

C.T.C.H. Limited

The Grange

Inspection report

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Ratings

Overall rating for this service	Good ●
Is the service safe?	Good ●
Is the service effective?	Good ●
Is the service caring?	Good ●
Is the service responsive?	Requires Improvement ●
Is the service well-led?	Good ●

Summary of findings

Overall summary

This was an unannounced inspection which took place over two days on the 2 and 3 February 2017. The Grange provides nursing and personal care for up to 65 people. Accommodation can be provided for people who wish to live together. People have access to lounges and dining areas on each floor, en-suite bedrooms, and assisted bathrooms. An internal courtyard provides an outdoor seating area and is accessible to all people. At the time of our inspection 46 people were living there. There were 18 people who had been assessed as needing nursing support.

There was no registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. Two managers had been appointed who were applying to be jointly registered with CQC as registered managers.

At our last inspection on 6 June 2016 this service was rated as requires improvement overall. We asked the provider to take action to make improvements to:

- ensuring people received their medicines safely and in line with the prescriber's instructions
- ensuring equipment was used correctly and safely
- establishing and sustaining processes to assess, monitor and improve the quality and safety of the premises and we found all these actions had been met.

We also asked the provider to take action to make improvements to:

- the accuracy of people's care records, ensuring an accurate, complete and contemporaneous record had been kept and we found although significant progress had been made by introducing new care records and methods of working. However, more work needed to be done to ensure these improvements were embedded and sustained.

There were systems in place to prevent and control infections. Although we found one issue we have therefore made a recommendation about infection control measures and the cleanliness of some equipment.

People were treated with dignity and respect and felt safe living in the home. Staff understood their needs well and had positive relationships with them. Staff were kind, caring and chatted amiably with people. They gently reassured people when needed, attending to their health and well-being and discreetly helped them with their individual needs. People's care records had been reviewed and amended when there were changes in their physical or mental health. Close working with health care professionals ensured their health care needs were responded to in a timely fashion. People's nutritional needs were catered for offering fortified or soft diets if needed and a menu appropriate for people living with diabetes. People had access to a range of meaningful activities which reflected their interests and choices such as games, poetry and

newspaper reading, knitting, quizzes and music. They also had access to therapeutic activities such as hand massage, fitness, music and reminiscence. People who wished to were supported to access places of worship and communion.

People were supported by staff who had access to training to equip them with the skills and knowledge they needed to provide people's care. Staff spoke positively about the individual support they received to develop in their roles. Staff recruitment procedures were robust and there were enough staff employed to meet people's needs. Changes to the working practices of the individual staff teams had improved people's experience of care. The manager strove to implement a "whole home approach" whereby all staff had a responsibility to provide personalised care and to take time to be with people. A hostess service had relieved care staff at busy times in the mornings and evenings when people needed help with personal care. All staff took their part in delivering activities until the new activities co-ordinator was in post.

Significant changes had taken place to improve people's experiences of their care and support. This was driven by a review of quality assurance processes and making sure any action plans had been completed to verify when improvements had been implemented. These included introducing care rounding whereby a senior member of staff monitored and supervised all aspects of care and support, new care planning processes, a new activities schedule and improved communication between staff. Future improvements were planned for the continued refurbishment of the home, additional activities and embedding the new care planning system. The manager had ensured people, staff and relatives were kept informed of any changes and feedback from them had been positive. This included the way in which the manager responded to complaints and their openness and accessibility.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good 

The service was safe. People were mostly protected by infection control procedures. Routine cleaning of some equipment was not taking place but steps had been taken to address this.

People's medicines were safely administered and managed. Strategies were in place to monitor and improve medicines administration.

People's rights were upheld and staff had a good understanding of safeguarding procedures.

People were protected against the risks of harm. Action had been taken in response to accidents and incidents to minimise further risks.

People benefited from staff who had been thoroughly recruited with the necessary checks being completed prior to appointment. There were sufficient staff to meet people's needs.

Is the service effective?

Good 

The service was effective. People benefited from staff who felt supported in their roles and were able to access a range of training to maintain their knowledge and skills.

People's consent was sought in line with the essence of the Mental Capacity Act 2005. People deprived of their liberty had the appropriate authorisations in place.

