staff. We saw they knocked on people's bedroom doors before they entered.
We observed care staff assisted people when required and care interventions were discreet when they needed to be. During meal times staff carefully supported people to wipe their mouths and hands to ensure there was no residual food on their hands or faces.

We found the care planning process centred on individuals and their views and preferences. Care plans

contained information about people's life histories which had been developed with people and their relatives. We read a person's one page profile. Under the title, "What people appreciate about me" was recorded, "My loving nature and devotion to my family." Another person's care plan stated that they used to enjoy going for picnics along the beach. This meant that information was available to give staff an insight into people's needs, preferences, likes, dislikes and interests, to enable them to better respond to the person's needs and enhance their enjoyment of life.

Staff involved people in choices about how they wanted to spend their day, what they wanted to eat and what they wanted to do. People and relatives told us that they were involved in people's care. One relative said, "I definitely feel involved." Another said, "We've been involved in mum's care plan." The manager stated, "The involvement of the people in our care in care treatment decisions is important."

One person was receiving end of life care. We spoke with their GP who stated that staff had appropriately involved him in their treatment. He said, "They are good with end of life care. They do the syringe drivers and [name of community matron] will also help out. Families can come and go as they please [to visit the person]." A syringe driver is a device used for the automatic administration of medicines such as pain relief. It helps to ensure consistent levels of pain relief or other medicines are maintained.

We visited this person in their room. We saw that they looked comfortable. We spoke with their relative who told us, "Her care has been good, as good as we could give, probably better…You have an end of life plan and at the time it was the last thing you wanted to discuss, but it's important."

The clinical lead was completing the nursing assessment in the "Care of the dying patient" documentation which the GP had brought on the day of the inspection. The assessment documentation was based on the recommendations outlined in the independent report, "One Chance to Get it Right" which sets out the priorities for care when a person was dying. All health and social care professionals involved in the person's care and treatment completed the relevant sections contained within the document. This helped ensure that a consistent and coordinated approach to end of life care was taken.

Good

Is the service responsive?

Our findings

At our previous inspection we identified shortfalls in accessing medical advice in a timely manner and the management of complaints.

At this inspection we found that improvements had been made. People and relatives informed us that staff were responsive to people's needs. Comments from relatives included, "I wouldn't have her in any other place and she enjoys it here," "Now when he falls, the first thing they do is phone me…He has fallen less. They never miss anything now" and "They have given us our lives back."

Health and social care professionals were complimentary about the staff. The GP said that he visited the home weekly to carry out reviews of people's care and treatment. He also said that they carried out six monthly general reviews to monitor people's condition. He told us, "They know the patients well and are good at deflecting challenging behaviour. I have very few requests for any sedation [medicines]…I have had no adverse reports from families. You are seeing the home today as it is. They play the right music and it has a good feel about it. They encourage people to be out and about. You hear lots of banter. [Name of manager] has brought back the buzz." The community matron for nursing homes told us, "They are now seeking advice more."

Each person had a care plan for their individual daily needs such as mobility, personal hygiene, nutrition and health needs. These gave specific information about how people's needs were to be met and gave staff instructions about the frequency of interventions. We noticed that a specific skin integrity pathway was followed for any skin damage. The clinical lead informed us that they now had a camera to take photographs of any skin damage, so any progress or deterioration could be immediately seen. People's consent for this had been sought. Disposable tape measures were available to accurately measure any wounds. Body maps were in place and used to record any skin damage. We noted that information about catheter care was available in one person's care plan we viewed. Urinary catheterisation is a procedure where a thin, flexible tube called a catheter is inserted into the bladder to drain it.

Care plans were regularly reviewed to ensure people's needs were met and relevant changes were added to individual care plans. Staff were in the process of changing to new documentation which they said was clearer and more person centred.

We checked how people's social needs were met. People told us that there was enough going on to occupy their attention. One person said, "There's a lot going on."

