Oldbury Grange Nursing Home Ltd

Oldbury Grange Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected this service on 10 October 2017. The inspection was unannounced.

Oldbury Grange provides accommodation, personal and nursing care for up to 89 people. The home has two floors; the ground floor provides nursing and residential care to older people living with complex health conditions. The first floor has two units; one nursing and one for people living with dementia. The home provides end of life nursing care. At the time of our visit there were 62 people using the service.

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

At our previous inspection in March 2017, we found a breach in the governance of the home and the legal requirements and regulations associated with the Health and Social Care Act 2008 were not being met. We found breaches of the regulations related to managing risks to people's safe care and treatment, ensuring only fit and proper persons were employed and the requirement to display performance ratings. We gave the home an overall rating of inadequate. The service was placed in 'Special Measures'. The special measures framework is designed to ensure a timely and coordinated response where we judge the standard of care to be inadequate. Services in special measures are inspected again within six months following the publication of the inspection report. The provider accepted a voluntary restriction on any new admissions to the home while they were in special measures.

At this inspection we looked to see if the provider and registered manager had responded to make the required improvements in the standard of care to meet the regulations. Whilst we found that sufficient improvements had been made to remove the service from 'special measures,' we found further breaches of the regulations relating to consent and equipment. We also found improvements were required in how senior managers assured themselves that improvements in service delivery were developed and sustained in the future.

Following our inspection in March 2017 the provider recognised they needed external support to improve the quality of the service. They appointed a 'consultant manager' to provide them with guidance and advice. The consultant manager had implemented a new management structure which provided a clear scheme of delegation within the home. Job descriptions had been refined so staff had a better understanding of their own role and responsibilities. The consultant manager was confident that action taken to improve the management of staff so they felt listened to would increase staff motivation and result in better outcomes for people. However, this was an area that required more work as there was still a culture of staff concerns not always reaching the management team.

The systems to assess and check the safety and responsiveness of the service had improved, but needed to

become embedded in every day practice to be completely effective. For example, the checks had not identified some clinical equipment had not been maintained and was dirty and that documentation around end of life care was not accurate. This meant there was an increased risk of cross infection and people's end of life wishes might not always be met.

There had been improvement in the assessment and management of individual and environmental risks within the home. Where people had fallen, their risk management plans had been reviewed and updated. However, there were still areas where plans to minimise risks were not consistently followed and records updated.

There were enough staff on each rota to provide safe, effective care but unexpected levels of absence, especially, at weekends could impact on the quality of care people received. The provider was recruiting more staff and their new recruitment procedure ensured staff who worked at the home were of good character.

Staff needed a more developed training programme to ensure they had the skills and knowledge to consistently follow best practice. The provider had recruited an operations manager to lead on staff development and training sessions in essential areas of health and social care were planned.

People were supported with their nutritional health. They were offered a choice of meals and high calorie snacks. However, some relatives were concerned that people did not always get the help they needed with drinks. People were supported to access healthcare professionals to maintain their health.

Interactions between staff and people were warm and compassionate. Staff took time to talk with people and communicated with them effectively. Staff were fully engaged with people, attentive to their needs and showed kindness towards them. However, issues we identified in the safety, effectiveness and responsiveness of the service could have a negative impact on people's emotional well-being.

Since our last inspection the provider had introduced an electronic care records system. Staff used hand-held mobile devices to access people's care plans and updated records as they completed tasks. The electronic system also provided a 'gateway' for relatives to look at care plans remotely so they were fully informed and involved in their family member's care. The provider was confident this would enable senior staff to be more responsive to concerns or complaints as this was an area that required further improvement.

The provider acknowledged that many of the improvements had been driven by the consultant manager who was only supporting the service on a temporary basis. The provider planned to recruit someone on a permanent basis to ensure the momentum for improvement was maintained so people had better outcomes in all areas of their care. We will continue to monitor the service to assess whether the improvements have been sustained.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Some items of clinical equipment were not maintained and/or clean which increased the risks of infection. The identification and management of individual risks had improved within the home. However, further improvements were required to ensure plans to minimise risks were consistently followed by staff. Medicines records confirmed people received their medicines at the times they needed them. The provider's new recruitment procedure ensured only staff with the right qualifications, experience and values were employed at the home. There were sufficient numbers of staff on the rota to provide effective care, but staff absence at weekends could impact on the level of care people received.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Records did not evidence the wishes of people and those closest to them had been sought in respect of end of life care in accordance with the principles of the Mental Capacity Act 2005. (MCA). However, staff worked within the principles of the MCA in their everyday interactions with people. Where people had been identified as having restrictions on their liberty, the appropriate applications had been made to the supervisory body. Staff required more in-depth training to support their learning and understanding of some aspects of care delivery. People were supported to maintain their nutritional and physical health.

Is the service caring?

Requires Improvement

The service was caring.

