Grange Cottage Limited

Grange Cottage Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Grange Cottage is a residential care home providing personal care and support to older people and people living with dementia. There were 29 people living there at the time of the inspection. The service can support up to 33 people.

People's experience of using this service and what we found
People were not always protected from the risk of infection. Staff did not always follow infection prevention and control policy and good practice.

People's risk assessments and care plans did not always contain detailed information for staff to be able to safely manage risks to people.

People were not always protected from being cared for by unsuitable staff because the provider had not always followed safe staff recruitment procedures.

People were not always cared for in line with their preferences. They were not always given a choice about what time they got up in the morning or what time they had their breakfast. Staff did not always give people a choice about what activities they did and did not always follow people's requests when they did choose what they wanted to do. People's care plans did not always contain personalised information about how they would like to be supported with their care needs.

People did not always experience a positive, person-centred culture that empowered them because they did not always receive personalised care. People's equality characteristics were not always fully considered. People's sexual orientation was not always explored or included in their care plans. The provider's quality assurance audits were not always effective and this meant people's care was less likely to be improved by internal processes.

People received their medicines safely and there were safeguarding procedures in place to protect people from abuse

People had visits and they were carried out safely in line with national guidance for COVID-19. People also stayed in touch with their families during the COVID-19 pandemic by using video calls, telephone calls and emails and social media.

People and their families could raise issues and make complaints and the provider investigated complaints and responded appropriately. People and families were given feedback forms to tell the provider what they thought of the service and how the service could be improved.

People received care from trained staff and the provider worked in partnership with medical professionals,

local authorities and community services to provide and improve people's care.

After our inspection the provider worked with the local authority's dietician to improve their understanding of the Malnutrition Universal Screening Tool (MUST) and when and how to re-refer people to the dietician. 'MUST' is a five-step screening tool to identify adults who are malnourished, at risk of malnutrition (undernutrition) or obese. It includes management guidelines which can be used to develop a care plan.

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

Rating at last inspection
The last rating for this service was Good (published 3 March 2020).

Why we inspected
We received concerns in relation to the safe care and treatment of people, person-centred care and infection prevention and control. As a result, we undertook a focused inspection to review the key questions of safe, responsive and well-led only.

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

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from the previous comprehensive inspection for those key questions were used in calculating the overall rating at this inspection.

We found evidence that the provider needs to make improvements. Please see the safe, responsive and well-led sections of this report. The overall rating for the service has changed from Good to Requires Improvement. This is based on the findings at this inspection.

You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment, person-centred care, fit and proper persons employed and good governance at this inspection.

Please see the action we have told the provider to take at the end of this report.

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

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 always safe.

Details are in our safe findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below

Grange Cottage Residential Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

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

Inspection team
The inspection was carried out by two inspectors.

Service and service type
Grange Cottage is a 'care home'. People in care homes receive accommodation and nursing 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.

The service had two managers registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 21 June 2021 and ended on 29 June 2021. We visited the care home on 21 June 2021.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We reviewed information we had received about the service since the last inspection. We used this information to plan our inspection.

During the inspection
We spoke with seven people who used the service and four relatives about their experience of the care provided. We spoke with eight members of staff, which included the two registered managers, four senior care workers and two care workers.

We reviewed a range of records. This included seven people's care records and multiple medication records. We looked at three staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures, training data and quality assurance records were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We spoke with one professional who visits the service.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement.

Preventing and controlling infection
• We were told by staff that visitors to the home and staff arriving for work had their temperature taken to check for symptoms of COVID-19. However, we observed one member of staff enter the home and start work without having their temperature taken. When we entered the home to carry out our inspection, we had to remind staff to take our temperatures.
• The failure to take the staff member's temperature and to remember to take our temperatures meant staff were not taking enough action to prevent COVID-19 infection being taken into the home.
• We were not asked to take a Lateral Flow Test (LFT) when we entered the home. We were also not asked to provide evidence that the CQC LFT we had taken before entering the home was negative. This meant staff were not taking enough action to prevent COVID-19 infection being taken into the home.
• Staff told us they donned and doffed (put on and took off) Personal Protective Equipment (PPE) in the two ground floor bathrooms that had yellow doors. Both bathrooms were also used by people. This meant there was a risk of spreading infections.
• We observed staff wearing the same gloves when supporting different people to eat by feeding them. This meant there was a risk of spreading infections.
• There was a basket in the hallway containing PPE. However, there were no gloves and only one face mask in it. The storage drawers for gloves and face masks in the small office were empty. This meant staff may not have had immediate access to enough PPE.
• The provider's IPC policy was not up to date. It stated, 'routine use of masks, as an infection control prevention is unnecessary'. This was not in line with current national guidance, which states care home staff should always wear PPE face masks at work.

