Oldbury Grange Nursing Home Ltd

Oldbury Grange Nursing Home

Inspection report

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Date of inspection visit:
09 October 2018
11 October 2018

Date of publication:
12 March 2019

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

A comprehensive inspection visit took place on 9 October 2018 which was unannounced. We returned announced on 11 October 2018 to conclude our inspection visit.

Oldbury Grange is a nursing home, which provides care for up to 89 people over two floors in three units. Anchor House on the ground floor provides mostly residential accommodation for people, some who are living with early on-set dementia. Hayes House on the first floor provides nursing care and Remember Me is a unit for people with more advanced dementia care needs. At the time of our inspection there were 89 people living at Oldbury Grange. Most people had their own bedroom although seven were shared bedrooms. Some bedrooms had en-suite facilities whilst others shared communal bathrooms.

People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

A requirement of the service's registration is that they have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and the associated Regulations about how the service is run. The service continues to have the same registered manager.

At our last comprehensive inspection in October 2017, we rated the service 'Requires Improvement' overall. This was an improvement as the home had previously been rated 'Inadequate' at an inspection in March 2017. At this inspection we found some improvements since the last inspection had been addressed, for example, clinical equipment was clean and in good working order and improvements had been made to ensure decisions made about end of life care were in accordance with the Mental Capacity Act 2005.

However, we also identified a number of new issues at this inspection where the provider still needed to take further action to improve and meet the essential standards and regulations. This was because risks to people's health were not always managed effectively to promote their health and wellbeing and staffing levels at night were insufficient and did not support staff to provide safe care. The provider's management and quality assurance systems required greater improvement. The service has therefore been rated 'Requires Improvement' overall and for all five key questions.

The management team were not cohesive and the roles and responsibilities of individual managers were not always clear. In some cases, there was a lack of ownership of tasks to ensure they were completed. Staff did not have a clear understanding of the management structure and delegated roles within the home and did not always feel their opinions and views were listened to.

The provider's quality assurance systems had failed to pick up a number of issues we identified during this

inspection. This included a culture where some staff did not consistently demonstrate the same level of understanding or behaviours in caring for people or show they had the skills or competence to deliver good and effective dementia care. The provider had not operated an effective system to identify trends or areas of risk that they could have addressed to improve people's experience of the service.

On the day of our inspection visit, there were enough staff on duty to keep people safe. However, we could not be assured the registered manager had fully risk assessed people's dependencies at night to ensure adequate levels of cover within all areas of the home and that staff could respond safely to emergencies. Following our inspection, the provider confirmed staffing levels had been increased at night.

People's care plans included risk management plans for staff to follow, which were regularly reviewed and updated. However, there were areas where plans to minimise risks were not consistently followed. Environmental risks and risks around wound care were not always effectively managed.

People's capacity had been assessed and there were capacity based care plans for the activities of daily living such as personal care and eating and drinking. When more complex decisions were required, there was evidence of healthcare professionals and others involved in people's care, making decisions in their best interests. However, during our inspection we saw inconsistency around staff offering people choice in accordance with the principles of the Mental Capacity Act 2005. For example, most people enjoyed the meals at Oldbury Grange, but people were not always given a choice of what they wanted to eat.

Staff monitored people's health and when a need was identified they were referred to other healthcare professionals. People received their medicines as prescribed and in accordance with good practice.

Most people were happy with the caring attitude of staff and spoke positively about them. People told us the staff were kind and helpful and treated them with respect. However, we found that people with more complex needs did not experience the same level of caring that other people told us they experienced. Staff told us they enjoyed working in the home, but would like more time to spend with people to meet their emotional and social needs.

We found a continued breach and an additional breach of the Health and Social Care Regulations. You can see what action we told the provider to take at the back of the full version of the report.

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

Further information is in the detailed findings below.

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.

Measures were in place to reduce identified risks to people's health, safety and welfare, but plans to minimise risks were not consistently followed. We could not be assured the registered manager had fully risk assessed people's dependencies at night to ensure adequate levels of cover within all areas of the home and that staff could respond safely to emergencies. People received their medicines as prescribed and in accordance with best practice. Clinical equipment was clean and in good working order. Improvements were required to ensure the provider's own policies to manage risks within the service were consistently followed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had received training in dementia awareness, but did not always demonstrate they had the skills or competence to deliver good and effective dementia care. People's capacity had been assessed and there were capacity based care plans for the activities of daily living but staff did not consistently work within the principles of the Mental Capacity Act 2005 and offer people choice. Most people enjoyed their meals, despite a lack of choice. People were referred to other healthcare professionals when needed, but health checks needed to be more robust.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were positive about the support they received and felt staff were caring in their approach. However, the individual caring attitudes of staff were not consistently reflected though the service as a whole. The provider did not always demonstrate a person centred approach to the delivery of care.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Staff did not always have the time or opportunity to respond to people's social and emotional needs. People had been consulted about their wishes at the end of their life when they wished to do so. The provider had not always ensured that people's complaints were listened to and responded to effectively or resolved satisfactorily.

