Grange Lea Rest Home

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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?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on 31 August 2016 and 02 September 2016 and was unannounced. The service was last inspected on 29 December 2014 and no breaches in regulations were found.

Grange Lea Rest Home is registered to provide accommodation and personal care for up to 20 older people. Refurbishment of the premises resulting in larger rooms means that the service can now accommodate up to 19 people. There were 17 people using the service during our inspection.

The provider is a husband and wife partnership with one of them registered as the manager of the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People and their relatives told us the service was safe. There were safeguarding policies and procedures in place, and staff were aware of the action to take if abuse or neglect were suspected. Refresher training in the safeguarding of vulnerable adults was being arranged. Risk assessments and regular checks on the safety of the building, premises and equipment were carried out. Individual risks to people were assessed, and measures put in place to mitigate these risks. Accidents and incidents were recorded and monitored by the provider to identify patterns or trends.

Suitable numbers of staff were deployed during our inspection and recruitment procedures ensured that the suitability of staff to work with vulnerable people was checked prior to appointment. Safe procedures were in place for the ordering, receipt, administration storage and disposal of medicines.

People were supported with eating and drinking. The nutritional needs of people were assessed and action was taken in the event of concerns related to dietary intake. People were offered a choice of meals and alternatives were readily available. Likes, dislikes and special diets were accommodated.

Staff received regular training, supervision and appraisals. Where there were gaps in refresher training, this had been identified and planned. People told us staff were knowledgeable and ensured their physical health and wellbeing needs were met. Staff had received training related to Deprivation of Liberty Safeguards and the Mental Capacity Act, and refresher training was planned. Capacity assessments had been carried out and people had signed consent forms to agree to care and treatment plans in place, and to reside in the home. Where people lacked capacity, applications had been made to the local authority to deprive people of their liberty in line with legal requirements.

All interactions we observed between staff and people were caring and respectful. The privacy and dignity of people was respected, and we received positive feedback about the care provided from people, relatives and visiting professionals. A number of relatives commented positively about the end of life care their family

members received and praised the staff and provider highly for the quality of care provided.

Person centred care plans were in place;, these were up to date and reviewed on a regular basis. Some care plans in place to meet the psychological needs of people required more details, and this had been added by the second day of the inspection. A range of activities were available and a volunteer visited the service during our inspection to spend time with people which they told us they enjoyed. A complaints procedure was in place but no formal complaints had been received in the last 12 months. People and relatives told us they had not needed to complain and that any minor concerns were dealt with swiftly and proactively by the registered manager.

People relatives and visiting professionals spoke highly of the provider and registered manager who they found helpful, caring and professional. Regular audits on the safety of the service, care delivered, and records were carried out. Feedback was sought from people, relatives and staff via an annual survey. Staff said they felt well supported but they would like more regular staff meetings. We spoke to the provider about this. The culture of the service was homely and inviting and several people and relatives told us that the home enjoyed an excellent reputation locally which is why they had chosen the service. There were strong links with the community including the local church.

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.

Safe recruitment procedures were followed which meant people were protected from abuse.

Risks to people were assessed and reviewed to ensure the safety and comfort of people living in the service.

Medicines were managed safely and a procedure was in place to ensure the competency of staff administering medicines.

Is the service effective?

Good

The service was effective.

People's capacity levels had been considered and the Mental Capacity Act (2005) (MCA) was applied appropriately.

Staff were skilled and experienced and had received regular training and supervision.

People were supported with eating and drinking and to maintain a balanced diet.

Is the service caring?

Good

The service was caring.

We saw that staff spoke kindly with people and treated them with respect.

Dignity was preserved and personal care was offered discreetly and sensitively.

We received positive feedback about care provided to a person at the end of their life.

Is the service responsive?

Good

The service was responsive.

Person centred care plans were in place and these were reviewed and updated regularly.

People were supported to take part in activities and a safe outdoor area was available.

A complaints procedure was in place but there had been no formal complaints received by the service. People and relatives told us they were happy with the service provided.

Is the service well-led?

Good

The service was well led.

A registered manager was in post. The manager was supported by two officers in charge. People staff and visitors told us the managers were helpful and approachable.

Regular audits to monitor the quality and safety of the service were carried out.

Feedback systems were in place to obtain people's views such as surveys and meetings.