There was an activities coordinator employed. She spoke enthusiastically about her role and about ensuring people's social needs were met. She said, "I'm continually looking for activities and what we can do, I scour the internet looking for information and ideas. We saw that a trip to a local seaside town was planned, with a fish and chips lunch. The activities coordinator explained how she met the social needs of those who had a dementia related condition. She said, "I use a lot of tactile things. I use things like sand and shells and I have pictures of the seaside and I use water, so residents can experience things like the seaside. They can feel the

sand, shells and water and look at the pictures of the seaside so it helps to give them the whole experience."

The activities coordinator told us that she worked with a local activities charity who organised community based activities. People were attending a local tea dance on the day of the inspection. We saw photographs of the Queen's birthday celebrations which had taken place at the home. One person was cutting out the photographs so they could be displayed around the home. The activities coordinator said to this person, "You're my right hand woman aren't you?"

The activities coordinator informed us that they had taken a person to Alnwick the previous week because they had wanted to visit the grave of their husband. She told us, "We took some flowers along." The activities coordinator said, "I always try and make sure that people do what they want to do or are interested in and like doing." She said, "[Name of person] was a plumber and we brought in plumbing tools, but now he is more interested in looking at things so I have started bringing in pictures of plumbing things – it's all about tapping into people's interests."

The activities coordinator also held another part time job working for the Workers Educational Association. She told us, "With my other hat on I have come in and carried out training with people such as 'Cooking for fun' courses and we have made memory boxes and I did a World War II session and people spoke about their memories."

Planned activities were displayed on notice boards around the home. We saw that the home was opening its doors to the local community as part of the national "Care Homes Open Day" on 17 June 2016. This initiative involves care homes opening their doors to visitors, inviting local people in to meet people and learn more about care homes. The activities coordinator told us, "We want to celebrate the home and Warkworth." The home was also taking part in the Alzheimer's Society's Cup Cake day on 16 June 2016. The home was hosting a party with lots of cupcakes and other fun activities to raise money to help defeat dementia.

People's spiritual needs were met. This was confirmed by people and relatives with whom we spoke. A monthly church service was held. One relative said, "[Name of church visitor] still comes in every week [to give Holy Communion]."

There was a complaints procedure in place. There had been no complaints since the manager had started at the home in February 2016. Meetings and surveys were carried out to obtain people's feedback. The manager stated in their action plan, "This committee has the responsibility to manage, promote and account for residents' fund raising projects and also act to represent families' interests in the general running of the home."

Requires Improvement

Is the service well-led?

Our findings

At the previous inspection in November and December 2015 we identified serious shortfalls with the management of the service and the maintenance of records. At this inspection we found that improvements had been made, although further improvements were required. The manager was not currently registered with CQC, additional work was required with regards to records at the service and we had not been notified in a timely manner of one person's injury which required hospital treatment. The previous manager had left the service. A new manager had taken up post in February 2016.

There was currently no nominated individual overseeing the management of the service. The previous registered manager had also been the nominated individual. A nominated individual represents the provider and has responsibility for supervising the way that the regulated activity is managed. Following our inspection, we were informed that one of the directors was to take on the role of nominated individual.

We found that the provider had not notified us of one serious injury in a timely manner. The manager informed us that he was now aware of the events and incidents which required notifying to CQC. This issue is being followed up. The submission of notifications is required by law and enables us to monitor any trends or concerns and pursue any specific matters of concern with the provider.

We have taken these issues into account when deciding upon the rating of this domain.

People, staff and relatives were positive about the manager and the changes that had been made. One visitor said, "It's a lot better now." Comments from relatives included, "It's definitely well led" and "There's no comparison, I think [name of clinical lead] has blossomed." One relative told us however, "It's not the same. It doesn't seem as homely." Comments from people included, "He mixes in well," "He is a happy man" and "He's not been here long, but he's made a big difference." Staff told us, "It's so, so good to be led by [name of manager]. The leadership is now here," "The two of them [names of manager and clinical lead] have led us on. It's a good partnership with [name of manager] and his social work background and [name of clinical lead] with her nursing," "He is so focussed, everything is getting streamlined," "He is a tunnel of knowledge and shares his knowledge. The changes that have been made have been brilliant," "[Name of manager] is great, he is very approachable and I really feel supported, more than I did before," "My God, we have come a long way and he is leading us on" and "I see such a massive change – there's a good network of support now."