Is the service well-led?

Requires Improvement

The service was not well-led.

The provider had governance systems in place, but they were not being implemented consistently or effectively. The management team were not cohesive and the roles and responsibilities of individual managers were not always clear. Staff worked as a team, but felt their views and opinions were not always taken into account to improve the quality of care provision within the home. The provider had displayed their last inspection report in accordance with their legal responsibility.

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 comprehensive inspection visit was undertaken by one inspector, an inspection manager, an assistant inspector, two specialist advisors and an expert by experience on 9 October 2018 and was unannounced. One inspector and a specialist advisor returned announced on 11 October 2018 to complete the inspection visit as there had been issues in accessing the electronic care planning system on the first day of our inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. The specialist advisors who supported our visit were both qualified nurses.

Prior to our inspection visit we reviewed the information we held about the service. We looked at information received from relatives, the local authority commissioners and the statutory notifications the registered manager had sent us. A statutory notification is information about important events, which the provider is required to send to us by law. Commissioners are people who work to find appropriate care and support services, which are paid for by the local authority.

The provider sent us a completed Provider Information Collection (PIC), as requested by us, during September 2018. This is information that we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We used the information within the PIC in the planning of our inspection visit.

During our inspection visit we spoke with 15 people about what it was like to live at the home and eight relatives/visitors about what they thought of the service provided. We spoke with the registered manger, operations manager, deputy manager and management consultant about their management of the home.

We spoke with one nurse, two team leaders, eight care staff, two activities co-ordinators and the cook about what it was like to work at the home.

Most of the people who lived at the home were not able to tell us in detail, about how they were cared for and supported because of their complex needs. To help us understand people's experiences of the service, we spent time during the inspection visit observing people in the communal areas of the home. This was to see how people spent their time, how staff involved them in making decisions about their care and how staff interacted with people and provided care and support.

We reviewed eight people's care plans and daily records in detail and specific aspects of one other care plan to see how care and support were planned and delivered. We looked at medicines administration records and other aspects of medicines management to check people received their medicines as prescribed. We checked whether staff were trained to deliver care and support appropriate to each person's needs. We reviewed elements of the provider's quality monitoring system to see what actions were taken and planned to improve the quality of the service.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in October 2017 we found risks to people's health, safety and wellbeing were not always managed consistently and rated the safety of the service as 'Requires Improvement'. At this inspection we found the provider had made some improvements, but we identified a number of new issues where the provider needed to take action to ensure risks were effectively managed. The rating of the safety of the service remains 'Requires Improvement'.

At our last inspection we found plans to minimise risks were not consistently followed. Records did not demonstrate that people received pressure relief in accordance with their care plans. At this inspection it was still an area that required improvement. We looked at the records of five 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 continued to show considerable gaps in repositioning for all five people. For example, one person's records indicated that on 25 September 2018 there had been a 12 hour gap between repositioning and on 26 September 2018 there had been a seven hour gap. Another person's records indicated that on 5 October 2018 they had gone 12 hours without being repositioned. Both these people had pressure ulcers that had recently deteriorated. This meant people continued to be at increased risks of further skin damage and/or developing pressure areas.

Risks around wound care were not always effectively managed. One person had a pressure ulcer on their sacrum. On 3 October 2018, records described the wound as a stage two pressure ulcer and 'improving'. On 5 October 2018, records described the wound as 'stable and improving'. However, the measurements on that date showed the size of the wound had increased and it was now graded as a stage three pressure ulcer. Records did not evidence a review of the care plan or an evaluation of the interventions already in place, despite the deterioration of the pressure ulcer showing they were no longer effective. Another person's wound management plan advised staff to 'change dressing regularly.' There was no information about the type of dressing or how often was meant by 'regularly'. A nurse acknowledged the information within the care plan was not adequate.

Charts to record the urine output of people with a urinary catheter had not always been completed, and where the recorded output was very low, it was not clear what action had been taken. Monitoring urine output is important as reduced output can be an indication of an infection, insufficient fluid intake or a blockage in the catheter.

Staff did not always use their training in safe moving and handling techniques to minimise risks to people's safety. Two members of staff attempted to lift a person from their wheelchair by taking hold of the person underneath their armpits. This is an unsafe and improper technique to support a person to stand. One person told us, "Staff couldn't hoist me as the sling was in the wrong position so they lifted me under my arms and on my legs." A member of staff explained how they repositioned people at risk of skin damage and said, "Downstairs it is done with one member of staff. We just put a cushion under their bottom and change it from right to left each hour."

Risks within the environment of the home were not always minimised. We found doors that were clearly marked they should be kept locked to ensure people's safety, were not always locked. One door on the dementia care unit had stickers on it reading 'Danger high voltage' and 'Keep locked at all times'. The door was unlocked throughout the first and second day of our inspection and contained a 'live' fuse box. This room was also used to store continence pads which was a potential fire risk. The boxes of pads were stored on the floor which posed an infection control risk as the room could not be adequately cleaned. In a bathroom plastic boxes were stored in the bath and a shower room had a missing panel leaving an exposed wooden frame which was an infection control risk. The window restrictors on the first floor did not meet the requirements of health and safety legislation.