People's health and well-being was monitored and promoted by close working with social and health care professionals. Their dietary needs were closely monitored and their individual requirements were catered for.

Is the service caring?

Good 

The service was caring. People were treated with kindness, reassurance and care. Staff understood people well and had positive relationships with people.

People had access to information about the service they received. They were involved in the planning of their care.

People were treated with dignity and respect. They were encouraged to do as much as they could for themselves.

Is the service responsive?

The service was not as responsive as it could be. People's changing care and support needs were being responded to and most of their care records had been updated to reflect these. New care planning systems had been introduced which were being monitored and amended during implementation. However these needed to be embedded.

People had access to meaningful activities and leisure pursuits. These included trips out, group and individual activities.

People were confident any concerns or issues would be looked into and addressed.

Requires Improvement ●

Is the service well-led?

The service was well-led. The manager had promoted an open culture, actively involving people, relatives and staff in the improvements planned to develop the service.

The home was well managed, the quality of the service was monitored closely, staff were supported and encouraged to share and understand the changes taking place.

The manager and staff strove to ensure quality standards improved and people's experience of their care and support was enriched.

Good ●

The Grange

Detailed findings

Background to this inspection

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

The inspection took place on 2 and 3 February 2017 and was unannounced. One inspector and a specialist advisor carried out this inspection. The specialist advisor's area of expertise was nursing and tissue viability (wound prevention and management of the skin). We reviewed information we have about the service including notifications. A notification is a report about important events which the service is required to send us by law.

As part of this inspection we spoke with six people using the service and four visitors. We spoke with the nominated individual and manager, the second manager, the training manager, the cook, three nurses, 12 care staff, three housekeepers and the maintenance person. We joined staff at a handover between shifts. We reviewed the care records for eight people including their medicines records. We also looked at the recruitment records for three staff, staff training records, complaints, accident and incident records and quality assurance systems. We observed the care and support being provided to people. We used the Short Observational Framework (SOFI) for inspection. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We asked three health and social care professionals for feedback about the service.

Is the service safe?

Our findings

At our inspection of 6 June 2016 we found people had not been protected against the risks associated with unsafe or unsuitable equipment because it had not been used safely or correctly. The provider told us they would address these issues and had put an action plan in place to describe how this would be achieved.

At our inspection of 2 February 2017 we found the provider had taken action to address these issues. New checks had been introduced to be carried out when staff were administering medicines to people in their rooms to ensure any bed rails were at the correct height and air mattresses had been set to the correct inflation pressure. We discussed with the managers the monitoring of call bells and checking the accuracy of blood pressure monitors. During the inspection staff raised concerns about two call bells which did not appear to be working and these were fixed straight away. New equipment audits had been introduced which were monitored by the managers.

People were mostly protected against the risks of acquiring infections. However there were some areas for improvement. However we found hoists, wheelchairs, the medicine trolleys and a sliding sheet needed cleaning. The managers said certain staff were responsible for cleaning these and they would follow this up. The domestic staff had cleaning schedules for day to day cleaning as well as schedules for deep cleaning such as carpets. There were plans to replace carpets in corridors which had become stained and stair carpets were due to be replaced. An annual report had been produced in line with the Department of Health's code of practice for the prevention and control of infections. The appropriate authorities had been informed about an outbreak of diarrhoea and sickness and action had been taken to control and reduce the effects of the outbreak. Audits were carried out each month and action plans confirmed what had been done to address any issues. For example, ensuring water temperatures were checked in bathrooms and replacing bins without lids.

We recommend that the service further considers current guidance on the prevention and control of infections.

At our inspection of 6 June 2016 we found people had been put at risk by not having their medicines (creams) administered accurately and in accordance with the prescriber's instructions. The provider told us they would address these issues and had put an action plan in place to describe how this would be achieved.

At our inspection of 2 February 2017 we found the provider had taken action to address these issues. Medication administration charts confirmed creams had been administered when needed. Staff confirmed they had received training in the administration of creams and further training was planned for new staff. Each person had creams administered from their own individual pot. Creams which were no longer in use needed to be disposed of and this was done before the end of our inspection. Monthly audits were carried out to make sure creams were still in date and that appropriate levels of stock were being maintained. People's medicines administration records (MAR) had been completed satisfactorily and handwritten entries were countersigned. Staff signed the MAR's once people had taken their medicines. The

temperatures had been recorded for fridges. The manager confirmed the stock of medicines had been strictly monitored.