Staff took time to talk with people and communicated with them effectively. Staff were patient and understanding of people when responding to their requests for assistance. Staff responded promptly, calmly and sensitively to people who were anxious. However, the individual caring attitudes of staff were not reflected within the service as whole. People were supported by staff who had an understanding of how supporting people to

maintain their appearance promoted their dignity and self-esteem.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

A new electronic care planning system enabled staff to complete records at the point of care delivery so they had more time to spend with people. However, care plans were often task and problem orientated and lacked focus on the individual. The electronic system allowed relatives to see their relation's records so they could immediately raise any concerns about how their relative was being cared for. Some improvements had been made in the provision of activities to support people's social and emotional wellbeing.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

A re-structure of the management team allowed more time to plan and implement improvements and provided staff with increased direction and leadership. Action had been taken to improve the management of rotas and staff performance so there were better outcomes for people. The oversight of delegated duties had improved and poor practice was more likely to be challenged. However, some records were still not fit for purpose and reviews had failed to identify this. Improvements needed to become embedded in every day practice to be consistently effective and ensure the momentum of improvement was maintained..

Oldbury Grange Nursing Home

Detailed findings

Background to this inspection

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

The inspection visit took place on 10 October 2017. The inspection visit was unannounced. The inspection team consisted of two inspectors, an inspection manager, two specialist advisors and a pharmacy inspector. A specialist advisor is a qualified health professional. One specialist advisor had experience in providing nursing care to people with complex medical needs. The other was a qualified occupational therapist.

Prior to our inspection visit, we reviewed the information we held about the service. We reviewed statutory notifications sent to us from the provider. A statutory notification is information about important events which the provider is required to send us by law.

We looked at information shared with us by the local authority commissioners. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority. The local authority had issued the provider with a 'service improvement plan' (SIP) because of concerns about the level of care being provided. A local authority commissioner joined our inspection to assess the provider's progress against their SIP.

We also reviewed the information in the provider's information return (PIR). This is a form we asked the provider to send to us before we visited. The PIR asked the provider to give some key information about the service, what the service does well and improvements they plan to make. We were able to review the information as part of our evidence when conducting our inspection visit.

Some people living at the home were not able to tell us about their experiences of living at the home due to

their complex health conditions. We used the short observational framework tool (SOFI) to help us assess whether people's needs were appropriately met and to identify if people experienced good standards of care. SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

During our inspection visit we spoke with five people and three sets of relatives about what it was like to live at the home. We spoke with staff on duty including one nurse, nine care staff, the activities co-ordinator, the cook, a laundry assistant and a maintenance person about what it was like to work at the home. We spoke with the provider, the consultant manager, registered manager, deputy manager and operations manager about the management of the home.

We reviewed a range of records; these included 10 care records, daily records and a selection of medicine administration records. We checked whether staff were recruited safely, and trained to deliver care and support appropriate to each person's needs. We reviewed the results of the provider's quality monitoring system to see what actions were taken and planned to improve the quality of the service.

Following our inspection visit, eight relatives and a healthcare professional contacted us by telephone or email to provide further feedback about the quality of care provided at Oldbury Grange Nursing Home.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in March 2017 we found risks to people's health, safety and wellbeing were not always assessed and planned for. Staff did not always have the skills or information they needed to keep people safe. We judged the provider was in breach of Regulation 12 and the safety of the service was rated as 'Inadequate'. At this inspection, we found the actions the provider had taken, along with actions by the local authority, had resulted in some improvements in risk management within the home. However, further improvements were still required to ensure all risks were managed consistently. The service is now rated as 'Requires Improvement'.

In March 2017 we identified some issues around the cleanliness of the home and there were some risks of cross infection because items had not always been cleaned effectively. At this visit we found this was an area that still needed to be addressed to ensure the risks of infection spreading were minimised. For example, some fabric chairs were worn which meant effective cleaning could not take place and some floors were sticky to walk on. There were unpleasant odours in some areas of the home.

At our October 2017 inspection we checked clinical equipment and found some items were not working, were not fit for purpose or clean. For example, the suction machine to clear secretions had last been tested on 24 August 2009. It was not working and the tubing was dirty. The SATs machine to measure people's oxygen levels had not been checked since 22 May 2014 and had a faulty 'on/off' switch. The nebuliser on the first floor was broken and dirty. A nebuliser is a machine that creates a mist of medicine which is then breathed in through a mask or mouthpiece. A new nebuliser had been purchased in August 2017 but was not being used. It was stored on the top shelf in a store room behind some boxes and staff struggled to reach it. The trolley used for dressing wounds was not clean and there was an open dressing on the trolley which meant the dressing was no longer sterile. There were cleaning and checking schedules for the medical equipment which were signed and dated weekly. However, the forms did not state what equipment had been checked or cleaned and the checks had not ensured the equipment we looked at was clean.

We saw other risks to infection control within the home. The taps in the medical clinic were not elbow taps which meant the user could not turn off the taps without contaminating their hands. People's 'handling belts' to facilitate safer transfers were hung over the handrails in corridors rather than being stored in their bedrooms. The nurse on duty agreed that storage in public areas presented a risk of cross infection.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Equipment used to deliver care and treatment was not always safe for use and the risks of spreading infection through the use of such equipment had not been identified.

The senior member of staff who had previously undertaken infection audits and checks had recently left the service. The newly appointed operations manager told us they were going to assume this role. They planned to undertake specific training so they had the skills and understanding to discharge their infection control responsibilities safely and effectively.