The provider's failure to implement and ensure safe infection prevention and control measures and practice was a breach of Regulation 12: Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

• Staff and people were being tested for COVID-19 in line with national guidance.
• The provider was safely admitting people to the home.
• The provider was facilitating visits for people living in the home in line with current guidance.

Assessing risk, safety monitoring and management
• The provider had risk assessments and care plans in place for people. However, some people's risk assessments and care plans did not contain enough information for staff to be able to manage the risks safely.
• One person had been assessed to be at medium risk of falls but there was no information about what

actions staff should take to manage the risk. This increased the person's risk of falls.
• Some people's COVID-19 risk assessments had been copied and pasted from other people's COVID-19 risk assessments. For example, one person's COVID-19 risk assessment contained a completed section for people from Black, Asian and Minority Ethnic (BAME) backgrounds even though they were not BAME. The provider's failure to carry out individual and accurate COVID-19 risk assessments for people meant people could be at increased risk from COVID-19.
• The risk assessment for one person diagnosed with diabetes did not contain any information about their diabetes and the only action it stated for staff was to 'assess dietary requirements'. The person's diabetes care plan did have actions for staff, but it did not contain any personalised information for staff to support the person with their diabetes in a person-centred way. This meant staff did not have enough information to be able to safely support the person with their diabetes.
• The provider did not always safely monitor and manage risks to people. Two people continued to lose weight after being referred to the dietician and a plan being put in place. The provider had failed to refer them back to the dietician for further assessment and a review of their support plans. This had put the people at increased risk of poor health.

The provider's failure to safely monitor and manage risks to people was further evidence of a breach of Regulation 12: Safe Care and Treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staffing and recruitment
• We looked at the provider's recruitment policy and three members of staff files.
• The provider's recruitment policy stated job applicants should provide a full work history since leaving full-time education and two written references should be obtained before appointing a member of staff. It stated one of the references must be the applicant's current or most recent employer and any gaps in employment history should be explored and discussed with the applicant. It also stated a Disclosure and Barring Service (DBS) check would be carried out. The DBS helps employers make safer recruitment decisions.
• One member of staff had only one reference in their file. Two members of staff did not have full work histories in their file and there was no record that the provider had explored this with them.

The provider's failure to ensure safe recruitment practice was a breach of Regulation 19: Fit and proper persons employed of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Systems and processes to safeguard people from the risk of abuse
• The provider had safeguarding procedures in place, which included guidance on the actions staff should take if they suspect a person has been abused. The actions included reporting safeguarding concerns to local authority social workers and notifying CQC.
• All staff had received safeguarding training to identify signs of abuse and the actions they should take to keep people safe. Staff had been given information about the whistleblowing process and had access to telephone numbers for the local authority safeguarding team and CQC. Whistleblowing is the term used when a worker passes on information concerning wrongdoing.

Using medicines safely
• People received their medicines safely.
• Senior carers were trained to administer medicines to people and only senior carers gave people their medicines.
• Medicines were safely stored in a locked cabinet in a locked medicines room. The keys to the medicines room and cabinet were held by the senior carer giving people their medicines. This meant people were

protected from risks associated with unauthorised access to medicines.
• Staff used an electronic Medicines Administration Record (MAR) system. The system prevented gaps in record keeping. Accurate medicines records were maintained and audited.
• There was a system for staff to report medicines errors so that action could be taken and lessons learned.

Learning lessons when things go wrong
• There were systems in place for staff to record and report accidents and incidents.
• The provider investigated accidents and incidents and took action to reduce the risk of them recurring.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

• People had care plans in place. However, some people's care plans did not contain person-centred information for staff to meet their needs and preferences.