People's medicines were administered at times to suit them. We observed nurses and care staff administering medicines. Observation of poor practice by one member of staff was seen and reported to the managers who took immediate action to address this. New medicines policies and procedures clearly stated how medicines should be managed and administered. Staff had been asked to sign these once they had read them. The manager had reminded a few staff they still needed to comply with this. Staff had received medicines training and new competency assessments were being carried out to ensure they were competent in the management of medicines. Medicines audits were also carried out by staff and monitored by the managers to make sure any actions had been completed. The manager said they had worked closely with a local pharmacy and the community pharmacist from a local surgery to review medicines procedures within the home.

People's medicines were being reviewed with their GP to make sure they were prescribed only those medicines they needed. Over the counter medicines had been approved by people's GP's and guidance was in place for any medicine to be taken as needed. Medicines which needed additional secure storage were managed and administered safely.

People's rights were upheld. One person commented, "I am safe". Relatives told us, "I am reassured and have peace of mind, she is safe here" and "We are reassured because she is safe and sound." Staff had a good understanding of safeguarding and their responsibilities to identify, record and raise any concerns they might have about people. For example, any unexplained bruising was noted on body maps and in daily records and raised with senior staff. Staff had access to local safeguarding procedures and were confident managers would take the appropriate action in response to any concerns they might raise. The manager had raised safeguarding alerts when needed and informed the appropriate authorities including safeguarding teams, the Police and CQC. Investigations had taken place and when necessary disciplinary action had been taken.

People had risk assessments in place to minimise any hazards. Accident and incident records documented any falls, trips or near misses. These were closely monitored to make sure the necessary action had been taken for people who had recurring accidents or incidents. For example, one person had been provided with a personal alarm which triggered if they tried to leave the building. Another person had bed rails fitted to their bed after a fall. Systems were in place for emergencies. An emergency file kept in reception provided information about emergency services and out of normal hours management support. Each person had an individual personal evacuation plan in place to describe how to help them leave the building in an emergency.

People were supported by enough staff with the right skills and knowledge to meet their needs. For the first time in 10 years a nursing team had been employed and the use of agency staff had significantly reduced. Staff levels had been maintained despite a drop in the numbers of people living there. A dependency tool was used to assess the levels of nursing and residential care staff. Staff said there were enough staff to meet people's needs and complemented the managers for changes they had made to the duties of staff teams. Domestic staff alternated their responsibilities each day to include providing a hostess service delivering meals and drinks and cleaning tasks. This had reduced the demands on care staff at peak times of the day. The result was call bells were answered more responsively. This was commented on by people living in the home and their relatives who said, "I don't have to wait long for the bell to be answered" and "Call bell answering has greatly improved." Senior staff had been appointed to carry out "care rounding" whereby they monitored and supervised the whole home, supporting staff when needed and ensuring duties and

checks had been carried out.

People benefited from staff who had been thoroughly recruited. The responsibility for ensuring all the checks had taken place fell to the training manager. Checklists confirmed all the information required had been obtained prior to appointment for example a full employment history, reasons for leaving former employment and a satisfactory Disclosure and Barring Service check. A DBS check lists spent and unspent convictions, cautions, reprimands, plus any additional information held locally by police forces that is reasonably considered relevant to the post applied for. New staff completed a corporate induction over three days and shadowed existing staff until assessed as competent.

Is the service effective?