Our specialist occupational therapist looked at the records of three people who were at high risk of falls because at our last inspection we found this was an area of concern. Following our last inspection, the provider had introduced a 'falls folder' which contained details of all the people who had fallen in the home each month. Records confirmed that following each fall, staff followed a 13 point action plan to ensure the person was safe. If emergency treatment was not required, people were seen by their GP within 24 hours, and observations were completed. People identified as being at high risk of falls had clear risk management plans to reduce the risks. The plans were reviewed after a fall to identify whether further measures were required to reduce the risks further.

We looked at the records of one person who had fallen four times in April 2017. It had been identified the person was not using their call bell to summon for assistance. Staff had worked with the person to encourage them to use their call bell when they needed support. The person had not had any further falls since April 2017.

Another person who was at risk of falling out of bed had been assessed as not requiring bed rails. The risks to this person had been regularly reviewed and bed rails had now been fitted. The assessments demonstrated good analysis of the risks to this person and sound clinical reasoning for the decisions taken. Where people were at risk of falling out of bed and bed rails were not suitable, crash mats were in place. Sensor mats were used for some people to alert staff when they attempted to move.

At our last inspection we found staff did not always stay in communal areas to monitor people to keep them safe. At this inspection there was a member of staff designated to remain in each communal lounge at all times to support people. For example, when we were in the lounge on the first floor, a person stood up. The person was a little shaky and the staff member immediately intervened and said, "Careful, do you want to hold my hand and go for a walk."

Records demonstrated there had been a decrease in the number of falls within the home which indicated the actions taken after our previous visit were starting to be effective.

At our last visit we found risks around people smoking had not been assessed and planned for. Only one person in the home smoked cigarettes at this visit, but the risks to the person had been assessed and plans had been implemented to support them to do this safely. The provider had also purchased fire retardant cloths that people could wear if they chose to smoke. This was particularly supportive of people who had health conditions, or symptoms such as tremors, that increased the risk of hot ash falling on their clothing.

In March 2017 we found airflow mattresses to reduce the risks of skin damage were not at the right setting appropriate to people's individual body weights. At this visit we found improvements had been made and mattresses were at the correct settings for people's individual weights.

However, we found there were still areas where plans to minimise risks were not consistently followed. We looked at the records of three people who were at high risk of developing skin damage. Each person had a care plan that stated they needed to be repositioned every two hours to relieve pressure on vulnerable areas of their skin. Records showed considerable gaps in repositioning. For example, records for the 4 October 2017 indicated that one person had gone 10 hours without being repositioned, a second person over 11 hours and a third nine hours. This meant people were at increased risks of skin damage and developing pressure areas.

At our last visit we found medicines were not always managed safely. This was because a staff member who had not received the appropriate training sometimes gave people their medicines. This was unobserved by

the nurse on duty which posed a risk of an error occurring. The consultant manager assured us this practice had been stopped. Only nurses and senior staff who had received training and been assessed as able to manage medicines safely were responsible for administering medicines.

At this inspection, a CQC pharmacist inspector looked at how medicines were managed by checking the Medicine Administration Record (MAR) charts for 14 people, speaking to staff and observing how medicines were given to people. We found the MARs were completed accurately and demonstrated that people received their medicines at the times they needed them. A member of the nursing staff supported people to take their medicines with care and followed safe administration procedures. We spoke with two people who needed some of their medicines to be administered at specific times of the day. They both confirmed these medicines were administered on time and as prescribed.

All medicines were stored securely and at the correct temperature to ensure their effectiveness. Medicines that required extra checks and special storage arrangements because of their potential for misuse, were stored correctly. The administration of these medicines was recorded accurately and showed they were being given as prescribed. We found pain relieving skin patches were changed after the prescribed time period and were rotated correctly around the body so people did not experience unnecessary side effects.

Where people needed to have their medicines administered directly into their stomach through a tube, staff had the necessary information to ensure these medicines were administered safely and consistently. There were written guidelines to inform staff how to prepare and administer the medicines, which promoted safe administration.

We found where people had to have their medicines given to them disguised in food or drink, the provider did not have all the necessary safeguards to ensure these medicines were given safely. For example, we found the provider was not always able to demonstrate what advice they had taken from a pharmacist on how the medicines could be safely prepared and administered. We also found there was no written information to tell staff how to carry out this process safely and consistently.

At our last inspection we found some environmental risks had not been addressed to ensure people were kept safe at all times. Large boiling water urns were left unattended in communal areas, radiators were so hot to touch, they presented a risk of causing burns to people and risks to people tripping over items had been created by staff. The provider had taken action to manage these risks since our last visit. Radiator covers had been installed so risks to people's skin being damaged were minimised. Insulated jugs were used to provide hot water on drinks trollies which reduced the risk of people being scalded by hot water. Whilst maintenance was being undertaken, people were not at risk as there were no tools or ladders left in the way as there had been during our previous visit. The communal area on the first floor had been rearranged to provide more space for people to move around safely without tripping over furniture or cables. The new arrangement made it easier for staff to monitor and support people and staff demonstrated a better understanding of the risks posed by leaving items unattended.

Prior to our visit we had received information that some areas of the home were very cold and there was insufficient hot water. We followed these concerns up during our inspection visit. The provider had fitted two new water tanks which had tripled the capacity for hot water in the home. We tested the temperature of the water in all areas and found it was within an acceptable range. The provider had made adjustments to some radiators to increase the flow of heat. Thermostats were all set to a minimum of 18 degrees centigrade and there was an ambient temperature of 22 degrees throughout the home. The member of staff responsible for maintenance confirmed there was now a process of audits which ensured water temperatures and thermostats were checked on a regular basis.