• Some people's care plans did not say what times they preferred to get up in the morning and go to bed at night. When we arrived for our inspection at seven o'clock in the morning there were ten people sitting in the main lounge and three of them were asleep in their armchairs. All of the people in the main lounge were already fully dressed.

• One person said, "The staff wake us up about between five thirty and six. I'd prefer it to be a bit later, about eight. That's just how things are here". Another person told us, "Ordinarily I get up when it's time to get up. I don't really get a say in it".

• We asked one person in the main lounge if they liked getting up so early and they said, "No, not really". We asked them why they had got up so early and they said, "They [staff] get me up". Another person told us, "I like to get up early. Not too early. They get me up. I prefer about nine, half past nine."

• During breakfast we observed people were only given their toast once they had finished their porridge or cereal. By this point the toast could have been cold. The toast could also have been soggy by this time because it had been buttered before it arrived. Staff did not tell people what flavour the jam was before putting it on their toast.

• Staff did not always tell people what they were going to do before they did it or give people a choice about it. On four occasions we observed staff pat people on the back when they were coughing without telling them what they were going to do or asking for permission before doing it. When people finished eating staff put a pack of baby wipes on their table and either prompted them to wipe their faces and hands or did it for them. The staff did not ask people whether they wanted to do this or give them a choice about doing it.

• We observed staff supporting people to leave the dining room when they finished eating, telling them, "We will go to the lounge to watch TV". Staff then escorted people to the lounge to watch television without asking them if that was what they wanted to do. One person told staff they wanted to go and lie down, and a member of staff said, "OK, no problem" and brought the person's walking frame. However, they then told the person they were going to the lounge. They did not offer the person a choice and did not check whether the person would have preferred to go to their room to lie down. We saw the person a few minutes later sitting in a chair in the lounge.

• Some people's care plans contained general information for staff about what to do when a person experiences a deterioration in memory. However, they had no personalised information about how each person behaves when they suffer memory loss or what specific actions staff should take for each individual.

• One person's care plan stated the person did not practice their religion and did not want to be visited by the church. However, the person told us they liked to go to church and specified which church they wanted

to go to. One person's care plan had no information about their cultural preferences and one person's care plan had no information about their life history. This meant staff did not have personalised information to support people in the ways people wanted.

End of life care and support
• At the time of our inspection no one was receiving end of life care. However, the provider had not explored people's preferences for their end of life care with them. People's care plans stated, '[person's name] is not at the end of life stage at the present moment' and 'no end of life actions required at present'.
• Some people did have advance decisions in place for the end of their life, such as Do Not Attempt Resuscitation orders for example.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
• When we arrived for our inspection, we observed staff were present but were mainly just standing in doorways observing people. There was very little interaction between staff and people. The atmosphere was very quiet and people who were awake were mainly just sitting in chairs not doing anything and not engaging with others.
• During our inspection we observed staff did not always support people to follow their interests and take part in activities. We observed staff mainly interacted with people when they needed to carry out care tasks. We saw staff spent a lot of time on their hand-held devices to access the electronic care system and write care notes.
• The main activity we heard staff offer people was to sit in the in the lounge to watch television. On one occasion we observed a member of staff come into the lounge and turn on the television to a news programme without asking people what they wanted to watch.
• Throughout our inspection we observed one person repeatedly said, "I don't know why I'm here" and "I don't know what I'm doing here". We noticed that often staff did not respond to the person. On one occasion we observed the person say this whilst the two members of staff with them had a conversation about football over their head and did not respond to them.
• We observed that people were not always given the opportunity or supported to engage in activities in line with their interests recorded in their care plans.

The provider's failure to plan people's care in a personalised way and to support people to follow their interests and engage in activities relevant to them was a breach of Regulation 9: Person-centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

• People had visits during the COVID-19 pandemic in line with national guidance.
• During the COVID-19 pandemic people were also able to stay in touch with family and friends using telephone calls and video calls.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
• The provider had assessed people's individual communication needs and people's care plans gave staff some person-centred information for how to communicate with people.

Improving care quality in response to complaints or concerns
• The provider had a complaint policy and procedures.

• The provider investigated complaints, took action to resolve them, recorded the details and informed people of the outcome.
• The provider audited complaints to identify themes and trends.

