The Grange (Chertsey) 2002 Ltd

The Grange Retirement Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
The Grange Retirement Home is a residential care home providing personal and nursing care up to 62 people. The service provides support to adults, including adults living with dementia. At the time of our inspection there were 60 people using the service. The care home supports up to 60 people in an adapted building over 3 floors.

People's experience of using this service and what we found
People were not always kept safe from the risk of harm. Some people's care plans had contradicting information throughout about what their risks were and contained insufficient guidance for staff on how to manage them. Some staff were not always aware of individual risks of the people they were supporting.

The management of medicine was not always safe and in line with guidance that should be followed by a nursing home.

Risk to the environment was not always managed well. For example, the fire log to ensure all people were accounted for in the building was not always completed by the staff on duty.

Audits had not always identified the concerns we found during the inspection. There were elements of the governance within the home which was not always effective to ensure full oversight of the quality of the home and staffing.

Generally people were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

People and relatives in general confirmed they were happy with the care provided and felt safe being supported by the staff.

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

Rating at last inspection and update
The last rating for this service was good (published 21 October 2023).

At our last inspection we recommended the provider considered current guidance on recording 'as and when required' medicines, when these are given to people and take action to update their overall medicine management practice accordingly. At this inspection we found the provider had not made enough improvement in this area.

Why we inspected

We received concerns in relation to the management of medicines and people's nursing care needs, safeguarding incidents, fire safety, staff knowledge and staffing levels. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

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

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

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

Enforcement and Recommendations
We have identified breaches in relation to safe care and treatment and good governance at this inspection.

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

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

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 well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

The Grange Retirement 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 Health and Social Care Act 2008.

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

Inspection team
This inspection was completed by 3 adult social care inspectors and 1 medicine inspector.

Service and service type
The Grange Retirement Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. The Grange Retirement Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there were 2 registered managers in post. The first registered manager was on

maternity leave completing a phased return and the second 'maternity cover' registered manager de-registered the day after our inspection.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and the ambulance service. We also reviewed information received from Surrey Fire and Rescue. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We did however, review the previous PIR. We used all this information to plan our inspection.

During the inspection
We spoke with 5 people who used the service and 6 relatives about their experience of the care provided. We spoke with 19 members of staff including the regional manager, clinical lead, senior care workers, maintenance staff and administrative staff. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included 11 people's care records and multiple medication records. We looked at 5 staff files in relation to recruitment, staff supervision and training. A variety of records relating to the management of the service were reviewed, including policies, procedures, audits and fire safety.

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 our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely
At our last inspection we recommended that the provider consider current guidance on recording 'as and when required' medicines when these are given to people and take action to update their overall medicine management practice accordingly. At this inspection we found that the provider had not made enough improvement in this area.

- Medicines were not always managed appropriately to ensure safe administration. For example, an 'as and when required' medicine had a protocol in place with contradictory information. The 'dosage' section stated administration 'every 4 hours', however, the 'frequency' section stated 'every 6-8 hours'. There was a risk staff may misunderstand this contradictory guidance and administer the incorrect dosage.
- We found on other 'as and when required' medicines there was inaccurate information for staff. For example, one person had eye drops 'for affected eye(s)', however, there was no detail of which eye was affected or whether it was both. Another person had similar lack of detail for ear drops. Another person had 1 'as and when required' protocol in place for a medicine containing paracetamol as well as paracetamol prescribed four times a day. There was no warning of taking these together or what was a safe dosage to take together in a 24 hour period. This meant there was a risk of administering an incorrect dosage to this person.
- People at risk of seizures did not always have adequate information and advice for staff to follow in their medicine protocols. One person, who had been experiencing an increase in seizures, had 2 different emergency medicines in place, neither protocols stated which should be taken first. Neither protocol mentioned the other rescue medicine so there was no advice for staff to inform them which medicine to use first, if they could be used together or when to call 999. This left the person at risk of receiving unsafe care.
- Medical equipment was not always regularly checked and serviced. For example, a nebuliser (a device for producing a fine spray of liquid to support people to inhale medicine), was last noted to have been checked and passed a safety test in November 2019. Records confirmed the next service was due in November 2020, however, there was no record or confirmation the nebuliser had been serviced or passed any test after November 2019. At the time of the inspection no person required the nebuliser, however, safe practise would be to have regular tests of all equipment in the home to ensure safe treatment for people that may require it in the future.