The provider had introduced a new colour coded maintenance system which identified work that needed to be completed and whether it was urgent. Records demonstrated staff were using the system to highlight environmental risks so appropriate action could be taken.

In March 2017 the provider did not have suitable arrangements to deal with emergencies that might arise from time to time. Not everyone who lived in the home had an up to date personal emergency evacuation plan. At this visit we found the emergency information had been updated. This ensured the emergency services had the information they required to safely evacuate the building in the event of an unexpected occurrence, such as a fire.

Previously we found there was not always a member of staff with a current first aid certificate on each shift and staff knowledge of emergency first aid procedures was not sufficient to ensure people's safety. At this inspection we were told 11 staff had now completed first aid training, but the provider acknowledged this was an area that required further improvement. The provider was considering various options, including an external training provider to deliver more in-depth training which could then be cascaded to other staff within the home. We will continue to monitor the provider's progress against this area of their action plan.

At our last inspection we found systems were not in place to ensure staff were of a suitable character to work with vulnerable people who lived in the home and we judged they were in breach of Regulation 19 which ensures fit and proper people are employed at services. Following our last inspection the provider had reviewed their recruitment process to ensure only staff with the right qualifications, experience and values were employed at the home. Potential staff were interviewed by two managers and the provider had checked those who were offered employment were of good character. The provider had obtained character references and references from previous employers and checked whether the Disclosure and Barring Service (DBS) had any information about them. The DBS is a national agency that keeps records of criminal convictions. New staff confirmed they were not able to start working at the home until all the checks had been completed. Further DBS checks had been requested for staff already working at the home to ensure they remained safe to work with people who lived there. The provider checked nurses had up to date PINS and there were no restrictions on their practice.

Previously, potential new staff had been allowed to do 'trial shifts' to decide whether they liked working at Oldbury Grange. Risk assessments had not been completed for workers on trial shifts and the registered manager had not monitored what care tasks they were allowed to complete. At this visit the consultant manager assured us trial shifts were no longer offered and explained, "To bring people in on a 'suck it and see' basis was dangerous."

At previous visits to the home we had received mixed feedback about staffing levels. Since our last visit some relatives had contacted us with concerns about staffing levels, especially at weekends. Our observations on the day of our visit were that there were enough staff to meet people's needs safely. Nobody was put at risk because of a lack of staff. Staff were available to check on people and to respond to their requests for support. People and their relatives said there were enough staff and told us staff responded to call bells within a reasonable time. However, one person said the call response, "Depends on how many staff are on" and that sometimes, "there weren't that many."

The consultant manager told us they were aware of some inconsistencies in staffing levels, mainly as a result of staff phoning in sick at weekends. Although they tried to cover any gaps on the rota, they accepted this could leave the home short staffed which impacted on the level of care people received. The consultant manager had introduced procedures and processes to monitor staff absence which they felt were already having a positive impact on staff motivation and sickness levels. They had also recruited new staff and

continued to do so.

We discussed how the provider assessed people's changing needs to inform staffing levels in the home. We were told the provider used a dependency assessment tool which calculated the number of care hours each person required. However, the tool did not take into account the challenges of the environment such as long corridors and bedrooms which were not in sight of communal areas. The consultant manager agreed the environment was a factor that needed to be taken into consideration to ensure staffing levels were relevant to people's needs within the environment of the home.

Staff understood their responsibility to protect people from abuse. They told us they would not hesitate to report any concerns about abuse or poor practice to senior staff or the provider.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in March 2017 we found staff were not consistently effective in meeting people's needs and rated the effectiveness of the home as requiring improvement. At this inspection we found further improvements were still required to ensure people received effective care. The rating remains as 'Requires Improvement'.

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.

Some people had a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) Order in place. We looked at 15 DNACPR forms. We could not be sure the wishes of the person and those closest to them had been sought in respect of end of life care. Eleven of the forms had been signed by a GP on 9 March 2017 and the records did not evidence who was involved in the review, that the person's capacity had been assessed and the views of those closest to the person had been considered. National guidance on DNACPRs states that full and clear documentation of decisions about CPR, the reasons for them and the discussions that informed the decisions is an essential part of high quality care. Whilst a DNACPR decision is that of the clinician, the registered manager has a responsibility to challenge and draw the clinician's attention to the code of practice and advocate on people's behalf. This meant people may not receive the support they wished for at the end of their life.

Some DNACPR forms had been implemented when people were very unwell with life limiting conditions such as 'sepsis and bronchitis' and 'bronchopneumonia'. These conditions had subsequently resolved, but there had been no assessments as to whether the DNACPR was still appropriate or whether people whose health had improved now had capacity to make their own decisions regarding their end of life care.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not always act in accordance with the Mental Capacity Act 2005.

At our last visit we found staff lacked an understanding of the importance of working within the principles of the MCA in their everyday interactions with people. At this inspection we saw staff demonstrated a better understanding of their responsibilities to obtain consent before assisting people. Staff accepted when people declined personal care or to participate in an activity. One member of staff explained, "If a person refuses something you can leave and go back later or ask someone else to try, including family members. If this becomes a regular occurrence and they are refusing something that could be of detriment to them, we would have a meeting and discuss what is in the person's best interests."

