Voyage 1 Limited

The Grange, Liss

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?	**Inadequate**

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service
The Grange, Liss is a care home, providing personal and nursing care to 14 people at the time of the inspection. The service can support up to 15 people.

People's experience of using this service and what we found

Right Support:
People were not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. We saw records describing incidents of restrictive practice that had not been identified as a concern and we observed staff encourage people back into communal areas when they attempted to move around the home. However, we also saw some staff supporting people to make choices, for example with their meals.

Right Care:
Care was not always person-centred and did not always promote people's dignity, privacy and human rights. The environment was poorly maintained, dull and was not homely. We saw care was sometimes provided in line with staff needs, instead of people's needs and preferences. Quality of care people received was inconsistent and dependant on individual staff members. We observed multiple poor and undignified interactions between people and staff. However, we also saw some kind and caring interactions.

Right Culture:
The ethos, values, attitudes, and behaviours of care staff did not always ensure people could lead confident, inclusive and empowered lives. The provider had not identified a period of particularly poor culture and atmosphere in the home that had been ongoing for many months. Staff statements from records indicated this had a negative impact on people. We saw no evidence the provider took sufficient action to address the culture in the home following this. However, the new manager demonstrated clear person-centred values and a commitment to improve the culture in the home. We also observed some very positive and caring interactions between some staff and people.

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

Rating at last inspection

The last rating for this service was good (28 February 2019).

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

We received concerns in relation to management of choking risks and robust management oversight. 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, Liss on our website at www.cqc.org.uk.

Enforcement and Recommendations
We have made recommendations about the administration of medicines prescribed 'when required' and falls management.

We have identified breaches in relation to safeguarding, person-centred care, governance, the environment, dignity and respect, and notification of incidents at this inspection.

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

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

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will 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?

Inadequate

The service was not well-led. Details are in our well-led findings below.

The Grange, Liss

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.

Inspection team
The inspection was carried out by 2 inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
The Grange, Liss 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, Liss 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 was not a registered manager in post. A new manager had recently started and had submitted an application to register. We are currently assessing this application.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we received about the service since the last inspection. We used the information

the provider sent us in the provider information return. This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 1 person and 2 people's relatives. We received written feedback from 5 relatives. We spent time observing care and support. We spoke with 4 members of staff, including the manager, a nurse and 2 care staff. We sent questionnaires to 12 other members of staff, but only received 1 response. We looked at a range of records, including care and medicines records, staff recruitment files, health and safety records and the provider's policies and procedures.

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 good. At this inspection the rating has changed to 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.

Systems and processes to safeguard people from the risk of abuse

● People were not always protected from the risk of abuse and improper treatment. The provider had a safeguarding policy and procedure, but this was not always followed. We saw multiple incidents not identified or reported as potential safeguarding concerns. For example, an incident where a staff member had prevented someone from leaving their bedroom by standing in front of their door, and unexplained bruising. We asked the manager to submit notifications for these incidents and raised our concerns with the local safeguarding authority.

● The provider did not always take sufficient action to safeguard people following allegations of abuse. For example, when multiple allegations were made against a staff member, they were still permitted to work with 1 of the people the allegations were about, exposing them to a risk of harm. In this time, further allegations of verbal abuse were made against the staff member.

The failure to safeguard people from abuse and improper treatment was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The manager was responsive when we raised concerns and made referrals to the local safeguarding authority as requested. People's relatives told us they did not have any concerns about their relatives' safety.

Assessing risk, safety monitoring and management

● The provider did not have an effective protocol for staff to follow in the event of people having a fall. The manager and a nurse could not describe or locate the provider's falls protocol. The inspection team were able to find this on the provider's electronic system, but staff were not aware of it. In addition, it did not include adequate instruction on post falls monitoring. This meant staff may not complete sufficient observations to be able to identify deterioration in a person's condition a timely way, exposing them to a risk of harm.

We recommend the provider reviews their falls policy and consults best practice guidance on post falls protocols.