Systems had not been established to safely manage medicines and ensure the safe administration for all people living in the home. Equipment used by the provider had not always been checked for its safety. This placed people at risk of harm. This was a breach of regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At our inspection we met the newly appointed clinical lead. They had been recruited to ensure full oversight of medicine management. They supported our inspection team throughout the inspection and were knowledgeable in their role and had positive ideas for what they wanted to implement at the home.
● We observed competent nursing staff administering medicine. They were knowledgeable and took their time to explain what medicine they were administering to people.
● We saw other examples of medicine protocols which had correct information detailed and a good amount of advice for staff.

Assessing risk, safety monitoring and management
● We spoke with 2 agency staff who were not always aware of people's individual risks. An agency nurse did not have all information of individual risks of the people on the floor they were in charge of. When asked for evidence of a handover from the previous shift they explained how they made handwritten notes, however, had misplaced these. When asked about a person who was receiving 1-2-1 care they did not know all of their risks.
● A second member of agency care staff who was supporting the same person with 1-2-1 again did not know all of the person's individual risks or how to manage them. Staff spoken with were only aware of a risk of falls, not the person's other health risks which included high risk of pressure sores and high blood pressure.
● A person at risk of falls and risks when mobilising did not always have care plans that effectively recorded these risks. Advice for staff contradicted other areas of their care plan. For example, a person was seen to be on the floor in a corridor of the home. Staff appeared unsure of how to support the person, the person's care plan detailed 4 different types of advice to support the person to mobilise. It was unclear what would be the correct guidance to follow to safely mobilise the person.
● A second person had restricted movement and they were described as 'bedbound' in their mobility care plan which detailed 2 staff required for any transfers. However, in their positive behaviour support plan when describing different moods it stated, '[Person's] walking pace will be very fast'. This contradicting information meant staff were at risk of not fully understanding the person's mobility and behaviour risks and needs.
● Fire safety risks were not always managed in line with guidance. We reviewed 9 days of fire 'log in' sheets, we saw staff did not always sign the fire log when attending shifts. This meant there was a risk of emergency services not knowing who was in the building in the case of an emergency.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service. This placed people at risk of harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We saw examples of other risks in care plans were managed well. These detailed clear advice and guidance for staff.
● The home had received a recent visit from Surrey Fire and Rescue where recommendations had been made to ensure the home was safe. We saw an action plan with various actions already completed in response to this.

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found overall the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met. There was an example of a covert medicine restriction that had not been applied for. However, the management team confirmed the process had been started immediately as soon as the omission had been identified by the inspection team.

Staffing and recruitment

● We did not always see examples where there were enough staff to meet people's needs during the night shift. For example, towards the end of the night shift we were trying to establish what staff were on duty and it was difficult to locate all staff in the building. When we were discussing the people that were receiving 24 hour 1-2-1 support, it was established a person who was at risk of falls and varying behaviour did not have their allocated 1-2-1 staff member with them. When we located the staff member they apologised and explained they had to support a colleague with another person's personal care. We will address the deployment of staff in the well-led section.

● When we reviewed staffing levels during the day shift we saw there were enough staff to meet people's needs. People and relatives provided mixed reviews on staffing levels. A person told us, "I am put to bed early, I don't want to go to bed at 6pm." However, another person said, "Oh yes, there is always enough staff whenever I need them." A relative said, "I've always thought there's enough staff." However, another relative said, "It just seems there isn't enough of them (staff) to complete all the jobs, they seem to rush a lot."