Grange Lea Rest Home

Detailed findings

Background to this inspection

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

The inspection was carried out on 31 August and 02 September 2016 and was unannounced. It was carried out by one inspector and a specialist advisor. A specialist advisor is a person employed by the Care Quality Commission to support inspectors during an inspection and have specialist knowledge in a certain area. The specialist advisor on this team had a background of working with older people with mental health related conditions and was a qualified nurse.

Prior to the inspection we consulted the Northumberland local authority safeguarding team and contract monitoring department and we used the information they provided when planning our inspection. We also reviewed information we held about the service including any statutory notifications that the provider had sent us. Notifications are made to us by providers in line with their obligations under the Care Quality Commission (Registration) Regulations 2009. These are records of incidents that have occurred within the service or other matters that the provider is legally obliged to inform us of.

As part of the inspection we spoke with eight people who used the service, seven relatives, a GP, a nurse, a volunteer and a community care worker who visited the service on a regular basis.

On this occasion, we asked for a Provider Information Return (PIR) prior to the inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. All of this information informed our planning of the inspection.

Good

Is the service safe?

Our findings

People told us they felt safe at Grange Lea Rest Home. One person told us, "I feel much safer and not so lonely here." A relative told us, "I am happy that [name of relative] is safe and well looked after."

Staff records confirmed they had received training in the safeguarding of vulnerable adults and refresher training was planned. A policy and procedure was in place and staff told us they knew what to do if neglect or abuse were suspected. One staff member told us, "I would report it to the owners and to the local authority if necessary. There are numbers available that we could refer to." A safeguarding log was maintained and contained only one occasion where advice had been sought regarding a possible safeguarding issue. This demonstrated that the provider sought advice to ensure that the safety of vulnerable people in their care was maintained.

Environmental risks had been assessed and routine checks on the safety of the premises and equipment were carried out. These included gas and electrical safety checks, and checks and services of equipment such as the passenger lift. A Legionella risk assessment was completed which meant that risks associated with Legionella bacteria had been assessed. Water temperatures were regulated and checked regularly, ; including each time people were supported with bathing or showering. Fire safety policies and procedures were in place, including regular checks of fire safety equipment, and training and drills for staff. The registered manager was previously employed as a retained firefighter and therefore had a good knowledge of fire safety requirements. An emergency contingency plan was in place which outlined the action staff should take and the registered manager, who lived locally was on call. An emergency generator was in place and arrangements had been made in the community to evacuate people to a place of safety if required.

The premises were clean and there were infection control policies and procedures in place. Personal protective equipment was in place such as gloves and aprons, to protect staff and people and to prevent the spread of infection. A recent inspection by the contracts monitoring unit had highlighted some areas for improvement such as the creation of a separate dirty utility area and improvements to the laundry including new shelving and flooring. They also found that some bins in use were not foot operated. This work was in progress during the first day of our inspection and was fully completed by the second day. New pedal bins had also been provided. The provider told us they welcomed feedback about any areas that they could improve on and we saw that they had acted promptly to make the necessary improvements.

Individual risks to people had also been assessed. We found that where a person had felt unsafe whilst mobilising they had been referred to a physiotherapist and an appropriate walking aid had been provided. Professional advice had also been sought in relation to risks associated with behaviour distress reactions or specific medical conditions. Allergies were highlighted in red in care files and staff were aware of these when questioned.

We checked the management of medicines and found that there were safe systems in place for the ordering, receipt, storage and administration of medicines. Medicines were stored securely in the treatment room and medicines to be administered on a daily basis were stored in locked cabinets in people's bedrooms. We

checked medicine administration records [MAR's] and found that these were completed appropriately. Staff had received training in the safe administration of medicines and their competency was checked on a regular basis by the registered manager. Training was also provided annually by NHS staff.

We checked the recruitment records of staff and found that safe procedures were followed. Candidates had completed application forms and two references were provided. There were no gaps in employment history and the identity of staff had been verified by the provider. An enhanced Disclosure and Barring [DBS] check was carried out for new staff. The DBS check a list of people who are barred from working with vulnerable people; employers obtain this data to ensure candidates are suitable for the role for which they are employed. This helped to protect the people who used the service from abuse.