● Risks to people were not always assessed and reduced. When people were assessed as posing a risk to themselves or others they were not always supported safely, or in a way that minimised restrictions on their

freedom, choice, and control. When people were at risk of skin breakdown, some mitigation was in place but there was no evidence of daily skin checks being completed to ensure skin integrity was closely monitored.
● When people were at risk of choking, we saw people assessed by Speech and Language Therapy (SALT) were provided with the recommended texture diet. However, some screening tools completed by the provider had not been completed accurately and reflected higher levels of risk than assessed by SALT. This meant people who may not have required a modified texture diet had less choices available to them.
● Other risks to people were assessed and we saw records reflecting people were supported in line with these risk assessments. For example, constipation and epilepsy.

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 appropriate legal authorisations were in place, or applied for, to deprive a person of their liberty.

Staffing and recruitment
● Staff recruitment files did not always contain all information in line with legal requirements. Although we saw confirmation of Disclosure and Barring Service (DBS) checks, the provider was not able to evidence the required level of check had been completed. DBS checks provide information including details about convictions and cautions held on the Police National Computer. In addition, the provider was not always able to demonstrate how they assessed whether applicants were of good character. We raised this with the manager who took action to address this. All other required checks were completed.
● Rotas showed some staff were working very high hours, such as frequently working 72-hour weeks, including night staff. Although staff had chosen to work these hours, we were not assured the provider had considered potential impact on staff practice. We identified concerns about the practice of 1 staff member who was working excessive hours.
● People's relatives told us they felt there was enough staff to support people safely. A relative told us, "They have good knowledge and know what my relative's needs are".

Using medicines safely
● When medicines were prescribed 'when required' (PRN), person-centred protocols were in place to guide staff on when and how to administer them safely. However, staff did not consistently record when, or why, they had administered them. For example, 1 person's medicines administration record (MAR) showed staff administered a medicine prescribed for agitation and distress 12 times between 14 July 2023 and 19 July 2023. However, staff only recorded the time and reason for administration on 10 of these occasions. This meant we could not be assured the required time between doses to ensure safe administration had been adhered to. In addition, the service was not able to monitor whether the medicine was being administered appropriately.

We recommend the provider reviews best practice regarding the administration and recording of PRN medicines.

● When people were prescribed PRN medicines for pain relief, staff could describe signs they may be in pain if they could not express this verbally.
● Medicines were stored and disposed of in line with relevant legislation, including controlled drugs.
● People's relatives were positive in their feedback about medicines management. For example, 1 relative told us, "We were concerned when [person's medicine prescribed to prevent seizures] was increased it was put too high. The nurses raised it with the GP and got it reviewed straight away".

Preventing and controlling infection
● The provider's infection prevention and control policy was written in line with current guidance and most areas of the home appeared clean. However, we found some areas of the home would have been difficult to effectively clean due to disrepair.
● We observed staff administering medicines did not always follow good hand hygiene practice. Access to the sink was blocked by a clinical waste bin in front of it and we saw items kept on it, making it difficult to access. We saw medicines pots stacked and drying on single paper towels, on a surface that was not visibly clean and had chipped paintwork.
● We observed staff wearing appropriate PPE. A relative told us, "It's always clean and tidy, there's always people cleaning, the wipes are always out."

Visiting in care homes
● The provider did not have restrictions on visiting at the time of the inspection.

Learning lessons when things go wrong
● We found most incidents had not been appropriately investigated in a timely way, with learning outcomes identified or shared. For example, we did not see evidence of any learning taken or applied following identification of multiple concerns staff had not reported.
●However, we saw some evidence of lessons being learned from incidents. For example, the service completed audits focused on risk of choking and aspiration, refreshed all staff training and competencies, and ensured all staff had access to information about modified texture diets and information about aspiration pneumonia.

Inadequate

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 inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● The culture of the service did not reflect the principles of the statutory guidance Right Support, Right Care, Right Culture. People did not consistently receive person-centred care that promoted choice, inclusion, control, and independence.