This was a breach of regulation 12 of the HSCA (Regulated Activities) Regulations 2014. Safe care and treatment

On the day of our inspection visit, there were enough staff on duty to keep people safe and be responsive to people's individual care needs. However, we received mixed responses when we asked people and staff whether there were always enough staff to provide the care people needed when they wanted it. One person told us, "The staff are pleasant, but we are supposed to have five of them and there is only ever four." They went on to say, "I often have to wait until 11.00am for them to get me out of bed, but I like to get up about 09.30am to 10.00am." This was confirmed by one staff member who told us, "We usually only have four staff. It is very stressful as there are two staff on each side and most people are double ups." Another staff member explained, "We are always understaffed and we are not getting breaks." They went on to say, "It is the pad changes that don't get done when they should." However other staff told us staffing levels were sufficient to meet people's needs safely. One staff member told us, "Staffing levels from last year to now have improved and we always try to have a mixture of skills on each unit."

However, we had particular concerns about the level of staffing at night. The registered manager told us there were four care staff and one nurse on duty at night to cover all three units in the home. This meant there were only two care staff on the first floor to cover both the nursing and dementia care units where people had high levels of need. For example, most of the 28 people on the nursing unit needed the support of at least two care staff for all personal care interventions, and nine people from one unit and two from the other needed to be repositioned by two staff at two hourly intervals throughout the night. The deputy manager told us on average it would take 10 minutes to reposition a person which meant both care staff on the first floor would constantly be with people, either providing personal care or repositioning them. This only left one nurse to respond to the needs of the other 52 people on the dementia and nursing units.

Records supported our concerns around staffing as they did not evidence that people were receiving the care set out in their care plan. For example, some people were on hourly checks to ensure their safety. We checked the daily records for three of those people and found there were large gaps in the records to confirm checks had been completed. On the 4 October 2018, records showed one person had only been checked four times in a 24 hour period and seven times on the 3 October 2018.

Whilst most people did not share any concerns about staffing at night, one person told us, "I have to use the buzzer in the night. I did come out one night when it wasn't answered, but I managed to find someone to help me." Another said, "People are always in and out of people's rooms, but they turn a blind eye at night." This was supported by a recent accident in the home when a person had been found on the floor of another person's bedroom at 6.00am. The person had sustained a laceration to their hand which required emergency treatment.

On 29 September 2018 one person fell at 3.00am and due to the person complaining of hip and leg pain, the

paramedics were called. The paramedics attended and after assessing the person, advised that they should be observed. At 5.10am this person fell again and after being checked by the nurse, they were put on one to one observations for the rest of the night. Another person fell at 5.15am. This meant at 5.15am the nurse and four care staff had to deal with two people who had fallen and were at risk of injury. When we asked the deputy manager how staff would have been able to manage this situation they responded, "I don't know, it would have been extremely difficult." The operations manager told us that until recently there had been five care staff at night, but the registered manager had recently decided the extra member of care staff was no longer required. They were unable to explain that decision.

We discussed staffing levels at night with the registered manager. They told us they were confident staffing levels were safe because night staff had not raised any concerns and the incidence of accidents and incidents was low. However, they did not provide us with any evidence to support their assessed staffing levels at night. We could therefore not be assured the registered manager had fully risk assessed people's dependencies at night to ensure adequate levels of cover within all areas of the home and that staff could respond safely to emergencies. When we raised staffing at night with the deputy manager they told us, "Personally I think it would be better with another one, but I haven't had any complaints from night staff." When we shared our concerns with the management consultant they said, "It is not safe staffing levels."

This was a breach of regulation 18 of the HSCA (Regulated Activities) Regulations 2014. Staffing

Following our inspection visit, the provider confirmed they had reviewed staffing levels with the nurses who worked at night. As a result of those conversations, they had added an extra member of care staff on the rota at night.

In October 2017 we identified a breach of the regulations because equipment used to deliver care and treatment was not always safe for use and the risks of spreading infection using this equipment had not been identified. At this inspection we found equipment was in good working order and cleaning schedules ensured they were regularly cleaned to reduce the risks of cross infection.

Care staff attended training in infection prevention and control, but did not always recognise when their actions could spread the risk of infection. We saw a member of staff leave a person's room carrying a soiled duvet and with a soiled continence pad in their hand. Both items should have been placed in the appropriately coloured plastic bags before the staff member left the bedroom. A senior member of staff confirmed this was not acceptable practice and said they would remind staff of their responsibilities for effective infection prevention and control.

The provider had dedicated domestic staff to clean the home. However, we identified some areas of the home, including people's bedrooms, that had a very strong and unpleasant odour. This meant we could not be assured all areas of the home had been cleaned effectively.