We found suitable numbers of staff on duty during our inspection and staff rota's confirmed this. We spoke with a member of staff who told us, "It can be very busy and there are time constraints, but the residents are happy and safe." Another staff member said, "There always seems to be enough staff." People told us they were attended to promptly by staff. One person said, "There is no question that someone will come and respond if I am in trouble."

Good

Is the service effective?

Our findings

People and relatives told us they were very happy with the care they received at Grange Lea Rest Home and a number of people and relatives remarked that the home enjoyed an excellent reputation locally. One person said, "I was sad to leave my own home but this is the best you could get. I wouldn't have gone anywhere else." Another person told us, "You couldn't find a better place, I'm very happy here." A relative told us, "My relative always said they would never move into a home but they said they felt it was the best move they'd ever made. It has been nothing but a wonderful experience."

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS are part of 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 make 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 to do so and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Capacity assessments had been carried out and the registered manager had submitted DoLS applications to the local authority for approval and was awaiting the outcome of these. Where people had capacity, we found that they had signed consent to care and treatment forms which were held in their care records. Postal votes were arranged for people with capacity who wished to vote but were unable to attend the polling station.

People had access to a range of healthcare services; these included a dentist, podiatrist, district nursing service, and GP's. We spoke with a GP who told us that any concerns about people were raised with them promptly. They told us, "It is very good here. Staff are sensible in their approach and will ask if they have any questions. They know the residents well." GP visits were recorded and included noting the reason for the visit and any after care instructions. A specialist nurse who was visiting the service during our inspection told us, "Communication is good here;, there is a diary and communication book." This meant that they felt supported to provide effective care through good communication with staff.

Staff received regular training. Training records confirmed that staff had received training in key areas such as principles of care, safeguarding, whistleblowing, infection control, moving and handling, food hygiene, mental capacity and health and safety. An induction was provided for new staff which included a 13 week probationary period. During this time new staff were informed of relevant policies and procedures, and then completed training deemed mandatory by the provider by the end of their probation. Where there were gaps in training, such as refresher training for safeguarding and the Mental Capacity Act, we found that the provider was aware and that plans were in place to address these gaps. Two staff members had requested more training in caring for people with dementia and were enrolled on an accredited course. We asked whether additional guidance was available to staff around the recognition of delirium, as we had seen that some people could be prone to this condition. Delirium causes a temporary increase in confusion, and is

often caused by physical illness or infections as well as other factors. We had no concerns about the management of the condition and a relative told us, "They are very on the ball with spotting when [name of relative] might be getting an infection." The registered manager told us they had not provided training specifically related to delirium, but by the second day of the inspection they had sourced a delirium resource for staff and planned to go through it at supervision. This demonstrated that the registered manager was proactive in providing additional support and information to staff.

We spoke with staff and records confirmed that they received regular supervision and annual appraisals from the registered manager. This meant that the support and development needs of staff were monitored. One staff member told us, "We get regular supervision, I have just had mine." A volunteer was present during our inspection and we found that appropriate steps had been taken to ensure they were aware of their role and restrictions in what they were able to do within the service. They were supervised and the registered manager told us they were discerning in the volunteers they allowed to work into the service. This was to ensure they fitted well with the people who used the service and displayed the necessary attributes including in their attitude and personality.

People were supported with eating and drinking. Nutritional needs were assessed and where weight loss was noted, we found that professional dietetic advice had been sought. Weights of people were monitored in line with risk, and we spoke with the cook who told us they were aware of how to cater for special dietary needs. They told us, "If people are losing weight I make smoothies to increase calorie intake with cream and yogurt and I know how to fortify main meals." A four week menu cycle was in place and this was regularly reviewed by the provider and head chef in consultation with people who used the service. A list of likes and dislikes was held in the kitchen in addition to a book which contained preferences such as white or brown bread, or bananas with breakfast. Breakfast was served to people in their room. It included porridge, toast, and boiled eggs. The cook told us that people did not routinely ask for a cooked breakfast but that this could be provided if required. The registered manager told us that this meant there was no hurry to go along to the dining room at a certain time in the morning, and that while people were at liberty to choose where they ate, this worked well. People told us they were happy with this arrangement and were encouraged to eat lunch and dinner in the dining area. Afternoon tea was served which included cakes and scones. We joined people for lunch and saw that they were sensitively and discreetly supported by staff. The atmosphere in the dining room was informal and relaxed and people told us they enjoyed the food. One person said, "The food is good and if you don't like anything there is always an alternative, like an omelette or salad." Adaptive cutlery was available if required to support people to maintain their independence.