● We observed practice and saw records demonstrating care was sometimes provided in line with staff needs, instead of people's needs and preferences. For example, we saw staff members direct people back into communal areas, without engaging with them, when they attempted to move around the home. A staff member told us this was because they needed to "keep an eye on them [people]". When we asked a staff member how they knew someone needed support with their incontinence aids, they said, "We just change pads every 4 hours".

The failure to provide person-centred care was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The home was in a poor state of repair, dull and impersonal. For example, there were large scuff marks and pieces out of skirting boards and walls, half-finished maintenance work and furniture was ripped and tatty. We saw an environment review document dated 05 May 2023 identifying 85 issues, but no associated action plans. This indicated a lack of respect for people's home and dignity. On the second day of our inspection, a maintenance worker was in the home to fix a door and had started work on completing the half-finished work around door frames.

The failure to ensure the premises was properly maintained and fit for purpose, in line with statutory guidance, was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We observed multiple incidents of poor, inappropriate and undignified interactions between people and staff. For example, we saw a staff member approach someone in the lounge and loudly ask "Are you wet?". On another occasion we observed them shout across the lounge, in front of multiple people, "Has [person] been done?", referring to supporting them with personal care.

The failure to ensure people were treated with dignity and respect was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Despite the concerns identified, we also saw some very positive interactions and care from some staff members. This demonstrated the quality of care people received was dependant on individual staff members, and not embedded across the whole service or staff team.
● The manager demonstrated person-centred values and addressed poor interactions we raised. They had identified and started work to improve some areas of concern and expressed a commitment to make the improvements required. However, the manager had only been in post for approximately 3 weeks when the inspection started. This meant there had not been enough time to make sufficient change to staff mindset or culture, identify or action all of the concerns we found during the inspection.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care
● The provider had not identified the service was not meeting the requirements of Right Support, Right Care, Right Culture. This meant they had missed opportunities to improve people's care, and exposed people to the risk of harm associated with closed cultures.
● There had been inconsistent oversight and management of the home since the last registered manager left. In addition, there was no clinical lead in post at the time of the inspection. The provider had not implemented robust contingency plans to mitigate any risks associated with the management changes and lack of clinical oversight. The concerns and breaches of regulation found during our inspection demonstrates this had a negative impact on people's care and support.
● When audits were completed, concerns were either not identified, or identified but not actioned in a timely way. For example, an action plan showed they identified on 24 January 2023 staff needed to complete safeguarding and moving and handling training. However, we found this was still not completed at the time of our inspection. Following the inspection, the manager sent evidence this had been completed.
● We saw investigation records showing there was a period of particularly poor culture and atmosphere in the home, which had been ongoing for many months before a concern was investigated. The provider had not identified this, despite interview records showed a minimum of 8 staff members had, or were aware of, concerns. We saw no evidence the provider had taken sufficient action to address the culture in the home following these findings. This meant people continued to be exposed to the risk of harm associated with closed cultures.

Failure to operate effective systems and processes to assess, monitor and improve the service and to monitor and mitigate risks to people's safety and welfare was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider did not ensure CQC were notified of all significant events, in line with regulatory requirements. For example, we found multiple allegations of abuse and potential safeguarding concerns had not been reported. Following the inspection, the manager submitted retrospective notifications.

Failure to notify the CQC was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009

● There was not a registered manager in post. However, the new manager had submitted their application to register. The new manager was open and responsive to feedback throughout the inspection.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● We received some feedback from health and social care professionals that it was sometimes difficult to gain required information from the provider. However, we also saw some evidence of working with other organisations such as external health professionals.

● We saw evidence of surveys sent to staff and relatives for their views and feedback. People's relatives told us, since the new manager started, they felt listened to and any issues raised were acted on.

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

● The provider had a duty of candour policy that reflected the requirements of the regulation, and the manager understood their responsibilities.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider failed to notify the Care Quality Commission of significant events

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's care was not always person-centred

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not always protected from the risk of abuse and improper treatment

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The premises was not properly maintained or fit for purpose, in line with statutory guidance

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Systems and processes were not established and operated effectively to ensure compliance with the regulations

The enforcement action we took:

Issued a warning notice