Health and social care professionals were also complimentary about the changes which had been made. The community matron for nursing homes told us, "It's much better now, he engages with me a lot better." We spoke with a safeguarding adults officer who told us, "The atmosphere was lovely when I visited. I have seen improvements in all areas."

We arrived early at the home. When the manager arrived, he greeted us and then immediately said, "I hope you don't mind, but I must go round and say hello to everyone. They will get upset if they have seen that I am in and I haven't said hello." A relative told us, "When he comes in, he will speak to every single resident; it

makes such a difference to them. It's little touches like that."

The service had gone through a period of change and uncertainty following our last inspection. Staff said however, that morale was now good and they enjoyed working at the home. We read the provider's action plan which stated, "We acknowledge that during your inspection there were multiple breaches of the Health and Social Care Act and CQC registration regulations. However, we have moved on from that position now."

The manager and staff were very honest about the changes that the service had been through and what actions still needed to be completed. Team work and high staff morale was evident as staff rallied around the manager to support him during the inspection. The clinical lead chose to come in on her day off. In addition, the administrator elected to stay well beyond her working hours to assist the manager to locate any required documentation and support him. One staff member said, "You just want to do your best for [name of manager] and support him to make all these changes."

Staff told us that they enjoyed working at the home under the leadership of the new manager and the provider. Comments from staff included, "Morale is good now, everyone wants us to succeed," "I'm enjoying my job more now, before I had to check about everything, now I am allowed to make decisions," "Generally the whole team is happier, we now know where we are going," "Morale is massive, it's lovely coming to work," "Last year at this time I was looking for somewhere else to work, but now morale is whoohooo" and "The atmosphere is 100 times better." This was confirmed by relatives. One relative said, "Whatever they have going on at home is left at the door. They are always jolly. You have [name of staff member] singing all the time." Another relative told us however, that they thought that the atmosphere had changed and it was not the same. We passed this feedback to the manager for his information.

An employee of the month scheme had been introduced. The manager told us that it was important that staff were recognised for their efforts and achievements. In the manager's update email he stated, "This award has proven to be a good intrinsic motivator that everybody aspires as employees of the month." This was confirmed by a care worker who had won April's employee of the month. She said, "I got a badge, voucher and key ring." Relatives were also aware of this scheme. One relative said, "It's a good initiative; it gives staff the recognition they deserve."

We checked the maintenance of records. 12 people's care plans had been updated and new person-centred documentation, such as one page profiles, was in place. Further work was required to ensure that all care plans were up to date and effective. The manager told us, "I think it is better to complete tasks accurately rather than rush and compromise on quality for the sake of quantity." At our previous inspection, we found inconsistencies and irregularities with consent forms. We discussed this with the manager who told us that he would discuss these forms with people and relatives to ensure their authenticity and accuracy. Ongoing work was being carried out with regards to MCA documentation to ensure records clearly evidenced how staff were following the principles of the MCA. The GP told us, and our own observations confirmed that health and social care professional were now recording their own entries and updates in the service's documentation. Care plans and risk assessments were accurate and up to date.

Since our previous inspection, the provider or manager had sent us regular updates about actions which had been completed at the home. On the last update, which the manager sent on 17 May 2016, he stated, "We can safely say the way we record and the quality of recording has drastically improved. Regardless, we will not tire to further improve because we aim to be outstanding one day….We are pushing for a recording culture that allows every employee, including carers, to record in the main files and get involved in other tasks such as assessments and care plan formulation and development. Our understanding is that staff feel more involved and valued and are more likely to perform tasks to the highest standards possible in order to

record these tasks appropriately."