Good

Is the service caring?

Our findings

People told us they felt well cared for. One person said, "The staff cannot do enough, they are so helpful and nothing is a nuisance."

Relatives commented positively about the atmosphere in the home and the attitude of staff. They told us, "It is more of a home than an institution because it is a house and it has a homely quality. We can pop in at any time." Another relative told us, "They are very attentive to [name of relative]. When they found out they liked to watch birds, they provided a bird table within two days." A GP told us, "It is a nice home; friendly. It feels like a home and people appear settled here." A nurse told us, "It is very friendly, people appear well cared for."

We observed polite and caring interactions between staff, people and relatives during the inspection. People also enjoyed joking with staff. One person told us, "We get on well with staff including the odd job man, the cook and the gardener. They take time to have a bit of banter." The privacy of people was respected. Staff were observed knocking before entering people's bedrooms, and support with care was offered discreetly. Care records were stored in a lockable cabinet to protect the confidentiality of information held about people. We observed that people and relatives were approached by staff on a regular basis and asked if they needed anything.

Regular 'residents' meetings were held which provided people with the opportunity to share their views about the service. Meeting minutes showed that there had been discussions with people about how to spend money which had been donated to the home, and decisions were made about entertainment, trips and which visiting speakers they would like to hear. People were also included in reviews about their care and treatment which gave them the opportunity to be involved in decisions affecting their health and wellbeing.

People were consulted about end of life care, and where appropriate the arrangements they would like to be in place were recorded. We met with the relatives of a person who had recently passed away in the home and they were keen for us to record and report their observations about the quality of the care their family member received at the end of their life. They were very happy with the care their loved one had received and told us, "This is where [relative] wanted to come. They were over the moon when there was a vacancy. I don't think you could fault the care. We had a full weekly update [from the registered manager] and then daily contact towards the end of life. I'm sure the home managed our relative beyond their residential status." This meant that the provider ensured that appropriate care was provided to enable people to remain in the home at the end of their life if this was their wish and it was possible to do so. Another relative praised the thoughtfulness of the provider for holding church services in the home in remembrance of people who had died, particularly for those unable to attend the funeral service. This was described this as, "A thoughtful gesture for those who were close to them and were upset when they died."

There were close links with the local church and regular prayers and communion were held in the home which people could attend if they wished. The registered manager told us they thought it was important that

communion was held on Sundays as this was in keeping with people's practices before moving into residential care.

None of the people living in the home were accessing any form of advocacy at the time of the inspection, but staff knew how to access this service if required. An advocate is someone who represents and acts as the voice for a person, while supporting them to make informed decisions.

Good

Is the service responsive?

Our findings

Pre admission assessments took place before people moved into the home. This meant that care needs were identified before admission so that appropriate care plans were in place. One relative told us that the provider had initially told them they did not feel their relative was ready to move into care when they carried out their first assessment, and the person remained at home until a later date when their care needs increased. They told us that they appreciated the honesty of the provider and that they had been right not to admit the person at that time. Information recorded upon admission to the service included the reason for the admission, medical history, medicines list, names of any specialists involved in the care and treatment of the person, and a list of their preferred health providers such as optician, chiropodist or dentist for example. People and their relatives were asked whether they wished to arrange their own appointments, or whether they wished staff to do so. This meant that the rights of people to remain independent or to enable their family members to remain involved in aspects of their care if they preferred was respected, rather than an assumption being made that the home would automatically take over this role.

Care records were person centred. This meant that people's personality, behaviour, likes, dislikes and previous experiences were taken into account when planning care. Person centred profiles were in place which included information about people's life experiences including what was important to them. People were consulted about their care and we saw that they were supported by relatives if necessary. Care plans were in place to support people with physical and psychological needs, and specialist input was provided to support the development of these plans where required. They were up to date and were evaluated monthly.