At our last inspection we found improvements had been made in the management of medicines within the home. At this inspection we found those improvements had been sustained. Medicines were securely stored in locked medicines trolleys and/or cupboards kept in lockable rooms. However, we did identify an occasion when a clinical room was left unlocked and people could have gained access to medicines which were kept at lower temperatures in the refrigerator.

Trained staff administered medicines safely and completed electronic medicines administration records (MARs). There were no gaps or omissions on MAR charts which indicated people had received their medicines as prescribed. Some medicines have to be given 30 to 60 minutes before food and other

medicines. Arrangements were in place to ensure these administration instructions were followed for some of these medicines, but not for others.

Some people received their pain relieving medicines via a trans-dermal patch applied directly to their skin. It is important patches are rotated around the body in line with the prescribing instructions, to avoid people experiencing unnecessary side effects such as skin irritation. Staff had recorded where patches had been applied to ensure people were protected from these risks. However, there was no record of daily checks to ensure the patches were still in place. Daily checks are important as patches can fall off or be removed by people, which could result in them experiencing unnecessary pain.

Where people were prescribed medicines on an 'as required' basis (PRN), guidelines were clear as to when these should be given. Where people required PRN pain relief, records showed pain was formally assessed within medicine support plans. There were descriptions of how people who were unable to verbalise their pain, might demonstrate pain and discomfort through their non-verbal behaviours.

Some people were given their medicines disguised in food or drink because they declined to take medicines that were vital in maintaining their health. The advice of the pharmacist had been sought to ensure the effectiveness of the medicines was not compromised.

The provider had procedures for staff to follow to identify, report and act on signs or allegations of abuse or neglect. Staff had received safeguarding adults at risk training and were familiar with the different signs of abuse and neglect, and the appropriate action they should take to report its occurrence. One member of staff told us, "It's about people being bullied or neglected and I would go straight to [registered manager]."

The provider's recruitment policy ensured staff recruited had the right skills and experience to meet the needs of people who lived in the home. This included carrying out a Disclosure and Barring Service (DBS) check and obtaining appropriate references. However, the provider did not always follow their own policies and procedures for safe recruitment. For example, a staff member was allowed to start work without a reference from a previous employer. The consultant manager confirmed they had taken over recruitment and such instances would not occur again.

The provider had a procedure to analyse any falls that had occurred within the home to ensure appropriate action had been taken to manage risks. The analysis included where and at what time the falls occurred to identify any trends and patterns. However, we noticed some errors in the analysis. For example, one person's accident form stated it had occurred at 00.57am but the analysis stated it had occurred at 04.35am. We also found that not all falls had been included because staff had not always logged falls on the central record systems in line with the provider's policy. The deputy manager assured us they would remind staff where to record falls on the system.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in October 2017 we rated the effectiveness of the service as requires improvement because the provider did not always work in accordance with the principles of the Mental Capacity Act 2005. At this inspection we found the provider had made some improvements in this area, but we identified a number of new issues which meant staff did not always effectively meet people's needs, especially those people living with dementia. The rating of the effectiveness of the service remains 'Requires Improvement'.

The provider was registered to provide accommodation and personal care for people who lived with dementia. However, although staff had received training in dementia awareness, they did not always demonstrate they had the skills or competence to deliver good and effective dementia care in line with current best practice. At lunch time on the dementia care unit there was loud music playing which could cause anxiety for some people. Staff did not explain choices and people were not shown the different meals which would have given them a better understanding of their options. Staff did not use visual prompts such as pictorial menus or photographs to encourage people to be independent in choosing what they would like to eat. People were given a choice of orange and blackcurrant juice, but the orange juice was in a green plastic jug which did not support people to make an informed choice.

The provider and staff had not considered people's individual needs in line with good dementia care guidance for privacy or comfort. For example, there had been no thought as to how the communal rooms were used. The chairs in the communal lounges on the dementia care unit were arranged around the edge of the room, which gave the appearance of a waiting room. When loud music was played in the dining room, people in the lounge could hear it over the more relaxed music being played in that room. Staff had not recognised the loud and conflicting music might be disturbing for people who lived with dementia.

Staff told us they needed more in-depth training so they had a better understanding of how to support and approach people living with dementia. A senior member of staff told us, "The dementia training gives staff a basic knowledge, but they need extra training to handle people with complex needs or challenging behaviours." We shared our concerns with the operations manager who was responsible for training. They assured us they would review the content of their dementia training course and that further training was being sourced from an external provider.

Other training considered mandatory by the provider gave staff an understanding of the fundamental standards of care. Records showed most mandatory training was up to date and one member of staff told us, "The training is really good. It is really informative, and it does help when you are working. You can put it into practice in every situation." However, we found this was not always supported by staff practice during both days of our inspection visit. We discussed this with two senior members of staff. They told us, "We always encourage our staff to develop their skills. If anything happens we would arrange further training for them to improve their skills." They assured us they would act to address the concerns around poor practice we identified during our inspection.