We looked at the records of people who had bedrails in place. Assessments had been completed to ensure the bedrails were the least restrictive option. For those people who did not have the capacity to consent, the

reasons why bedrails were in their best interests were recorded.

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).

The registered manager understood their obligations under the MCA and had applied to the supervisory body for the legal authority to deprive people of their liberty. This was because the home operated a 'locked door' policy and most people were unable to leave the home independently or understand the risks of going out alone. The new operations manager had taken responsibility for monitoring DoLS authorisations. They explained the system they had introduced would ensure any conditions on authorisations were met, and new applications were submitted in good time when they were due to expire.

In March 2017 we found staff lacked the guidance and knowledge to meet people's individual needs in a way that was effective, caring and responsive. At this inspection some improvements had been made, but it was still a large area for improvement.

The consultant manager told us they had introduced a new induction pack which all new staff members had to complete. The induction included an introduction to the policies and procedures of the home and new staff had to be supernumerary for at least two or three days. New staff were also allocated an experienced member of staff to mentor them in their new role. The induction was linked to the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life.

At our last inspection we found the provider needed to deliver more effective training to ensure staff had the necessary skills to provide person-centred care. At this inspection we found this was still an area that needed to be addressed. We were told the consultant manager, who had a specialist dementia care background, was going to train the new operations manager to deliver most of the training in-house. However, until the operations manager felt they had the necessary skills and competencies, the consultant manager was going to provide training in fire awareness, safeguarding, moving and handling and dementia care.

From our observations and conversations with staff, it was clear they would benefit from a more developed training programme. For example, we saw staff correctly used equipment to transfer people and support them to move around the home. However, staff did not always understand why they were using the equipment. When we asked one staff member what they would like to see improved in the home, they said they would like more people to be supported with stand aids rather than full hoists. The staff member was not aware that people had to be able to weight bear to use a stand aid. Staff were due to have training in safe moving and handling the week after our visit.

At our last inspection we found people were not always offered choices about what they wanted to eat and drink. At this visit we saw people were offered a choice of a full cooked breakfast as well as cereals and toast with jams and marmalade. At mid-morning and mid-afternoon, a tea trolley was taken around which was stacked with fruit, cakes and milk puddings. People were offered a choice of snack. A member of staff asked a person if they wanted cakes or a milk pudding. The person responded, "Have you got any biscuits?" The staff member acknowledged they had forgotten the biscuits and quickly made sure the person had what they wanted. Staff asked people whether they wanted tea or coffee and, if they preferred a cold drink, what type of squash they wanted. However, some relatives raised concerns that people did not always get the prompting or assistance they required to ensure they had enough to drink.

Care staff told us they had access to a variety of food to make additional snacks and sandwiches for people in between meals and if they were hungry during the night.

People's preferences, allergies and special dietary requirements were recorded in their care plans and shared with the cook. There were lists in the kitchen to remind the cook and staff about who needed a soft or diabetic diet and who needed their food fortified because they were at risk of losing weight. On the day of our visit people had the option of pork steaks or tuna salad for lunch. The cook explained they used pork mince for those people who needed a soft diet so they had similar options to everyone else.

At lunch time we saw staff made sure people were supported according to their needs. This ranged from encouragement and prompting, support to cut up food or full assistance to eat their meal. However, there was no adapted cutlery or aids to support people to maintain their independence. One person was observed to have some difficulty getting their food onto their fork and used their fingers. A plate guard would have remedied this. We raised this with the registered manager who told us they had specialised equipment in the home. They were unable to explain why it was not being used on the day of our visit.

At our last inspection we found appropriate action had not always been taken when people had lost weight. At this inspection the records we looked at demonstrated that people's weight was monitored regularly and Speech and Language Therapy (SALT) and dietician referrals had been made when concerns were identified. One person told us they did not have much of an appetite, but had put weight on since coming to the home. Their relatives confirmed the person had lost weight in their own home, but seemed 'much brighter' since moving to Oldbury Grange.

One person received their food and fluids through a tube directly into their stomach. The care plan was clear as to the feeding regime which had been reviewed by a dietician. The person's weight was stable and there was clear information about the care and management of the 'entry site' and any early warning signs of complications.

Prior to our visit we had received some concerns that people were not always seen by other healthcare professionals if a need was identified. We checked a selection of care records which demonstrated people had various other healthcare professionals involved in their care dependant on their health needs. In addition, records showed that people had regular access to their optician, dentist, audiologist and chiropodist to maintain good health.

Requires Improvement

Is the service caring?

Our findings

At our last inspection visit in March 2017 we rated caring as 'Requires Improvement'. During this inspection people were positive about the support they received and felt staff were caring in their approach. Comments included: "It's nice living here, the staff are very nice" and, "The staff are alright, they do things for you in the middle of the night without complaining." Relatives were equally positive in their feedback following our visit. One family member wrote, "My elderly relative was looked after by Oldbury Grange. The care and attention that was provided was of the highest standard. Nothing was too much trouble and the staff were always kind and compassionate in addition to being efficient." Another told us, "The staff are always friendly and helpful both towards [person] and the family." A professional visitor provided the following feedback: "A warm welcome and friendly, caring staff that go above and beyond." However, the rating remains 'Requires Improvement' because the individual caring attitudes of staff were not consistently reflected though the service as a whole.