Some of the care plans we read which related to psychological needs of people were lacking in explicit detail to ensure that staff were consistent in their approach. This was particularly important where medicine could be administered as required to relieve anxiety. We discussed this with the registered manager, and by the second day of the inspection additional information had been added to the care plans which had been updated and shared with staff. We spoke with a GP who told us that the registered manager and staff responded well to the physical and psychological needs of people and that this was due to the fact that they knew people so well. They told us, "They tend to pick up on psychological changes and emotional needs and seem to manage these well. They know what to suggest to lift a person's mood. They follow instructions well and they make a careful note of information. If something needs to be reviewed in a week to ten days they will have noted it and will be checking even though we will have made our own record. They pay good attention to appointments."

In depth information about the level of support people needed was available including the level of support they needed with personal care and how much they were able to do for themselves. This was important to ensure that staff supported people to remain independent but were available to offer help if required. Information related to specific medical conditions was available to staff to enable them to respond appropriately and to maintain the comfort of people who were unwell. For example, we observed guidance on 'Hydration advice for those with a urinary tract infection' in one person's records.

A range of activities were available and people were encouraged and supported to take part but never

forced. The manager told us, "Our activities are person centred and individualised. We find out as much as we can about people's life history and we find that some people prefer one to one activities. An activities file was available which contained information about activities that had taken place. When church services were held in the home, printed service sheets were provided as they would be in church but were printed with the name of the home for a personal touch. An art class was held monthly and entertainers and speakers also visited the home. Records were kept of activities and how people had responded to them. These records were used to evaluate the success of activities and to ensure fairness and equity in access to activities for all people. The registered manager also told us that they welcomed visitors to join in activities, and this was confirmed by a relative who told us they had enjoyed parties held in the home. People were supported to entertain their guests in a quiet room or bedroom, with staff providing refreshments for them to serve as they would have at home. An accessible garden area was available which was well maintained. Patio furniture was available and one person told us, "We sit outside in the afternoon, we like the fresh air." Bus trips to the beach and countryside had taken place. A number of people had lived in the country, and had enjoyed seeing the lambs in spring.

A complaints procedure was in place and people and relatives told us they knew how to complain if they needed to. One person said, "I would speak to [names of provider]. They are exceptionally helpful, nothing is too much trouble." A relative told us, "We have never had any issues." Another relative said, "The parking isn't great but I can't think of anything else I would change!" The registered manager told us they had not received any formal complaints and that they always tried to resolve any issues immediately. The views of people who used the service were sought and we read surveys that had been completed this year. The responses were all excellent or good and were positive overall.

Good

Is the service well-led?

Our findings

The provider was a husband and wife partnership and they both took an active role in managing the service. One of them was the registered manager. They took a lead role in the management of care, and was supported by two officers in charge who could deputise in their absence. There were clear lines of accountability. A relative told us, "If the manager isn't there [names of officers in charge] are very good. We are always put through to someone who can help us."

The registered manager told us about the ethos of the service which was to provide, "A home from home environment for our residents as well as our relatives, somewhere they can feel safe and protected but also respected. Grange Lea is not only our business; it is our way of life and is very personal to us."

People, relatives and staff spoke highly of the management of the service. One person said, "I have known the home for a long time and used to visit often, it has always been well managed and people have always been well looked after, I had no hesitation in coming to stay here." Comments from relatives included, "The manager knows everything that is going on", "The manager is very patient and diplomatic" and "The manager works on the floor so knows people well." A staff member told us, "There is structure and routine here, it seems organised."

A number of quality checks and audits were carried out. These included checks of the safety of the premises, and care and recruitment records were regularly audited. The registered manager had recognised that the auditing and monitoring the quality of the service was a significant task, and had appointed a consultant to support with this on a regular basis. The consultant had a background in care home management and social care and visited the service unannounced to carry out audits and checks on behalf of the provider. A new audit tool had been developed and we saw that a report was provided following external monitoring visits with recommended action where required. The registered manager told us that they had recognised that there was a risk of becoming isolated due to the small size of the service and that the use of an external auditor helped to ensure they remained up to date with current best practice.

The views of people and relatives were obtained via satisfaction surveys and meetings. Staff satisfaction surveys were carried out annually but staff told us they did not have regular meetings and that they would find this beneficial. We spoke with the provider about this who said it had been difficult to facilitate meetings with groups of staff as a number of them worked part time, and they were reluctant to bring people in on their days off. They explained that they saw staff regularly and they were a small service and worked closely with them, but they would arrange staff meetings in future. We spoke with staff who said they felt well supported and would go to either provider if they needed anything.