Nursing staff felt competent in their roles because they received appropriate training to meet the clinical

needs of people who lived in the home. One nurse told us most training was delivered through the local hospital and included diabetes, wound care and management of percutaneous endoscopic gastrostomy (PEG) feeding tubes.

New staff received an induction which included working alongside experienced staff for a number of days. As staff progressed into their role, the provider encouraged them to gain further qualifications and attend external courses provided by other organisations. The registered manager explained this increased staff knowledge and understanding so they could share it with the rest of the staff team. For example, one staff member had recently achieved a qualification in Safe Handling of Medicines and others were completing distance learning courses in dementia care. Staff had opportunities to meet with senior staff to discuss their training and development.

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 are called the Deprivation of Liberty Safeguards (DoLS).

At our last inspection there was a breach of the regulations because 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. At this inspection we found people's care plans included the RESPECT form, as agreed with the local clinical commissioning group. The RESPECT form confirmed that the person or their representative had been consulted about their wishes in the event of the person going into cardiac arrest. For people who did not have the capacity to understand the decision to be made, those closest to them had been involved in making the decision with a qualified healthcare professional in the person's best interests.

People's capacity had been assessed and there were capacity based care plans for the activities of daily living such as personal care and eating and drinking. When people refused to take their medicines, we did not see their capacity to make that specific decision had been assessed. However, records demonstrated that a decision to give people their medicines hidden in food and drink had been the subject of a best interests' decision by the doctor, nurse and others involved in the person's care.

Staff continued to have a limited knowledge of the principles of the Mental Capacity Act 2005 and we saw inconsistency around staff offering people choice. Some staff gave people choice and sought consent before providing care. For example, one staff member asked a person, "I'm going to sit you up, is that okay?" However, some staff did not explain choices, especially at meal times. The consultant manager recognised this was an area that required improvement and had issued staff with a pocket guide called, "The Ten Commitments". The guide reminded staff to offer choices and provide personalised care that met people's preferences. One staff member explained how the guide reminded them of their responsibilities and said, "We have to make decisions for people based on experience."

Where it had been assessed that people had restrictions within their care plans which they did not have capacity to consent to, an application had been made for the legal authority to deprive them of their liberty. Some people had conditions on their authorised DoLS, and these had been incorporated into their care plans.

Overall, people's nutritional needs were met. Most people told us they enjoyed the meals at Oldbury Grange. Comments included: "No one should complain about the food. It's well cooked, hot; and there's a good variety", "The lunch here is good" and, "I enjoy the food, it satisfies me. I always eat what I have." However, one person was unhappy with the quality of the food and another person who was on a soft diet said they would like more variety. We were also told that a person who followed a mainly vegetarian diet was often given the same meal as everyone else, but without the meat. This meant we could not be sure this person was receiving a nutritionally balanced diet.

People told us they were not always given a choice of what they wanted to eat. Comments included: "We don't get a choice" and, "We get what we are given." A lack of choice was confirmed by a staff member who told us, "They tell us just to give everyone the main option. One table we offer a choice, but not everyone else." Our observations at lunch time confirmed not everybody was offered a choice of what they would like to eat.

We observed lunch being served in two communal dining rooms. Although people were given a large serving, when people finished their meals, staff took the plates and dishes away without offering people a second helping. One person had a pureed meal because they were on a soft diet. More could have been done to make this look appetising as it did not look well-presented on the plate.

One person received their food and fluids through a PEG feeding tube directly into their stomach. There was a comprehensive care plan and guidelines for how this should be managed safely. Advice had been sought from a dietician as to the feeding regime, and this had been incorporated into the nutritional care plan.

Another person had lost a significant amount of weight since April 2018. The person had been referred to a dietician, but there was no evidence of what further investigations into this person's weight loss had been explored in the meantime.

People received support to maintain their health and well-being and care plans set out how staff should be meeting people's specific health care needs by regular health checks and referrals to other professionals. However, we found checks could be more robust when people had sustained injuries. For example, following a fall one person's basic life signs were checked as well as their blood sugar levels, but no neurological checks had been recorded.

Each person had a 'hospital pack' which went with them if they were admitted to hospital. This informed other health professionals about the person's current care plan and any immediate risks to their health and wellbeing. It also detailed the care the person had received in the previous few days, including their nutritional intake, so other health professionals had an accurate picture of how the person had been.

The environment of the home was spacious and there were various communal lounges where people could choose to spend their time. Hand rails along the corridors were at different heights and on the dementia care unit they were painted red to enhance people's ability to find their way easily and promote safe mobility. However, there was limited directional signage and memory boxes outside people's bedrooms to help them identify their own room more easily, were mostly empty and not a true reflection on people's life story. There were spacious outside areas and many rooms had pleasant views to trigger conversations and enhance people's wellbeing.

Requires Improvement

Is the service caring?

