The Grange Care Centre (Cheltenham) Limited

The Grange Care Centre (Cheltenham)

Inspection report

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Date of inspection visit:
14 May 2017
15 May 2017

Date of publication:
03 July 2017

Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 5 and 6 October 2016. At this inspection we found that people had not always received their medicines as prescribed. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breach. We undertook a focused inspection on the 14 and 15 May 2017 to check that they had followed their plan and to confirm that they now met legal requirements. At this inspection, we also followed up on concerns raised following a HM Coroner's inquest in March 2017 and whistle blowing concerns we received in relation to staffing levels within The Grange Care Centre (Cheltenham). This report only covers our findings in relation to these topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'The Grange Care Centre (Cheltenham)' on our website at www.cqc.org.uk'

The Grange Care Centre (Cheltenham) provides residential and nursing care for up to 60 older people. 58 people were using the service at the time of our inspection. Many of the people living at the home were living with dementia. This was an unannounced inspection.

The home has a registered manager. 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 and associated Regulations about how the service is run.

At our focused inspection on the 14 and 15 May 2017, we found that the provider had followed their plan and the legal requirements in relation to the management of medicines had been met.

People mostly received their medicines as prescribed. Where mistakes in the administration of people's medicines had occurred, nursing and care staff took immediate action to ensure people were safe. The service maintained a clear record of people's prescribed medicine stocks, and following our last inspection had reduced the amount of individual boxed medicines and sought advice from healthcare professionals. People's prescribed medicines were stored securely.

In relation to concerns raised following the HM Coroner's inquest we found people's care needs were not always recorded effectively. Records relating to people's healthcare needs, such as food and fluid and repositioning charts were not always consistently completed. Care plans did not always provide care staff with clear details on how to assist people with their healthcare needs.

There was enough staff deployed to meet people's needs in the main however we raised concerns regarding levels of staffing at certain specific times with the registered manager and provider. We were informed of the immediate action that was being taken to address these concerns. We recommended the provider review

their staffing levels against the dependency of people living at The Grange Care Centre (Cheltenham).

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what actions we told the provider to take at the back of the full version of this report.

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

People received their medicines as prescribed for the most part. Where mistakes in the administration of people's medicines had occurred, care staff took immediate action to ensure people were safe.

People's care needs were not always recorded effectively. Records relating to people's healthcare needs, such as food and fluid and repositioning charts were not always consistently completed. Care plans did not always provide care staff with clear details on how to assist people with their healthcare needs.

In the main there were enough staff deployed to meet people's needs. The provider took immediate action to address some concerns.

The Grange Care Centre (Cheltenham)

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 service was 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.

We undertook a focused inspection of The Grange Care Centre on 14 and 15 May 2017. This inspection was completed to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection 5 and 6 October 2016 had been made. We inspected the service against one of the five questions we ask about services: is the service safe. This is because the service was not meeting legal requirements in relation to that question.

We also checked to see the actions the service had carried out following a Regulation 28 Report to Prevent Future Deaths from HM coroners and reviewed staffing levels following whistleblowing concerns.

Before our inspection we reviewed the information we held about the home, this included the provider's action plan, which set out the action they would take to meet legal requirements.

The inspection was undertaken by an inspector and a specialist advisor and was unannounced. We spoke with four people and two relatives. Additionally we spoke with three nurses, 10 care staff, the deputy manager, the home's administrator and the registered manager. Following the inspection we spoke with the nominated individual for the provider. We reviewed four people's care records. We also reviewed people's medicine administration records and management records regarding staffing at The Grange Care Centre (Cheltenham).

Requires Improvement

Is the service safe?

Our findings

In March 2017, HM Coroners Gloucestershire issued the provider with a Regulation 28 Report to Prevent Future Deaths following an inquest into the death of a former resident. The Coroner's report stated "The Care Centre records documented the presence of the pressure sore appropriately but there was a very substantial absence of documentation recording measures in place to treat the pressure sore and in particular a very substantial absence of turning charts making it impossible for Senior Staff to know if the condition was being treated properly." As a result of this concern we reviewed care documented in relation to people's health care needs.

People's health care needs were not always effectively documented. For example, we reviewed the care plans of three people who had specific healthcare needs which included skin integrity risks and diabetes. We found it was difficult to follow the care and treatment people received as records in relation to people's needs including their food and fluid chart and pressure area care had not been consistently maintained. For example, one person required frequent assistance to reposition, however there was only one record of the assistance they received on the 1 and 2 May 2017. People's ongoing care records, including monitoring charts were held in communal areas rather than in people's rooms, which meant there was a risk care staff might not complete these records accurately and there was a risk records could be seen by others. This concern was discussed with the registered manager who has taken action to ensure people's ongoing records are kept securely and discreetly in their bedrooms.

Pressure sore risk assessments and care plans were not always current and reflective of people's care needs. For example, we found that information in relation to actions nursing and care staff had taken were not always clearly documented. Staff had identified that one person had an 'open wound', however there was no clear information on the actions staff had taken to safeguard the person's health and wellbeing and manage their wound.