Our findings

People were supported by staff who had access to training to develop the skills they needed. A new system had been put in place to monitor the training needs of staff working for the provider. The training manager kept a schedule of the training needs of all staff working at The Grange and each month reminded them when their refresher training was due. It was their responsibility to undertake this training and to confirm when completed. The training manager followed up any training not carried out with individual letters and support meetings with staff. They explained how they were planning more face to face training for staff from external providers and from staff who had completed training to deliver for example, safeguarding or moving and handling training. This training could focus on the people being supported and their individual needs. Staff confirmed they had access to training considered mandatory such as first aid, infection control and fire. They also completed training specific to people's needs such as dementia awareness, end of life and learning disability. Additional training had been sought in tissue viability awareness and the 5 Step Approach to personalised care planning for behaviours that challenge in Dementia. These were both ongoing. The manager said nurses would be evidencing their ongoing professional development for revalidation and would be supported through this. Staff had been appointed to take the lead responsibility for key areas within the home. For example, tissue viability and infection control. Training was to be provided if needed. Health care professionals commented staff had really engaged with them and wanted to learn.

People benefited from staff who had individual meetings arranged with managers to discuss their roles, responsibilities and training needs. Staff said they had met with a manager who they found "so supportive" and "has helped me to reflect and change for the better". Staff spoke positively about the support and encouragement they had received during a time of change. They said they felt "nervous" and "anxious" when the new managers were appointed but had found the changes were "positive" and "for the better". Schedules were maintained for individual meetings, annual appraisals and observations of practice.

People made choices about their day to day lives. Staff understood about people's capacity to consent to their care and support. Staff were prompted in people's care plans to "allow her to make choices for herself; give appropriate time to respond". Staff provided the opportunity for people to make decisions about what to eat, drink, and wear and how to spend their time. They recognised people's capacity to make decisions might be affected by their health and well-being. When people refused help or support, they were observed checking back with people again to make sure they had not changed their minds. People's ability to make decisions had been assessed in line with the Mental Capacity Act 2005 (MCA). The 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's records provided evidence when they had appointed lasting powers of attorney to represent them in either health and welfare or finances when they were unable to make decisions for themselves.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be

deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. People deprived of their liberty or with restrictions in place had the necessary authorisations agreed by the supervisory body and 16 further applications had been submitted which were awaiting an outcome. Conditions attached to DoLS had been complied with, for instance making a referral to a dietician and to the community learning disability team for advice and support. An urgent authorisation had been submitted and agreed which the manager said was due to be reviewed.

People were supported to eat and drink. People's care plans clearly highlighted when they had been assessed as at a high risk of losing weight. A malnutrition screening tool had been used to assess and monitor people's risks. If needed people's weights were recorded every two weeks or monthly to monitor any further weight loss or gain. The cook confirmed they fortified meals with cream, milk powder and butter. They were aware of people's individual dietary requirements and provided soft and pureed meals for people at risk of choking and meals suitable for people living with diabetes. People chose where to eat their meals either in the dining rooms or their own rooms. If support was needed this was provided. Staff chatted amiably with people whilst helping them, supporting people at their own pace and offering encouragement to eat and drink. A person had been referred to a dietician for advice about losing weight. Food allergies information was available if needed in line with the Foods Standards Agency guidance.

People had access to drinks and snacks around the home to help themselves. New kitchen and drink making facilities had been provided on each floor so that visitors could help themselves to drinks but also prepare snacks with people they were visiting if they wished. People told us they enjoyed their meals and liked afternoon tea as well as special events. They said, "The food is lovely" and "Lunch is lovely." Relatives commented they had been able to join people for Christmas lunch and had really enjoyed the food. They said they had been particularly impressed with the waitress service and had not realised staff served vegetables to people individually at the table. The cook said they had tried different ways of delivering breakfast and were about to trial using a hot trolley in each dining room so hot food could be served promptly to people if this was their choice. In response to a comment from one person who said they really liked poached eggs but did they have to have them every day, staff had been prompted to check each day what people's preferences were.

People's health and well-being was closely monitored. Staff said they raised concerns immediately if they noticed any changes and the relevant health care professionals were contacted for advice or to visit people. People living with diabetes had access to regular blood tests, the optician and chiropodist. People who had tissue viability concerns were referred promptly to tissue viability nurses and the appropriate equipment and treatment was provided. Staff said they had three GP surgeries who were involved with people and two of these had regular visits scheduled every two weeks. This provided the opportunity for GP's to review people's medicines and to maintain an overview of people's general health. Records had been kept of all contact with social and health care professionals. The manager described how they had started a weekly clinic with a community psychiatric nurse (CPN). This had provided the opportunity for staff to discuss people's mental health issues and to introduce monitoring tools to assess why and when people became anxious.