Our findings

At our last inspection visit in October 2017 we rated caring as 'Requires Improvement'. Although people were positive about the support they received and felt staff were caring in their approach, the individual caring attitudes of staff were not consistently reflected through the service. At this inspection we identified the same concerns and the rating remains 'Requires Improvement'.

Most people were happy with the caring attitude of staff and spoke positively about them. People told us the staff were kind and helpful and treated them with respect. People said, "The staff have been fantastic. They are sympathetic and friendly", "The carers are friendly and helpful and give me lots of advice" and, "If you want something, you only have to ask."

The provider had equality and diversity policies and procedures in place which made it clear how they expected staff to uphold people's rights and ensure their diverse needs were respected. However, staff did not consistently adhere to these policies and procedures when caring for people. We found that people with more complex needs did not experience the same level of caring that other people told us they experienced.

We saw one person being supported to drink by a member of staff. The staff member sat with the person, explained what the drink was and encouraged the person to try it. It was done in an unhurried manner and the staff member spoke gently to the person whilst assisting them. However, during lunch on the first day of our inspection, we observed two people being assisted to eat their meals by staff. Both staff members stood up when supporting people to eat and there was little engagement to make the mealtime a pleasurable experience. One staff member was using a dessert spoon to assist a person and with each mouthful, they overloaded the spoon so food dropped out of the person's mouth. The staff member then scraped the side of the spoon across the person's mouth to scoop up the fallen food. The staff member gave no thought to putting less food on the spoon, using a smaller spoon or using a napkin to wipe the person's face.

Improvements were required to ensure people felt cared for. Some people had been supported by family and friends to personalise their bedrooms with photographs and small ornaments. However, some people's bedrooms did not provide a homely, comforting place for people to spend time. For example, we visited two people's bedrooms, both of which were very basic and contained minimal decoration. There was nothing in the rooms to remind the person of their lifetime's experience or memories or to give them a sense of belonging within the home. One of the bedrooms had a very strong, unpleasant odour which was emanating out into the corridor. These examples showed us there was a lack of care and consideration into how some people may have viewed their surroundings. The consultant manager recognised that more thought was needed to provide people with an environment where they felt valued.

We found more could be done to ensure a person-centred approach to the delivery of care. At lunch time on the first day, people living on the dementia care unit was given their meals on plastic plates and bowls. This demonstrated an institutionalised approach to people living with dementia, rather than care based on an assessment of each person's individual needs and abilities. One person told us, "I am institutionalised, let's face it."

We saw several occasions when staff demonstrated an inconsistent approach to caring. Some staff had a real understanding of their role in promoting people's privacy and dignity. For example, one staff member stopped to rearrange a blanket over a person's knees so their legs were not exposed. We saw another member of staff discreetly ask a person if they needed support with personal care. Staff knocked on bedroom doors before entering and ensured toilet, bathroom and bedroom doors were kept closed when they were supporting people with their personal care. One person told us, "I am nicely treated, like a person and with dignity."

However, we also saw occasions when more could have been done to demonstrate a respectful approach. For example, each person had a photograph of themselves on their bedroom door. One person's photograph had been taken when they had very severe bruising to their face. This was not only disrespectful, but could also cause upset to the person by prompting unpleasant memories for them, and for any family or friends visiting them.

People told us there was a lack of respect for their personal possessions. One person told us, "I can't buy anything nice here at all. All my stuff gets taken." Another person told us they were wearing another person's clothes and said, "I am not a happy bunny, these are not my clothes." Several relatives raised similar issues. One relative said, "They lose things here a lot including [name's] bottom teeth. His glasses have been lost and his watch disappeared." Another said, "I've labelled his clothes, but I can still find him in clothes that aren't his. Even shoes disappear, but they did come back." One relative explained, "[Name's] outdoor coat has disappeared, but one lady doesn't go out any more, so we've been given her coat which is pretty similar."

Relatives could visit without being unnecessarily restricted. Visitors told us they were not aware of any restrictions on times they could visit their family members. One relative told us they regularly enjoyed having a meal with their family member in the dining room.

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 further improvements were still required to meet people's emotional and social needs and respond to their concerns. The rating remains as 'Requires Improvement'.

People's care plans were kept electronically and staff accessed all the information they needed to know about how to meet people's care needs and wishes on portable hand-held devices. The provider had also developed a system of symbols on people's bedroom doors to highlight if they were living with dementia, their level of dependency, were at risk of falls or had a do not attempt resuscitation decision in place. This acted as a prompt for staff to deliver person centred care without breaching confidentiality.

Staff used their knowledge to respond to people when they became anxious or distressed. For example, one person became anxious and started shouting. The person's care plan advised what action staff should take to divert this person from their anxiety. Staff followed the care plan and took the person into the garden where they appeared much calmer. Another person became distressed and a staff member gave them a book they knew they enjoyed looking at. A relative told us staff understood their relative and pointing to one member of staff said, "He's an exceptional carer over there. When she goes into her shell, he brings her cake or a cup of tea and reassures her."