At our last inspection we found staff did not consistently show a caring approach towards people. Staff frequently walked past people and offered them no interaction. At this visit we spent time observing the care and support people received and this involved us undertaking a Short Observational Framework inspection (SOFI). During the SOFI we saw staff acknowledged each person in the room and were caring in meeting their needs.

Interactions between staff and people were warm and compassionate. Staff took time to talk with people and communicated with them effectively. They used different ways of enhancing their communication such as touch, ensuring they were at eye level with those people who were seated and altering their tone of voice appropriately.

Staff were patient and understanding of people when responding to people's requests for assistance. One person said they were cold. A member of staff was heard to respond, "We'll get a nice fleece to put over you." The staff member immediately fetched the person a fleece, but the person still said they were cold. Staff brought the person another fleecy blanket to wrap around them.

We spent time on the unit for people living with dementia. There was a calm and happy atmosphere. Staff were fully engaged with people, attentive to their needs and showed kindness towards them. Staff responded promptly, calmly and sensitively to people who were anxious. For example, one person walked in the lounge and began to get upset. A staff member stopped what they were doing, guided the person to a chair and gave them a hug with lots of verbal reassurance.

Another person saw a staff member coming towards them. Their eyes lit up and a big smile came on their face. The staff member had been on annual leave for a few days and responded positively saying, "Hello you, have you missed me?"

Where possible, staff encouraged people to engage with each other. For example, we saw staff encouraged one person to play a ball game with another person in the communal lounge. However, one person told us

they preferred staying in their bedroom because there was not much engagement with others. However, they said they were happy because, "They're (staff) so caring, they will do anything for you."

However, we were concerned that issues we identified in the safety, effectiveness and responsiveness of the service, negatively impacted on people's emotional wellbeing. For example, inaccurate and incomplete DNACPRs meant we could not be sure the provider had considered people's best interests or wishes for their end of life care. Care plans lacked personalisation and the unavailability of adapted cutlery compromised people's ability to eat independently and was not consistent with person centred care. Those people who spent their day in their bedroom had limited opportunities for engagement with others which left them at risk of social isolation.

At our last inspection visit we found people's dignity was not consistently promoted because they had not always received good personal care and clothes looked ill-fitting and unkempt. At this visit we found staff had a better understanding of how supporting people to maintain their appearance promoted their dignity and self-esteem. Staff were observed and heard to be discreet when people needed assistance. When staff supported people with personal care they took them back to their bedrooms and shut the doors. People looked clean and tidy, their glasses looked clean, and so did their finger nails. A staff member commented to one person about the top they were wearing. This positive interaction pleased the person who smiled in response.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection we found staff were not consistently responsive in meeting people's individual needs and rated the service as 'Requires Improvement'. At this inspection we found improvements had been made but further improvements were still required. The rating remains as 'Requires Improvement'.

At our last inspection we found no pre-admission assessments were completed to ensure the service could meet people's needs before they moved to Oldbury Grange. No admissions had been made to the home since our last inspection visit. However, the consultant manager told us they were reassessing the balance of the units and would only admit people if they had the capacity to meet their individual, assessed needs.

Since our last inspection the provider had invested in an electronic care records system. Staff had been provided with hand-held mobile devices so they had immediate access to people's care plans and could update records as they completed tasks. Advantages to the system included staff no longer needed to spend time writing up daily records, which gave them more time with people. Each person's electronic care plan included prompts to make sure time-critical actions were completed by staff. For example, when medicines were due to be administered. The electronic care system showed a red flag if actions were 'late'. Care records were reviewed monthly and in response to changes in health.

However, we found the care plans were often task and problem orientated rather than person centred. They lacked focus on the individual and maintaining and promoting their health, wellbeing and independence. Records did not evidence that people or their relatives had been involved in the planning or evaluation of people's care. Despite care plans lacking personalisation, staff who had worked in the home for some time, spoke about people in a person centred way. They knew people's routines and likes and dislikes in areas such as dressing and food preferences. We discussed with the registered manager the importance of ensuring this information was captured and shared with new staff so people continued to receive responsive and consistent care.

From our discussions with staff and our own observations, there were some teething problems with the new electronic care system, for example double entries. The management team were confident these would resolve as staff became more familiar with the system and record keeping improved.

The electronic system also provided a 'gateway' which provided an opportunity for relatives to stay fully informed and involved in their family member's care. People who had capacity had consented to information being shared in this way. Relatives had password protected access to an on-line version of their relation's records so they knew how their relative was being cared for. This enabled the management team to provide a more responsive service to families of people who lived at the home. For example, if a relative was concerned about what they saw, they could use 'gateway' to message a manager who could message back to either re-assure or explore what those concerns were. The system also allowed staff to share photographs of people taking part in activities and engaging with staff. One relative told us, "We as a family love the relative gateway scheme because we can keep an eye on what [person] is up to if we cannot visit."