A new quality monitoring system had been put in place to assess all aspects of the service including care plans, medicines, infection control and health and safety. These highlighted any issues which needed to be addressed, such as the reconciliation of medicines and the dementia care environment. The provider had organised for a health and safety consultant to carry out a full audit of health and safety at the home. The consultant had visited the day before our inspection and the report was not yet available to view. The manager and administrator were working on the training matrix to ensure there was an overview of staff training and what training needed to be updated or refreshed.

Staff meetings were carried out. Staff told us that they felt able to raise any issues and their views would be listened to. One staff member said, "I now feel in the know." Another staff member said, "Staff are now involved in everything, we have staff meetings and we are involved in decision making." In the manager's update email, he stated, "The meetings are still monthly to ensure that we all embrace the changes constructively. As compared to previous meetings, it was amazing to see all staff members contributing, challenging and positively argue about our way forward. That suggests that they are now more interested, feel empowered and putting all effort to contribute to the changes."

The whistleblowing procedure had been rewritten and staff told us that they felt able to go to the provider or manager with any issues. One staff member said, "[Name of manager] is fab. He is easy to talk to. I have brought concerns to him which have been acted upon. They weren't in the past. It boosts you knowing something will be done, otherwise you just feel demoralised if you are repeatedly saying something and nothing gets done."

The community matron for nursing homes attended nurse meetings as a "permanent guest." The manager stated in his update email, "As a guest yesterday she informed nurses on good reporting skills to the GP, advised on our care plans and other processes from a clinical point of view…This just shows that our meetings, communication channels, multi-disciplinary working approaches and transparency are helping us move forward."

Since April 2015, adult social care providers have to comply with the Duty of Candour regulation. This regulation states that providers must be open and transparent with people and those acting lawfully on their behalf about their care and treatment, including when it goes wrong. Relatives and staff said that there was an emphasis on openness and transparency. One staff member said, "Before everything was a secret, now we are included in everything – there is no them and us." A relative said, "What a difference. They are so much more open, all the closedness has gone," "You can talk to the manager and the owner." The community matron for nursing homes stated, "It's a lot more open now." One relative told us however, that they felt that more transparency would be appreciated. We passed this information onto the manager for his information.

People and relatives were involved in the running of the service. Meetings for people and their representatives were carried out. One person said, "They have meetings – they're good. That lady there [activities coordinator] does them." A relative said, "I tell you what – they now have meetings for family and friends. The manager attends." Another relative said, "[Name of manager] has introduced friends and family meetings. It's good because it's a place to voice any concerns." A staff member said, "The meetings are great. People are being given a chance to say things." Staff and relatives told us that the provider also attended these meetings.

The manager and staff worked with other providers as a learning opportunity and to share good practice.

The manager told us that he was working with two local care homes with regards to the dementia care environment. We contacted a manager from one of the care homes. She told us, "[Name of manager] works so hard to put himself in his residents' shoes. He is constantly seeking out new ways and new ideas to improve resident's way of life in The Grange. I have great admiration for his dedication and his own and his staff's commitment to make The Grange a safe and homely environment."

The manager was also attending the local nursing homes managers' meetings which were facilitated by the community matron for nursing homes. These meetings took place to share good practice and experiences of nursing homes in the area. The community matron for nursing homes confirmed that the manager attended these meetings.

We noticed that the provider displayed their ratings of their previous inspection in line with legal requirements. The manager had included a summary of the home's action plan so people, relatives and visitors to the home could see what action was taken.

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 RA Regulations 2014 Safe care and treatment People who required assistance with moving and handling were unable to have a bath or shower because the bathroom had not been fully adapted to meet people's needs. There was no evidence that fire instruction had been given to night staff regularly to ensure they were aware of what action to take in the event of an emergency. Regulation 12 (1)(2)(a)(b)(d)(e)(f).