People were not always protected from the risks associated with their care. For example, one person was admitted to the home in February 2017 and was assessed as being at high risk of malnutrition and pressure sores. Even though staff had assessed the person was at high risk of malnutrition a referral to the dietician had not been carried out until April 2017. The dietician recommended that staff monitored the person's food and fluid intake for a week and ensured the person was weighed weekly. However, the person's weight chart showed their weight had not been recorded weekly, with the last record completed a month before our inspection. Another person had been assessed at high risk and requiring weekly weight monitoring; however this had not been carried out consistently, even though the person had lost weight since January 2017. This meant care and nursing staff were not following guidance to ensure people's health and wellbeing needs were being maintained.

The support people received to maintain their health needs was not always effectively recorded and therefore there was a risk the appropriate care and support would not be provided. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection in October 2016 we found people did not always receive their medicines as prescribed. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued the service with a requirement notice regarding the relevant breach. At this inspection we found action had been taken and the service had now met this regulation.

People mainly received their medicines as prescribed. We counted 15 people's prescribed medicine stocks and found most people received their medicines as prescribed. However, one person had not received their medicines as prescribed. The service had taken immediate action once they had identified this concern to ensure no harm had come to the person.

Nursing and care staff kept an accurate record of when they had assisted people with their prescribed medicines. For example, care staff signed to say when they had administered people's prescribed medicines and kept a record of prescribed medicine stocks and when they had opened people's prescribed medicines. Where gaps in recording of people's administered medicines had been identified by staff, appropriate action had been taken to ensure people had received their medicines as prescribed.

People's medicines were stored securely. Nursing staff had recorded the temperature of the room where the medicines were stored in, and also recorded the temperature of the medicines fridge.

People were supported in a calm and patient manner with their prescribed medicines. For example, we observed one nurse assisting two people with their prescribed medicines. The nurse explained to the people what their medicines were for and gave people time to take their medicines and provided them with a drink. The nurse ensured people had taken their prescribed medicines before signing to say they had been administered.

Staff raised concerns in relation to fire safety. One member of care staff stated they were concerned about the actions they would take in the event of a fire alarm during nights. They informed us they had received some training regarding fire safety, however had not received practical training. The deputy manager was aware of this concern and fire safety training was being planned. Additionally the registered manager and deputy manager were planning to ensure night drills were being carried out to ensure all staff understood their responsibilities in relation to fire safety.

Care staff working during the day were generally positive about staffing levels and felt there was enough skilled staff deployed to meet people's needs. Comments included: "We have four of us on today, it's enough, we meet people's needs"; "We have enough time to do what we need to do"; "We have two staff on (this unit), two is fine. This is a nice unit, it's quiet, staff like to work on this unit" and "Generally we have enough staff to meet people's needs. Sickness can cause a problem." Call bells were answered quickly and we observed that care staff had time to spend with people. We observed care and nursing staff respond to an emergency bell promptly. Staff then ensured the person was safe.

However, some staff raised concerns about the staffing on the home's Berkeley unit, which provides support to people living with dementia. Staff told us people on this unit can be anxious and can exhibit behaviours which may challenge others. Care staff told us generally the staffing levels was safe, however they felt there was occasions where three care staff were left to assist 20 people (which included the afternoon of the 15 May 2017). Care staff told us 14 people required two members of staff to assist them with their personal care, which meant some afternoon's only one member of staff was available to assist people who could become anxious. Additionally, nurses, activity co-ordinators and members of the management were available to assist people.

Concerns were raised with the inspection team in relation to the staffing levels form the night staff. Comments included: "One unit can be left unattended for times, up to an hour. A few people get up and need assistance, they can be at risk"; "We're constantly under pressure. My main concern is people who walk, they are at risk"; "I try to minimise the impact on people. Sometimes I can't check on them for over an hour" and "Some nights we only have four carers from 20:00 – 22:00, which can cause a problem." Whilst staff had raised concerns regarding night staffing, there was no evidence that this had an impact on the safety of people living at The Grange Care Centre (Cheltenham). However, care staff felt there was a risk that people walking with a purpose may be left unsupervised for long periods of time. Additionally the service had recently updated their fire safety policy which stated six care staff were required in the event of a fire, this amount of staff was not always been deployed at night.

The provider had taken immediate action to address a gap in their determined safe number of staff to meet the needs of residents. Additionally, the registered manager was reviewing their dependency tool to ensure the safe number of staff required to meet people's needs at night had been identified. The registered manager had arranged to meet all night staff to discuss their concerns and was planning to carry out night spot checks to ensure people's needs would continue to be met.
We recommend the provider should seek best practice guidance in relation to the deployment of suitable and trained care staff within the service.

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 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The support people received to maintain their health needs was not always effectively recorded and therefore there was a risk the appropriate care and support would not be provided. Regulation 12 (1)(2)(a)(b).

The enforcement action we took:

We issued the provider and registered manager with a warning notice in relation to regulation 12(1)(2)(a). This notice is to be complied with by 31 July 2017.