Is the service caring?

Our findings

People were treated with kindness by staff who were conscientious and knew people well. People said, "Carers are very good" and "Staff are nice." Relatives commented, "Really good staff, brilliant care" and "Staff are great, they have looked after mum." One relative reflected, "She is really fond of one member of staff and looks forward to her being on duty". Staff told us, "I really love working here" and "Residents are happy and relatives are happy, it's really good." People were observed having chats with staff, whether domestics, the care staff or nurses. When people were anxious or upset staff responded quickly, gently supporting them or encouraging them to help them become calmer. A person was unresponsive and the member of staff showed concern and was gentle and kind in their approach to them. People were greeted individually by the cook and staff as they entered the dining room for lunch. The manager said looking after people was a whole home approach and everyone had a responsibility to take time to be with people. A number of people enjoyed sitting together at meal times and tables had been joined together to make meal times a sociable event. One person commented, "We like to sit together, like a family."

People's disabilities and their religious, spiritual and cultural needs had been noted in their care plans. One person said they attended communion in the home. Another person went to a local place of worship and was visited by people they had met there. Adjustments had been made to the environment to promote people's independence around their home. For example, grab rails and ramps. For people living with dementia some signs had been displayed to indicate the purpose of rooms. People's preferences for the gender of care staff providing their personal care was highlighted and wherever possible respected. People's right to confidentiality was respected with personal information being kept securely. People were able to meet with family and friends in private if they wished. Staff had completed equality and diversity training and the manager confirmed the needs of LGBT (Lesbian, Gay, Bisexual and Transgender) people would be considered upon admission.

People's backgrounds and personal histories had been discussed with them. A profile had been produced giving an overview of their lifestyles, likes, dislikes and routines important to them. A person was distressed and was observed being reassured by a member of staff who did not have responsibility for their care. They explained they knew the person well who appeared to be more settled after the interaction. Other staff without caring responsibilities were heard chatting with people, sharing a joke and friendly banter. People's ability to communicate was described in their care records. Pictorial communication books had been produced to enable people unable to express themselves verbally to communicate through pictures. Another person had been given a pen which when pointed at items on a page spoke for them. Staff said this had "opened up a new world" for the person.

People had access to information about the service they received in their rooms and displayed around the home. They had summaries of their care plans in their rooms. People and relatives said they were involved in planning their care. People had signed their records where able. A newsletter had been produced to give people information about new people moving into the home, new staff and other changes which were taking place. People were observed reading the activities schedule for February which had just been produced. This was provided in an easy to read format using pictures and symbols. The manager was aware

of the need to make information available in accessible formats. Feedback from surveys and the resident's council were provided around the home. People had information about access to advocacy services.

People were treated with dignity and respect. Staff spoke respectfully about people and were discreet when asking them if they needed help or support. A member of staff described how she would sit with people at the end of their life to reassure them someone was there. They also told us they checked with people before they left them to make sure there was nothing else they could do for them. We observed a person asking for help to put on some clothing and staff immediately closed the door. Another person wished to have help with some personal equipment and was taken to a nearby toilet so this could be done in privacy. People were encouraged to be as independent as possible. Their care records clearly detailed what they could do for themselves and what they needed help with. A person told us they liked to pour out the drinks at lunch time and to help other people generally. People were visited by relatives at times to suit them. Some relatives chose to stay through lunch but others left so they would not distract the person during their meal.

Is the service responsive?

Our findings

At our inspection of 6 June 2016 we found an accurate, complete and contemporaneous record had not been kept in respect of each person's care records to reflect the care they were receiving. The provider told us they would address these issues and had put an action plan in place to describe how this would be achieved.