● Staff members also gave us mixed feedback. A staff member said, "It's true, we need more staff." A second member of staff was seen to be finishing late and they said, "[Staff member name] was sick last night, but we managed because the day shift helped. Yes, it was very busy but we had a floater (staff member supporting all floors of the home)." However, another staff member said, "I would say there is enough staff." We reviewed the dependency tool for the home and found there to be enough staff to meet people's needs according to the system. However, we were not always assured the deployment of these staff was always effective, for example, the person who was left alone when required 1-2-1 support.

● We saw the management team had followed safe recruitment processes. This included full reference checks, work history reviews and checks with the Disclosure and Barring Service (DBS). DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Preventing and controlling infection

● We saw minor infection control concerns, however, these were dealt with quickly by staff. For example, we saw a used face mask on the floor and this was picked up by staff within 5 minutes. We also noticed a pedal bin was broken, leaving staff no option other than to lift the lid with their hand causing an infection control risk. However, we were assured the management team were replacing this during our inspection.

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was supporting people living at the service to minimise the spread of infection.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was responding effectively to risks and signs of infection.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or

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

Visiting in care homes
Staff supported people to see relatives. Relatives were welcome in the home at any time and no appointment was needed. Where relatives wanted to take their loved ones out for the day or for lunch, where appropriate, a staff member would join them to ensure the person continued receiving support if needed.

Learning lessons when things go wrong
● There was an accidents and incidents process in place. We reviewed the tracker which detailed what action had been taken and advice for staff. We could not always identify meaningful updates in response to incidents, similar wording was used in the summary of action for staff box which appeared generic. For example, the wording, ''Continue to monitor behaviour and try to use distraction techniques" and "Give space and time to calm himself down" was used on 11 different entries and appeared to be a generic paragraph used for action taken and advice for staff. It failed to identify people's individual needs and any personalised actions that needed to be taken to ensure the best result for the person. We will address this in our well-led section.
● There was an accidents and incidents policy in place. Staff could refer to this if needed at any time, this offered advice and guidance to follow.

Systems and processes to safeguard people from the risk of abuse
● People told us they felt safe in the home and supported well by staff. A person said, "I feel very safe here."
● Staff received regular safeguarding training and they could tell us what action was required of them if they had any safeguarding concerns. A staff member said, "I had safeguarding training recently and it was really helpful to me – it enhanced my knowledge – it is good to know that I feel confident about (reporting things)."
● There was a safeguarding policy in place which offered advice and guidance for staff. Staff could access this at any time if they needed a reference. The management team were also keen to report all safeguarding concerns to the local authority and CQC in a timely way.

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 our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Managers and staff were not always clear about their role and regulatory requirements and did not always continually learn to improve care. There were a number of quality assurance audits completed, however, they were not always effective in identifying shortfalls. For example, a medicine audit, completed on 29 September 2023 confirmed there was a copy of the British National Formulary (BNF) available to staff. However, the audit advised staff to use online resources and 'previous copies (of the BNF) available for reference only'. We observed two out of date copies in the home. This meant if staff used these for reference, they may not follow the correct up to date guidance. The audit had failed to identify this.
- The medicines audit had not identified the concerns and issues we found and detailed in the safe section of this report. We noted a number of out of date blood vial tubes that pre-dated the last medicine audit, this meant during the last medicine audit they were out of date and this was not identified through the audit.
- Deployment of staffing teams had not always been successful in ensuring there were enough staff to meet people's needs. For example, a person was left without their 24-hour 1-2-1 staff member as they had to support another colleague.
- Care plan audits had not always been effective in identifying concerns. A member of the management team completed care plan audits and identified which care plans required review. They informed the registered manager and operations manager of the overdue care plans on 14 August 2023. This included the care plan of the person we had identified as having contradictory information around their mobility. The care plan had been reviewed after the audit and the review had failed to identify contradicting advice for staff for this person's mobility.
- Quality audits had not always identified a need for training oversight of agency staff or deployment throughout the home. An HR and training quality audit had been completed on 4 September 2023. There were 2 sections completed and ticked 'compliant', one section of the audit stated, "Agency/bank use is less than 20% on any shift to promote continuity of care." And the second stated "Where agency is used this is utilised across units equally to promote continuity of care." During our inspection, rotas reviewed demonstrated that agency staffing levels were above 20%. During the night shift our observations confirmed this. There was no mention in the audit of training oversight for agency staff members. Therefore, the audit undertaken on 4 September was either ineffective or the provider had failed to review this audit when there was a change in agency staffing levels.
- Initial checks relating to agency staff were not always comprehensive to detail the training they had received, this included training in moving and positioning. We reviewed 2 agency induction checklists which were substantial documents. In both induction checklists neither agency worker had signed to confirm they