In March 2017 we identified there were numerous occasions when people did not have their call bells to hand to call staff for assistance. At this visit we found staff had ensured people in their bedrooms had been left with their call bells within reach.

At our last inspection we found there were limited activities provided for people and the person responsible for providing activities was often busy supporting people to eat and drink. At this inspection we found improvements had been made.

The provider had developed the role of activity co-ordinator and there were now two activities co-ordinators working in the home. On the morning of our visit one of the activities co-ordinators provided activities on the unit for people living with dementia. They played a ball game with people and then did some art work with one person to help decorate the unit for a party. This person had appeared disengaged earlier in the morning, but enjoyed helping with the arts and crafts. The activities co-ordinator told us that activities were matched to individual needs following discussion with people and their family.

The environment on the dementia unit had been improved. Activities boards showed pictures of what activities were available each day; and there was information displayed telling people the day, date, season and weather. At our last visit we found staff left people watching television with little thought as to the content of the programme they were watching. During this visit, music was playing and some people enjoyed singing along to it. The music was appropriate to the people who lived there and staff did not rely on television to keep people entertained and engaged.

We particularly looked to see if people were offered activities to encourage movement and build strength as this can help reduce the risks of people falling. We found the activities programme incorporated activities that supported reality orientation for people living with dementia and also physical exercise to support mobility and upper limb function. For example, the activities co-ordinator asked two people whether they would like to go for a walk with them the following day. Both people said they would like to. However, another person said they would like the opportunity to go out more often.

Some people preferred to spend time in their rooms and did not choose to participate in group activities. One person who preferred to be in their room was quite happy and showed us that staff had painted their nails the previous day. Other people in bed had radios and televisions on, but it was not always clear whether these people were looked after in bed because of their care needs or by their own choice. Care records did not demonstrate that these people had regular support to reduce their social isolation.

At our last inspection visit some people felt their concerns had not always been resolved to their satisfaction. For example, one relative told us they had raised concerns about the offensive odour from the carpet in their family member's bedroom. At this visit we saw action had been taken and the carpet had been replaced by the provider. The provider had also fitted a blind in another person's room after we raised concerns at our last inspection that the sun was shining directly in to their eyes.

However, complaints management was still an area that required improvement because some people still did not feel confident their concerns would be responded to by the management team. In order to ensure people felt confident their concerns would be listened to and appropriate action taken, the provider had delegated the management of concerns and complaints to the new operations manager. The operations manager told us how they had managed a recent concern about water jugs in bedrooms not always being clean. They told they had introduced a new system to ensure the issue had been resolved and records demonstrated the complainant had been informed of the actions taken. The provider had received five complaints in the six months since our last visit.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in March 2017 we found the provider did not have effective systems in place to assess, monitor and improve the quality of care and manage risks to people's health and wellbeing. Planned improvements had not taken place or not been sustained. There was insignificant management oversight to check delegated duties were carried out effectively. We judged this was a breach of Regulation 17 and rated the leadership of the service as 'Inadequate'. The service had been placed in 'special measures'.

At this inspection we found sufficient improvements had been made to remove the service from 'special measures'. Systems and processes had been introduced by the provider and registered manager to monitor the quality of the service. However, the service continues to be rated 'Requires Improvement', because although some action had been taken, the improvements needed to become embedded in every day practice to be consistently effective. We will schedule a follow up inspection to check that the improvements have been consistently sustained throughout the home.

Following our inspection in March 2017 the provider and senior management team recognised they needed external support to improve the quality of the service. They had appointed a 'consultant manager' to provide them with guidance and advice. The consultant manager had a proven track record of providing quality care in a specialist dementia care home and meeting the regulations within the Health and Social Care Act 2004. The appointment of the consultant manager had increased management capacity, which had allowed more time to plan and implement improvements.

The provider had also commissioned an external Health and Safety Consultant to produce an independent Health & Safety Audit which was completed in August 2017. The identified actions had been prioritised and work scheduled to address any issues identified. We were told 80% of the work had been completed at the time of our inspection visit.

At our last inspection we found staff were not always clear about the role and responsibilities of each staff member and shifts were not always well led. The consultant manager told us their first priority was to strengthen the management team so staff had proper leadership and direction. They also reviewed and amended each staff member's job description so they had a clear understanding of their role and responsibilities and who they reported to. They explained, "The staff were willing but rudderless and there was a blurring of roles. I have achieved a management structure and role clarification. I have defined and clarified the roles of each staff member and created a flow of command." They gave us a copy of the new management structure. This clearly indicated the scheme of delegation within the home.

Action had been taken to provide managers and senior staff with the skills to lead and manage staff effectively. The operations manager explained this was necessary because management had often been ineffective and 'there was a culture of challenging the nurses'. The registered manager and senior nurses had attended training to equip them with the skills and knowledge to be more successful in their managerial roles. The registered manager told us the training had given them an understanding of where they needed to develop.

Staff felt the changes were positive and they had a better understanding of their roles and responsibilities. One staff member explained, "In March it wasn't good. It is a lot better now. There are more staff and there is more training. The management supervise you now. They walk around and tell you what to do." This member of staff told us stronger management made them feel more confident in their role.