At our inspection of 2 February 2017 we found the provider had taken action to address these issues. New care plans had been put in place with the involvement of people and as many of their relatives who wished to be involved. Staff spoke positively about the new care plans saying they were much easier to work with. They now had direct responsibility for writing care records and the manager said they proudly took ownership of this. In order to make sure people's care records were being monitored and reviewed each day a resident was selected for a complete review of their care. This involved a review of their care records with them. In addition a new summary sheet had been provided to give an overview of people's care needs. This was kept in their rooms. Care records had been adjusted to reflect people's changing needs but some of the summary sheets had not been updated in line with people's care records. The managers said this had been an oversight and summaries were updated and amended during the inspection. A monitoring checklist used by senior staff as part of care rounding was amended during the inspection to include checking summary sheets to ensure they had been reviewed alongside care records. Care staff spoken with said they preferred to refer to the care plans which had greater detail and also contained the daily entries as well as monthly reviews. We found there were still some inaccuracies in some care plans but the manager said these would have been picked up during care plan audits and dealt with. These had not impacted on the care being provided to people.

The action to address the shortfalls of the inspection of 6 June 2016 need to be embedded and sustained to ensure people's care records reflect their current individualised needs taking into account changes to their health and wellbeing.

People's changing needs were responded to quickly and involved working closely with social and health care professionals. For example, a person had an increasing number of falls and had been checked over by their GP for any physical health concerns and/or changes in their mental health. As the majority of falls had been at night staff tried improving the lighting in their en-suite bathroom so they could see their way to the toilet. A referral had also been made for an alarm to alert staff if they had a fall in their room. Staff also made sure they were wearing appropriate footwear. Another person fell out of bed although a bed which lowered to the floor had been provided with a crash mat. They had no history of falls of this nature. The manager discussed with them how they could keep them safe and they agreed they would like to have bed rails fitted. Relatives confirmed staff kept in touch with them, "Staff ring if there is a change, they keep us informed" and "They phone up if there is a problem." Health care professionals said staff had worked with them to implement any suggestions or recommendations they had made which had resulted in positive benefits for people living in the home.

People at risk of developing pressure ulcers had the appropriate care plans and risk assessments in place.

Staff reported any changes in the condition of people's skin and kept records verifying the area of concern and what action had been taken. For instance, applying creams, ensuring repositioning was taking place or contacting community nurses and the tissue viability nurse for support. No one had a tissue viability (skin care) concern at the time of our inspection although people were being monitored where there was any pinkness to their skin. The manager said they were currently using two tools to assess the risks of tissue viability but were gradually moving over to use one tool, as old care records were replaced with the new version. A new monitoring tool was introduced on the first day of our inspection to replace several monitoring tools to record for example repositioning of people, food and fluid intake and delivery of personal care. Not all staff had received training on how to use this tool. The tool was being reviewed and amended during its implementation and guidance had been provided to staff by the second day of our inspection. Staff were observed personalising the tool to reflect the needs of each person so not all sections needed to be completed.

People had access to a range of meaningful activities. This was the responsibility of all staff to help deliver. However there were plans to appoint an activities co-ordinator. The cook described how they had been involved giving a smoothies demonstration and cake and biscuit decorating. Staff encouraged people to take part in group and individual activities. These ranged from quizzes, flower arranging, armchair exercises to hand massages, manicures and poetry and newspaper reading. Activities provided by external providers included a fitness group and music. Reminiscence talks and rummage boxes were provided as stimulation for people living with dementia. Outings to places of interest had also been arranged and people had enjoyed a trip to a local market. A village style shop had been opened so people could purchase items which they asked to include chocolate and biscuits. People living in the home helped to run this venture. A person told us, "There are lots of activities, like fitness." A relative commented people had been to a pantomime and held special events such as for the Queen's birthday celebrations. One person said they liked to keep fit by walking to the nearby shops.

People said they would talk with staff or the manager if they had any concerns. Relatives said some issues had been raised with the manager and a meeting had been arranged to talk through these. Other relatives said, "We have no complaints, if I had any I would talk with the manager and she would chase up" and "I have never had a problem which wasn't dealt with." People, relatives and staff said any issues or concerns were listened to and action was taken straight away to address them. There had been nine complaints raised in the last 12 months and all had been dealt with. Action had been taken to address the issues raised for example, call bells not being answered quickly enough, access to drinks for people, lack of information for people and their relatives. In response, the duties of staff had been rearranged and call bell answering had improved. We observed people with access to drinks in their rooms and where they were sitting as well as from the new drinks stations around the home. A newsletter had been produced sharing information as well as setting up a resident's council and meetings for relatives.

Is the service well-led?