People and relatives could not remember being involved in developing care plans. Responses included: "I wasn't aware of making a care plan when [name] arrived" and, "They've not really asked me how best to look after him." However, records showed that relatives were informed of any changes in people's health and this was confirmed by those we spoke to.

Two activities co-ordinators provided activities six days a week between the hours of 10.00am and 2.00pm. The activities co-ordinators told us they were committed to ensuring as many people as possible joined in with each activity, but the activities plan in the main entrance was not accessible to everyone. The activities co-ordinator explained they told people each day what activities were planned, but this did not give people much time to decide if they wanted to take part in an activity, or to look forward to an activity. On the day of our inspection we could see that activities planned for the coming weeks included a seasonal party, ukulele player, an autumn walk and cinema screening, as well as a monthly 'Creative Mojo' session. There were lots of photographs of people engaged in activities which by their smiles, they appeared to enjoy.

The activities co-ordinator told us they visited people when they moved to the home to find out what they liked to do, but that this was not recorded anywhere. They agreed that recording this information would benefit other staff so they could identify common interests with people. The activities co-ordinator had implemented a new form to record what activities people had enjoyed, to help them tailor activities to meet people's individual needs.

On both days of our inspection the main activities were centred around music. We saw groups of people

enjoyed singing and dancing in various lounges throughout the morning. Some people followed the activity from lounge to lounge which encouraged movement to help build strength. The activities co-ordinator told us that before they finished work, they left different activities in each area of the home which staff could do with people during the afternoon and evenings. On the first day of our inspection visit we saw a member of care staff sitting with people and playing a variety of games. However, one staff member told us, "There aren't many activities in the afternoon, and there isn't enough time for staff to do activities either."

We received mixed responses when people spoke about their opportunities to engage in meaningful activities in the home. Comments included: "There's never enough things for them to do, there could always be more, but the activities girls do a good job", "[Name] has been on trips to the garden centre and a canal boat", "I went for a walk last week with the home" and, "There's not enough to do. I have a mobility problem but I enjoy reading, crosswords and quizzes."

People who were less able to express themselves verbally, or who did not want to join in the group activities, did not experience the same quality of engagement or interaction with staff. We did not see any engagement outside the delivery of care tasks for people who were cared for in bed or chose to stay in their bedrooms, to reduce their social isolation.

In the minutes of a staff meeting in July 2018, we saw reference to staff who were on the rota until 9.30pm being sent home at 7.30pm. We queried this with the registered manager who confirmed they told some staff to finish earlier if people were in bed and did not require the same level of support. However, other members of the management team felt this did not support consistency of care delivery or demonstrate person centred care. No thought had been given as to whether staff could use this time to respond to people's social and emotional needs by spending quality one to one time with them, especially those people who spent the majority of their day in their bedrooms. One staff member told us, "We are always rushed and don't get time to sit with people and when we do, we get slated for it as they don't see that as part of the job, but it is important."

Each person was assigned a named nurse and a key worker. A key worker is a member of staff who is allocated to support a person on an individual basis and provide a named link between the service and people's families. People did not have positive experiences of the named nurse or keyworker systems. Comments included: "There's no particular nurse I've got to meet my needs", I don't think there's one particular carer who cares for me" and, "No I don't have a keyworker; I go to the nearest one." Sending staff home early from their shift was a lost opportunity for staff to develop their relationships with those people they were keyworkers for.

People had been consulted about their wishes at the end of their life when they wished to do so. Plans showed people's wishes about where they wanted to spend their final days, who they wanted with them at this time and the medical interventions they had agreed to.

We asked people and relatives about what they would do if they wanted to raise a concern or were unhappy about an aspect of the home. Most told us they had no complaints. One person told us they had no concerns, but if they did they would, "Probably speak to the manager. She introduced herself."

However, we found the provider had not always ensured that people's complaints were listened to and responded to effectively or resolved satisfactorily. Prior to our inspection visit, we had received concerns that the home smelt of urine, people at risk of skin breakdown were not receiving appropriate pressure relief and weight loss was not being effectively managed. People told us they had raised these concerns with staff and members of the management team, but felt they had not been listened to. We found the provider had

failed to ensure staff changed their practice in response to these concerns.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in October 2017 we rated the leadership and management of the service as 'Requires Improvement'. Providers must have effective governance systems to assess, monitor and drive improvement in the quality and safety of the service provided. This should include acting on feedback to improve outcomes for everyone using the service. Whilst the provider had governance systems in place, they were not being implemented consistently or effectively and the rating of this key question remains 'Requires Improvement'.

At our last inspection the provider had recruited a consultant manager to support the registered manager and drive improvement within the home. Shortly after that inspection the consultant manager left the home and a new manager was appointed who it was anticipated would eventually become the registered manager. However, that appointment had only lasted six months and the provider had asked the consultant manager to resume their role in ensuring the quality and safety of the service provided.