There had been some changes to the structure of the home in that the dementia care unit had been separated from the nursing unit. Staff felt this had improved the deployment of staff and resulted in better outcomes for people. A typical comment was, "The dementia side and nursing side are separated now and it works better. Everybody knows what they are doing and where they are working." One staff member explained the allocation of tasks was much clearer now as, "It is on paper rather than just word of mouth, so you know what to do."

The consultant manager had identified that a major issue related to the management of rotas and staff performance and the impact this had on staffing levels in the home. Staff made changes to the rota without a 'manager sign off' which caused unexpected staff shortages and there had been a high level of sickness, especially at weekends. For example, one weekend seven staff had phoned in sick which left the service vulnerable and unsafe. Staff now had a return to work interview after any period of sickness and, if necessary, disciplinary procedures were instigated to manage poor attendance and performance.

There was also an issue of high staff turnover. The consultant manager had started to do informal exit interviews to learn why staff were leaving their employment at Oldbury Grange. They told us a typical response was, "I'm unhappy here because people don't listen to me." The consultant manager acknowledged this was an area that required more work as there was still a culture of staff concerns not reaching the management team. To address this, the consultant manager had met with staff from all areas to explore whether they felt they had a voice in the home. Staff meetings had been implemented to ensure essential information was shared and acted upon. One staff member confirmed, "We did have a meeting and discussed what we could improve and how we can help each other out."

At this inspection we found the oversight of delegated duties had improved and poor practice was more likely to be challenged. The consultant manager regularly walked around the home and if they saw anything which staff could improve, they took the staff member to one side and explained how they could do the task better.

In March 2017 health, safety and environmental audits were not effective in identifying risks of harm or injury to people. Equipment, such as hoists were not maintained and/or available for use. At this inspection we found action had been taken. Environmental risks we had identified had been addressed and action taken. For example, covers had been put on radiators to reduce the possibility of burns. There were now five hoists available within the home, which were all in good working order. However, we still identified issues around the checks and audits carried out to ensure the cleanliness of the premises and equipment. The provider's audits had not identified the issues we found around dirty and broken clinical equipment which continued to put people to risk. The provider took immediate action to order new equipment, but this was reactive rather than proactive risk management.

At our last inspection we found the audit of care plans had not identified when records were not accurate or sufficiently detailed and risk assessment tools did not accurately reflect the level of risk to people. Following that visit, the provider had invested in an electronic care plan system. All risk assessments were now completed using the electronic system to ensure consistent scoring of risk. Staff had instant access to the care records via hand held mobile devices and recorded all care interventions or engagement at the point of delivery. The provider was able to audit the system to identify any gaps in care delivery or individual staff

knowledge so appropriate action could be taken. However, the checks had not identified that records indicated people were not being repositioned in accordance with their risk management plans. We discussed this with the management team. They were confident that once staff became more competent in using the system, they would be able to quickly identify where improvements were required to improve care delivery within the home.

However, we noted that some paper records that were not kept on the new electronic system were not fit for purpose and reviews had not identified this. For example we found some serious concerns around Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) Orders. We identified four were not on the correct form, three had the wrong address on them and one stated 'DNAR valid for the duration of hospital admission' which meant it was no longer valid. A number of forms had recorded that the reason for the DNAR were not life limiting conditions, for example 'left cataract' and 'alcoholism'. This meant people may not have the appropriate treatment at end of life in accordance with their wishes. We asked the provider to take urgent action to review paper documents to ensure they were relevant and accurate.

Previously we found the management of falls and actions to reduce the risks of people falling were ineffective which put people at risk. At this visit we found improvements had been made to fall management systems. Falls were audited monthly to identify any trends or patterns and the number of falls occurring in the home had reduced.

The registered manager and deputy manager had visited two other homes in the local area to explore new care initiatives and observe best practice in action. One of the homes had been rated by the CQC as 'Outstanding'. The deputy manager told us the managers of both homes had been welcoming and supportive and the introduction of a computerised care system to Oldbury Grange had been a direct result of these visits.

A major concern at this inspection was that the driving force behind the changes within the organisation and management of the home was the consultant manager. Action had been taken to deal with the issues we raised at our last inspection visit, but we needed to be assured there was more proactive management of the service in the future. However, the consultant manager was only supporting the home on a temporary basis. We were subsequently informed the consultant manager's role had ceased on 30 October 2017.

The provider told us they believed one of the major issues earlier in the year was that they had not planned effectively when the number of beds in the home had increased. They explained, "It took time to adjust to the size of the home." The provider acknowledged the role of the consultant manager was only temporary and they needed to ensure the improvements were developed and sustained. They accepted that they often visited the home as a GP providing healthcare, rather than as a provider and therefore lacked oversight of the service as whole. The provider told us they were therefore going to recruit someone to take on the responsibilities of the consultant manager on a permanent basis and explained, "I want a responsible person who will look after my interests when I am not here. I want them to be my eyes and ears in the service." They felt this would ensure the progress made in the last few months was sustained.

At our last inspection the provider was not displaying the ratings from their last inspection visit as required by the regulations. At this visit the ratings were displayed in the entrance to the home.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We 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 11 HSCA RA Regulations 2014 Need for consent The provider had not always assessed whether people had the capacity to make their own decisions about their end of life care.

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 Equipment used to deliver care and treatment was not always safe for use and the risks of spreading infection through the use of such equipment had not been identified.