Our findings

At our inspection of 6 June 2016 we found robust systems or processes to assess, monitor and improve the quality and safety of the service had not been established. The provider told us they would address this and had put an action plan in place to describe how this would be achieved.

At our inspection of 2 February 2017 we found the provider had taken action to address these issues. Quality assurance systems had been reviewed and when needed new systems put in place. The manager had developed an action plan for improvements after their initial assessment of the home and this had been developed over time. The action plan was a work in progress and evidenced when improvements had been made such as introducing new care plan formats and reviewing the duties of staff to ensure more efficient ways of working. When actions had not been met by their initial targets this was identified and new dates identified. The manager was accountable to the board of trustees who monitored the improvements and quality of the service. Staff said the changes which had been made were "for the better" and "it feels like we have moved to a better place". Other improvements included changing the times of handovers to include nursing and care staff together and the use of walkie talkies (mobile communication devices) to improve communication. The manager said they had block booked agency staff to ensure consistency and continuity of care and they had introduced care rounding to improve the monitoring of the quality of care and supervision of staff.

Other audit tools continued to be used to monitor and assess the quality of care records, medicines administration, health and safety systems, staff training and accidents and incidents. The manager planned to use a quality assurance tool which reflected CQC's five key questions. They recognised there was still work to do to introduce a "whole home approach" to care whereby everyone was involved in all aspects of the home. They had successfully introduced some new improvements which had benefited people. For example, care staff writing care plans, domestics providing a hostess service and all staff being "released time to care" and to be there for people.

The manager had been in post just over six months and was supported by the deputy manager who had been promoted to a manager role. They were both in the process of applying to become registered with CQC. Staff liked having two managers who they found "extremely supportive, approachable and focussed on people's needs". A nursing team was in place and the home was almost fully staffed with much less use of agency staff. Staff said they "felt well supported" and "the manager has helped us to reflect and change for the better". They told us they found the manager to be "brilliant", "amazing" and "very hands on, she works alongside us and I can go to her with anything". The manager said debriefs were held with staff after incidents or accidents supporting them when needed. Health care professionals had noted a significant improvement in morale in the home. Relatives said, "We chose The Grange based on previous experience, it's very good" and "They provide brilliant care."

The manager was aware of their responsibilities with respect to submitting notifications to the Care Quality Commission. Statutory notifications had been submitted when necessary. The previous inspection rating had been displayed in home and on the web-site. The manager was responsive to feedback given during the

inspection and immediately took action to address any issues raised. The manager described the challenges of "change management" and acknowledged there was still work to be done but feedback so far had been positive. Plans for future improvements included appointing an activities co-ordinator, developing facilities to promote active participation around the home and on going refurbishment of the environment.

People's views were sought in a variety of ways. A resident's council had been set up and at the first meeting there was an exchange of information about planned changes in the home. People had talked about having new activities. There were plans to set up a games room as well as an allotment and potting shed. Issues about lost laundry had been raised by relatives and in response each month a lost property event was held where relatives could look through items without labels to ascertain ownership. People also talked with staff each month about their care needs. Managers, during observations of staff supporting people, asked them for feedback about the member of staff. This included such comments as "happy" and "very happy". Annual surveys had been sent out to people in December 2016 and an action plan was displayed in the reception area describing changes to the laundry, producing a newsletter to improve communication and improving the answering of call bells. Suggestion books had been displayed around the home for people and visitors to leave comments whether concerns or compliments. A relatives meeting had also been held and they said they were happy to hold these every few months.

People benefited from links which had been made with their local community. The manager had made contact with a nurse practitioner and a community pharmacist from local surgeries to provide guidance and advice. The manager and a nurse planned to attend a new tissue viability forum being set up locally to learn about new wound care management. They also attended a local care provider's forum and dementia link workers were members of a dementia network within CTCH and locally. Local schools had provided entertainment and joined people in activities at The Grange and people had also visited local schools for carol concerts. People were engaged with local places of worship and also accessed local shops. The managers maintained their own professional development as nurses and for revalidation. The manager had been awarded an "Aspiring Leadership" award in 2016 by a local care provider's organisation. The home had been awarded the top score of five stars by the Food Standards Agency in 2016 for its food service delivery.