Requires Improvement

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• The provider had not effectively reviewed whether people received person-centred care and had not always ensured a person-centred culture. This meant people were not always included in decisions made about them and were not always empowered to be as independent as possible.

The provider's failure to promote a positive, person-centred culture was a breach of Regulation17: Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

• There were two registered managers running the home. A registered manager is a person registered with CQC who is responsible for managing the service along with the provider.
• The provider promoted open and inclusive staff communication and provided staff with supervision, support and reassurance. Staff were encouraged to raise issues or discuss things informally at any time as well as formally or during meetings. The provider assessed staff performance and supported staff with their professional development.
• Staff were supported with health and personal issues. The provider had kept in touch with staff that were off work due to Covid-19, offered them help with shopping and kept their positions open until they felt ready to return to work. The provider was flexible with shift start and finish times for staff with travel difficulties or childcare needs.
• The provider told us they were planning to start employee of the month and employee of the year schemes. They said staff would be rewarded with either a cash payment or a voucher. The provider said staff also received a pay rise every year.
• The provider had plans to refurbish one of the home's wings in 2022 and had received planning permission for an extension to the home. The provider said the extension would include a room for staff to don and doff PPE and a staff room with a shower and toilet. The provider told us they hoped to start work on the extension in 2022.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
• The provider had quality assurance audits, systems, processes and checks in place. However, they were not always effective because they had not identified any of the failings found by us during this inspection. This meant the provider was less likely to be able to identify areas for improvement and in some cases, people were potentially at risk of harm.

The provider's failure to carry out effective quality assurance audits and understand risks was further evidence of a breach of Regulation17: Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

• The provider had a statement of purpose with clear values. Staff were given a copy of it and part of it was displayed on the service's website. It was also in the policies folder and the provided said they would add it to their new electronic care recording system.
• All staff had a contract of employment, a person specification and a clear job description. Staff handover meetings were held before the start of each shift for staff finishing work to discuss people's care with staff starting work and give them updates.
• New staff received induction training and staff completed ongoing compulsory training. Staff also did training provided by the local authority. The provider carried out staff competency checks, supervision and yearly appraisals.
• Both registered managers were Registered General Nurses (RGNs) and were registered with the Nursing and Midwifery Council (NMC). Both registered managers had over 15 years' experience in nursing and social care.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• The provider did not always fully consider people's equality characteristics. For example, care plans for some people from BAME backgrounds did not always contain information about their cultural and social preferences. And people's sexual orientation was not always explored or included in their care plans.

The provider's failure to consider people's equality characteristics was further evidence of a breach of Regulation17: Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

• People were given feedback forms and staff, or family supported people to complete the forms if necessary. People's relatives were given a satisfaction survey when they visited. Visiting professionals were also given feedback forms.
• Telephone calls and emails were used to give people's families information and updates. This included keeping in touch with some people's relatives in other countries.
• The provider had a social media group. People's families used it to keep up to date with their relative's activities and to join in with some activities, such as people's birthday celebrations for example.

Continuous learning and improving care
• The provider held a management meeting every week, which included a discussion about quality assurance audit findings when necessary. There were regular staff meetings and staff received one-to-one supervision and participated in group supervision discussions about the service.
• Staff completed training on a regular basis and some members of staff were champions for certain parts of the service. Champions took the lead on monitoring and improving the areas of the service they championed, including sharing learning for those areas with other staff.
• The provider used parts of the Skills for Care certificate for new staff induction training. Skills for Care is an organisation that helps create a well-led, skilled and valued adult social care workforce. Some staff were also studying for their National Vocational Qualification (NVQ) in Health and Social Care.
• Changes and updates to people's care were shared with all staff via the provider's new electronic care recording system. This included staff that were not on shift. The system ensured staff read any updates before they could continue using the system.
• Managers received emails with new information from local authority public health teams and weekly

updates to guidance from the local authority's commissioner. One of the registered managers attended a weekly IPC interactive webinar and both registered managers attended the local authority's providers' network meeting.

Working in partnership with others
• The service worked in partnership with people's families; health and social care professionals; local authorities; faith groups and local education establishments to provide and improve people's care.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider failed to plan personalised care and provide people with person-centred care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to implement and ensure safe infection prevention and control measures and practice and to safely monitor and manage risks to people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure good governance of the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to follow safe staff recruitment procedures.