The management team consisted of the registered manager, deputy manager, operations manager and consultant manager. We found the management team were not cohesive and the roles and responsibilities of individual managers were not always clear. In some cases, there was a lack of ownership of tasks to ensure they were completed. Despite regular meetings to discuss the governance and direction of the home, from our conversations with individual managers, it was clear that decisions were taken outside of those meetings which did not have the support of the whole management team. Other managers felt this was detrimental to delivering high quality care, but felt their voices had not been heard when they raised concerns.

Not all staff had a clear understanding of the management structure and delegated roles. Staff said they did not understand how it 'fitted together' as they were unsure who was 'in charge' which had an impact on their ability to raise concerns. Some staff said they had raised issues in the past, but did not always feel they had been listened to. One staff member told us "I don't really feel confident to raise things. I just feel like they are not listening."

People's experiences of living at Oldbury Grange were very different. Whilst most people were happy with the care and support they received, some people felt the standard of care they received did not support them to live a life that was fulfilled and meaningful to them. The management consultant acknowledged that one of the biggest challenges was to ensure every person who lived at Oldbury Grange consistently received good quality care. They explained, "Sometimes it (the quality of care) is good and sometimes it dips."

Prior to our visit we received some information that relatives did not always feel listened to when they shared concerns about care standards within the home. One relative told us, "It is the management that I have an issue with. Emails are never replied to and they always blame each other or someone else."

Managers and senior staff were responsible for undertaking regular audits and spot checks at the care

home. For example, the registered manager and her management team carried out routine checks on infection control and food hygiene, health and safety, pressure areas and incidents and accidents. However, these systems had failed to pick up the issues we identified. This included a culture where some staff did not consistently demonstrate the same level of understanding or behaviours in caring for people and did not always show they had the skills or competence to deliver good and effective dementia care. The registered manager had also not identified that staff felt stretched at times during the day and was unable to provide us with any assurance that staffing levels at night were safe and staff were able to be proactive in providing effective and responsive care.

The provider had invested in an electronic care records system and staff had immediate access to people's records through hand held mobile devices. The registered manager could monitor the quality of care people received daily through the system and prompt staff if any gaps were identified. However, the registered manager's observations and checks had not identified that staff were not always providing the care set out within people's care plans. For example, people were not always receiving pressure relief or safety checks in accordance with their risk management plans. They had also not identified that staff were not recording accidents and falls in accordance with the provider's policies so the analysis of such was not entirely accurate.

When the provider completed a root cause analysis of significant events that had occurred in the home, the information was not detailed enough to provide assurance the circumstances of the incident had been comprehensively explored.

The provider had not identified that policies and procedures relating to safety were not always implemented effectively. For example, doors that should have been locked to prevent people entering and harming themselves, were frequently left unlocked. The provider's checks had not identified that their window restrictors did not meet the requirements of health and safety legislation.

These shortfalls represent a continuing breach of regulation 17 of the HSCA (Regulated Activities) Regulations 2014. Good governance.

We asked the consultant manager why the momentum of improvement we had seen at our last inspection had not been maintained. They responded, "When I came back in June the home had slipped back a bit, continuity was splintered and there was no continuity to the management of the home." When we asked what the main issues were, they told us, "A lack of accountability. Too many staff not knowing what they were doing and no obvious standards of control. There was a lack of supervision to make sure things got done." The consultant manager told us they walked around the home every time they visited so they could monitor staff practice and identify areas where improvements were required. They acknowledged this was a work in action and more work was needed to improve standards within the home.

Staff felt more positive since the return of the consultant manager to the home. One staff member told us "[Operations manager] and [consultant manager] have been brilliant. That's when improvements started." They went on to say, "They are much more approachable. You can take things to them and they deal with it. I have faith in them." Another said, "[Consultant manager] is always going around on the floor and checking for this and talking to the relatives." A member of the management team confirmed, "I feel better now [consultant manager] is back because he is there in an advisory capacity and he is good to bounce ideas off."

Following our feedback at the end of our inspection visit, the provider took immediate action to address some of the concerns raised. They consulted with staff and increased staffing levels at night. They also

approached another provider within the local area who has track record of providing outstanding dementia care. This provider had agreed to support the home with dementia care training within Oldbury Grange.

Despite the challenges, staff we spoke with told us they enjoyed working in the home and spoke positively of the support they received from each other. One staff member told us, "We have good team work. We do work brilliantly together." Another staff member said, "We work together as a family for the people we look after. We have a laugh."

It is a legal requirement that the provider's latest CQC inspection report rating is displayed at the service. This is so people, visitors and those seeking information about the service can be informed of our judgements. The provider had displayed the rating in the entrance reception area of 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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not always done everything that was reasonably practicable to manage identified risks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent and skilled staff were available to meet people's needs.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's systems and processes to assess, monitor and improve the quality and safety of the service were not operated effectively.

The enforcement action we took:

We issued a Notice of Decision to impose a condition on their registration.