understood key documents in the home, key equipment in the home, key policies, training to include moving and handling and these sections all remained blank. This had not been noticed or highlighted by any management oversight which meant it was unclear if the agency workers had received the correct training, and were aware of the provider's policies, systems and best equipment to use for people.

● A nurse had completed a shorter 'Day 1' checklist for the two agency staff members, where all boxes on the checklist had been marked as complete. It was unclear why items within this checklist, including training, had been marked as completed when the induction checklists highlighted above had identified the agency staff had not completed all areas including training confirmation. This meant it was not clear whether the training had been completed or whether the nurse had full oversight before completing these checklists.

● We reviewed a different agency staff member's mandatory training list, which recorded that they had not undertaken moving and handling training. This same agency staff member had a certificate of 'online training' which included moving and handling. This meant there was insufficient or ineffective oversight of the training completed. All permanent staff received face to face moving and handling training to ensure full understanding and safe practice. However, the provider had not ensured the same level of training was being provided to agency staff employed by the service.

● We saw on the HR and training audit that permanent staff received supervision and appraisals, however, there was no evidence of competency checks completed by the management team. We were informed a member of staff's competency had been checked by the deputy manager and concerns were raised about their ability regarding moving and handling. We were shown a copy of their refresher training, however there was no documented evidence of this competency check completed or investigation in to concerns around their moving and handling capability. The operations manager immediately added a competency check addition to their supervision and appraisal online system during our inspection and assured us this would begin to be rolled out.

● Some trackers and oversight audits of systems in place were not always thoughtfully completed and appeared generic. For example, there had been a number of person on person assaults in the home since our last inspection. We found on the accident and incident tracker the majority of these incidents had similar worded guidance for staff to follow such as, "Staff to continue to monitor behaviour and use distraction techniques" and, "Try to maintain safety at all times." These recorded summary actions lacked personalised guidance for staff to follow, for example, there was no mention of individual behaviours, no record of review of positive behavioural support plans, no recorded evidence that different distraction techniques that worked for the individuals had been considered.

Systems had not been established to have effective oversight of the quality of the service. This placed people at risk of harm. This was a breach of regulation 17(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The first registered manager was away on long term leave and was completing a phased return, the second registered manager de-registered the day after our inspection. The operations manager was supporting the home as well as a newly appointed clinical lead. There was management team presence to support us on our inspection and the home in general.

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

● The service had a positive and inclusive culture where people were involved and engaged with the running of the service. People and their relatives told us they received personalised care. A relative said, "The staff are brilliant and really friendly. They all know my name every time I go in there I am greeted with a smile and

they are keen to know everything about [person]."
● Care plans detailed life histories of people so staff were aware of what was important to people and they could deliver person-centred care.
● People were involved in the service. There were meetings for people and staff and relatives were asked for feedback.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● There was a clear duty of candour process in place. Relatives, where appropriate, were made aware and information was shared by staff to ensure accidents and incident details were relayed.
● The provider had submitted all safeguarding concerns to the local authority and stated they were keen to work with the local authority to ensure the best results for the people involved.
● CQC had been notified of significant events in the service when appropriate and in line with guidance and the law.

Working in partnership with others
● Staff and management worked in partnership with others. We saw evidence of referrals made in care plans in a timely way and information shared with health professionals to ensure effective care.
● The provider was working with the local authority investigating and managing recent safeguarding concerns. The local authority quality team had completed recent visits to the home and been accommodated by the provider.
● Following the inspection, the management team supplied all relevant documents requested in a timely way.